Disaster Behavioral Health
First Aid Specialist Training with Children

C-FAST

Florida Center for Public Health Preparedness
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Disaster Behavioral Health First Aid Specialist Training with Children

Course Authored By: Jennifer N. Baggerly, PhD, LMHC-S, RPT-S & Nadine D. Mescia, MHS, CFM, CFT

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Introduction

*Sponsors
* Facilitators
* Program
* Participants
The Florida Center for Public Health Preparedness

* Located at the USF College of Public Health
* Designated & funded by the Centers for Disease Control & Prevention in April 2001 through a cooperative agreement with the Association of Schools of Public Health
* Mission: Dedicated to improving the capacity of front line public health workers to respond to current, new, and emerging public health threats, including bioterrorism preparedness & infectious diseases, in Florida & the nation, by providing workforce development, training & resources
Centers for Public Health Preparedness

* One of 27 national Centers for Public Health Preparedness (CPHP) funded by the Centers for Disease Control & Prevention (CDC)

* CPHP Mission: In partnership with state & local public health agencies, to systematically & measurably enhance the preparedness of public health workers & public health agencies by generating innovative learning opportunities to prepare state & local public health workers & others to respond to bio-terrorist incidents, infectious disease outbreaks & emergent public health threats.
Program Facilitators

Jennifer N. Baggerly, PhD, LMHC-S, RPT-S, CFT
Nadine D. Mescia, MHS, CFM, CFT
Program Overview

* Description
* Continuing Education Credits
* Bioterrorism and Emergency Readiness Competencies
  * Aim
  * Program Objectives
  * Learning Objectives
  * Instructional Methods
  * Agenda
Program Description

* 8 contact hours
* Competency-based; didactic & applied learning
* Designed to prepare learners to effectively offer systematic, theory-based, evidence-supported trauma intervention services to children & adolescents, who are survivors of bioterrorism & other mass disasters
* Approved for continuing education credit
Continuing Education Credits

* Physicians
* Nurses
* Licensed Clinical Social Workers
* Licensed Mental Health Counselors
* Marriage and Family Therapists
* Certified Health Education Specialists
* Psychologists
* Pharmacists

* Note: Program facilitators have no commercial interests or relationships
Bioterrorism and Emergency Readiness Competencies

* Core Competency 4. **Describe** his/her functional role(s) in emergency response.
* Core Competency 6. **Describe** communication role(s) in emergency response.
* Core Competency 7. **Identify** limits to own knowledge/skill/authority & **identify** key system resources for referring matters that exceed these limits.
* Core Competency 8. **Recognize** unusual events that might indicate an emergency & **describe** appropriate action.
* Core Competency 9. **Apply** creative problem solving & flexible thinking to unusual challenges within his/her functional responsibilities.

*(CDC, 2002)*

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Program Aim

* To provide public health workers & other professionals on the front-lines of terrorism & disaster response with the necessary knowledge & skills to effectively recognize & respond to the initial behavioral health needs of children & adolescent disaster survivors & to promote behavioral wellness through demonstrating systematic, theory-based, evidence-supported individual & group interventions for traumatized children & adolescents
Program Goals

* Create an awareness of the behavioral health consequences of natural & human-caused disasters on children & adolescents


* Demonstrate the Child C³ARE Model of Disaster Behavioral Health First Aid protocol

* Introduce theory-based, evidence-supported individual & group disaster behavioral health interventions with children & adolescent trauma survivors

* Offer strategies for helping families respond to the needs of child & adolescent trauma survivors
Learning Objectives

1. Recognize the purpose, principles, practices & protocol of systematic, theory-based, evidence-supported interventions with children & adolescents.
2. Discuss examples of potentially traumatic events for children & adolescents.
3. Describe children's & adolescents' common responses to trauma.
4. Identify risk & resiliency factors of children & adolescents experiencing trauma.
5. Identify the signs, symptoms & syndromes of children & adolescents who need follow-up intervention.
6. Identify appropriate referral resources & services for children & adolescents who need further intervention.
7. Describe & demonstrate the Child C³ARE Model of Disaster Behavioral Health First Aid protocol.
9. Describe strategies for helping families respond to the needs of child & adolescent trauma survivors.
Instructional Methods

