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How Schools Can Help Students Recover from Traumatic Experiences

A Tool-Kit for Supporting Long-term Recovery

LISA H. JAYCOX, LINDSEY K. MORSE,
TERRI TANIELIAN, BRADLEY D. STEIN

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How Schools Can Help Students Recover from Traumatic Experiences: A Tool-Kit for Supporting Long-term Recovery

Lisa H. Jaycox

Lindsey K. Morse

Terri Tanielian

Bradley D. Stein

RAND Corporation

1200 South Hayes Street

Arlington, Virgina 22202

Please direct all correspondence to Lisa Jaycox (703-413-1100, x5118 or jaycox@rand.org)

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SECTION 1: INTRODUCTION

What is a "trauma"?

Traumatic events are thought to be those extremely stressful events in a person's life in which there is a threat of injury or death, and the person exposed to it feels terrified, horrified, or helpless. There are a large number of potentially traumatic events, these might include:

- Natural disasters
- Sudden or violent death of a loved one
- Witnessing violence in the home, at school, or in the community
- Physical or sexual assault
- Child abuse (emotional, physical or sexual abuse)
- Medical trauma (a sudden illness or medical procedure)
- Refugee or war zone experiences
- Terrorism experiences
- Complex trauma (exposure to multiple or prolonged traumatic events as a child)

Many people have experienced more than one of these types of traumatic events in their lifetimes. For instance, many hurricane survivors may have experienced other forms of traumatic events prior to the hurricane. Generally the event that bothers a person the most, even if it happened a long time ago, is what is focused on in mental health programs.

What are the consequences of trauma that schools can expect to see in students?

Reactions to trauma vary, but usually include both anxiety and nervousness, and sadness or depression. Alternatively, some students act out more in school, with peers, and at home. Some of these consequences directly interfere with school performance.

For instance, research has shown that violence exposure leads to:

- Decreased IQ and reading ability (Delaney-Black et al., 2003)
- Lower grade-point average (Hurt et al., 2001)
- More days of school absence (Hurt et al., 2001)
- Decreased rates of high school graduation (Grogger, 1997)
- Significant deficits in attention, abstract reasoning, long term memory for verbal information, decreased IQ, and decreased reading ability (Beers & DeBellis, 2002)

The reason for these changes in student performance and behavior stems from the emotional and behavioral problems that people experience following trauma. For instance, classroom performance can decline because of an inability to concentrate, having flashbacks or being preoccupied with the trauma, and wanting to avoid school or other places that might remind students of the trauma. In addition, school performance and functioning can be affected by the development of other behavioral and emotional problems, including substance abuse, aggression, and depression**.**

The way students show their distress can vary by age. For instance, preschool students sometimes act younger than they did before the trauma, and often re-enact the traumatic event in their imagination play. They may have more temper tantrums, or talk less and withdraw from activities.

Elementary students often complain about physical problems, like stomach aches and headaches. They too might show heightened anger and irritability, and may do worse on their assignments, miss school more often, and have trouble concentrating. Some may become more talkative, and talk or ask questions excessively about the traumatic event.

Middle and high school students may be absent from school more often, and may engage in more problem behaviors (substance abuse, fighting, reckless behavior). School performance may decline, and interpersonal relationships can be more difficult.

Why should schools be thinking about mental health programs for students?

Even though there are good mental health resources available in most communities, many of those children in need of such services never actually access them. Thus, schools become the "de facto" mental health system for many children, since schools make it their business to help students with emotional and behavioral difficulties that interfere with learning. School mental health programs are particularly well suited to overcome barriers faced by many disadvantaged children, since issues like transportation and health insurance are less important. In addition, schools play a central role in most communities, a place where community members come together to discuss important issues. In many communities, the school is a trusted institution and resource.

Over the last few decades, there has been dramatic growth in mental health programs in schools. For instance, many special education students have mental health interventions written into their Individualized Education Programs, schools have launched school-based health clinics that incorporate mental health programs, community mental health providers are sometimes co-located in schools, and expanded school mental health programs have been developed to pull together local resources for students.

The emphasis on mental health in the schools is seen as important by many, and is likely to continue. For instance, the Surgeon General's National Action Agenda for Children's Mental Health and President's New Freedom Commission both call for increases in school mental health programs.

How can schools help students immediately after a traumatic event?

In the immediate aftermath of a traumatic event, the focus is on stabilizing and supporting students and their families. One promising model for this phase of early recovery is called Psychological First Aid. Extensive materials are available at: http://www.nctsnet.org/nccts/nav.do?pid=typ_terr_resources_pfa.

Other resources include:

Responding to Hurricane Katrina: Understanding Reactions of Children and Youth.
http://www.nasponline.org/NEAT/katrina.html

Responding to Hurricane Katrina: Information for Schools
http://www.nasponline.org/NEAT/katrina.html

Responding to Hurricane Katrina: Helping Students Relocate and Supporting their Mental Health Needs
http://www.nasponline.org/NEAT/katrina.html

Responding to Hurricane Katrina: Helping Students Children Cope
http://www.nasponline.org/NEAT/katrina.html

After the Storm: A guide to help children cope with the psychological effects of a hurricane. Dr. Annette M. La Greca (UMiami) and 7-Dippity, Inc.
http://www.7-dippity.com/other/After_The_Storm_(Special_Edition_2005).pdf

Rebuilding Louisiana through Education: Creating and Maintaining Healthful Psychosocial Environments in the Aftermath of Disasters. Louisiana Department of Education.
http://www.doe.state.la.us/lde/uploads/8043.pdf

When the Hurricane Blew. Hurricane Kids Network.
http://www.hurricanekidsnetwork.org/

What can schools do to help support the long-term recovery of traumatized students?

Fortunately, there are a number of programs that have been developed to help children deal with traumatic events, and some of these have been developed specifically for use in schools. Most of them attempt to both reduce emotional and behavioral problems related to trauma exposure, and to foster resilience in students for the future. The rest of this tool-kit is devoted to describing these programs and how to find resources to fund the implementation of such programs in your school.

How were programs selected for this tool-kit?

The development of this tool-kit and selection of programs was guided by important groundwork from the National Child Traumatic Stress Network, which is funded by the Substance Abuse Mental Health Services Administration (SAMHSA). This network has identified programs and examined the evidence-base for their use, the work is summarized at:

http://www.nctsnet.org/nctsn_assets/pdfs/promising_practices/NCTSN_E-STable_21705.pdf.

In this toolkit, we include programs from their list that have been developed for or used in schools. In addition, we asked national experts and program developers for nominations of programs. While we aimed to be inclusive of programs documented in the Fall of 2005, it is possible that we may have missed some programs that are in development.

We did exclude certain types of programs. They include programs for young children (before school age), programs that are not specifically oriented to trauma, programs developed outside the United States, and programs designed for immediate crisis intervention or psychological first aid rather than the longer-term recovery from trauma.

How is this tool-kit used?

We have divided the description of programs into two sections, and grouped the programs within each by the type of trauma that they address. We suggest that you use the tool-kit in the following way:

1. Begin by selecting a type of trauma that you want the program to focus on. The **tables in Section 3** comparing programs are organized by type of trauma: non-specific (any trauma), disaster, traumatic loss / death of loved one, exposure to violence, and complex trauma (exposure to multiple or prolonged traumatic events as a child, particularly those in which a caregiver abuses the child). Programs focusing on any of these problems may be applicable to survivors of Hurricane Katrina, depending on the type of exposure they had, and whether or not they were exposed to other traumas in their lifetimes.
2. Look at the various programs for the characteristics that best meet your needs and resources. For instance, consider the staff you have already in your schools, and whether they would be qualified to be trained to run each program.
3. Look up the **program description in Section 4** for programs that seem to match your needs and resources, and learn more about their characteristics, history, and present use.
4. Contact the developers of programs that seem right for you to talk to them directly about options in your community. All of the program contacts listed here have agreed to be listed and will be prepared for your call.
5. Consider **funding options in Section 5** that would help to support the program that best meets your needs.

References

Beers, S., & DeBellis, M. (2002). Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. American Journal of Psychiatry, 159, 483-486.

Delaney-Black, V., Covington, C., Ondersma, S. J., Nordstrom-Klee, B., Templin, T., Ager, J., & Sokol, R. J. (2003). Violence exposure, trauma, and IQ and/or reading deficits among urban children. Journal of the American Academy of Child & Adolescent Psychiatry, 42(1), 48.

Hurt, H., Malmud, E., Brodsky, N. L., & Giannetta, J. (2001). Exposure to violence: Psychological and academic correlates in child witnesses. Archives of pediatrics & adolescent medicine, 155, 1351 (1356 pages).

Grogger, J., (1997). Local violence and educational attainment. The Journal of Human Resources, 659-682.

SECTION 2: HOW TO SELECT STUDENTS FOR PROGRAMS

There are many different types of programs listed in this toolkit that are designed for students exposed to trauma. Some programs target the entire school population, without selecting students based on their level of need or particular situation. Whereas other programs use some sort of assessment (such as a screening tool) or referral to choose students that might benefit from the programs. There are several possible ways to select students:

1) Counselor or teacher referral. School counselors or teachers can be asked to nominate students who are perceived as needing the intervention program. This requires orienting the teachers and counselors to the kinds of problems addressed by the program so that they can make appropriate referrals. Still, counselors and teachers tend to notice the behavior problems more easily than the withdrawn or anxious student, so it may be difficult to identify all the students in need with this method. A brief one-on-one meeting with the student to verify that the program might be appropriate is also recommended.

2) Parent nomination. Schools may also describe the program to parents and ask them to nominate their own children (or give permission for an assessment) if they feel the program might be helpful to the student. The limitation to this method is similar to counselor or teacher referral because parents do not always notice the withdrawn or anxious behaviors as easily as behavioral problems. A brief one-on-one meeting with the student to verify need and interest is recommended in this method as well.

