SAMHSA
Disaster Technical Assistance Center Supplemental Research Bulletin:

Disaster Behavioral Health Interventions Inventory

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Substance Abuse and Mental Health Services Administration
SAMHSA
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This *Supplemental Research Bulletin* is an inventory rather than a review of current research in the field of disaster behavioral health (DBH). The inventory primarily comprises disaster-specific interventions, although several may also be used to assist people who are suffering with distress or disorders associated with other types of traumatic events. The interventions used to support survivors of other types of traumatic events are generally applicable to disaster survivors in the later stages of response activities. Finally, a few of the interventions (those used in the long-term recovery phase of disaster) are applicable only when the survivors have been fully assessed by a licensed or certified professional and determined to have a diagnosable disorder, such as major depression, posttraumatic stress disorder (PTSD), or other anxiety-related disorders.

The immediate and intermediate interventions help achieve two goals of disaster behavioral health:

- Mitigate the development of serious mental disorders.
- Provide tools that support the natural recovery process that occurs with time for the majority of the affected population.

The majority of interventions applied in the acute/immediate and intermediate response phases are appropriate for survivors who continue to function well but may have continuing bothersome symptoms and who have not been formally diagnosed with a mental illness. According to a recent study, the prevalence of PTSD 6 years after a disaster was 11.3 percent, and the current prevalence was 4.2 percent, with onset mainly within 1 month and remission within 3 years post-disaster.[i] Many variables contribute to whether a person will experience PTSD, such as their history of trauma, preexisting mental health condition, socioeconomic status, access to social supports, and other influences. These survivors should be provided with treatment options as soon as their condition has been identified, or as soon as they have been formally assessed by a mental health professional. Formal mental health treatment services are at the far end of the spectrum in terms of DBH.

Most interventions are categorized by the time in which they should be administered after a disaster (early, intermediate, and long term) and can be applied to the majority of survivors who experience the most common reactions. Interventions that are available via Internet, smartphone applications, and other electronic technology are inventoried within their own category. We also use checklists that identify standard aspects of each intervention, including:

- The modality by which they can be delivered (e.g., individual, family, group)
- The settings in which they can be delivered (e.g., in the field, in schools, at the workplace)
- The status of their research base (with a wide spectrum from empirical evidence to unpublished)
- References

We hope this inventory of interventions is helpful to your work in responding to the behavioral health needs of disaster survivors.

Warmest regards,

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[i] Arnberg, F.K., Johannesson, K.B., and Michel, P. (2013). Prevalence and duration of PTSD in survivors 6 years after a natural disaster. *Journal of Anxiety Disorders*, 27(3), 347-352.

Please note: SAMHSA does not officially endorse each intervention; rather this document presents intervention practices commonly used in the field and reported in the science- and evidence-based research literature.

CONTENTS

EARLY INTERVENTIONS

A National Institutes of Health study published in the *International Journal of Emergency Mental Health* in 2005 examined the behavioral health of a sample of New York City residents 2 years after 9/11. The authors recommended that "crisis intervention services should be considered as a first line of emergency management for those potentially affected by large-scale community disasters."[1] Early interventions are typically defined as any form of psychological intervention delivered within the first 4 weeks of a potentially traumatic event.[2] Some early interventions are intended for implementation during the acute phase (within hours or days of a traumatic event), whereas others are initiated 1 to 4 weeks post incident.[3] These interventions are meant to "lend" survivors the strengths needed to decrease their fear responses (thereby calming themselves) and access immediate care and support, allowing them to move to the next stage of recovery.

1. Assessment, Crisis Intervention, and Trauma Treatment (ACT)

Author: Albert R. Roberts

Website: http://btci.edina.clockss.org/cgi/reprint/2/1/1

Brief Description: ACT is a conceptual three-stage framework and intervention model that can be useful in helping mental health professionals provide acute crisis and trauma treatment services. This model may be thought of as a sequential set of assessments and intervention strategies, as it integrates various assessment and triage protocols with the seven-stage crisis intervention model and the 10-step acute traumatic stress management protocol.

Delivery Mode	
☒ Individual	☐ Family (general)
☐ Group	☐ Community
☒ Victim Family	☒ Direct Survivors
☐ Rescue and Recovery Responders	☐ Other Responders
Delivery Setting	
☐ Family Assistance Centers	☒ Field/Community
☐ Private Homes	☐ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☒ Other
Research Base	
☒ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
☐ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☒ Qualitative Research

[1] Boscarino, J.A., Adams, R.E., & Figley, C.R. (2005). A prospective cohort study of the effectiveness of employer-sponsored crisis interventions after a major disaster. *International Journal of Emergency Mental Health*, *7*(1), 9–22.
[2] National Institute of Mental Health. (2002). *Mental health and mass violence. Evidence-based early psychological intervention for victims/survivors of mass violence. A workshop to reach consensus on best practices*. NIH Publication No. 02-5138. Washington, DC: U.S. Government Printing Office.
[3] Bryant, R.A., Harvey, A.G., Dang, S.T., Sackville, T., & Basten, C. (1998). Treatment of acute stress disorder: A comparison of cognitive-behavioral therapy and supportive counseling. *Journal of Consulting and Clinical Psychology, 66*(5), 862–866.

2. Cognitive Behavioral Therapy for Acute Stress Disorder (CBT for ASD)

Author: Richard Bryant, University of New South Wales, Australia

Website: http://www.istss.org/treating-trauma/treatment-materials/cognitive-behavioral-therapy-for-acute-stress-diso.aspx

Brief Description: ASD encompasses posttraumatic stress reactions that are present just after an event until 4 weeks post-trauma. Past studies (Bryant, Sackville, Dang, Moulds, & Guthrie, 1999; Harvey & Bryant, 1998) suggest that up to 80 percent of people with ASD will go on to suffer PTSD within 6 months. This early intervention treatment manual includes descriptions for six sessions of structured CBT, including prolonged exposure. More recent research indicates that people who receive CBT in the initial month after trauma present with less intense PTSD than those who receive supportive counseling (Bryant, Moulds, & Nixon, 2003).

Delivery Mode	
☒ Individual	☐ Family (general)
☐ Group	☒ Community
☒ Victim Family	☒ Direct Survivors
☒ Rescue and Recovery Responders	☒ Other Responders
Delivery Setting	
☐ Family Assistance Centers	☐ Field/Community
☐ Private Homes	☐ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☒ Other: Clinical Setting
Research Base	
☒ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
☐ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

Bryant, R.A., Harvey, A.G., Dang, S.T., Sackville, T., & Basten, C. (1998). Treatment of acute stress disorder: A comparison of cognitive-behavioral therapy and supportive counseling. *Journal of Consulting and Clinical Psychology, 66*(5), 862–866.

Bryant, R.A., Moulds, M.L., & Nixon, R.V.D. (2003). Cognitive behaviour therapy of acute stress disorder: A four-year follow-up. *Behaviour Research and Therapy, 41*(4), 489–494.

Bryant, R.A., Sackville, T., Dang, S.T., Moulds, M., & Guthrie, R. (1999). Treating acute stress disorder: An evaluation of cognitive behavior therapy and supportive counseling techniques. *American Journal of Psychiatry, 156*(11), 1780–1786.

Harvey, A.G., & Bryant, R.A. (1998). The relationship between acute stress disorder and posttraumatic stress disorder: A prospective evaluation of motor vehicle accident survivors. *Journal of Consulting and Clinical Psychology, 66*(3), 507–512. doi: 10.1037/0022-006X.66.3.507

3. Community Emergency Response Teams (CERT)

Authors: The first CERT teams were developed and implemented by the Los Angeles City Fire Department in 1985. The training in this model was made available nationally in 1993 by the Federal Emergency Management Agency (FEMA) at the Emergency Management Institute and the National Fire Academy, who adopted and expanded the CERT materials, believing them to be applicable to all hazards.

Website: http://www.fema.gov/community-emergency-response-teams

Brief Description: The goal of the CERT program is to educate people about disaster preparedness for local hazards and train them in basic disaster response skills, such as fire safety, light search and rescue, team organization, and disaster medical operations. Using the training learned in the classroom and during exercises, CERT members can assist others in their neighborhood or workplace following an event when professional responders are not immediately available to help.

Delivery Mode	
☒ Individual	☒ Family (general)
☒ Group	☒ Community
☒ Victim Family	☒ Direct Survivors
☒ Rescue and Recovery Responders	☒ Other Responders
Delivery Setting	
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☐ Private Homes	☐ Schools (general)
☒ Classrooms	☐ Faith-Based Settings
☒ Responder Agencies	☐ Other
Research Base	
☐ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
☒ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

4. Consultation, Outreach, Debriefing, Education, and Crisis Counseling Disaster Mental Health Service Model (CODE-C DMHSM)

Authors: Diane Myers and David Wee

Website: http://www.psychceu.com/disaster/disaster.asp

Brief Description: CODE-C DMHSM is a comprehensive, integrated, multiservice model that can be used to address the wide range of survivor mental health needs in communities following disasters. CODE-C DMHSM facilitates communication between disaster mental health practitioners, emergency managers, and persons who will receive services by using a standard nomenclature. The tool also helps users understand service components and the differences between disaster mental health services and other more traditional approaches to mental health service delivery.