* Didactic Presentation
* Co-Facilitation
* Group Activities
* Application Exercises
* Demonstration
* Role Play
* Reflection
* Assessment
* Evaluation
Instructional Materials

* Program manual
* Resource folder
* Child C³ARE job aid (slick)
* Field preparedness kit
## Morning Agenda

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<th>Time</th>
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<td>8:00 – 8:45</td>
<td>Introductions &amp; Program Overview</td>
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<tr>
<td>8:45 – 9:30</td>
<td>Module 1: Disaster Behavioral Health First Aid with Children: Purpose, Principles, Practices, &amp; Protocol</td>
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<tr>
<td>9:30 – 9:45</td>
<td><strong>BREAK</strong></td>
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<td>9:45 – 11:45</td>
<td>Module 2: Recognizing &amp; Responding to Behavioral Health Emergencies in Children &amp; Adolescents</td>
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<td>11:45 – 12:30</td>
<td><strong>LUNCH</strong></td>
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## Afternoon Agenda

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<td>12:30 - 2:15</td>
<td>Module 3: Disaster Behavioral Health First Aid Protocol with Children: Child C³ARE Model</td>
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<td>2:15 - 2:30</td>
<td>BREAK</td>
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<td>2:30 - 4:00</td>
<td>Module 4: Structured Group Disaster Behavioral Health Interventions with Children &amp; Adolescents</td>
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<td>4:00 - 4:15</td>
<td>Module 5: Strategies for Helping Families Respond to the Needs of Child &amp; Adolescent Trauma Survivors</td>
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<td>4:15 - 4:30</td>
<td>Wrap-Up</td>
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<td>4:30 - 5:00</td>
<td>Learner Assessment &amp; Program Evaluation</td>
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Participant Introductions

* Use your puppet to introduce yourself & make contact with 2 other program participants. “Hi, my name is (name puppet). What’s your name?”

* Inquire about things such as:
  * Name
  * Agency
  * Job/Position title
  * Motivation for attending training
Module 1

Disaster Behavioral Health First Aid with Children: Child C³ARE Purpose, Principles, Practices & Protocol
Learning Objective

* Recognize the purpose, principles, practices & protocol of systematic, theory-based, evidence-supported interventions with children & adolescents.
Child Disaster Behavioral Health First Aid Purpose

* To limit emotional distress & negative health behaviors in child & adolescent disaster survivors by:

1. **Protecting** child survivors from further danger & harm;

2. **Directing** child survivors to safety;

3. **Connecting** child survivors with support & services;

4. **Promoting** survivor resiliency & recovery; &

5. **Preventing** adverse behavioral health outcomes.
Child Disaster Behavioral Health
First Aid Specialist Principles

* Expectation of normal recovery
* Non-anxious presence
* Flexibility
* Hardiness
* Reunite with families
* Provide comfort & security
* Maintain developmentally appropriate view

(NIMH, 2002)
Children are unique & worthy of respect.

* Children are relational & culturally diverse.

* Children are capable of positive self-direction.

* Children are not miniature adults.

(Landreth, 2002)
Child Disaster Behavioral Health First Aid Practices

* Theory-based;
* Evidence-supported
* Child-centered
* Herman’s Model: Trauma Recovery Stages
  * 1. Establish safety & security
  * 2. Reconstruct the “trauma story”
  * 3. Restore connection between child survivor & the community

(Herman, 1992)
Child Disaster Behavioral Health First Aid Protocol Guidelines

* Early, brief, systematic & phase-appropriate

* Phases of Disaster:
  * Pre-incident phase - improve resistance & resilience
  * Impact phase (0-48 hours) - survival, communication
  * Rescue phase (0-1 week) - adjustment
  * Recovery phase (1-4 weeks) - appraisal, planning
  * Return to life phase (2 weeks-2 years) - reintegration

(NIMH, 2002)
Child Disaster Behavioral Health Protocol
(Adapted from Mitchell & Everly, 2001)

1. Pre-incident planning - developing protocol
2. Pre-incident training - experiential, systematic, theory-based interventions
3. Need assessment - observing & asking local leaders

* CHECK (scene, structure, self, survivor)
* CONNECT (survivor, specialized services, support)
* C-A-R-E (Comfort; Assess; Refer; Educate)
  * Comfort - stabilization/supportive communication/practical assistance
  * Assess - behavioral health assessment & triage
  * Refer - assistance, natural & formal services & resources, follow-up
  * Educate - typical stress reactions, stress management, coping & resiliency

(Mescia, 2005)
Child Disaster Behavioral Health Protocol (Cont.)