3) Targeted school screening. Students known to have been affected by a traumatic event can be assessed with a screening tool to determine their level of potential need for a trauma-focused program, and those with high scores indicating distress can be invited to participate in the program. Parental permission for such assessment is usually required. Assessments for referral to the programs described in this tool-kit should take place at least a few months (usually about 3 months) post-trauma, since the majority of students are distressed in the immediate

aftermath, but many of these students' symptoms may decrease over time without any intervention.

4) General school screening. Another option is to screen all students in the school (with parental permission). This approach is potentially less stigmatizing, and in some settings, reveals high rates of trauma exposure that are sometimes unknown to parents, teachers, and counselors. For instance, though some students may be affected by a hurricane, others may be affected by exposure to violence in their community, and some will have both types of experiences. Often an one-on-one meeting with each student who discloses high levels of distress is still recommended in order to verify need for the program, but more students may be detected who are in need.

Many of the programs described here have ways of identifying students who may benefit from them. Thus, once a potential program is selected, schools can ask the program developers the best way to identify students in need.

SECTION 3: TABLES COMPARING PROGRAMS

Programs for non-specific (any kind of) trauma

Program	Who is this program for?			What is targeted within the program?	What is the format of the program?	Implementation in schools	Evaluation / Evidence Base	How can this program be implemented?		
	Type of Trauma	Targeted Population & How Selected	Age/Grade Targeted					Materials Available	Training Requirements	Contact Information
Better Todays, Better Tomorrows for Children's Mental Health (B2T2) FORMERLY RED FLAGS IDAHO	Any traumatic life events.	All adult school employees and volunteers, parents, and community groups. No selection.	N/A	Awareness of treatment, stigma, and prevention of traumatic symptoms and mental illnesses.	School employees are instructed on signs and symptoms of trauma and mental illnesses in youth and barriers to treatment at a 1-day training program supplemented by online information and a free in-state telehealth program.	Implemented in the majority of Idaho's public school system and under review for implementation in Oregon.	Surveys of people who have been trained: 70%+ indicated that they felt that the program had improved their knowledge of treatment-seeking information and had reduced stigma of mental health problems in the school environment. Designated as a "promising practice" by the NCTSN.	Informational packet on trauma and mental illnesses, treatments / interventions, and stigma as a barrier (customized to each school's needs). Other information online.	Idaho State has conducted all the programs to date.	Ann Kirkwood (208-562-8646, kirkann@isu.edu) at the Institute o Rural Health, Idaho State Univeristy www.isu.edu/irh/bettertodays
Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)	Any traumatic life events (program usually screens for exposure to community violence, but students focus on any trauma except child sexual abuse in groups).	Students with exposure to trauma and elevated symptoms of PTSD. Students screened via survey and then meet with staff.	Grades 5 through 9.	Reduction of PTSD and depressive symptoms and behavior problems. Provision of peer and parent support and improved coping skills and cognitive skills	10 group sessions (6-10 students) held weekly for 45-60 minutes, 1-3 individual sessions, 2-4 parent and 1 teacher educational sessions.	Implemented extensively within Los Angeles Unified School District (for recent immigrants and general student population). Trainings and implementation are occuring broadly: Maryland, Wisconsin, Illinois, Washington, New Mexico, Montana. Trainings beginning in New Orleans region.	In school settings: Two published studies to date indicating positive impact on PTSD symptoms, depressive symptoms, and parent (but not teacher) reports of behavior problems. Designated "supported and probably efficacious" by the NCTSN.	Manual, screening measures, implementation guide, handouts. Parent materials available in Spanish.	Mental health clinicians: 2-day intensive training. Ongoing consultation and supervision with local CBT expert or developers is recommended.	For training inquiries, Audra Langley UCLA, ALangley@mednet.ucla.edu, 310-825-3131. Other inquiries: Lisa Jaycox, RAND, jaycox@rand.org, 703-413-1100. Manual available at www.sopriswest.com
Community Outreach Program - Esperanza (COPE)	Any traumatic life events (physical abuse, sexual abuse, witness to murder, loss from 9/11, natural disasters).	Students with behavioral and social-emotional problems who have barriers to accessing and remaining in traditional mental health services. Selection by school counselors or teachers.	Ages 4-17.	Reduction of behavioral, social and emotional problems. Improved coping skills. Provision of basic needs	12-20 individual (parent and student) and joint sessions held weekly or biweekly for 45-90 minutes, with case management and outreach.	Implemented extensively in 3 counties in South Carolina and in other schools throughout the US Plans for implementation in NY and San Diego.	In school settings: Not yet evaluated except for case studies but systematic review planned for next year. Uses Trauma-focused CBT and PCIT, both efficacious elements. Combination with intensive case management not yet evaluated. Designated "supported and acceptable" by the NCTSN.	Background reading, treatment manuals, and journal articles. Manuals available in Spanish.	NCVRTC employees and NYC Department of Mental Health mental health clinicians and potentially other mental health clinicians: 1 full day of training, reading, supervision (2-3+ hours of joint and/or individual supervision each week for 6-10 cases).	Michael de Arellano, PhD, Director, COPE (843-792-2945, dearelma@musc.edu) at the National Crime Victims Research and Treatment Center, Medical University of South Carolina in Charleston, SC. www.musc.edu/ncvc
Multimodality Trauma Treatment (MMTT) or Trauma Focused Coping	Single-incident trauma (disaster, exposure to violence, murder, suicide, fire, accidents).	Students with a history of trauma, diagnosis of PTSD, depression, anger, or other sub clinical symtoms. Selection by school counselors or teachers.	Grades 4th through high school.	Reduction of PTSD symptoms, depression, anger and anxiety. Improved grief management and coping.	14 group sessions (6-8) held weekly for 45-60 minutes and 2 individua sessions.	Implemented in several school districts, original testing of the program in North Carolina.	In school settings: 2 published articles and related studies show significant improvements in symptoms following the program. Designated "supported and acceptable" by the NCTSN.	Manual (available free of charge); Organizational Readiness Assessment.	Mental health clinicians with a master's degree or higher: 1-2 days intensive skills-based training, ongoing expert consultation, advanced training if requested for schools that plan long term use and wide-spread dissemination to build capacity for training & supervision.	Ernestine Briggs-King, PhD, Director, Trauma Evaluation and Treatment Program (919-419-3474 ext. 228, Ernestine.Briggs@mc.duke.edu) OR Robert Murphy, PhD, Executive Director (919-419-3474 ext. 291, Robert.Murphy@duke.edu), at the Center for Child and Family Health in Durham, NC www.ccfh.nc.org

Programs for non-specific (any kind of) trauma (continued)

Program	Who is this ro ram for			What is targeted within the program?	What is the format of the program?	Implementation in schools	Evaluation / Evidence Base	How can this ro ram be im lemented		
	Type of Trauma	Targeted Population & How Selected	Age/Grade Targeted					Materials Available	Training Requirements	Contact Information
School Interaction Project (SIP)	Any traumatic life events	Whole classroom. No selection.	Elementary and Middle School; (future plans to expand to high school)	Alleviation of general stress, trauma, and social, emotional, and behavioral problems; improve academic performance and social relationships	Integrated into classroom (8-10 up to 30). Curriculum or activities used biweekly for the school year.	2 Elementary Schools and 2 Middle Schools in Kalamazoo, MI; a 1st-3rd grade self-contained, emotionally impaired classroom, a 5th grade general education class, and an 8th grade resource classroom	Only qualitative information so far from reflective writing and exit interviews that indicate a positive impact	Curriculum	Teachers: 2-day workshop that reviews complex trauma, brain development, integration, problem solving in the classroom, etc., and the SIP curriculum	Mary Blashill (269-387-7025, BlashillM@certauth.cc.wmich.edu) or Ben Atchison (269-387-7073, Ben.Atchison@wmich.edu) at the Southwest Michigan Children's Trauma Assessment Center, University of Western Michigan www.wmich.edu/traumacenter
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	Any traumatic life events (sexual abuse, other interpersonal violence, traumatic grief/loss).	Students with significant behavioral or emotional problems related to traumatic life events (depression, PTSD, anxiety, shame, mistrust). Selection by school counselors or screening tool.	Ages 4-18.	Alleviation of depression, anxiety, shame, mistrust, and other symptoms. Improvement of emotion management, social competence, and family communication.	12-16 sessions: individual (caretaker or student), joint, or group. Sessions held weekly for 60-90 minutes.	Some school-based implementation with adaptations to group format. Some challenges in including caretakers to the same degree that they are included in clinic-based program.	In school settings: Not yet evaluated. In clinical settings: 12 published articles that cover initial findings,1-2 year follow-ups, and randomized controlled trials, focused on treatment of sexually abused children, show reduction in symptoms and superior impact to other treatments. Designated "well supported and efficacious" by the NCTSN.	Fact sheet, program developers' treatment book(s), readiness assessment. Spanish version of program is under development.	Mental health clinicians with master's degree or higher: 1-2 Intensive skills-based training followed by 1-2 days of advanced training, plus ongoing consultation for 6 months. Introductory training available on website (includes 10 CME hours).	Anne Marie Kotlik (akotlik@wpahs.org) at the West Penn Allegheny Health System and the Medical University of South Carolina www.musc.edu/tfcbt
UCLA Trauma/ Grief Program for Adolescents	Moderate to severe trauma, bereavement, accidents, community violence, natural and man-made disasters, war, terrorist events.	Students with anxiety, depression, complicated grief, PTSD, and other symptoms. Students screened via survey and then meet with staff .	Ages 11-18 (adaptable to younger).	Alleviation of antiosocial, aggressive, and risk taking behavior and trauma syptoms. Improvement of emotionial management and coping skills.	16-20 group sessions held weekly and lasting 50 minutes. Also provided in individual, joint, and family format.	Implementation is primary and secondary schools in various states and countries including: five school districts as an on-going trauma/grief program for schools in communities with high levels of community violence; numerous schools across New York City following the World Trade Center attack; secondary schools across post-war Bosnia.	Evaluated in domestic and international school settings, including a large sample of schools in post-war Bosnia. These results indicate significant treatment reductions in PTSD and depression and improvements in academic performance and classroom behaviors. Other pre-post studies of program effectiveness with similar results have been conducted in schools in California. Designated "supported and acceptable" by the NCTSN.	Screening measures, interview protocol, manual, workbook.	Mental Health Clinicians: 2 days of training, ongoing supervision and consultation.	Bill Saltzman (wsaltzman@sbcglobal.net) at the UCLA Trauma Psychiatry Program