Delivery Mode	
☒ Individual	☒ Family (general)
☒ Group	☒ Community
☒ Victim Family	☒ Direct Survivors
☒ Rescue and Recovery Responders	☒ Other Responders
Delivery Setting	
☐ Family Assistance Centers	☒ Field/Community
☐ Private Homes	☐ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☐ Other
Research Base	
☐ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
☒ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

5. Crisis Counseling Assistance and Training Program (CCP)

Authors: FEMA and SAMHSA

Website: http://samhsa.gov/dtac/ccp

Brief Description: FEMA implements the CCP as a supplemental disaster assistance program available to the United States and its territories. The mission of the CCP is to assist individuals and communities in recovering from the effects of natural and human-caused disasters through the provision of community-based outreach and psycho-educational services.

Delivery Mode	
☒ Individual	☐ Family (general)
☐ Group	☒ Community
☐ Victim Family	☒ Direct Survivors
☐ Rescue and Recovery Responders	☐ Other Responders
Delivery Setting	
☐ Family Assistance Centers	☒ Field/Community
☐ Private Homes	☐ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☒ Other
Research Base	
☐ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
☒ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

Boscarino, J.A., Adams, R.E., & Figley, C.R. (2005). A prospective cohort study of the effectiveness of employer-sponsored crisis interventions after a major disaster. *International Journal of Emergency Mental Health*, *7*(1), 9–22.

6. Critical Incident Stress Debriefing (CISD)

Author: Jeffrey T. Mitchell

Website: http://www.info-trauma.org/flash/media-e/mitchellCriticalIncidentStressDebriefing.pdf

Brief Description: CISD is a 7-phase, small group, crisis intervention process. It is one of the crisis intervention techniques that fall under the umbrella of Critical Incident Stress Management. The process was developed exclusively for small, homogeneous emergency incident responder groups who have encountered a powerful traumatic event, with the goals of reducing distress and restoring group cohesion.

Delivery Mode	
☐ Individual	☐ Family (general)
☒ Group	☒ Community
☐ Victim Family	☐ Direct Survivors
☒ Rescue and Recovery Responders	☒ Other Responders
Delivery Setting	
☐ Family Assistance Centers	☒ Field/Community
☐ Private Homes	☐ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☐ Other
Research Base	
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7. Early Psychological Intervention (EPI)

Authors: Multiple affiliates (e.g., the American Red Cross, Salvation Army, National Organization for Victim Assistance, and the International Critical Incident Stress Foundation)

Website: http://www.nimh.nih.gov/health/publications/massviolence_34410.pdf

Brief Description: EPI refers to a body of psychological interventions designed to mitigate acute distress while not interfering with the natural recovery processes. These interventions typically occur within the first month of a traumatic event, are multicomponent systems, and may involve Psychological First Aid, triage, needs assessments, consultation, crisis intervention, and fostering of resilience and natural supports, as well as psychological and medical treatments.

Delivery Mode	
☒ Individual	☒ Family (general)
☒ Group	☒ Community
☒ Victim Family	☒ Direct Survivors
☒ Rescue and Recovery Responders	☒ Other Responders
Delivery Setting	
☒ Family Assistance Centers	☒ Field/Community
☒ Private Homes	☒ Schools (general)
☒ Classrooms	☒ Faith-Based Settings
☒ Responder Agencies	☐ Other
Research Base	
☐ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
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8. The Families' GOALS Project: Going on After Loss

Author: Mental Health Association New Jersey

Website: http://www.mhanj.org/new-jersey-hope-and-healing-emotional-support-for-those-impacted-by-superstorm-sandy-2/

Brief Description: The Families' GOALs project has a firm theoretical grounding in disaster mental health, grief theory, family systems theory, and resiliency work and is designed to provide a series of psycho-educational support groups for families that have experienced a traumatic loss event. The structured curriculum is detailed for groups from pre-K through high school, as well as adults and families, with clear, specific instructions for course execution. The project was supported by the New Jersey Department of Human Services Division of Mental Health through funding from SAMHSA and FEMA.

Delivery Mode	
☐ Individual	☒ Family (general)
☒ Group	☐ Community
☒ Victim Family	☒ Direct Survivors
☐ Rescue and Recovery Responders	☐ Other Responders
Delivery Setting	
☐ Family Assistance Centers	☒ Field/Community
☒ Private Homes	☐ Schools (general)
☐ Classrooms	☒ Faith-Based Settings
☐ Responder Agencies	☒ Other
Research Base	
☐ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
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9. Group Crisis Intervention: Public Mental Health Service Delivery Protocols: Group Interventions for Disaster Preparedness and Response

Author: American Group Psychotherapy Association

Website: http://www.agpa.org/home/practice-resources/member-benefit-programs/agpa-at-work-in-the-community/programs-and-services-available

Brief Description: A set of best practice interventions for use in delivering group-based mental health support services following disasters to population-specific survivors and responders, including Uniformed Services personnel (also applicable to the Armed Services), children and families, school communities, adolescents, survivors, witnesses and family members, helpers, and service delivery workers.

Delivery Mode	
☒ Individual (children)	☒ Family (general)
☒ Group (children)	☒ Community
☒ Victim Family	☒ Direct Survivors
☒ Rescue and Recovery Responders	☒ Other Responders
Delivery Setting	
☐ Family Assistance Centers	☒ Field/Community
☐ Private Homes	☐ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☒ Other
Research Base	
☐ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
☒ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

10. Healing After Trauma Skills (HATS)

Authors: Robin H. Gurwitch and Anne K. Messenbaugh

Website: http://www.nctsnet.org/nctsn_assets/pdfs/edu_materials/HATS2ndEdition.pdf

Brief Description: HATS was designed to be facilitated by teachers, psychologists, and other counselors working with kindergarten, elementary, and early middle school children who have experienced a disaster or other traumatic event. The manual provides information about how children are affected by trauma/disaster, as well as tools for enhancing the sharing of experiences, ideas, and thoughts about the trauma/disaster and for building a repertoire of coping skills. Although HATS was developed for use in the classroom or with small groups, it can be amended for use with individual children.

Delivery Mode	
☒ Individual (children)	☐ Family (general)
☒ Group (children)	☐ Community
☐ Victim Family	☒ Direct Survivors
☐ Rescue and Recovery Responders	☐ Other Responders
Delivery Setting	
☐ Family Assistance Centers	☐ Field/Community
☐ Private Homes	☒ Schools (general)
☒ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☐ Other
Research Base	
☐ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
☒ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

11. National Organization for Victim Assistance (NOVA) Crisis Response Team (CRT)

Author: NOVA

Website: https://www.trynova.org/help-crisis-victims/crisis-training/

Brief Description: A CRT is made up of individuals trained to provide trauma mitigation and education in the aftermath of a critical incident, either small-scale or mass-casualty, scaling the response to the need, from one individual to thousands. NOVA CRT training participants have a minimum of 24 hours of skill-based, field-tested training. These teams could be state-based (e.g., out of a state attorney general's office) or local (e.g., a school district). Most teams have extensive training and experience in a wide range of traumatic events, from shootings to natural disasters.

Delivery Mode	
☐ Individual (children)	☐ Family (general)
☒ Group (children)	☒ Community
☐ Victim Family	☒ Direct Survivors
☐ Rescue and Recovery Responders	☐ Other Responders
Delivery Setting	
☐ Family Assistance Centers	☒ Field/Community
☐ Private Homes	☐ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☐ Other
Research Base	
☐ Empirically Supported Treatment (EST)	☒ Evidence-Supported Treatment (EST)
☒ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

12. Operation Solace Program Model

Authors: Former U.S. Army Surgeon General, Lieutenant General James B. Peake (2000–2004)

Website:
http://www.researchgate.net/publication/11095067_Operation_Solace_overview_of_the_mental_health_intervention_following_the_September_11_2001_Pentagon_attack/file/9c960521bf7884bf0d.pdf

Brief Description: The goal of Operation Solace is to reduce the severity and/or chronicity of the stress reactions, grief reactions, other psychiatric morbidity, and unexplained physical symptoms among the "at-risk" population occurring as a result of the September 11, 2001, attack on the Pentagon. The model is a comprehensive behavioral health system that integrates primary, secondary, and tertiary prevention strategies, and preclinical as well as clinical intervention strategies. Although the efficacy of this type of program in preventing psychiatric disorders is not known, the program has received wide support and praise from Pentagon employees and senior military leadership.