5. Crisis management briefing – provide accurate, timely, factual information about disaster & stabilization to large groups

6. Defusing – brief, small group process; usually 20-45 minutes in duration

7. Psychological debriefing – a 7-phase, small group process, lead by a trained & licensed mental health professional; usually 1.5-3 hours
8. Family support - provide reassurance, information, & guidance
9. Play therapy - ongoing treatment by a registered play therapist
10. Consultation with school staff & community leaders - information to meet child survivor’s needs
11. Team demobilization - process to provide structured support to behavioral health support/strike team members after the shift
12. Team care - compassion fatigue & stress management resistance & resiliency building
Module 2

Recognizing & Responding to Behavioral Health Emergencies in Children & Adolescents
Learning Objectives

* Discuss examples of potentially traumatic events for children & adolescents.
* Describe children's & adolescents' common responses to trauma.
* Identify risk & resiliency factors of children & adolescents experiencing trauma.
* Identify the signs, symptoms, & syndromes of children & adolescents who need follow-up intervention.
* Identify appropriate referral resources & services for children & adolescents who need further intervention.
**Traumatic Event**

* Any event outside the usual realm of human experience that is markedly distressing

* An extraordinary circumstance that leaves a child feeling terrified, powerless &/or horrified in the face of threatened, potential, or actual injury or death

(Everly, 2003)
Trauma Definition

An overwhelming, **uncontrollable** experience that psychologically impacts children survivors by creating in them:

* Feelings of helplessness
* Vulnerability
* Loss of **safety**
* Loss of control

(James, 1989)
Children’s Trauma Responses

* Majority of children & adolescents have predictable, typical & temporary responses
* Trauma responses vary by event type & child’s developmental age
**Children’s Characteristics After Trauma**

* Recurrent, **intrusive** visualizations
* Play re-enactments
* Trauma-specific fears or avoidance
* Changed attitudes about people, life & **future**

(Terr, 1991)
Children's Drawings of Tsunami
Children's Drawings of Tsunami
Children’s Drawings of Tsunami

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Children's Drawings of Tsunami
Activity 1: Recognizing Traumatic Events & Children’s Common Responses to Trauma

Related Learning Objectives:
* Discuss examples of potentially traumatic events for children & adolescents.
* Describe children’s & adolescents’ common responses to trauma & disaster.

Time: 15 minutes

Instructions:
* Assemble into groups of five to six members.
* Discuss & list examples of potentially traumatic events for children & adolescents. (5 minutes)
* Describe children’s & adolescents’ common responses to these traumatic events. Discuss how these events may affect responses & how responses to these events may differ by event. (5 minutes)
* Record your group’s responses in the table provided below & on the easel tablet.
* Select a group speaker.
* Share your group’s unique responses with the large group. (1 minute per group; 5 minutes total)
Common Trauma Responses
Preschool – 2nd Grade

* Believes death is reversible
* Magical thinking
* Intense, but brief grief responses
* Worries others will die
* Separation anxiety
* Avoidance
* Regressive symptoms
* Fear of the dark

(Braden & Duchin, 2002)
Intervention Guidelines
Preschool – 2nd Grade

* Give simple, concrete explanations as needed
* Provide physical closeness
* Allow expression through play
* Read story books
  * A Terrible Thing Happened
  * Brave Bart
  * Don’t Pop Your Cork on Monday

(Braden & Duchin, 2002)
Common Trauma Responses
3rd–6th Grade

* Asks lots of questions
* Begins to understand death is permanent
* Worries about own death
* Increased fighting & aggression
* Hyperactivity & inattentiveness
* Withdrawal from friends
* Re-enactment through traumatic play