Programs for disaster

Program	Who is this program for?			What is targeted within the program?	What is the format of the program?	Implementation in schools	Evaluation / Evidence Base	How can this program be implemented?		
	Type of Trauma	Targeted Population & How Selected	Age/Grade Targeted					Materials Available	Training Requirements	Contact Information
Healing After Trauma (HAT) Skills	Natural or man-made trauma or disaster (developed after 1995 Oklahoma Bombing and altered after 9/11 and Florida hurricanes).	Students who are experiencing anxiety, PTSD, fear, numbing, avoidance, clingy behavior, mood changes, arousal (not for those who lost a loved one). Selection by school counselors or teachers. Screening measure currently in development.	Ages 4-12	Coping skills	12-15 classroom or small group sessions held weekly for 30-90 minutes (can be broken into shorter segments and adaptable to individual or clinical settings).	Implemented in schools in the US and worldwide after the Oklahoma City bombing, 9/11, and hurricanes in Florida.	In progress, only qualitative so far.	Manual available free of charge, by request and online http://www.nctsnet.org/nctsn_assets/pdfs/edu_materials/HATS2ndEdition.pdf	Teachers, mental health professionals, or other professionals with a background in child development who work with children: review and follow manual, may request in-depth training.	Robin H. Gurwitch, Ph.D.(405-271-6824 ext. 45122, robin-gurwitch@ouhsc.edu), at the University of Oklahoma Health Sciences Center and the Terrorism and Disaster Center of the National Child Traumatic Stress Network.
Resiliency and Skills-Building Workshop Series	For schools impacted by disaster (e.g., NY schools after 9/11) and for students with mild psychological distress	Whole school / classroom. No selection	High School	Reduction in acting out behaviors; improvement in anger management and stress reduction skills	5 meetings in Health classroom (25-35 students). Meetings held on consecutive days for 35 minutes.	Currently being implemented in 1 school in Manhatten.	In school settings: 2 years of program evaluation underway not yet complete, but preliminary results indicate reduced anxiety levels and suspension rates.	Manual, Supplemental Materials (Homework, handouts, checklists). A middle school curriculum is in development.	So far only NYU Center employees have conducted programs but hope to eventually train other mental health clinicians.	Elizabeth Mullett (212-263-3682, elizabeth.mullett@med.nyu.edu) of the School-Based Intervention Program at the New York University Child Study Center, New York, NY www.aboutourkids.org
UCLA Trauma/Grief Program ADAPTED Enhanced Services for Post-Hurricane Recovery: An Intervention for Children, Adolescents & Families	Hurricane-related trauma (injury, life threat, witnessing of injury or destruction, injury to loved one, relocation, loss of contact with friends, family hardships).	Students with PTSD and related symptoms and problems with separation anxiety, family conflict, and lack of support. Students screened via survey then meet with staff.	Ages 8-18	Alleviation of anxiety, depression, and other symptoms. Improvement of emotional awareness & expression and coping, problem-solving, and communication skills.	10 individual sessions held weekly for 50 minutes and 1-3 joint sessions.	It is slated for use in various settings, including schools, in Gulf States impacted by recent hurricanes.	No evaluation of this program to date, but see evidence for the original UCLA Trauma/Grief Program listed in the section on any kind of trauma.	Manual, handouts and screening materials. Handouts and screening materials available in Spanish.	Mental Health Clinicians: initial 2-day training with follow-up trainings recommended.	Bill Saltzman (wsaltzman@sbcglobal.net) at the UCLA Trauma Psychiatry Program

Programs for traumatic loss

Program	Who is this program for?			What is targeted within the program?	What is the format of the program?	Implementation in schools	Evaluation / Evidence Base	How can this program be implemented?		
	Type of Trauma	Targeted Population & How Selected	Age/Grade Targeted					Materials Available	Training Requirements	Contact Information
Loss and Bereavement Program for Children and Adolescents (L&BP)	Simple and complicated bereavement.	Students who have lost a parent, caregiver, or other significant family/friend to death. Selection by school counselors.	Age 6-adolescence	4 Tasks of Mourning, conversation about death, alleviation of anxiety, heightened imagery, misconceptions about death, and scary dreams.	12 group sessions held weekly for 60-90 minutes, and 1-2 joint sessions with surviving caretaker and child.	All NYC boroughs.	In school settings: Preliminary reports show improved attendance and student satisfaction.	Contact program for information.	Mental Health Clinicians: contact program for information.	Loss and Bereavement Program Office (212-632-4692) or Dr. Nina Koh, Program Director (212-632-4492 or 212-795-9888) of the Jewish Board of Family and Children's Services in New York, NY (www.jbfcs.org)
Three Dimensional Grief (also known as the School-based Mourning Project)	Loss by death.	Students who have lost a parent, caregiver, or other significant family/friend to death. Selection by school counselors.	All school-age children and youth.	Facilitation of mourning and grief. Improved readiness to engage, emotional literacy, and sense of ego-integrity.	8+ group sessions (6-8) held weekly for 45-90 minutes.	Public, charter, and parochial schools in Washington, DC, 30 schools in past 6 years, currently in 12-15 schools.	In school settings: 3-year pre-post study, ongoing evaluation of past 2 years, 1 published article and 1 book chapter. All describe positive changes after students receive the program.	Manual, references, resource lists.	Mental Health Clinicians: 1-2 day training (1/2 day clinical review, 1/2 day active practicing) with another follow-up day and monthly consultations.	Susan Ley (sley@wendtcenter.org) or Dottie Ward-Wimmer (dottie@wendtcenter.org) at the Wendt Center for Loss and Healing in Washington, DC (202) 624-0010, www.wendtcenter.org

Programs for exposure to violence

Program	Who is this program for?			What is targeted within the program?	What is the format of the program?	Implementation in schools	Evaluation / Evidence Base	How can this program be implemented?		
	Type of Trauma	Targeted Population & How Selected	Age/Grade Targeted					Materials Available	Training Requirements	Contact Information
Safe Harbor Program and Relationship Abuse Prevention Program (RAPP)	All forms of violence, victimization (sexual violence, domestic violence). RAPP focuses on domestic and teen relationship abuse.	Most services (room, workshops, school-wide programs) open to all, counseling restricted to those with exposure to violence and/or acting out, depression. Selection for counseling by school counselors or teachers.	Grades 6th-12th	Allievation of acting out, depression, and other trauma symptoms; improvement of coping skills both for self and for interactions with others, communication skills, and positive self-talk and self-esteem.	11-17 individual or group (6-10) sessions held weekly, duration varies. Workshops in classroom setting also possible.	Safe Harbor is being implemented in several schools in Louisville, KY, Long Beach, CA, Virgin Islands, NYC, and other parts of the US. RAPP is being implemented in 30 schools (including 3 schools that Safe Harbor operates).	Designated "supported and acceptable" by the NCTSN.	PEARLS counseling curriculum and facilitation manual.	Social Workers or Mental Health Clinicians: 6 hours to 3 days depending on trainee skill level.	Christian Burgess (212-629-6298, wburgess@safehorizon.org) at Safe Horizon, New York, NY www.safehorizon.org