Delivery Mode	
☒ Individual	☐ Family (general)
☐ Group	☒ Community
☒ Victim Family	☒ Direct Survivors
☒ Rescue and Recovery Responders	☒ Other Responders
Delivery Setting	
☐ Family Assistance Centers	☒ Field/Community
☐ Private Homes	☐ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☒ Responder Agencies	☒ Other
Research Base	
☐ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
☐ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☒ Qualitative Research

13. Psychological First Aid (PFA)*

Authors: The National Child Traumatic Stress Network and the National Center for PTSD. Development and production of this program model was supported by SAMHSA.

Website: http://www.ptsd.va.gov/professional/materials/manuals/psych-first-aid.asp

Brief Description: PFA is an evidence-informed modular approach for assisting people in the immediate aftermath of disaster and terrorism to reduce initial distress, and to foster short- and long-term adaptive functioning. It can be used in a variety of settings by first responders, incident commanders, primary and emergency health care providers, school crisis response teams, faith-based organizations, disaster relief organizations, CERT programs, the Medical Reserve Corps, and the Citizens Corps.

Delivery Mode	
☒ Individual	☐ Family (general)
☒ Group	☒ Community
☒ Victim Family	☒ Direct Survivors
☐ Rescue and Recovery Responders	☐ Other Responders
Delivery Setting	
☒ Family Assistance Centers	☒ Field/Community
☐ Private Homes	☐ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☒ Other
Research Base	
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*There are currently several adaptations of PFA, most of which are targeted to specific populations, including community religious professionals, Medical Reserve Corps members, and staff at facilities for families and youth who are experiencing homelessness. PFA has also been translated into several languages. Directly below are links to those PFA models which follow the primary structure of PFA, but are tailored to specific populations.

- Psychological First Aid for Schools
- Psychological First Aid Field Operations Guide for Community Religious Professionals
- Psychological First Aid Medical Reserve Corps Field Operations Guide
- Psychological First Aid for Families Experiencing Homelessness
- Psychological First Aid for Youth Experiencing Homelessness

The four PFA models on the following pages include somewhat more expanded content from the original PFA.

14. The PFA RAPID Model

Authors: Johns Hopkins Preparedness and Emergency Response Learning Center

Website: http://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-center-for-public-health-preparedness/training/PFA.html

Brief Description: The PFA RAPID Model is a six-hour, interactive, face-to-face training that provides public health professionals without former mental health education with the concepts and skills associated with PFA. The RAPID model (Reflective Listening, Assessment, Prioritization, Intervention, and Disposition) provides health professionals who volunteer or are asked to respond in times of emergency with information on non-physical injuries and trauma. Additionally, the model is readily applicable to public health settings, the workplace, the military, mass disaster venues, and the demands of more well circumscribed critical incidents (e.g., dealing with the psychological aftermath of accidents, robberies, suicide, homicide, or community violence).

Delivery Mode	
☒ Individual	☒ Family (general)
☒ Group	☐ Community
☒ Victim Family	☒ Direct Survivors
☒ Rescue and Recovery Responders	☒ Other Responders
Delivery Setting	
☒ Family Assistance Centers	☒ Field/Community
☐ Private Homes	☐ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☒ Responder Agencies	☒ Other
Research Base	
☐ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
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15. Nebraska PFA

Authors: Robin Zagurski, Denise Bulling, and Robin Chang

Website:
http://www.nebhands.nebraska.edu/files/psych%20first%20aid%20participant%20guide%2005r.pdf

Brief Description: The purpose of the Nebraska PFA program is to equip disaster response professionals (referred to as "natural helpers") to provide psychological support to survivors of critical events. The training program is segmented into seven modules: Psychological Support, Stress and Coping, Supportive Communication, Promoting Community Self-Help, Populations with Special Needs, Helping the Helper, and De-Escalation.

Delivery Mode	
☒ Individual	☐ Family (general)
☐ Group	☒ Community
☐ Victim Family	☒ Direct Survivors
☐ Rescue and Recovery Responders	☐ Other Responders
Delivery Setting	
☐ Family Assistance Centers	☒ Field/Community
☐ Private Homes	☐ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☒ Other
Research Base	
☐ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
☒ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

16. PFA for Schools

Authors: The National Child Traumatic Stress Network and the National Center for PTSD

Website: http://www.nctsn.org/content/psychological-first-aid-schoolspfa

Brief Description: This manual is written for school staff and provides an evidence-informed approach for assisting children, teens, adults, and families in the aftermath of a school crisis, disaster, or terrorism event. The guide includes handouts and worksheets for adults and children.

Delivery Mode	
☒ Individual	☐ Family (general)
☐ Group	☐ Community
☐ Victim Family	☒ Direct Survivors
☐ Rescue and Recovery Responders	☐ Other Responders
Delivery Setting	
☐ Family Assistance Centers	☐ Field/Community
☐ Private Homes	☒ Schools (general)
☒ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☐ Other
Research Base	
☐ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
☒ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

17. Building Workforce Resilience Through the Practice of Psychological First Aid—A Course for Supervisors and Leaders (PFA-L)

Authors: Office of the Assistant Secretary for Preparedness and Response of the U.S. Department of Health and Human Services, and the National Association of County and City Health Officials

Website:
https://live.blueskybroadcast.com/bsb/client/CL_DEFAULT.asp?Client=354947&PCAT=7365&CAT=9403

Brief Description: PFA-L is a 90-minute online course that uses scenarios and exercises to teach leaders and staff the principles and application of PFA for them to use every day as well as during emergencies. Offered free of charge, the course covers topics including stress reactions during disaster response, core components of PFA, and how to provide PFA as a manager or supervisor. It is designed for leaders in areas including emergency management, public health, and disaster response to help them build and sustain the resilience of their staff.

Delivery Mode	
☒ Individual	☐ Family (general)
☒ Group	☒ Community
☐ Victim Family	☐ Direct Survivors
☒ Rescue and Recovery Responders	☒ Other Responders
Delivery Setting	
☐ Family Assistance Centers	☒ Field/Community
☐ Private Homes	☐ Schools (general)
☐ Classrooms	☒ Faith-Based Settings
☒ Responder Agencies	☒ Other
Research Base	
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18. PsyStart Rapid Mental Health Triage and Incident Management System

Author: Merritt Schreiber

Website: http://www.cdms.uci.edu/PDF/PsySTART-cdms02142012.pdf

Brief Description: PsySTART, or Psychological Simple Triage and Rapid Treatment, is a strategy for rapid mental health triage and incident management during large-scale disasters and terrorism events that can help responders rapidly assess and provide for any surge in acute and longer-term mental health impacts after disasters. PsySTART has three components: community resilience, rapid triage "tag" (designed for field use by responders without mental health expertise), and an information technology platform to manage the collection and analysis of triage information.

Delivery Mode	
☒ Individual	☐ Family (general)
☐ Group	☐ Community
☒ Victim Family	☒ Direct Survivors
☐ Rescue and Recovery Responders	☐ Other Responders
Delivery Setting	
☐ Family Assistance Centers	☒ Field/Community
☐ Private Homes	☐ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☒ Other
Research Base	
☐ Empirically Supported Treatment (EST)	☒ Evidence-Supported Treatment (EST)
☒ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

19. Listen, Protect, Connect Model of PFA

Authors: Merritt Schreiber and Robin Gurwitch

Website: For Parents: http://www.ready.gov/sites/default/files/documents/files/PFA_Parents.pdf

For Teachers: http://www.ready.gov/sites/default/files/documents/files/PFA_SchoolCrisis.pdf

Brief Description: Listen, protect, and connect are the three steps of PFA for assisting a child after a disaster. The authors suggest that professionals listen and observe a child's reactions, talk simply and honestly about what happened, and encourage parents and guardians to connect to members of their family and community for resources for disaster survivors.

Delivery Mode	
☒ Individual	☒ Family (general)
☐ Group	☐ Community
☒ Victim Family	☒ Direct Survivors
☐ Rescue and Recovery Responders	☐ Other Responders
Delivery Setting	
☐ Family Assistance Centers	☐ Field/Community
☒ Private Homes	☒ Schools (general)
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☐ Responder Agencies	☐ Other
Research Base	
☐ Empirically Supported Treatment (EST)	☒ Evidence-Supported Treatment (EST)
☐ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

Ramirez, M., Harland, K., Frederick, M., Shephard, R., Wong, M., & Cavanaugh, J.E. (2013). Listen protect connect for traumatized schoolchildren: A pilot study of psychological first aid. *BMC Psychology*, *1*(26). Retrieved from: http://www.biomedcentral.com/2050-7283/1/26

20. Recovery Efforts After Adult and Child Trauma (REACT)

Author: Russell T. Jones, Virginia Tech University

Website: http://www.firetrauma.com

Brief Description: The REACT model is an interactive reference tool for families that can help them prepare and recover from house fires (the original intent of the model) and other traumatic events. The model was based on work done at the Yale Child Study Center and was expanded to include training for community responders. The model has been implemented after various traumatic events, including Hurricane Katrina.