(Braden & Duchin, 2002)
Intervention Guidelines
3rd – 6th Grade

* Give clear, accurate explanations
* Allow expression through art, play, journaling

(Readen & Duchin, 2002)
Common Trauma Responses
Middle School

* Physical symptoms of headaches, stomachaches
* Wide range of emotions
* More verbal, but still needs physical outlet
* Arguments, fighting
* Moodiness

(Braden & Duchin, 2002)
Intervention Guidelines

Middle School

* Be accepting of moodiness
* Be supportive & discuss when the children are ready
* Conduct groups with structured art activities or games

( Braden & Duchin, 2002 )
Common Trauma Responses
High School

* Understands death is irreversible, but believes it will not happen to them
* Depression
* Risk-taking behaviors
* Lack of concentration
* Decline in responsible behavior
* Apathy
* Rebellion at home or school

(Braden & Duchin, 2002)
Intervention Guidelines
High School

* Listen
* Encourage expression of feelings
* Conduct groups with guiding questions & projects

( Braden & Duchin, 2002)
Psychological Responses After a Biological Terrorist Attack

* Magical thinking about microbes & viruses
* Fear of invisible agents & contagion
* Attribution of arousal symptoms to infection
* Panic & paranoia
* Children will be most afraid that:
  * The event will happen again.
  * Someone will be injured or killed.
  * They will be separated from the family.
  * They will be left alone.

(Braden & Duchin 2002)
Realms Affected by Trauma

1. Cognitive / Beliefs / Judgment
   * Difficulty concentrating, making decisions
   * Visual images, intrusive thoughts
   * Safety, trust/dependence, morality

2. Emotional / Feelings
   * Management of feelings
   * Inner connection with others
   * Worthy of life, self-esteem, intimacy

(James, 1989; APA, 2003; Norman, 2001)
Realms Affected by Trauma (Cont.)

3. Behavioral
   * Social withdrawal, hypervigilance, aggressiveness, drugs/alcohol, poor hygiene, sexual acting-out

4. Physical / Body & Brain
   * Muscle tension, nausea, headaches, sleeplessness, 1000-yard stare, fatigue

5. Spirituality / Frame of Reference
   * Doubting God, own identity, world view
Activity 2: Predicting Typical Trauma Responses of Children & Adolescents

Related Learning Objective: Describe children’s & adolescents’ common trauma responses.

Time: 25 minutes

Instructions:
* Assemble into groups of five to six members.
* Read your assigned scenario below.
* Compare & contrast the following predicted responses of a 5, 10 & 15 year-old child. (15 minutes)
  * Physical
  * Emotional
  * Behavioral
  * Cognitive
  * Spiritual
* Record your group’s responses on the easel tablet.
* Select a group speaker.
* Share your group’s responses to your scenario with the large group. (2 minutes per group; 10 minutes total)
Traumatized Children
Type I & II

* Type I - single incident of trauma
* Type II - prolonged, repeated trauma
* “Repeated trauma in childhood forms & deforms the personality.
* The child must compensate for the failures of adult care & protection with the only means at his or her disposal, an immature system of psychological defenses.”

(Terr, 1990; Herman, 1992, p. 96)
Type II Symptoms

* Overwhelming fear & helplessness
* Hyperarousal & alertness
* Inability to concentrate
* Exaggerated startle
* Self-mutilation

(Terr, 1990)

* Self-punishing
* Impulsivity
* Lower I.Q. & esteem
* Perfectionism
* Insecurity
* Automatic obedience
* Inability to tolerate ambiguity / to appreciate other’s feelings

(Terr, 1990)
Continuum of Posttraumatic Responses: Signs, Symptoms & Syndromes

* Assimilation & growth
* No effect
* Bereavement – “typical”; < 2 months
* Acute Stress Disorder - < 30 days
* Posttraumatic Stress Disorder - >= 30 days
* Separation Anxiety Disorder - from caregivers
* Generalized Anxiety Disorder - worry 6 months
* Major Depressive Episode - depressed 2 weeks
Activity 3: Continuum of Posttraumatic Responses

Related Learning Objective: Identify the signs, symptoms & syndromes of children & adolescents who need follow-up intervention.