Programs for complex trauma

Program	Who is this program for?			What is targeted within the program?	What is the format of the program?	Implementation in schools	Evaluation / Evidence Base	How can this program be implemented?		
	Type of Trauma	Targeted Population & How Selected	Age/Grade Targeted					Materials Available	Training Requirements	Contact Information
Life Skills / Life Story (Formerly known as Skills Training in Affective and Interpersonal Regulation / Narrative Story-Telling (STAIR/NST)	Complex, multiple and/or sustained trauma related to sexual/physical abuse, community violence, domestic violence, or sexual assault.	Female students with a history of abuse/violence and either PTSD symptoms or other trauma-related symptoms such as depression and dissociation. Selection by school counselors.	Ages 12-21	Life Skills - emotional and social competency, emotionial regulation, social skills, positive self-definition, goal setting. Life Story - processing of traumatic event, positive life narrative.	16 group (4-8) or individual sessions held weekly, duration varies.	Has been implemented in residential school settings, afterschool programs, and lunch periods in 9/11 communities in NYC. Currently being implemented as a NCTSN Learning Collaborative in 6 sites including school, outpatient community, outpatient hospital, and inpatient hospital settings.	In school settings: A randomized trial in a residential school setting is ongoing. In clinical settings: Results of a completed study indicate a reduction in PTSD and related symptoms and an improvement in emotion regulation capacities and social skills. A randomized control study of adult women also showed positive results. Designated "supported and acceptable" by the NCTSN.	Manual, worksheets, and treatment materials (all provided at training). Video workbook is in progress.	Employees of the NYU Medical Center (serving as the mental health providers for NYC schools) and other Mental Health Clinicians: 1-day workshop, weekly supervision by phone, and monthly in-person group supervision for the clinician's first case.	Marylene Cloitre, PhD, (212-263-2471, marylene.cloitre@nyumc.org)Director, the Institute for Trauma and Stress at the NYU Child Study Center, New York, NY
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)	Chronic traumatic stress (interpersonal violence, life threatening illness)	Students with a history of trauma along with intrapersonal distress, somatic symptoms, social and behavior problems. Selection by school counselors or via screening tool.	Ages 12-19	Improve emotion regulation, self-perception, coping, and relationships.	22 group sessions (6-10) held weekly or biweekly for about 60 minutes. Individual format under development.	Current pilots in schools in NYC, CA, GA, WI, and NC.	In school settings: Initial Pilot in School for Pregnant Teens showed that physical confrontations decreased and student satisfaction was high. Further evaluation is in progress and expected to be complete at the end of the 05-06 academic year. Designated "supported and acceptable" by the NCTSN.	Manual, session-by session clinician guides, and color activity handouts for group members available upon request. Some handouts are available in Spanish.	Mental Health Clinicians: 2 one-day training sessions (1 before implementation, 1 one month into program) and weekly consultations throughout.	Victor Labruna, PhD (516-562-3245 vlabruna@nshs.edu,) at the North Shore University Hospital, Manhasset, NY
Trauma Adaptive Recovery Group Education and Therapy for Adolescents and Pre-Adolescents (TARGET-A) Model Program	Child physical or sexual abuse, exposure to domestic or community violence, traumatic loss, or high stress and behavioral problems.	Students with trauma symptoms such as anger issues, anxiety problems, or problems controlling their emotions. Various means of selection.	Ages 8-18	Alleviation of depression, anxiety, guilt, and problems with relationship trust; impovement of body self-regulation, memory, interpersonal problem solving, stress management	3-12 group sessions (6-8) by gender held weekly or biweekly, duration varies, or 12 individual and joint sessions, duration also varies.	4 residential school sites in a juvenile detention center setting	In school settings: No evaluations to date. In juvenile justice & community settings: Pilot studies show reduced trauma symptoms. Ongoing pre-post study in a community-based setting and ongoing randomized control study of individual sets with girls with PTSD. Designated "promising and acceptable" by the NCTSN.	Manual for group available. Manual for individual and teaching curriculum in progress and will be available in early 2006. Check website.	Mental Health Clinicians: 12 hours over 1-3 days; supervision and co-leading of 1 group session cycle (5-12 weeks), followed by weekly consultation	Marisol Cruz-St. Juste (860-679-2734, cruz@psychiatry.uchc.edu) at the University of Connecticut Health Center. www.ptsdfreedom.org

SECTION 4: PROGRAM DESCRIPTIONS

Better Todays, Better Tomorrows for Children's Mental Health (B2T2)
(Formerly Red Flags Idaho)

Objective: B2T2 is an education program for school employees and the wider community that provides a general overview of signs and symptoms of trauma and mental illnesses in youth and barriers to treatment. It is intended to raise awareness, encourage early intervention and treatment, and reduce stigma. B2T2 emphasizes all forms of traumatic stress as well as suicide prevention.

Intended Population: This program is appropriate for all types of school faculty and staff, school volunteers, as well as various community groups such as faith-based groups, public safety, scouting, etc. There is also a parent module.

Format: The program consists of a full day, interactive training session, led by employees of the Institute for Rural Health at Idaho State University. The program also offers a telehealth component, which has 50 sites within Idaho and offers programs on supplemental topics such as suicide and depression in school-aged children. Training materials are online and interactive instruction through videoconference is available.

Implementation: B2T2 is currently in place in three quarters of Idaho's public school systems and is under review for use in Oregon. One unique aspects of the program is that it accommodates urban and rural communities. Since its inception in 2000, it has trained approximately 2,367 community caregivers and gatekeepers and 2,629 teens in 66% of Idaho's towns that contain 90% of the state's population. All participants are surveyed 12-18 months after initial training. Survey results indicate that over 70% feel that the program improved their knowledge of treatment-seeking information and reduced stigma of traumatic symptoms and mental health illnesses. 1779 adults reported referring one or more children for mental health care as a result of participating in the program (Kirkwood & Stamm, 2005).

Training: While B2T2 has only been given in Idaho by employees of the Institute for Rural Health at Idaho State University, it is expanding into in other states. Ongoing program evaluation has been conducted over its five-year history in order to improve program quality. The model is recognized as a promising practice by the National Child Traumatic Stress Network and as a best practice model program by *Advances in School Based Mental Health Care: Best Practices & Program Models* (2004). It is currently under review by several other organizations as an evidence-based practice.

Materials: Internet-based informational and training materials, announcements, and available training dates are provided on the website (www.isu.edu/irh/bettertodays).

Funding: The program is funded by the Idaho Governor's Generation of the Child Initiative with additional support from the U.S. Department of Health and Human Services National Institute of Mental Health, Substance Abuse and Mental Health Services Administration Center for Mental Health Services, and the Health Services Resources Administration Office for the Advancement of Telehealth.

For more information: Visit the website (www.isu.edu/irh/bettertodays) or contact Ann Kirkwood (208-562-8646, kirkann@isu.edu) at the Institute for Rural Health at Idaho State University.

Adapted from the National Child Traumatic Stress Network Fact Sheet available at: http://www.nctsnet.org/nctsn_assets/pdfs/materials_for_applicants/BetterTodaysTomorrows_2-11-05.pdf and from B2T2's overview at http://www.isu.edu/irh/bettertodays/overview.htm
Contents verified and modified from phone interviews with developers in December 2005.

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

Objective: CBITS is a skills-based, group intervention that is aimed at relieving symptoms of Post Traumatic Stress Disorder (PTSD), depression, and general anxiety among children exposed to trauma. CBITS uses cognitive-behavioral techniques from which children learn skills in relaxation, challenging upsetting thoughts, social problem solving, and how to process traumatic memories and grief. CBITS relies on the use of drawings and on talking in individual and group settings. Between sessions, children complete assignments and participate in activities that reinforce skills learned and apply them to real life problems. CBITS also includes parent and teacher education sessions.

Intended Population: CBITS is used for children in grades 5-9 (ages 10-15) who have experienced events such as violence, natural or man-made disasters, accidents, house fires, or physical abuse/injury, and who are suffering from moderate to severe levels of PTSD symptoms. Preliminary versions of the CBITS program have been used in children as young as 8 years old. A screening procedure is recommended for use in the general school population to assist in identifying children in need of the program. A brief (less than 5 minute) screening instrument has been developed for this purpose, and should be followed by an individual meeting with a clinician to confirm the screening results. The CBITS intervention has now been effectively implemented with a wide range of racially and ethnically diverse children. Several Network members are currently working to adapt the CBITS intervention for Native American children.

Format: The program consists of ten group sessions (6-8 children/group) of approximately an hour in length, usually conducted once a week in a school setting. It is recommended that someone with clinical mental health training lead the sessions. In addition to the group sessions, participants receive 1-3 individual sessions, usually held before the exposure exercises. CBITS also includes two parent education sessions and one teacher education session. The CBITS intervention has also been delivered in other settings, such as mental health clinics.

Implementation: CBITS is currently being used in the general school population in the Los Angeles Unified School District, where it underwent a randomized controlled study in which children in the CBITS intervention group had significantly greater improvement in PTSD and depressive symptoms compared to those on the waitlist at a three-month follow-up. Parents of children in the CBITS intervention group also reported significantly improved child functioning compared with children in the wait list group. All improvements continued to be seen at a subsequent follow-up at 6 months. Publications on CBITS include five journal articles and one book entry since 2002.

Training: Depending on the level of pre-existing expertise and the availability of an on-site CBT expert, the recommended training of the mental health clinician varies.

Materials: A step-by-step guide to each session, including scripts and examples for use by the group leader, common obstacles and their solutions, and handouts and worksheets for group participants is available. Copies of the treatment manual (CBITS, Jaycox, 2003) in English, only can be ordered from Sopris West Educational Services (800) 547-6747, www.sopriswest.com.

For more information: Contact Audra Langley (ALangley@ucla.edu).

Adapted from the National Child Traumatic Stress Network Fact Sheet available at: http://www.nctsnet.org/nctsn_assets/pdfs/materials_for_applicants/CBITSfactsheet_21105.pdf. Contents verified and modified from phone interviews with developers in December 2005.

Community Outreach Program - Esperanza (COPE)

Objective: COPE is a parent-child intervention that aims to address behavior and social-emotional problems among traumatized children who have been unable to attend traditional school counseling successfully. The program relies on cognitive behavioral therapy to teach coping skills training, affective identification and processing, trauma narrative, and risk reduction. However, it also uses parent-child interactive therapy to improve family interactions and intensive case management and advocacy to find services for family members (e.g. substance-abuse treatment for parents) or to address the family's basic needs.

Intended Population: COPE is used with children ages 4 to 17 who are traditionally underserved, including ethnic minorities and those of low socioeconomic status, who have behavior and social-emotional problems and have barriers to accessing and remaining in traditional mental health treatment. The program can be offered for ongoing or past trauma. COPE has successfully been used with rural and urban children and recent immigrants. It is offered in both Spanish and English.

Format: The program includes individual child and parent sessions and joint sessions, conducted in a combination of school, community, and home settings. It is recommended that someone with clinical mental health training lead the sessions. COPE consists of 12-20 weekly or biweekly sessions, 45-90 minutes in length, with follow-up booster sessions. Outreach and case management are essential components to the program.

Implementation: COPE was developed for use in and by schools but with a focus on parental involvement and the family. COPE has been implemented in over twenty schools in three counties in South Carolina, covering both urban and rural populations, as well as in other schools throughout the U.S. COPE has been ongoing since 1997 and there are plans for future implementation in New York and San Diego, CA. Several case studies have been published on COPE and there is currently ongoing data collection. A systematic review has been funded for next year. Trauma-focused cognitive behavioral therapy and parent-child interaction therapy have been shown to be effective but their combination with intensive care management has not been directly evaluated yet.