Delivery Mode	
☒ Individual	☒ Family (general)
☐ Group	☐ Community
☒ Victim Family	☒ Direct Survivors
☐ Rescue and Recovery Responders	☒ Other Responders
Delivery Setting	
☒ Family Assistance Centers	☒ Field/Community
☒ Private Homes	☒ Schools (general)
☒ Classrooms	☒ Faith-Based Settings
☒ Responder Agencies	☐ Other
Research Base	
☐ Empirically-Supported Treatment (EST)	☐ Evidence Supported Treatment (EST)
☒ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

21. Screening, Brief Intervention, Referral to Treatment (SBIRT)

Author: SAMHSA evidence-based treatment

Website: http://www.samhsa.gov/sbirt

Brief Description: SBIRT is a public health approach to the delivery of early intervention and treatment services for people with substance use disorders and those at risk of developing these disorders. Many different types of community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

Delivery Mode	
☒ Individual	☐ Family (general)
☐ Group	☐ Community
☐ Victim Family	☒ Direct Survivors
☐ Rescue and Recovery Responders	☐ Other Responders
Delivery Setting	
☐ Family Assistance Centers	☒ Field/Community
☐ Private Homes	☐ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☒ Other
Research Base	
☐ Empirically Supported Treatment (EST)	☒ Evidence-Supported Treatment (EST)
☐ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

22. Seeking Safety

Author: Lisa M. Najavits

Website: http://www.treatment-innovations.org/seeking-safety.html

Brief Description: Seeking Safety is a present-focused therapy to help people attain safety from trauma/PTSD and substance abuse. It has been conducted in group and individual formats; for women, men, and mixed-gender individuals; using all topics or fewer topics; in a variety of settings (outpatient, inpatient, residential); and for both substance abuse and dependence. It has also been used with people who have a trauma history, but do not meet criteria for PTSD.

Delivery Mode	
☒ Individual	☐ Family (general)
☒ Group	☐ Community
☐ Victim Family	☒ Direct Survivors
☐ Rescue and Recovery Responders	☐ Other Responders
Delivery Setting	
☐ Family Assistance Centers	☒ Field/Community
☒ Private Homes	☐ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☒ Other
Research Base	
☐ Empirically Supported Treatment (EST)	☒ Evidence-Supported Treatment (EST)
☒ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

23. Wave Riders

Author: Mental Health Association in New Jersey

Website: http://www.mhanj.org/new-jersey-hope-and-healing/

Brief Description: This after school, psycho-education based intervention offers empowerment, encouragement, positivity, and ongoing resiliency building. The Sandy Wave Riders (SWR) program is a six-session, group intervention involving a series of highly structured, expressive-behavioral activities. The aim of the activities is to significantly reduce stress reactions, anxiety, fear, and sadness (which can interfere with a sense of security) as well as have an impact on academic performance or behavior by allowing and guiding children to do what they do best: playing, learning, and creative problem-solving. The activities also work toward developing an increase of hope, self-esteem, self-efficacy, daily functioning, and adaptive skills.

Delivery Mode	
☐ Individual	☐ Family (general)
☒ Group	☐ Community
☐ Victim Family	☒ Direct Survivors
☐ Rescue and Recovery Responders	☐ Other Responders
Delivery Setting	
☐ Family Assistance Centers	☒ Field/Community
☐ Private Homes	☐ Schools (general)
☒ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☒ Other
Research Base	
☐ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
☒ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

24. Mental Health First Aid (MHFA)*

*While MHFA is not a DBH-specific model of intervention, it may be useful in a crisis intervention situation, such as a disaster that involves persons experiencing a mental health emergency.

Author: National Council for Behavioral HealthCare

Website: http://www.mentalhealthfirstaid.org/cs/
http://nrepp.samhsa.gov/ViewIntervention.aspx?id=321

Brief Description: MHFA is an adult public education program designed to improve participants' knowledge and modify their attitudes and perceptions about mental health and related issues, including how to respond to individuals who are experiencing one or more acute mental health crises (e.g., suicidal thoughts and/or behavior, acute stress reaction, panic attacks, and/or acute psychotic behavior) or are in the early stages of one or more chronic mental health problems (e.g., depressive, anxiety, and/or psychotic disorders, which may occur with substance abuse).

Delivery Mode	
☒ Individual	☒ Family (general)
☒ Group	☒ Community
☐ Victim Family	☐ Direct Survivors
☒ Rescue and Recovery Responders	☒ Other Responders
Delivery Setting	
☐ Family Assistance Centers	☐ Field/Community
☐ Private Homes	☐ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☒ Other
Research Base	
☐ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
☒ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

INTERMEDIATE INTERVENTIONS

Prior to reporting to a disaster scene, it is important for DBH responders to have knowledge of the level and types of behavioral health response activities being conducted in the communities to which they are assigned. This knowledge can help responders prepare for survivors' emotional responses, particularly if their basic needs for safety, shelter, food, and medical care were not met in the early aftermath of the incident. Other survivors may just be getting a sense of their losses as the calendar stretches out from the date of the event. Thus, in the intermediate phase (approximately 6 months through the 1-year anniversary period), responders can expect to see some responses that are more typical during the immediate phase. Many survivors who received PFA and other immediate interventions may still experience disturbing symptoms and may welcome and benefit from intermediate interventions. These interventions primarily include educational and cognitive types of activities meant to decrease anxiety symptoms and increase coping skills, as well as the survivor's sense of competence in his or her ability to recover (i.e., self-efficacy) without mental health treatment. The interventions generally include psycho-education, anxiety management techniques, coping strategies, exposure, and cognitive restructuring. The research indicates that cognitive behavioral interventions, which emphasize the teaching of skills that can be used across a range of settings or problems, continue to be the most effective and easily accepted by clients. In this section, we include cognitive-based intermediate treatments for disaster survivors.

1. Cognitive Behavioral Therapy for Post-Disaster Distress (CBT-PD)

Author: Jessica Hamblen, National Center for PTSD

Website: N/A

Brief Description: CBT-PD is a manualized, 10-session intervention that focuses on identifying and challenging maladaptive disaster-related beliefs. "Post-disaster distress" encompasses a range of cognitive, emotional, and behavioral reactions to disaster, including symptoms of depression, stress, vulnerability, and functional difficulties. The intervention includes four components: psycho-education, breathing retraining, behavioral activation, and cognitive restructuring.

Delivery Mode	
☒ Individual	☒ Family (general)
☒ Group	☐ Community
☒ Victim Family	☒ Direct Survivors
☒ Rescue and Recovery Responders	☒ Other Responders
Delivery Setting	
☐ Family Assistance Centers	☒ Field/Community
☒ Private Homes	☐ Schools (general)
☐ Classrooms	☒ Faith-Based Settings
☒ Responder Agencies	☐ Other
Research Base	
☐ Empirically Supported Treatment (EST)	☒ Evidence-Supported Treatment (EST)
☒ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☒ Qualitative Research

Hamblen, J.L., Gibson, L.E., Mueser, K.T., & Norris, F.H. (2006). Cognitive behavioral therapy for prolonged postdisaster distress. *Journal of Clinical Psychology*, *62*(8), 1043–1052.

Hamblen, J.L., Norris, F.H., Pietruszkiewicz, S., Gibson, L.E., Naturale, A.J., & Louis, C. (2009). Cognitive behavioral therapy for postdisaster distress: A community based treatment program for survivors of Hurricane Katrina. *Administration and Policy in Mental Health, 36*, 206–214. doi: 10.1007/s10488-009-0213-3

2. Classroom-Based Intervention (CBI)

Author: Robert Macy, Center for Trauma Psychology

Website: N/A

Brief Description: CBI is a 4-week, 12-session classroom, clinic, and camp-based group intervention involving a series of highly structured expressive-behavioral activities. These activities can significantly reduce traumatic stress reactions, anxiety, fear, and depressed moods by allowing and guiding children to do what they do best: playing, learning, and engaging in creative problem solving. CBI was especially designed and developed to be implemented in schools and community centers in order to assist teachers and administrators with stabilization and resiliency building during the school day or in after-school time utilizing curriculum design that is similar to the current educational model.

CBI was *not* developed to prevent PTSD or other major behavioral health disorders. Rather, CBI aims to identify existing coping resources among children and youth facing difficult circumstances, and to sustain the utilization of those resources in the service of psychological and psychosocial recovery over time.