Time: 20 minutes

Instructions:
* Assemble into groups of five to six members.
* Refer to pages 12-13 in your program manual.
* For each of the five scenarios, identify which category in the "continuum of posttraumatic responses" the following children are exhibiting & describe your rationale for selecting the category of posttraumatic response. (15 minutes)
* Record your responses to each of the scenarios on the form below.
* Record your group’s responses to your group’s assigned scenario on the easel tablet.
* Select a group speaker.
* Share your group’s responses to one of the scenarios with the large group. (1 minute per group; 5 minutes total)
PTSD Prevalence in Children

* 55% of children had moderate to very severe symptoms 3 months after Hurricane Andrew

* PTSD prevalence varies by incident:
  * 2% after a natural disaster
  * 28% after an episode of terrorism
  * 29% after a plane crash
  * 20% after road traffic accident
  * 12% after hospitalization
  
  (NIMH, 2001; Vernberg, 1996; Vincent, 1998)

* Although 90% of adults were exposed to at least 1 trauma, only 8-9% of adults developed PTSD.
  
  (NIMH, 2001; Vernberg, 1996; Vincent, 1998; Yule, 2001)
Risk Factors Predicting PTSD

* Characteristics of the trauma exposure
  * Proximity to trauma, severity & duration
* Characteristics of the individual
  * Prior trauma exposures, family history / prior psychiatric illness
  * Female gender
  * Ethnic minority
* Post-trauma factors
  * Availability of social support
  * Emergence of avoidance / numbing, hyper-arousal & re-experiencing symptoms

(NIMH, 2001)
PTSD Risk Factors (Cont.)

* Severe marital discord
* Authoritarian perspective of parents
* High anxiety in maternal figure
* Low employability of father
* Low socio-economic status

* Overcrowding of home
* Criminality of father
* Psychiatric disorder of mother
* Poor quality of mother-child interactions
* Admitting child to care of authorities

(Garbarino, 1986)
PTSD Risk Factors (Cont.)

* Trauma that occurs before the age of 11 results in a three-times greater chance of traumatic stress reaction in children.

* When 4 or more risk factors are present, the chance of permanent problems increases 10-fold.

(Garbarino, 1986)
PTSD Resiliency or Protective Factors

* High verbal abilities
* One caring parent or adult in immediate surroundings
* Child’s capacity for goal-oriented behavior
* Open, supportive educational climate
* Early identification & intervention
* Strong natural supports & resources
* Trauma is not of human design & not in the family.
Identifying Children Who Need Follow-Up Intervention

* Avoidance behavior
  * Resist being near places / things that remind them of the trauma

* Emotional numbing
  * Diminished emotional response or lack of feeling toward the event

* Emotional loss of control
  * Frequently hysterical

* Impeded social or academic functioning

* Posttraumatic reenactment in play, drawings & verbalizations

(Cohen, Berliner, & March, 2000; Terr, 1990; NIMH, 2001)
Identifying Children Who Need Follow-Up Intervention (Cont.)

* Disorientation
* Depression
* Anxiety
* Mental illness
* Refusal to eat, sleep, bathe
* Suicidal or homicidal thoughts
* Clear indicators of abuse
* Alcohol or drug use

(DeWolfe & Nordboe, 2002)
Assessing for Further Interventions

* Frequency, intensity, duration
* Functioning support system?
* Instruments
  * Children’s Trauma Symptom Checklist
  * Impact of Events’ Scale - children’s version
  * Children’s Depression Inventory
  * Revised Children’s Manifest Anxiety Scale
Identifying Children Who Need Referral for Medication

* Symptoms that impair school or social functioning persist for months despite counseling
* Family &/or other support systems are consistently supportive & healthy
* Typical medications
  * Anti-depressants - Lexapro, Zoloft, Paxil
  * Anti-anxiety - Imipramine, Effexor, Klonopin

(Wozniak, et. al, 1997)
Activity 4: Identifying Children Who Need Follow-Up Services

Related Learning Objective: Identify the signs, symptoms, & syndromes of children & adolescents who need follow-up intervention.