Training: Therapists from the National Crime Victims Research and Treatment Center have delivered COPE as have therapists from the Department of Mental Health. Trainees require a full day of training, thorough reading of the treatment manuals and related journal articles, and supervision for 1-3 hours of joint and/or individual sessions each week for 6-10 cases. Ongoing consultation is also provided.

Materials: Materials, in both Spanish and English, are available upon request.

For more information: Contact Dr. Michael de Arellano, Director of COPE (843-792-2945, dearelma@musc.edu) at the National Crime Victims Research and Treatment Center (www.musc.edu/ncvc), Medical University of South Carolina in Charleston, SC.

Adapted from the National Child Traumatic Stress Network Fact Sheet available at: http://www.nctsnet.org/nctsn_assets/pdfs/materials_for_applicants/COPE_2-11-05.pdf. Contents verified and modified from phone interviews with developers in December 2005.

Multimodality Trauma Treatment (MMTT) or Trauma-Focused Coping

Objective: MMTT is a skills-based, peer-mediated group intervention aimed at relieving symptoms of Post Traumatic Stress Disorder (PTSD), depression, anxiety, anger, and external locus of control among children exposed to trauma. It relies on cognitive-behavioral techniques to teach such skills as anxiety and grief management, anger coping, and narrative exposure.

Intended Population: MMTT has been used with students from 4th grade through high school who have experienced events such as being in a disaster or exposure to violence, murder, suicide, or fire. PTSD or subthreshold but prominent symptoms after a traumatic event are criteria for eligibility. The program is not recommended until after one month has passed since the traumatic incident. It is not intended to serve as crisis counseling or psychological first aid but instead focuses on longer term trauma-related symptoms. MMTT can address intrafamilial violence and abuse in individual treatment or clinic-based groups where homogeneity of group membership can be assured and treatment can be adapted to the child's needs.

Format: The program consists of fourteen group sessions (6-8 children/group), held weekly during class time and lasting a minimum of 45-50 minutes but ideally 50-60 minutes. There is also one individual assessment session prior to group work and one individual pull-out session midway through the group sessions. It is recommended that someone with clinical mental health training (a master's degree or higher) deliver the program.

Implementation: MMTT is currently used in several school districts in the U.S. It was initially implemented in two elementary schools and two junior high schools. An NIMH funded experimental controlled study of this initial stage demonstrated robust beneficial effects. Additional studies in two more elementary schools, a high school, and a community based clinic revealed similar results. Publications on MMTT include two journal articles and several unpublished studies. MMTT has also been adapted to other settings, including clinical and residential treatment settings.

Training: Trainees are expected to have a master's degree or higher in clinical mental health training and have a basic understanding of PTSD and related symptoms. Training consists of a readiness assessment for cognitive behavioral therapy and participation in 1-2 days of intensive, skills-based training. Trainees are also expected to read the manual and select articles. Initial training will be following by ongoing expert consultation for 4-6 months. An Organization Readiness Assessment is also required for the school. Advanced training is available for schools that would like to build a capacity for training and supervising MMTT on their own.

Materials: The manual, in English only, is available free of charge.

For more information: To request copies of the manual and for more information on MMTT, please contact either Ernestine Briggs-King, PhD, Director, Trauma Evaluation and Treatment Program (919-419-3474 ext. 228, Ernestine.Briggs@duke.edu) or Robert Murphy, PhD, Executive Director (919-419-3474, Robert.Murphy@duke.edu), at the Center for Child and Family Health in Durham, NC and Duke University Medical Center where they are faculty members along with treatment developers Drs. John March and Lisa Amaya-Jackson.

Adapted from the National Child Traumatic Stress Network Fact Sheet available at: http://www.nctsnet.org/nctsn_assets/pdfs/materials_for_applicants/MMTT_fact_sheet_final.pdf. Contents verified and modified from phone interviews with developers in December 2005.

School Intervention Project (SIP) of the Southwest Michigan Children's Trauma Assessment Center (CTAC)

Objective: SIP is a curriculum-based, self-inclusive model that addresses general stress, trauma, and social, emotional, and behavioral symptomology within classrooms in order to improve the students' academic performance and social relationships.

Intended Population: The program is currently being offered to students in Head Start and elementary and middle schools. The curriculum could be modified for high school students, and the CTAC anticipates working in high schools in the future. SIP has been successfully used with Caucasian and African American students.

Format: SIP consists of a curriculum to be used throughout the school year in the classroom on a biweekly basis. The goal is for classroom teachers to deliver the program.

Implementation: SIP has been implemented in the Kalamazoo Public Schools in Kalamazoo, MI, for the past two years by CTAC staff. CTAC staff delivered the program in two elementary schools and one middle school and have been indirectly involved, through consulting, in one middle school. It is currently being implemented in a 1st, 2nd, and 3rd grade self-contained, emotionally impaired classroom, a 5th grade general education class, and an 8th grade resource classroom. The program has gathered qualitative information through reflective writing and exit interviews, which have been positive with reports of decreased behavioral problems and increased student problem-solving in the self-contained classrooms. Quantitative data has not yet been analyzed.

Training: Training for teachers implementing the curriculum consists of a 2-day workshop that reviews complex trauma and brain development, discusses problem-solving and dysregulation in the classroom, compares the "ideal classroom" to the SIP classroom, etc., and reviews the SIP curriculum.

Materials: The curriculum is available, in English only.

For more information: To request a curriculum or for more information, contact Mary Blashill (269-387-7025, BlashillM@certauth.cc.wmich.edu) or Ben Atchison (269-387-7073, Ben.Atchison@wmich.edu) at the Southwest Michigan Children's Trauma Assessment Center, University of Western Michigan (www.wmich.edu/traumacenter).

Contents obtained from phone interviews with developers in December 2005.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Objective: TF-CBT is a clinic-based individual and group treatment that is aimed at relieving behavioral and emotional problems, depression, anxiety, Post Traumatic Stress Disorder (PTSD), sexualized behaviors, trauma-related shame, and mistrust among children with trauma. It uses an eclectic mix of intervention techniques, including cognitive behavioral therapy, to build and enhance management of thoughts and feelings, interpersonal trust, social competence, parenting skills, and family communication. TF-CBT also includes individual caretaker and joint caretaker-child sessions.

Intended Population: TF-CBT is used with children ages 4 to 18 who have experienced either single or multiple traumatic life events, including sexual abuse, other interpersonal violence, and traumatic grief/loss. A diagnosis of PTSD is not required but the program is aimed at children with significant behavioral or emotional problems related to trauma. The UCLA Reaction Adolescent form can be used for a quick assessment but is not the recommended identification process. This program can be used at any point after a trauma, as long as the current symptoms are related to an index trauma. TF-CBT has been successfully adapted to special populations including Latino and the hearing-impaired and deaf.

Format: TF-CBT can be delivered either as an individual and joint caretaker-child intervention or as a group intervention. Both consist of 12-16 sessions, 60-90 minutes in length, and are recommended to take place weekly, but the frequency can be modified to meet clinical needs. For the individual intervention, TF-CBT offers individual sessions for both caretaker and child. It is recommended that someone with clinical mental health training (master's degree or higher) deliver the TF-CBT program.

Implementation: TF-CBT was developed for the clinical setting and has not been tested in a schools setting. However, there is on-line training now available that school counselors have been using and there are plans for follow-up training of some school-based clinicians who have taken the on-line training. Also, in the near future there will be a study of TF-CBT use by school-based therapists in South Carolina. For the clinical setting, a series of randomized controlled trials have shown TF-CBT to be superior to nondirective play therapy and supportive therapies in children with multiple traumas. TF-CBT has also been shown to improve the symptoms it addresses, its effect on children enhanced by the caretaker component. 12 journal publications have demonstrated positive results, mainly for sexually abused children.

Training: Training consists of an introductory, intensive skills-based training for 1-2 days followed by 1-2 days of advanced training, followed by ongoing consultation for 6 months. Introductory training, with live video, is available at www.musc.edu/tfcbt. Clinicians can log in, complete the training, and receive 10 free Continuing Medical Education credits. During the first month of operation, 100 people finished the online training.

Materials: The program developer's treatment book(s), related materials, and the Readiness Assessment are available. A Spanish version of the program is currently under development.

For more information: Contact Anne Marie Kotlik (akotlik@wpahs.org) at West Penn Allegheny Health System and the Medical University of South Carolina.

Adapted from the National Child Traumatic Stress Network Fact Sheet available at: http://www.nctsnet.org/nctsn_assets/pdfs/materials_for_applicants/TF-CBT_fact_sheet_2-11-05.pdf. Contents verified and modified from phone interviews with developers in December 2005.

UCLA Trauma/Grief Program for Adolescents (Original) and Enhanced Services for Post-Hurricane Recovery: An Intervention for Children, Adolescents & Families (Adaptation)

Objective: The UCLA Trauma/Grief Program is an individual and group intervention that aims to alleviate anxiety, depression, somatic complaints, risk-taking, aggressive and antisocial behaviors, complicated grief, and Post Traumatic Stress Disorder (PTSD) among traumatized or bereaved youth. It does so through cognitive behavior therapy (narrative reconstruction, psychoeducation, cognitive restructuring, developing coping skills and managing activity). This program has been adapted into the Post-Hurricane Recovery Intervention, which aims to relieve specific post-traumatic stress symptoms, generalized and separation anxiety, depression, inappropriate coping responses, and family conflict or lack of support related to the trauma. It does so by increasing emotional awareness and emotion expression and enhancing a variety of other skill areas, such as communication, coping, and problem-solving.

Intended Population: The UCLA Trauma/Grief Program is aimed at youth ages 11-18 who have experienced moderate to severe trauma from such events as bereavement, accidents, community violence, natural and man-made disasters, war, and terrorist events. The Post-Hurricane Recovery Intervention is to be used with youth ages 8-18 who have experienced hurricane-related trauma including personal injury, life threat, witnessing of injury or destruction, or having a loved one threatened or injured, as well as relocation, loss of contact with friends, and family hardships. The program is intended to be used for intermediate or long-term recovery and thus is best used after at least 1-2 months have passed since the trauma. Both programs use a two-step screening protocol administered in classrooms or to individual students.