Delivery Mode	
☒ Individual	☒ Family (general)
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☐ Rescue and Recovery Responders	☐ Other Responders
Delivery Setting	
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☐ Private Homes	☒ Schools (general)
☒ Classrooms	☒ Faith-Based Settings
☐ Responder Agencies	☐ Other
Research Base	
☐ Empirically-Supported Treatment (EST)	☒ Evidence Supported Treatment (EST)
☒ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

Tol, W.A., Komproe, I.H., Susanty, D., Jordans, M.J., Macy, R.D., & De Jong, J.T. (2008). School-based mental health intervention for children affected by political violence in Indonesia: A cluster randomized trial. *Journal of the American Medical Association*, *300*(6), 665–662.

3. Cognitive Behavioral Intervention in Schools (CBITS)

Author: Lisa Jaycox

Website: N/A

Brief Description: CBITS is a 10-session CBT group intervention that was designed for use in an inner-city school mental health clinic with a multicultural population. CBITS incorporates CBT skills in a group format (5–8 students per group) to address symptoms of PTSD, anxiety, and depression related to exposure to violence. A new set of techniques is introduced in each session using a mixture of didactic presentation, age-appropriate examples, and games to solidify concepts. Individuals work on worksheets during and between sessions. The techniques taught to the students are similar to those used in other CBT groups for individuals with PTSD. The CBITS intervention emphasizes applying techniques learned in the program to the child's own problems. Homework assignments are developed collaboratively between the student and the clinician in each session and are reviewed at the beginning of the next session.

Delivery Mode	
☐ Individual	☐ Family (general)
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☐ Victim Family	☒ Direct Survivors
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Delivery Setting	
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☐ Private Homes	☒ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☐ Other
Research Base	
☒ Empirically Supported Treatment (EST)	☒ Evidence-Supported Treatment (EST)
☒ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

Stein, B.D., Kataoka, S., Jaycox, L., Wong, M., Fink, A., Escudero, P., & Zaragoza, C. (2002). Theoretical basis and program design of a school-based mental health intervention for traumatized immigrant children: A collaborative research partnership. *The Journal of Behavioral Health Services & Research*, *29*(3), 318–326.

Stein, B.D., Jaycox, L.H., Kataoka, S.H., Wong, M., Tu, W., Elliott, M.N., & Fink, A. (2003). A mental health intervention for schoolchildren exposed to violence: A randomized controlled trial. *Journal of the American Medical Association*, *290*(5), 603–611. doi: 10.1001/jama.290.5.603.

4. Mind/Body Therapies

Authors: Various authors

Website: N/A

Brief Description: Mindfulness-Based Cognitive Therapy includes mindfulness, which Kabat-Zinn (1992) defined as "paying attention in a particular way: on purpose, in the present moment, and non-judgmentally." Mindfulness is seen as an important agent of change in these approaches because it shifts the individual's perspective in a way that counteracts psychopathological processes. Mindfulness is not, however, the only mechanism of change in these therapies because behavioral and cognitive principles are also strongly incorporated. These interventions may best be considered hybrids rather than Complementary and Alternative Medicine (CAM), but future research will be necessary to determine the relative contribution of their components. Mindfulness-based interventions show promise for stress reduction in general medical conditions, and initial evidence suggests that they are accepted in trauma-exposed individuals.

Mindfulness-based stress reduction is a group intervention that incorporates mindfulness practices, including meditation and yoga. The literature on cognitive changes related to mindfulness suggests that through practice of shifting attention and assuming a nonjudgmental stance, patients may learn to be less reactive to intrusive or ruminative thoughts. Mantra meditation has more commonly been linked to decreasing physiological arousal. For patients with PTSD, this may be a good coping strategy for times when memories are intentionally (as in exposure-based therapy) or unintentionally triggered. Compassion meditation, which involves directing feelings of warmth and compassion towards others, has been linked to increases in positive emotion and social connectedness. Given the deficits in positive emotion and feelings of connection with others that are characteristic of PTSD, compassion meditation is a promising strategy but is without empirical application to PTSD. At this point, there is very limited empirical evidence of the effectiveness of this type of therapy, so it may be best applied as an adjunct to other PTSD treatments.

Analysis of recent, systematic reviews identified limited but promising support for the efficacy of mind-body therapies for depression and anxiety disorders, and no relevant findings for manipulative and body-based, movement-based, or energy therapies. Overall, the current evidence base does not support the use of CAM interventions as an alternative to current empirically established approaches for PTSD, or as first-line interventions recommended within evidence-based clinical guidelines. Yet, anecdotally, many report liking mind-body therapies and engaging in them.

Delivery Mode	
☒ Individual	☒ Family (general)
☒ Group	☒ Community
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Delivery Setting	
☒ Family Assistance Centers	☒ Field/Community
☒ Private Homes	☒ Schools (general)
☒ Classrooms	☒ Faith-Based Settings
☒ Responder Agencies	☐ Other
Research Base	
☐ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
☒ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

Kabat-Zinn, J., Massion, A.O., Kristeller, J., Peterson, L.G., Fletcher, K.E., Pbert, L., … Santorelli, S.F. (1992). Effectiveness of a meditation-based stress reduction program in the treatment of anxiety disorders. *American Journal of Psychiatry*, *149*(7), 936–943.

5. Skills for Psychological Recovery (SPR)

Authors: National Center for PTSD and the National Child Traumatic Stress Network

Website: http://www.ptsd.va.gov/professional/materials/manuals/skills_psych_recovery_manual.asp

Brief Description: SPR is a modular intervention designed to follow PFA in the weeks and months following disasters and mass violence events and includes a brief information-gathering component to determine skills that would most benefit survivors immediately. SPR can help survivors gain skills to manage distress and cope with post-disaster stress and adversity. SPR utilizes skills-building components from mental health treatments that have been found helpful in a variety of post-trauma situations, including problem-solving, positive activities scheduling, managing reactions, helpful thinking, and building healthy social connections. SPR is culturally informed and appropriate for survivors across the lifespan.

Delivery Mode	
☒ Individual	☒ Family (general)
☒ Group	☒ Community
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Delivery Setting	
☒ Family Assistance Centers	☒ Field/Community
☒ Private Homes	☐ Schools (general)
☐ Classrooms	☒ Faith-Based Settings
☒ Responder Agencies	☐ Other
Research Base	
☐ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
☒ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

6. Specialized Crisis Counseling Services (SCCS)

Author: SAMHSA

Website: http://www.samhsa.gov

Brief Description: SCCS was created in 2007 to provide more individualized and enhanced services to children, adults, and families affected by the U.S. Gulf Coast hurricanes of 2005. The primary objectives of the program were to engage survivors through outreach, empower survivors to take an active role in the services they receive, and to provide solution-focused, skill-based interventions and other resources to facilitate their recovery. Specialized Crisis Counselors and Resource Linkage Coordinators utilized a dyadic model to assist survivors with their recovery needs.

SCCS is organized within a 5-step model that includes: (1) assessing the current needs of survivors, (2) reviewing cases through team meetings to determine appropriate services, (3) providing services and resources to survivors, (4) monitoring and supporting staff through ongoing training, supervision, and consultation, and (5) reviewing successes and further resource needs with survivors during the final visit.

Delivery Mode	
☒ Individual	☒ Family (general)
☒ Group	☐ Community
☒ Victim Family	☒ Direct Survivors
☒ Rescue and Recovery Responders	☒ Other Responders
Delivery Setting	
☒ Family Assistance Centers	☒ Field/Community
☒ Private Homes	☐ Schools (general)
☐ Classrooms	☒ Faith-Based Settings
☒ Responder Agencies	☐ Other
Research Base	
☐ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
☒ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

7. Writing for Recovery

Author: James Pennebaker

Website: N/A

Brief Description: Writing about an emotional experience can help survivors normalize their distressing reactions to a traumatic event. The use of narrative technique is increasingly incorporated in CBT with adults (Neuner et al., 2004; Schauer, Neuner, & Elbert, 2005) and recently with children (Schauer et al., 2004). The Writing for Recovery model provides specific instruction to survivors on a writing exercise, including two short periods of writing each day for three days (the days can be consecutive or spaced apart). The participants are asked to write about their innermost thoughts and feelings for 15 minutes. At the end of the period, participants leave their writing aside. Writing can even be once a week over 3 weeks if it is difficult to have shorter-spaced periods. Even writing on a single day on three occasions is likely to be beneficial.