Time: 15 minutes

Instructions:
* Assemble into groups of five to six members.
* The following children in each of the five scenarios survived a hurricane at night that killed 50 people & destroyed 500 homes. For each of the children in the five scenarios, identify the individual child’s need for services. Triage (rank) each child by prioritizing their need for services. (1 is the highest, 5 is the lowest.)
* Record your group’s responses to the scenarios on the easel tablet. (10 minutes)
* Select a group speaker.
* Share your group’s unique responses with the large group. (1 minute per group; 5 minutes total)
Activity 5:
Identifying Referral Resources & Services for Children & Adolescents

Related Learning Objective: Identify appropriate referral resources & services for children & adolescents who need further intervention.

Time: 15 minutes

Instructions:
* Assemble into groups of five to six members.
* Refer to pages 47-48 in your program manual.
* Review the list of national, state, & local resources for traumatized children & adolescents, & discuss group members’ experiences with & knowledge of the listed resources. (5 minutes)
* Identify & list additional informal & formal behavioral health referral resources & services. (5 minutes)
* Share your group’s unique responses with the large group. (1 minute per group; 5 minutes total)
Lunch
Module 3

Disaster Behavioral Health
First Aid Protocol with Children:
The Child $C^3$ARE Model

(Mescia, 2005)
Learning Objective

* Describe & demonstrate the Child C³ARE Model of Disaster Behavioral Health Protocol.
Child C³ARE Model of Disaster Behavioral Health First Aid

* Dynamic, one-on-one, behavioral health intervention with children & adolescents
* Usually delivered soon after the disaster (0-48 hours post-event)
* After site is cleared by Incident Commander
* After child survivor is cleared by EMS
* Brief, 5 to 15 minutes
Child C³ARE: Action Steps

Step 1: CHECK

Step 2: CONNECT

Step 3: C-A-R-E

Comfort  Assess  Refer  Educate
Child C³ARE: Action Steps

Action Step 1: CHECK

Action Step 2: CONNECT

Action Step 3: C·A·R·E (Comfort, Assess, Refer, Educate)
Action Step 1:
CHECK

The Child $C^3$ARE Model
Action Step 1: CHECK
Roles & Responsibilities

* Protect
  * Recognize behavioral health emergencies
  * Protect self, as well as affected child survivors, from further harm
  * Promote safety & security of self & child survivors
  * Identify distressed children & conduct initial assessment
  * Identify limits to own knowledge, skill, authority & identify key system resources for referring matters that exceed these limits

* Direct

* Survey

* Assess
Action Step 1: CHECK

* Scene
* Structure
* Self
* Child Survivor
Action Step 1: CHECK Scene

* Survey the scene
  * Is scene safe for self & others?
  * Has scene been cleared as “safe” by incident command?
  * What is happening?
  * Is any child in physical or emotional distress & in need of immediate assistance?
  * Who is available to help?
  * What resources are there?
  * Has EMS been contacted?

* If so, have the child survivors been evaluated by EMS?
Action Step 1: CHECK Structure

* Determine formal response structure & get authorization to help - “Check-in”
  * Is there an incident commander, team leader, or another person in charge?
  * Who is the incident commander, team leader, or person in charge?
  * When & where do I check-in?
  * Who are my team members?
  * Do they need or want my help?
  * Have I received authorization to help?
    * If so, how may I help?
Action Step 1: CHECK Self

* Perform self-awareness check
  * Am I safe?
  * Am I prepared to help?
  * Do I have the necessary knowledge, skill, abilities?
  * Am I emotionally & psychologically ready to help?
  * Do I have a non-anxious presence?
    * How may I be most helpful?
**Action Step 1: CHECK**

**Child Survivor**

* Identify child(ren) needing immediate assistance
  * Has the child survivor been cleared by EMS?
  * Does the child survivor have any immediate medical needs or concerns?
  * Is child survivor showing signs of physical / emotional / behavioral distress?
  * Is child survivor safe?
  * Is child survivor stable?
  * Is child survivor oriented?
  * Is child survivor bleeding, vomiting, or convulsing?
* Is immediate & more specialized help needed?
Action Step 2: CONNECT