Format: The UCLA Trauma/Grief Program consists of individual, group, parent, and family sessions. The Post-Hurricane Recovery Intervention consists of 10 individual, 50-minute sessions held once a week plus up to 3 optional joint parent-child sessions and may be adapted to a group setting. It is recommended that someone with clinical mental health training deliver sessions for both programs, whether in school or clinical settings.

Implementation: The UCLA Trauma/Grief Program has been implemented in primary and secondary schools in various states and countries including: 5 different school districts in communities with high levels of community violence; numerous schools in New York City following 9/11; and secondary schools in post-war Bosnia. In the latter site, a randomized controlled study was conducted. Results indicate significant treatment reductions in PTSD and depression and improvements in academic performance and classroom behaviors. Other pre-post studies in schools in California have demonstrated similar results. The Post-Hurricane Recovery Intervention is slated for use in various settings, including schools, in Gulf States impacted by recent hurricanes. Because of its recent introduction, it has not yet been evaluated.

Training: Training for both programs consists of an initial 2-day workshop followed by ongoing supervision and consultation.

Materials: Screening measures, interview protocol, the manual, and the workbook for the UCLA Trauma/Grief program are available. The manual, handouts, and screening materials for the Post-Hurricane Recovery Intervention are also available.

For more information: To request materials and for more information about both programs, please contact Bill Saltzman (wsaltzman@sbcglobal.net), UCLA Trauma Psychiatry Program.

Adapted from the National Child Traumatic Stress Network Fact Sheet available at: http://www.nctsnet.org/nctsn_assets/pdfs/materials_for_applicants/UCLA_Tr_Grief_pgm_for_adol_2-11-05.pdf. Contents verified and modified from phone interviews with developers in December 2005.

Healing After Trauma Skills (HATS)

Objective: HATS is an evidence-informed intervention manual for use with classrooms, groups, or individuals to relieve re-experiencing trauma, anxiety, fear, numbing, avoidance, clingy behavior, mood changes, arousal, and other trauma-related symptoms among children who have experienced a natural or man-made disaster. It relies on the principles of cognitive behavioral therapy to build positive coping skills.

Intended Population: HATS is used with children in kindergarten, elementary, and early middle school (ages 4-12) who have experienced a natural or man-made trauma or disaster. It was originally developed after the 1995 Oklahoma Bombing and was altered after 9/11 and again after the major Florida hurricanes. This program is not for traumatically bereaved children. It is recommended that HATS be used after at least a month has passed since the traumatic event.

Format: The program consists of 12 exercises plus three additional, optional exercises, which last between 30-90 minutes but that can be split into shorter segments. It is recommended that teachers or mental health professions deliver the program. The exercises also include take-home family exercises. HATS was developed for the classroom and group setting but it can be adapted to individual settings and to clinical settings.

Implementation: HATS has been implemented in many schools throughout the U.S. and the world. It has been translated into other languages by people who have requested the manual. Evaluation so far has only been qualitative but more rigorous evaluation is currently in progress.

Training: It is recommended that teachers or mental health professionals facilitate this program. However, it could be used by other professionals with a background in child development who work with children. Other than having professional training and experience, training consists of reviewing and following the manual. In-depth training is also available.

Materials: The manual, in English only, is available free of charge, by request and online at: http://www.nctsnet.org/nctsn_assets/pdfs/edu_materials/HATS2ndEdition.pdf.

For more information: To request the manual or for more information, contact Robin H. Gurwitch, Ph.D. (05-271-6824 ext. 45122, robin-gurwitch@ouhsc.edu) at the University of Oklahoma Health Sciences Center and the Terrorism and Disaster Center of the National Child Traumatic Stress Network.

Contents adapted from the HATS Manual at: http://www.nctsnet.org/nctsn_assets/pdfs/edu_materials/HATS2ndEdition.pdf. Contents verified and modified from phone interviews with developers in December 2005

The Resiliency and Skills Building Workshop Series
By the School-Based Intervention Program (SBIP) at the NYU Child Study Center's Institute for Trauma and Stress

Objective: The Resiliency and Skills Building Workshop Series is a cognitive-behavioral, classroom intervention designed to reduce acting out behaviors, enhance and develop anger management and stress reduction skills, and increase levels of resiliency among students experiencing typical ups and downs of adolescence, as well as those experiencing low to moderate levels of psychological distress after a trauma. The Resiliency and Skills Building workshops are not a substitute for treatment of moderate to severe psychological symptoms. This program is also intended to inform students of the mental health services available at their school and to introduce them to therapists.

Intended Population: This program has been developed for use with high school students.

Format: The five 35-minute sessions are integrated into the health class curriculum and given for five consecutive days in a classroom setting (25-35 students). It is recommended that a team of two professionals, both with clinical mental health training, deliver these sessions. The SBIP is currently developing a curriculum for middle school aged children that consists of eight sessions held biweekly.

Implementation: The School-Based Intervention Program (SBIP) at the NYU Child Study Center's Institute for Trauma and Stress was developed within the first days after the 9/11 attacks, as the Center assisted the New York City Department of Education in its response to the crisis. It has provided an estimated 7,500 children and their families in the NYC downtown public schools a range of mental health services. The Resiliency and Skills Building Workshops were developed by the SBIP as a result of a dramatic increase in suspension rates at Murry Bergtraum High School (MBHS) in Lower Manhattan the year after September 11, 2001. The program was implemented at MBHS two years after September 11, 2001. To date, approximately 2,500 students have received these workshops. The workshops have undergone two years of evaluation. Data for year 1 has shown that the program decreased student anxiety levels and suspension rates. Data for year 2 and for years 1 and 2 combined is currently being prepared for publication.

Training: Currently only employees of the SBIP have implemented the program. However, the program's goal is to train others.

Materials: The manual, Resilience and Skill Building: A Manual to Manage Anger and Increase Interpersonal Skills, and its accompanying packet of Supplemental Materials (Homework, handouts, checklists) are available.

For more information: To request materials or for more information about the SBIP, contact Elizabeth Mullett- Hume (212-263-3682, elizabeth.mullett@med.nyu.edu) at the New York University Child Study Center (www.aboutourkids.org), New York, NY.

Adapted from SBIP's Resilience and Skill Building Manual and program information at: http://www.aboutourkids.org/aboutus/programs/trauma_stress.html#school. Contents verified and modified from phone interviews with developers in December 2005

UCLA Trauma/Grief Enhanced Services for Post-Hurricane Recovery

Please see the UCLA Trauma/Grief Program description in the section of non-specific trauma (page 28).

Loss and Bereavement Program for Children and Adolescents (L&BP)

Objective: The Loss and Bereavement Program is a group intervention program designed to alleviate anxiety, heightened imagery, misconceptions about death, and scary dreams among children who have experienced a permanent loss of a loved one due to death. The program uses an eclectic mix of intervention techniques to help children understand death, discuss and answer questions about death, and follow Dr. J. W. Worden's Four Tasks of Mourning: accept the reality of the loss, experience the pain of grief, adjust to living without the deceased, and emotionally relocate the deceased and move on with life.

Intended Population: The Loss and Bereavement Program is used with children, ages 6 through to adolescence, who have experienced the death of a parent, caregiver, or other significant family member or friend and is experiencing simple or complicated bereavement. School counselors refer students to the program. The Loss and Bereavement Program can be used for recent losses as well as for longer term recovery. The program has been successfully used with inner-city, Hispanic, and African-American populations.

Format: The program consists of 12 group sessions, 60-90 minutes in length, that meet weekly along with 1-2 joint sessions with the surviving parent or caregiver and the child. It is recommended that sessions be led by someone with clinical mental health training.

Implementation: The Loss and Bereavement Program has been implemented in New York City with funds from the NYC Office of Mental Hygiene. Evaluation of the program is limited. Its initial pilot study was done in 1991. There is indication that attendance records improve. Students report that they like the program.

For more Information: Contact the Loss and Bereavement Program office (212-632-4692) or Dr. Nina Koh, Program Director (212-632-4492 or 212-795-9888) of the Jewish Board of Family and Children's Services (www.jbfcs.org).

Three Dimensional Grief (also known as the School-Based Mourning Project)

Objective: Three Dimensional Grief is a group intervention process to facilitate mourning and grief among children who have experienced permanent loss from death. The program uses a mix of approaches and techniques – developmental, psychodynamic, child-centered play therapy, and gestalt – to build children's readiness to engage, emotional literacy, and sense of ego-integrity.

Intended Population: This program is used with all school-age children who have experienced the death of a parent, caregiver, or other significant family member or friend. Children are referred to Three Dimensional Grief by teachers and counselors. The program can be used for recent losses or for longer term recovery.

Format: The program consists of 45-90 minute group sessions (6-8 children/group) held weekly. It is recommended that only someone with clinical mental health training, who has familiarity with grief and group work, lead the sessions. The program is very adaptable, and thus very dependent on the mental health clinician delivering the program. It can be given for eight sessions or can be adapted to last the entire school year.

Implementation: Three Dimensional Grief has been implemented in public, charter, and parochial schools in Washington, DC. It has been used in 30 schools in the past six years and is currently in 12-15 schools. This program has been successfully used with African-American populations and populations of low socio-economic status. There has been a 3-year pre-post study using the Reynolds Anxiety and Draw Persons measurement. Currently, there is ongoing evaluation of the past 2 years. Publications on the program include a journal article and a book chapter.

Training: It is recommended that someone with clinical mental health training who has familiarity with grief and group work deliver this program. Three Dimensional Grief is very reliant on the clinician's skill in using a range of activities as best matches the group's needs and setting. Training consists of 1-2 days, with at least ½ day of clinical review and at least another ½ day of active practicing of the program. Training is followed with another training day and monthly consultations.