Delivery Mode	
☒ Individual	☒ Family (general)
☒ Group	☐ Community
☒ Victim Family	☒ Direct Survivors
☒ Rescue and Recovery Responders	☒ Other Responders
Delivery Setting	
☒ Family Assistance Centers	☒ Field/Community
☒ Private Homes	☐ Schools (general)
☐ Classrooms	☒ Faith-Based Settings
☒ Responder Agencies	☐ Other
Research Base	
☐ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
☒ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

Neuner, F., Schauer, M., Klasnick, C., Karunkara, U., & Elbert, T. (2004). A comparison of narrative exposure therapy, supportive counseling, and psychoeducation for treating posttraumatic stress disorder in an African refugee settlement. *Journal of Consulting and Clinical Psychology, 72,* 579–587.

Schauer, E., Neuner, F., Elbert, T., Ertl, V., Onyut, L.P., Odenwald, M., & Schauer, M. (2004). Narrative exposure therapy in children: A case study. *Intervention, 2*(1), 18–32.

Schauer, M., Neuner, F., & Elbert, T. (2005). *Narrative exposure therapy: A short-term intervention for traumatic stress disorders after war, terror, or torture.* Ashland, OH: Hogrefe & Huber Publishers.

LONG-TERM INTERVENTIONS

Long-term interventions include those that are conducted in both the early and intermediate phases of the disaster response in addition to those that are listed throughout this report. Again, while it may be somewhat unusual, larger-scale traumatic events may inhibit survivors from attending to their emotions until much later, when protective denial or a break in daily stressors finally gives way. This allows a release of the "emotional holding" that was necessary for safety, and eases other concerns such as "being strong for one's family." It is very important to also note that long-term interventions are much more geared toward people who are diagnosed with a mental illness; most of that research focuses on PTSD. Thus, most of the interventions listed in this section are geared toward survivors who have been professionally diagnosed with PTSD.

According to the *Practice Guidelines* from the International Society for Traumatic Stress Studies, cognitive-behavioral approaches are the best-established treatment of PTSD (Foa, Keane, & Friedman, 2000). A number of studies have compared cognitive-behavioral treatment (CBT) to different control conditions in individuals with acute stress disorder or PTSD in the weeks or first few months following a trauma. In a recent literature review, Ehlers and Clark (2003) reported that brief CBT appeared to be more effective than supportive counseling, self-help, repeated assessment, or a naturalistic control group. Research has also shown that CBT is effective months or even years after a traumatic event.

1. Cognitive Processing Therapy (CPT)

Authors: Patricia Resick and Monica Schnicke

Website: http://www.ptsd.va.gov/

Brief Description: CPT was developed to specifically treat PTSD among people who have experienced a sexual assault. CPT lasts 12 sessions and can be viewed as a combination of cognitive therapy and exposure therapy. CPT is like cognitive therapy in that it is based in the idea that PTSD symptoms stem from a conflict between pre-trauma beliefs about the self and world (for example, the belief that "nothing bad will happen to me") and post-trauma information (for example, the trauma as evidence that the world is not a safe place). These conflicts are called "stuck points" and are addressed through the next component in CPT—writing about the trauma.

Like exposure therapy, in CPT, the client/survivor is asked to write about his or her traumatic event in detail. The patient is then instructed to read the story aloud repeatedly in and outside of the session. The therapist helps the client identify and address stuck points and errors in thinking, sometimes called "cognitive restructuring." Errors in thinking may include, for example, "I am bad person" or "I did something to deserve this." The therapist may help the client/survivor address these errors or stuck points by having the client gather evidence for and against those thoughts.

Delivery Mode	
☒ Individual	☐ Family (general)
☐ Group	☐ Community
☐ Victim Family	☒ Direct Survivors
☒ Rescue and Recovery Responders	☒ Other Responders
Delivery Setting	
☐ Family Assistance Centers	☐ Field/Community
☐ Private Homes	☐ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☒ Other
Research Base	
☒ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
☐ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

Resick, P.A., & Schnicke, M.K. (1992). Cognitive processing therapy for sexual assault victims. *Journal of Consulting and Clinical Psychology, 60*(5), 748–756.

Resik, P.A., Nishith, P., Weaver, T.L., Astin, M.C., & Feuer, C.A. (2002). A comparison of cognitive-processing therapy with prolonged exposure and a waiting condition for the treatment of chronic posttraumatic stress disorder in female rape victims. *Journal of Consulting and Clinical Psychology*, *70*(4), 867–879.

Foa, E.B., Keane, T.M., & Friedman, M.J. (2000). *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies*. New York, NY: The Guilford Press.

Ehlers, A., & Clark, D.M. (2003). Early psychological interventions for adult survivors of trauma: A review. *Biological Psychiatry*, *53*(9), 817–826.

2. Eye Movement Desensitization and Reprocessing (EMDR)

Author: Francine Shapiro

Website: http://www.emdr.com/general-information/what-is-emdr.html

Brief Description: EMDR is a comprehensive, integrative psychotherapy approach. It combines elements of many effective psychotherapies into structured protocols that are designed to maximize treatment effects. These include psychodynamic, cognitive behavioral, interpersonal, experiential, and body-centered therapies. EMDR psychotherapy is an information processing therapy and uses an eight-phase approach to address the experiential contributors of a wide range of pathologies. It attends to the past experiences that have set the groundwork for pathology, the current situations that trigger dysfunctional emotions, beliefs and sensations, and the positive experience needed to enhance future adaptive behaviors and mental health. During treatment, various procedures and protocols are used to address the entire clinical picture. One of the procedural elements is "dual stimulation" using bilateral eye movements, tones, or taps. During the reprocessing phases, the client attends momentarily to past memories, present triggers, or anticipated future experiences while simultaneously focusing on a set of external stimulus. During that time, clients generally experience the emergence of insight, changes in memories, or new associations. The clinician assists the client in focusing on appropriate material before the initiation of each subsequent set.

Additionally, the U.S. Department of Veterans Affairs (VA) offers an online training course on EMDR by Josef Ruzek at the National Center for PTSD website: http://www.ptsd.va.gov/professional/continuing_ed/emdr.asp.

This PTSD 101 online course reviews the VA/Department of Defense (DOD) 2010 clinical practice guideline recommendations regarding EMDR for PTSD. It also provides an overview of the components of each treatment and presents the research evidence behind EMDR for PTSD. Continuing education credits are available.

Delivery Mode	
☒ Individual	☐ Family (general)
☐ Group	☐ Community
☒ Victim Family	☒ Direct Survivors
☒ Rescue and Recovery Responders	☒ Other Responders
Delivery Setting	
☐ Family Assistance Centers	☐ Field/Community
☐ Private Homes	☐ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☒ Other
Research Base	
☒ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
☐ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

Shapiro, F., & Maxfield, L. (2002). Eye movement desensitization and reprocessing (EMDR): Information processing in the treatment of trauma. *Journal of Clinical Psychology*, *58*(8), 933–946.

A full description of the theory, sequence of treatment, and research on protocols and active mechanisms can be found in: Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols and procedures* (2nd ed.). New York, NY: Guilford Press.

3. Stress Inoculation Training (SIT)

Author: Josef Ruzek, National Center for PTSD

Website: http://www.ptsd.va.gov/professional/continuing_ed/emdr.asp (online training course with CEU opportunity)

Brief Description: The basic goal of SIT is to help a client/survivor gain confidence in his ability to cope with anxiety and fear stemming from trauma reminders.

In SIT, the therapist helps the client become more aware of things that serve as reminders or cues for fear and anxiety. The therapist helps the patient learn how to detect and identify cues as soon as they appear so that the patient can put the newly learned coping skills into immediate action. In doing so, the patient can tackle the anxiety and stress early on before it gets out of control. Clients also learn a variety of coping skills that are useful in managing anxiety, such as muscle relaxation and deep breathing.

Online Training: SIT

This PTSD 101 online course reviews the VA/DOD 2010 clinical practice guideline recommendations regarding Eye Movement Desensitization and Reprocessing (EMDR) and SIT for PTSD. The training provides an overview of the components of each treatment and presents the research evidence for EMDR and SIT for PTSD.

Delivery Mode	
☐ Individual	☐ Family (general)
☐ Group	☐ Community
☐ Victim Family	☐ Direct Survivors
☐ Rescue and Recovery Responders	☐ Other Responders
Delivery Setting	
☐ Family Assistance Centers	☐ Field/Community
☐ Private Homes	☐ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☐ Other
Research Base	
☐ Empirically Supported Treatment (EST)	☒ Evidence-Supported Treatment (EST)
☐ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

4. Prolonged Exposure Therapy

Author: Edna Foa

Website: N/A

Brief Description: The goal of exposure therapy is to help reduce the level of fear and anxiety connected with trauma reminders, thereby also reducing avoidance, or anxiety and fear when encountering a reminder. This is usually done by having the client confront (or be exposed to) the reminders that he fears without avoiding them. This may be done by actively exposing someone to reminders (for example, showing someone a picture that reminds him of the traumatic event) or through the use of imagination.