The Child $C^3$ARE Model
Action Step 2: CONNECT

Roles & Responsibilities

* Support
  * Make contact with child survivor & establish rapport

* Contact
  * Connect child survivor with appropriate informal & formal support & services

* Communicate
  * Practice supportive communication

* Assess
  * Identify limits to own knowledge, skill, & authority & identify key system resources for referring matters that exceed these limits

* Identify
  * Provide behavioral health support for child disaster survivors and guardians

* Triage
Action Step 2: CONNECT

* Child Survivor
* Social Support
* Specialized Services
Action Step 2: CONNECT

Child Survivor: Tasks

* Make contact with child survivor & guardian
* Ask for child survivor’s & guardian’s permission to help
* Establish rapport with child survivor
* Engage in non-threatening conversation with child
* Determine child survivor’s level of functioning
* Practice supportive communication
* Demonstrate cultural competence
* Maintain a non-anxious presence

Hint: Offering a bottle of water may help with introduction
Action Step 2: CONNECT
Child Survivor: Ask

* “Hello, my name is ____ , and I’m helping out here today. This is (puppet’s name). What’s your name?”
* “Is it okay if I visit with you?”
* “Does anything hurt or feel bad?”
* Is there evidence of functional impairment?
Action Step 2: CONNECT
Social Support

* Contact child survivor’s loved one(s) to establish social support (e.g., parents, family)
  * Is parent or guardian with child survivor or coming to be with child?
  * If not, “Who may I call to come be with you?”
**Action Step 2: CONNECT**

**Specialized Services**

- Survey child survivor & determine the need for immediate specialized services
- Triage child survivor, as indicated
  - Does the child survivor need immediate or more sophisticated & specialized services than I am able to provide right now?
  - If so, what services are needed?
Action Step 3: C-A-R-E

The Child $C^3$ARE Model
### Action Step 3: C-A-R-E

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Action Step 3: C-A-R-E

C³ARE-Giver Roles

* Support
* Stabilize
* Identify
* Assess
* Inform
* Educate
* Refer
Action Step 3: C-A-R-E Responsibilities

* Stabilize & comfort distressed child survivor
* Address child survivor’s immediate physical needs & provide practical assistance and emotional support
* Provide concrete information about disaster & what will happen next
* Listen to & validate child survivor’s feelings
* Link child survivor to systems of support
* Educate child survivor & guardian about stress reactions, reduction & management
* Reinforce positive coping & resiliency
* Identify limits to own knowledge, skill, authority & identify key system resources for referring matters that exceed these limits
Action Step 3: C-A-R-E Comfort
Action Step 3: C-A-R-E

Comfort: Tasks

* Goals: To stabilize distressed child survivor & provide practical assistance & emotional support
* Calm & stabilize child survivor
* Create a safe haven or comfortable environment
* Provide support, reassurance & practical assistance
* Supply immediate & basic “survival” & security needs & help child survivor identify 1 or 2 things they can do to help meet their own needs
* Practice supportive communication & cultural competence
* Communicate positive expectations of a normal recovery
* Help child survivor develop skills for managing potential traumatic stress
Action Step 3: C-A-R-E

Comfort: Ask

* How may I best assist the child survivor?
* What are the child survivor’s immediate needs?
* What can I do to help comfort &/or stabilize the child survivor?
* Which interventions will be most helpful?
* “Are you comfortable?”
* “Are you safe here?”
* “May I get you something to drink or eat?”
* “What has helped you before when you feel bad or sad?”
* “I know some things that may help you feel better. Would you like me to show or tell you?”
Action Step 3: C-A-R-E

Comfort: Interventions

* Stabilization techniques:
  * Diaphragmatic “deep” breathing (e.g., balloons, bubbles)
  * Progressive relaxation (e.g., “Tense like a tin man, relax like a rag doll.” “Shake & wiggle like a wet puppy.”)
  * 3-2-1 Sensory grounding
    * Use stuffed animals, puppets, make worry dolls
Action Step 3: C-A-R-E