Materials: The manual, references, and resource lists, all in English only, are available.

For more Information: Contact Susan Ley (202-624-0010, sley@wendtcenter.org) or Dottie Ward-Wimmer (202-624-0010, dottie@wendtcenter.org) at the Wendt Center for Loss and Healing (www.wendtcenter.org) in Washington, DC.

Content obtained and verified from interviews with the developers in December and from Sklarew et. al. (2002).

The Safe Harbor Program: A School-Based Victim Assistance & Violence Prevention Program

Objective: Safe Harbor is a comprehensive, multifaceted program that addresses violence, victimization, and related trauma. It includes counseling, workshops, school-wide campaigns, peer leadership development, and outreach to parents, staff, and the community. Another key component is a designated room, described in full below, to create a safe environment for the other activities. The counseling component aims to relieve behavioral and/or psychological concerns students may be experiencing: acting out, depression, and other trauma symptoms in students who have had exposure to violence. It teaches communication skills, positive self-talk meant to boost self-esteem, as well as healthy coping skills directed at the self and in interactions with others. Group counseling uses a trauma education/violence prevention curriculum. Workshops are on various violence-prevention topics.

Intended Population: Safe Harbor is used with students in middle school and high school (6th grade to 12th grade). The designated room, workshops, and school-wide campaigns are open to the entire school population. The counseling is restricted to those with exposure to violence, including sexual abuse, domestic violence, bullying and harassment, terrorism, natural disasters, and child abuse. Students are referred to Safe Harbor counseling by teachers or school counselors. This program can be used for recent or ongoing violence and for long term treatment of trauma related to violence in the past.

Format: The Safe Harbor counseling component consists of 11-17 individual or group sessions (6-10 youth/group) held weekly. A key component of the Safe Harbor program is that all counseling and groups take place in a room designated as the "Safe Harbor" in the school. The room should be able to accommodate groups of 10-15 students, and should be decorated as a safe, comfortable, inviting place (sofas, art supplies, colorful posters, books, games, etc.). Workshops can be given to entire classrooms (30 students). It is recommended that someone with clinical mental health training deliver and coordinate the Safe Harbor programs and staff the Safe Harbor room.

Implementation: Safe Harbor has been implemented at the Meyzeek Middle School in Louisville, KY, Long Beach Preparatory in Long Beach, CA, and in New York City in four schools: two in the Bronx, one in Brooklyn and one in Manhattan. Safe Harbor has also been used in other parts of the U.S. and in the Virgin Islands.

Training: Training of social workers or mental health clinicians can take 6 hours to 3 days, depending on the trainee's skills.

Related Program: Safe Horizon also offers another program, very similar to Safe Harbor, with the exception that it is focused on domestic violence and teen relationship abuse. The Relationship Abuse Prevention Program (RAPP) is currently in thirty schools, including three which Safe Horizon operates.

Materials: Although Safe Horizon offers services in many languages and is willing to accommodate any specific requests, written materials regarding the Safe Harbor program have not yet been provided in languages other than English. Thus, both the counseling curriculum and facilitation manual are available in English only.

For more information: To request materials and for more information on Safe Harbor or RAPP, contact Christian Burgess (212-629-6298, wburgess@safehorizon.org) at Safe Horizon, New York, NY (www.safehorizon.org).

Adapted from the National Child Traumatic Stress Network Fact Sheet available at: http://www.nctsnet.org/nctsn_assets/pdfs/materials_for_applicants/Safe_Harbor_Program_2-11-05.pdf. Contents verified and modified from phone interviews with developers in December 2005.

Life Skills/Life Story (Formerly Skills Training in Affective and Interpersonal Regulation / Narrative Story-Telling or STAIR/NST)

Objective: Life Skills/Life Story is a two-module, group or individual intervention to relieve depression, dissociation, and Post Traumatic Stress Disorder (PTSD) for girls who have experienced complex, multiple and/or sustained trauma. Life Skills targets emotional and social competency building, emotional regulation skills, social skill development, positive self-definition, and goal setting. Life Story addresses emotional processing of the traumas and in the context of developing a positive life narrative and future plan.

Intended Population: The program is used with girls ages 12 to 21 who have experienced complex, multiple, and/or sustained trauma related to sexual or physical abuse, community violence, domestic violence, or sexual assault. A PTSD diagnosis is not required but participants should display trauma-related symptoms and have a history of repeated exposure to violence. This program is not a single incident crisis intervention, but rather for recovery from sustained problems in functioning related to chronic symptoms and derailed development resulting from sustained trauma. It can be used for youth who experience an acute trauma and have a history of previous trauma. Life Skills/Life Story has been successfully conducted with ethnically diverse populations, including African-American and Hispanic.

Format: Life Skills and Life Story can both be conducted in either individual or group sessions (4 girls/group with 1 therapist, 6-8 girls/group with 2 therapists). It is recommended that someone with clinical mental health training lead the sessions. Life Skills consists of 10 sessions and Life Story consists of 6 sessions, all held once a week. Each module can be done without the other.

Implementation: Life Skills/Life Story was developed for use in a free-standing community mental health program but has been implemented in a variety of settings, including residential school settings, after school programs, and lunch periods. It is currently being implemented as a NCTSN Learning Collaborative in six sites including school, outpatient community, outpatient hospital, and inpatient hospital settings. A completed study of Life Skills/Life Story indicated that, compared to a no treatment group, high school and middle school girls experienced a reduction in PTSD symptoms, depression, dissociation, and conduct and interpersonal relations, and improvement in emotion regulation capacities and social skills. A randomized trial of the program is ongoing in a residential school setting. Life Skills/Life Story has been shown to have positive results in a completed randomized control study of adult women with histories of sustained childhood trauma.

Training: So far, training for Life Skills/Life Story has been completed with community mental health providers, school psychologists, hospital inpatient and outpatient providers, and psychology and social work trainees. Training includes one day of workshops, weekly supervision by phone, and monthly in-person group supervision for the clinician's first group.

Materials: The manual, worksheets, and treatment materials are provided at training workshops.

For more information: Contact Marylene Cloitre, PhD, Director (212-263-2471, marylene.cloitre@MED.NYU.EDU) at the Institute for Trauma and Stress, The NYU Child Study Center, New York, NY.

Adapted from the National Child Traumatic Stress Network Fact Sheet available at: http://www.nctsnet.org/nctsn_assets/pdfs/materials_for_applicants/STAIRNST_2-11-05.pdf. Contents verified and modified from phone interviews with developers in December 2005.

Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)

Objective: SPARCS is a group intervention that was specifically designed to address the needs of chronically traumatized adolescents who may still be living with ongoing stress. SPARCS focuses primarily on 6 domains of functioning in order to help teens to cope more effectively, make better choices, and cultivate supportive relationships. These domains include problems with emotion regulation and impulsivity, self-perception, relationships, somatization, alterations in attention/consciousness, and struggles with their own purpose and meaning in life. SPARCS is predominantly cognitive-behavioral and draws upon Dialectical Behavior Therapy and two other mental health programs, Trauma Adaptive Recovery Group Education and Therapy (TARGET) and the UCLA Trauma/Grief Program.

Intended Population: SPARCS has been used for adolescents between the ages of 12 and19 who have been exposed to chronic traumatic stress (including interpersonal violence, community violence, life-threatening illness, etc.) A diagnosis of Post Traumatic Stress Disorder is not required. Identification of trauma history and current psychological distress is sufficient to select students; the SPARCS developers recommend using assessments that are sensitive to clinical changes, such as the Youth Outcome Questionnaire Self-Report (YOQ-SR 30.1: www.oqfamily.com).

Format: SPARCS consists of 22 group sessions (6-10 children/group), approximately 1 hour in length, conducted weekly in a school setting. Sessions can be split in half and conducted biweekly to accommodate shorter class periods in a school setting. It is recommended that someone with clinical mental health training deliver this program. The program has found it helpful to collaborate with school personnel, teachers, administrators and other support staff, before and during the treatment to address organizational readiness and facilitate group members' generalization of coping skills introduced in treatment.

Implementation: SPARCS is currently being piloted in schools and outpatient settings in California, Georgia, New York, North Carolina, and Wisconsin. In initial pilots of the intervention participants' scores improved on the Youth Outcome Questionnaire and participants' satisfaction with the group was high. In addition, school administrators noted a dramatic decrease in physical confrontations and fights after the intervention began. Anecdotal reports from other sites have also been positive which include outpatient, day treatment, and resident treatment settings. The interventions and programs upon which SPARCS draws have empirical evidence to support their effectiveness. Further evaluation is currently in progress and evaluation for up to 10 schools should be complete by the end of the 2005-2006 academic year.

Training: Training consists of 2 one-day training sessions (1 prior to program implementation and 1 one month into program) and weekly consultations throughout.

Materials: A training/clinician manual, session-by-session clinician guides, and color activity handouts for group members are available. Some handouts are available in Spanish.

For more information: For more information, contact Victor Labruna, PhD, at the North Shore University Hospital (516-562-3245, vlabruna@nshs.edu).

Adapted from the National Child Traumatic Stress Network Fact Sheet available at: http://www.nctsnet.org/nctsn_assets/pdfs/materials_for_applicants/SPARCS_2-11-05.pdf. Contents verified and modified from phone interviews with developers in December 2005.

Trauma Adaptive Recovery Group Education and Therapy for Adolescents and Pre-Adolescents (TARGET-A)

Objective: TARGET-A is a problem-solving group or individual intervention that is aimed at alleviating depression, anxiety, negative coping, problems with anger, guilt, emotional detachment, and improving trust in relationships among students who have experienced trauma. TARGET teaches practical skills for bodily self-regulation, emotion regulation, autobiographical and working memory, interpersonal problem solving, and stress management through didactic and nonverbal experiential exercises.