By dealing with the fear and anxiety, the patient can learn that these feelings will lessen on their own, eventually reducing the extent to which these reminders are viewed as threatening and fearful. Exposure therapy is usually paired with teaching the patient different relaxation skills.

Delivery Mode	
☐ Individual	☐ Family (general)
☐ Group	☐ Community
☒ Victim Family	☒ Direct Survivors
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Delivery Setting	
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☒ Private Homes	☒ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☐ Other
Research Base	
☒ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
☐ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

5. Psychodynamic Psychotherapies

Authors: Numerous authors of varied therapies have shown to be effective over time.

Website: N/A

Brief Description: Psychodynamic approaches to PTSD focus on a number of different factors that may influence or cause PTSD symptoms, such as early childhood experiences (particularly parental attachment), current relationships, and defense mechanisms (i.e., what people do to protect themselves from upsetting thoughts and feelings that are the result of experiencing a traumatic event). The treatment works by helping clients get in touch with and work through those painful unconscious feelings. To do this, the psychodynamic therapist will assist the client/survivor with recognizing the defense mechanisms being used and what they are being used for, and connecting with and appropriately releasing those feelings and thoughts that were previously being avoided.

Psychodynamic psychotherapy for PTSD has not been studied as extensively as cognitive behavioral therapy for PTSD. Of the studies that have been conducted, though, it has been shown that psychodynamic psychotherapy can have a number of benefits. For example, studies of psychodynamic psychotherapy for PTSD have shown that after therapy, people report improvement in their interpersonal relationships, fewer feelings of hostility and inadequacy, more confidence and assertiveness, and reductions in PTSD symptoms and depression.

Delivery Mode	
☒ Individual	☒ Family (general)
☒ Group	☐ Community
☒ Victim Family	☒ Direct Survivors
☒ Rescue and Recovery Responders	☒ Other Responders
Delivery Setting	
☐ Family Assistance Centers	☒ Field/Community
☒ Private Homes	☐ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☐ Other
Research Base	
☒ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
☐ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

6. Skill Training in Affect and Interpersonal Regulation (STAIR)

Author: Marylene Cloitre, National Center for PTSD

Website: http://www.ptsd.va.gov/professional/continuing_ed/STAIR_online_training.asp

Brief Description: STAIR is an evidence-based cognitive behavioral therapy for individuals with PTSD, including chronic and complicated forms, as well as for individuals with PTSD and co-occurring disorders. DBH professionals using STAIR can teach clients skills in emotion regulation and interpersonal functioning.

This online STAIR training consists of eight modules covering several core treatment components. STAIR can be provided as a standalone therapy or as a complement to trauma-focused therapies. The goals and objectives of this intervention include:

- To become informed about the impact of trauma on emotion regulation and social (interpersonal) functioning
- To be able to identify at least one strategy that increases emotional awareness
- To be able to identify at least three strategies that improve emotion regulation in PTSD patients
- To be able to formulate interpersonal schemas related to problematic social and interpersonal functioning
- To be able to develop and test alternative interpersonal schemas with the client
- To learn at least two strategies for effective assertiveness behaviors
- To learn at least one strategy for improving flexibility in interpersonal expectations and behaviors

Delivery Mode	
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☒ Private Homes	☐ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☐ Other
Research Base	
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7. Systematic Desensitization

Author: Joseph Wolpe

Website: N/A

Brief Description: Joseph Wolpe developed this technique to help treat anxiety-related disorders and phobias. This technique is based on the principles of classical conditioning and the premise that what has been learned (conditioned) can be unlearned. Ample research shows that systematic desensitization is effective in reducing anxiety and panic attacks associated with fearful situations.

Systematic desensitization usually starts with having the client imagine him or herself in a progression of fearful situations and using relaxation strategies that compete with anxiety. Once the client can successfully manage anxiety while imagining fearful events, he or she can apply the technique to real-life situations. The goal of the process is to become gradually desensitized to the triggers that are causing distress.

Before beginning systematic desensitization, clients should have mastered relaxation training and developed a hierarchical list of feared situations (from least feared to most feared). Some techniques commonly used in relaxation training include deep breathing, progressive muscle relaxation, and visualization.

Delivery Mode	
☒ Individual	☐ Family (general)
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☐ Private Homes	☐ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☒ Other
Research Base	
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8. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Authors: Judith Cohen and Anthony Mannarino

Website: http://tfcbt.musc.edu/

Brief Description: TF-CBT*Web* is a 10-hour, web-based, multimedia distance education course for mental health professionals seeking to learn TF-CBT (Cohen, Mannarino, & Deblinger, 2006; Deblinger & Heflin, 1996). It was developed for professionals holding a master's degree or above or graduate students in a mental health discipline such as clinical social work, professional counseling, clinical psychology, psychiatry, marital and family therapy, or psychiatric nursing. The training modality was designed to be used by busy, front-line practitioners who often have little time and few resources for traditional approaches to professional education. The modular, self-study approach of TF-CBT*Web* allows practitioners to learn at their own pace when it is convenient for them. They can access the training whenever they have time, and from virtually any computer with Internet access. The modular approach means they can space their learning over time and return to the course whenever they like. TF-CBT*Web* is offered at no charge, and mental health professionals who complete the course receive 10 contact hours of continuing education from the Medical University of South Carolina. Another intervention, Trauma Systems Therapy, has its roots in TF-CBT and is described on the following page.

Delivery Mode	
☒ Individual	☒ Family (general)
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Delivery Setting	
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☐ Private Homes	☐ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☒ Other
Research Base	
☒ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
☐ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

Cohen, J.A., Mannarino, A.P., & Deblinger, E. (Eds.). (2012). *Trauma-focused CBT for children and adolescents: Treatment applications.* New York, NY: The Guilford Press.

Deblinger, E., & Heflin, A.H. (1996). *Treating sexually abused children and their nonoffending parents: A cognitive behavioral approach*. Thousand Oaks, CA: Sage Publications, Inc.

9. Trauma Systems Therapy (TST)

Authors: Glenn Saxe, B. Heidi Ellis, and Julie B. Kaplow

Website: N/A

Brief Description: With its roots in TF-CBT, TST is a phase-based type of therapy for children and youth ages 6 to 19 who have experienced at least one trauma. Specifically, it is designed for children and youth who have trouble regulating their emotions because of their traumatic experience and stressors in their social environment, including family, school, and neighborhood. TST has up to five phases—surviving, stabilizing, enduring, understanding, and transcending—although a child or youth may not move through all the phases; providers of TST may opt to place him or her in the phase that corresponds to what he or she needs upon entering therapy. If a child or youth completes all phases, TST takes 1 year. TST involves treatment modules including home- and community-based services, services advocacy, emotional regulation skills training, cognitive processing, and psychopharmacology. It requires more integration of services and collaboration of service providers than do some other types of therapy, as well as legal advocacy for the services advocacy module. A manual is available to help people learn about and provide this type of therapy; it is titled *Collaborative Treatment of Traumatized Children and Teens: The Trauma Systems Therapy Approach.* Generally, the treatment team meets weekly for purposes of collaboration and supervision.

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☒ Classrooms	☐ Faith-Based Settings
☒ Responder Agencies	☐ Other
Research Base	
☒ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
☐ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

Bronfenbrenner, U. (1979). Contexts of child rearing: Problems and prospects. *American Psychologist, 34,* 844–850.

Casey, R., Saxe, G., Ellis, B. H., Rubin, D., & Allee, L. (2005). *Children with medical traumatic stress: Expanding Trauma Systems Therapy.* Presented at the annual meeting of the American Psychological Association Conference, Washington, DC.

Ellis, B. H. (2004, October). *Trauma Systems Therapy for refugees.* Paper presented at the International Conference, Anthropology and Health: Cross-Cultural Aspects of Mental Health and Psychosocial Well-Being in Immigrant/Refugee Adolescents. Hvar, Croatia.

Ellis, B. Heidi, Saxe, G., & Hansen, S. (2005, November). *Trauma Systems Therapy: Dissemination and implementation in two settings.* Paper presented at the annual meeting of the International Society for Traumatic Stress Studies, Toronto, Canada.

Saxe, G., & Ellis, B. H. (2005, June). *Comprehensive care for traumatized children: Trauma Systems Therapy.* Paper presented at the annual Boston University Trauma Conference, Boston, MA.

Saxe, G., Ellis, B. H., & Kaplow, J. (2004, June). *Treating child traumatic stress: Self regulation and the social environment.* Paper presented at annual Boston University Trauma Conference, Psychological Trauma: Maturational Processes and Therapeutic Interventions. Boston, MA.

Saxe, G. N., Ellis, B. H., & Fogler, J. (2005). Comprehensive care for traumatized children: An open trial examines Trauma Systems Therapy. *Psychiatric Annals, 35*(5), 443–448.