Intended Population: TARGET-A has been used with children aged 8 to 18 who have been exposed to physical or sexual abuse, domestic or community violence, disasters or severe accidents, traumatic loss, or who are experiencing high stress and behavioral problems. A diagnosis of PTSD or complex PTSD is not required. Students are identified by trauma symptoms such as anger issues, anxiety problems, or problems controlling their emotions. This program is effective for children who have had either recent or past trauma, and may be useful as a brief or long-term form of treatment.

Format: The program can be done in group sessions (6-8 children/group) separated by gender and age, or as individual sessions (some of which include a parent when this is possible). The group intervention's length ranged from 3-12 sessions and is adaptable to the setting, usually held once or twice weekly. The individual intervention also varies in length but usually is 12 sessions. It is recommended that the group leader or individual therapist conducting TARGET have mental health counseling training. Groups may be co-led by other staff or teachers who need not have mental health training.

Implementation: TARGET-A was developed for students in juvenile justice programs and has been used in Boys & Girls Clubs and outpatient and residential programs and detention centers, including in schools in those settings and is adaptable to other school settings. Currently, there is an ongoing pre-post study of small group (3-7) sessions for boys and girls who have been referred to community-based programs by juvenile justice judges. In addition, a randomized controlled trial has just begun that compares TARGET-A with a different problem-solving therapy conducted one-on-one with girls with PTSD. Other findings with adults, from pilot open trials and a randomized controlled effectiveness study that compared TARGET to an outpatient addiction treatment, show that TARGET is successful in reducing a variety of trauma symptoms.

Training: Training involves a 12-hour introduction (that may be done in 1.5 days or in several briefer sessions), and supervision or co-leading of sessions with a TARGET trainer during a first cycle of sessions (5-12 weeks), followed by weekly consultations.

Materials: The manual for the group setting is available. The manual for the individual intervention is currently in development, with an estimated completion in January. The teaching curriculum will also be available in early 2006. At this time, the materials are only available in English. TARGET-A is also being modified as a version for teachers based on requests from teachers and guidance counselors.

For more information: To access materials and for the latest updates, visit www.ptsdfreedom.org. For questions and requests, contact Marisol Cruz-St. Juste (860-679-2734, cruz@psychiatry.uchc.edu) at the University of Connecticut Health Center.

Adapted from the National Child Traumatic Stress Network Fact Sheet available at: http://www.nctsnet.org/nctsn_assets/pdfs/materials_for_applicants/TARGET_2-11-05.pdf. Contents verified and modified from phone interviews with developers in December 2005.

SECTION 5: FUNDING

How to find funding to support my school's use of these programs

Funding for mental health programs can come from a number of different sources. According to SAMHSA's School Mental Health Services in the United States, 2002–2003, the top sources of funding used by U.S. schools for mental health intervention services are: Individuals with Disabilities Education Act (63% of schools); state special education funds (55%); local funds (49%); state general funds (41%); Medicaid (38%); and Title I of the Elementary and Secondary Education Act of 1965, Improving Academic Achievement of the Disadvantaged (20%). The top sources of funding for mental health prevention services are Title IV Safe and Drug-Free Schools and Communities (57% of schools); local funds (43%) and state general funds (39%).
(**http://www.mentalhealth.samhsa.gov/publications/allpubs/sma05-4068/**)

Here we summarize information as of December, 2005, about funding related to Hurricane Katrina for school mental health activities. We note, however, that this information can change rapidly, and that it will take some investigation to understand which resources might be available in any particular location or school.

1) FEMA / SAMHSA Crisis Counseling Assistance and Training Program (CCP) Grants:

- CCP grants provide funding for counseling outreach and for training local crisis counselors to provide assistance after Federal relief workers leave the area.. Through an interagency agreement with FEMA, SAMHSA monitors the CCP, which FEMA funds. Entities that are eligible to apply are state mental health agencies and tribal authorities.
- Eligible entities may apply for the Immediate Services CCP Grant (provides funding for up to 60 days of counseling services) and/or the Regular Services CCP Grant (provides funding for up to 9 months of counseling services). The application for the Immediate Services CCP Grant is due within 14 days of a Presidential declaration; application for the Regular Services CCP Grant is due within 60 days of a Presidential declaration.

- CCP Grants have supported school mental health programs following other FEMA declared disasters, such as in New York after September 11.
- It may be possible to link with the state agency that applied for these funds in order to implement a mental health program. In order to find out more about how the funding will be spent, you will need to find out who the applicant was in your state (which agency received the funding) and contact them directly.
- As of October 14, 2005, fifteen CCP Grants had been approved: Alabama ($1,564,109); Arkansas ($20,000 initially, further funding pending); Arizona ($187,336); California ($1,003,982); Colorado ($348,333); Florida ($1,461,517); Iowa ($102,000); Indiana ($192,5530); Louisiana ($6,790,608); Massachusetts ($64,000); Maryland ($111,499); Missouri ($542,250); Mississippi ($2,413,498); Nebraska ($46,789); Oklahoma ($365,568); Pennsylvania ($261,270); Rhode Island ($36,910); South Carolina ($378,003); Tennessee ($127,584); Texas ($3 million initially, further funding pending); Washington, D.C. ($47,184); Wisconsin ($110,233); and West Virginia ($45,7910). (CRS Report for Congress http://www.uscongress.com/section/pdf/rs22292.pdf). Other applications were still under consideration at that time, so more may be funded in the near future.

2) SAMHSA Emergency Response Grants:

- These SAMHSA grants fund crisis mental health and substance abuse services and are available when local resources are overwhelmed and other resources are unavailable.
- To date, SAMHSA has provided $600,000 in Emergency Response Grants to Louisiana ($200,000), Texas ($150,000), Mississippi ($150,000) and Alabama ($100,000) (http://www.hhs.gov/katrina/fedpayment.html) to ensure that mental health assessment and crisis counseling are available in areas impacted by Hurricane Katrina.
- Using these funds, states took a variety of actions: Louisiana created a team of behavioral health specialists to provide counseling to disaster workers and first responders; Alabama created a pool of funding to support clinical assessments and immediate direct services; Texas supported existing methadone providers to allow

for services to evacuees in shelters; Mississippi provided emergency support for populations in mental health treatment facilities.

- We are uncertain if any of these funds are currently available to support school mental health services. Contact your state department of health to find out what programs are being funded and if other opportunities exist for you to access these SAMHSA emergency funds.

3) US Department of Education Project SERV:

- This program is designed to support mental health services for students exposed to violent events.
- Following the hurricanes in 2005, Project SERV funds have been awarded to State Educational Authorities in Louisiana, Texas, and Mississippi and are pending in Alabama.

For more information about the status of funding in your state, you can contact the persons listed below:

In Louisiana, you can contact:
Monique Preau [Monique.Preau@LA.GOV] and
Donna Nola-Ganey [Donna.Ganey@LA.GOV]

In Mississippi, you can contact:
Nikisha Ware [mailto:NWare@mde.k12.ms.us]

In Texas, you can contact:
Cory Green [mailto:Cory.Green@tea.state.tx.us]

4) Medicaid:

- Schools with existing arrangements with local community mental health providers, or with a pre-existing mental health unit, can use these providers to bill Medicaid for any clinical mental health services provided to students.
- Although students normally need to be Medicaid-eligible, some locales have relaxed the restrictions in the aftermath of Hurricane Katrina.

5) Private Insurance:

- Some commercial insurance providers may also choose to reimburse school mental health clinicians for clinical services provided after a disaster.

6) Local Foundations and Businesses:

- Some local foundations or businesses have chosen to support mental health services in schools for Katrina victims as their way of supporting the community's recovery after Katrina. Once a program is identified, school officials could approach local funding sources to request support.

7) State Victims of Crime Compensation (VCC) Funds:

- VCC Funds can be used to support a variety of services, including mental health services, for individuals who are experiencing symptoms as the result of an exposure to a crime.
- Though not relevant to all student survivors of Katrina, some students were exposed to crime during or after the hurricane.
- The specific criteria about eligibility and available funds can be obtained from the office in each state.
  For information on your state's Crime Victims Fund and how to apply, go to the National Association of Crime Victim Compensation Boards at http://www.nacvcb.org/. In Louisiana, the Crime Victim Compensation Board is administered by the Louisiana Commission on Law Enforcement. Go to http://www.cole.state.la.us/cvr.htm.

8) Other possible funding mechanisms not listed above include the following:

- Medicaid's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program (http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/)
- State Children's Health Insurance Program (http://www.cms.hhs.gov/home/schip.asp)
- Maternal and Child Health (Title V) Block Grant (https://perfdata.hrsa.gov/mchb/mchreports/Search/core/MchAppContmenu.asp
- Bureau of Primary Health Care Healthy Schools Grant (http://bphc.hrsa.gov/bphc/)
- Substance Abuse Prevention and Treatment (SAPT) Block Grant (http://www.samhsa.gov/Matrix/programs_treatment_SAPT.aspx)
- Centers for Disease Control and Prevention's Healthy Youth Programs and Funding (http://www.cdc.gov/HealthyYouth/funding/index.htm)
- Community Mental Health Services Block Grant (CMHSBG) (http://www.mentalhealth.samhsa.gov/publications/allpubs/KEN95-0022/)
- Healthy Schools, Healthy Communities (http://bphc.hrsa.gov/HSHC/Default.htm)
- Safe Schools/Healthy Student Initiative (http://www.sshs.samhsa.gov/)
- Federal Grants for Mental Health Services (http://www.federalgrantswire.com/mental_health_services_health_federal_grants.html)
- No Child Left Behind (http://www.nasponline.org/pdf/SchoolMentalHealthProvisions.pdf)

References:

http://www.healthinschools.org/mhs4.asp

http://www.astho.org/pubs/ASTHO_Insert_3a.pdf