Saxe, G. N., Ellis, B. H. & Kaplow, J. (2006, October). *Collaborative care for traumatized children and teens: A Trauma Systems Therapy approach.* Guilford Press, NY.

INTERNET-BASED INTERVENTIONS (IBIs)/APPLICATIONS (APPS)

As more of the general population engages in accessing information on the Internet via personal and public access computers, tablets, smartphones, and now Google Glass (an eye glass-propped, head-and-eye-movement-initiated electronic tool), Internet-based interventions developed for use in the aftermath of disasters are increasing. Additionally, apps containing content that can be downloaded pre- and post-disaster to assist with preparedness and response activities are also now available. These means of intervention provide immediate access (when Internet services are available) and are often free (for those who own the electronic equipment that is used to access the programs and apps). These programs also deliver a standardized intervention, although some IBIs and apps can provide a degree of personalization depending on the sophistication and interactive aspects of the application. The broadest audience—everyone who has been affected by the disaster—can access the interventions, and everyone can access them at the same time (as long as the tools and the Internet remain accessible and functional). Such interventions also have a feel of self-help, and are certainly self-applied, because the survivor makes the decision to access them and can do so without the presence of a DBH responder or other mental health or substance misuse professional. Here, we note several disaster specific apps, that are internet and smart phone based (including texting from smartphones), from psycho-educational based tools to screening and more clinically intense interventions.

1. Cognitive Processing Therapy (CPT) Coach Mobile App

Authors: CPT Coach was a collaborative effort between VA's National Center for PTSD, VA's Sierra Pacific (VISN 21) MIRECC, and DOD's National Center for Telehealth and Technology.

Website: http://www.ptsd.va.gov/professional/materials/apps/cpt_mobileapp_pro.asp

Brief Description: Cognitive Processing Therapy (CPT) is an evidence-based psychotherapy for PTSD. Research has shown CPT to be one of the most effective treatments for PTSD.

CPT Coach is an application (app) for mobile devices (iPhone, Android phone, iPod Touch, iPad, or Android tablet) that was created to increase conveniences for clinicians and patients working through the CPT treatment manual. The app is downloaded onto a patient's mobile device to be used as a treatment companion during CPT. Features include:

- Psycho-education, including graphics, about CPT and its treatment components
- PTSD symptom tracking over time to evaluate treatment progress and outcomes
- Continuous availability of homework assignments and worksheets to facilitate feedback and monitor patient adherence to between-session assignments
- Reminders for therapy sessions

Download the free CPT Coach mobile app from iTunes (iOS).

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Delivery Setting	
☐ Family Assistance Centers	☐ Field/Community
☐ Private Homes	☐ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☒ Other Internet
Research Base	
☐ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
☒ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

2. Disaster Distress Helpline/TalkWithUs

Authors: Link2Health Solutions (funded by SAMHSA); administered by the Mental Health Association of New York City

Website: http://disasterdistress.samhsa.gov

Brief Description: The Disaster Distress Helpline is the first 24/7, year-round crisis intervention hotline for people experiencing the emotional effects of a disaster. Calls are answered by trained crisis counselors at 1-800-985-5990 (toll-free). Disaster survivors can also text "TalkWithUs" to 66746.

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☒ Individual	☐ Family (general)
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☐ Private Homes	☐ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☒ Other: Telephone; Texting
Research Base	
☐ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
☒ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

3. My Disaster Recovery (web based)

Authors: Charles Benight and Josef Ruzek

Website: http://disaster.bluesunsupport.com/

Brief Description: My Disaster Recovery is a self-help service designed to help survivors who have experienced a recent disaster to learn more about post-disaster stress and cope more effectively with the effects of the disaster. It provides important knowledge concerning what to expect regarding recovery from the disaster. It teaches specific skills to help make survivors stronger in dealing with the challenges of moving forward. It can also provide feedback on how the client/survivor is progressing and, if necessary, how to seek professional help.

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☐ Private Homes	☐ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☒ Other: Internet
Research Base	
☒ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
☐ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

Benight, C.C., Ruzek, J.I., & Waldrep, E. (2008). Internet interventions for traumatic stress: A review and theoretically-based example. *Journal of Traumatic Stress, 21*, 513–520.

4. National Suicide Prevention Lifeline

Authors: Link2Health Solutions, Inc., an independent subsidiary of the Mental Health Association of New York City (MHA of NYC), as well as MHA of NYC, the National Association of State Mental Health Program Directors, and Living Works, Inc. The Lifeline is funded by SAMHSA.

Website: http://www.suicidepreventionlifeline.org

Brief Description: People experiencing emotional distress or suicidal crisis may call the National Suicide Prevention Lifeline 24/7 for confidential support free of charge. The Lifeline also features a specialized service for prevention of suicide among U.S. veterans. The toll-free Lifeline number is 1-800-273-TALK (8255) for support in English and 1-888-628-9454 for support in Spanish. Through the English-language website, people can also access an online chat feature for another mode of emotional support.

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☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☒ Other: Telephone; Texting
Research Base	
☐ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
☒ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

5. PTSD COACH

Authors: The VA's National Center for PTSD in partnership with the Department of Defense's National Center for Telehealth and Technology.

Website: http://www.ptsd.va.gov/public/materials/apps/PTSDCoach.asp

Brief Description: The PTSD Coach app can help users learn about and manage symptoms that often occur after trauma by providing them with facts and self-help skills based on research. Features include:

- Reliable information on PTSD and treatments that work
- Tools for screening and tracking symptoms
- Convenient, easy-to-use tools that can help people handle stress symptoms
- Direct links to support and help

Download the free PTSD Coach from iTunes (iOS) and Google Play (Android).

Delivery Mode	
☒ Individual	☐ Family (general)
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Delivery Setting	
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☐ Private Homes	☐ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☒ Other Mobile App
Research Base	
☐ Empirically Supported Treatment (EST)	☐ Evidence-Supported Treatment (EST)
☒ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

6. Bounce Back/Bounce Back Now (technology based)

Author: Kenneth Ruggiero

Website: N/A

Brief Description: Disaster Recovery Web is a web-based intervention designed to address post-disaster mental health and general symptom distress in the acute aftermath of disasters. Modules are centered on translation of evidence-based cognitive–behavioral approaches into brief web-deliverable formats, and users are screened into modules only when they endorsed relevant symptoms. The interactive web modules provide education and recommendations regarding effective coping strategies to manage mental health and health-risk behavior.

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Delivery Setting	
☐ Family Assistance Centers	☐ Field/Community
☐ Private Homes	☐ Schools (general)
☐ Classrooms	☐ Faith-Based Settings
☐ Responder Agencies	☒ Other Internet
Research Base	
☒ Empirically-Supported Treatment (EST)	☐ Evidence Supported Treatment (EST)
☐ Evidence-Informed or Evidence-Based Behavioral Practice (EBBP)	☐ Qualitative Research

Ruggiero, K.J., Resnick, H.S., Paul, L.A., Gros, K., McCauley, J.L., Acierno, R., … Galea. S. (2012). Randomized controlled trial of an Internet-based intervention using random-digit-dial recruitment: The disaster recovery web project. *Contemporary Clinical Trials*, 33, 237–246.

APP-BASED RESOURCE TOOLS FOR RESPONDERS

1. SAMHSA Behavioral Health Disaster Response App

Author: SAMHSA

Website: http://store.samhsa.gov/apps/disaster/

Brief Description: The SAMHSA Disaster App makes it easy to provide quality support to survivors. Users can navigate pre-deployment preparation, on-the-ground assistance, post-deployment resources, and more—at the touch of a button from the home screen. Users also can share resources, like tips for helping survivors cope, and find local behavioral health services. And, self-care support for responders is available at all stages of deployment.

2. SAMHSA Suicide Safe Mobile App

Author: SAMHSA

Website: http://store.samhsa.gov/apps/suicidesafe

Brief Description: The SAMHSA Suicide Safe Mobile App is designed to help responders and other health care providers support survivors experiencing suicidal ideation. Based on the Suicide Assessment Five-step Evaluation and Triage (SAFE-T) practice guidelines, the app helps responders understand the guidelines and how to use them. It also allows them to download resources, talk with survivors about suicidal ideation, share crisis line numbers and other resources with survivors, and help survivors find behavioral health treatment in their area.

Download the free Suicide Safe Mobile App from iTunes (iOS) and Google Play (Android).

3. Psychological First Aid (PFA) Mobile App

Author: U.S. Department of Veterans Affairs

Brief Description: Following disasters or emergencies, the free PFA Mobile app can assist responders who provide PFA to adults, families, and children.

Download the free PFA Mobile app from iTunes (iOS) and Google Play (Android).