Comfort “Guided” Practice

* Diaphragmatic “Deep” Breathing
  * Bubbles
  * Balloons
* Progressive Relaxation
  * Simon says, “Tense like a tin man, relax like a rag doll.”
  * Simon says, “Shake & wiggle like a wet puppy.”
Action Step 3: C-A-R-E
Assess
Action Step 3: C-A-R-E
Assess: Tasks

* Goals: To monitor child survivor’s physical & behavioral health status & assess child survivor’s coping & functioning
* Monitor child survivor’s physical & behavioral health status
* Assess child survivor’s coping & functioning
* Identify child survivor’s risk & resiliency factors
**Action Step 3: C-A-R-E**

**Assess: Ask**

* Is child survivor experiencing signs of physical, behavioral &/or emotional distress?
  * How is child survivor’s physical & emotional health?
  * Does child survivor have any immediate health or behavioral health needs?

* Does the child survivor appear to be functionally impaired?
  * Does child survivor appear oriented?
  * Is child survivor experiencing severe post-traumatic stress reactions or distress symptoms?

* Is child survivor a harm to self &/or others?
**Action Step 3: C-A-R-E**

**Assess: Ask** (Cont.)

* **How is child survivor coping?**
  * Is child survivor displaying self-mastery & control?
  * Is child survivor’s parent(s) or guardian with him / her?

* **What are child survivor’s risk & resiliency factors?**
  * Does child survivor have any pre-existing conditions or factors which place him / her at increased risk for adverse outcomes?
Action Step 3: C-A-R-E
Assess: Interventions

* Physical assessment
* Behavioral health assessment
* Risk assessment
* Triage
Action Step 3: C-A-R-E
Assess: Checklist

✓ Medical & health conditions
✓ Trauma & loss exposure
✓ Emotional & physical distress
✓ Presence of risk & resiliency factors
✓ Current behavioral distress
✓ Availability of social support
✓ Sensory, cognitive, behavioral abilities & needs
Action Step 3: C-A-R-E

Refer
Action Step 3: C-A-R-E
Refer: Tasks

* Goals: Identify & refer child survivor to formal support, specialized services & resources
* Identify appropriate behavioral health services & resources
* Provide child survivor’s guardian with handouts of indigenous behavioral health helpers, agencies, & services
* Recommend system services & resources
  * Triage
  * Follow-up
  * Outreach
Action Step 3: C-A-R-E
Refer: Ask

* What are the child survivor’s current & potential future needs?
* Triage:
  * Does child survivor need more sophisticated & specialized services?
  * If so, which services & resources are appropriate?
Action Step 3: C-A-R-E

Refer: Ask (Cont.)

* Outreach & Referral:
  * What services & resources are available to the child survivor?
  * Does child survivor have access to these services & resources?
  * Any barriers to services?

* Follow-up:
  * Does the child survivor need follow-up services?
  * Is child survivor’s guardian willing to allow my agency or other agencies to collect contact information for follow-up services?
Action Step 3: C-A-R-E
Refer: Interventions

* Needs assessment
* Triage
* Referral
* Provide resource & service information to guardian (e.g., handout of indigenous helpers, agencies & services or service directory)
* Follow-up
Action Step 3: C-A-R-E

Educate
**Action Step 3: C-A-R-E**

**Educate: Tasks**

* **Goals:** To offer information and education to child survivor and guardian on stress reactions, stress management, coping & resiliency

* Help child survivor make sense of the symptoms s/he is experiencing or may experience as a result of the trauma

* Help child survivor understand that s/he is a “typical kid having typical responses to a horrible thing”

* Help child survivor and guardian normalize common reactions to trauma, improve coping & resiliency

* Help child survivor develop skills for managing potential traumatic stress
Action Step 3: **C-A-R-E**

**Educate: Ask**

* What are children’s typical responses to trauma?
* What information about managing stress & coping & resiliency may I offer the child survivor & guardian?
* “Would you like to learn some things that might help you feel better?”
Action Step 3: C-A-R-E
Educate: Interventions

* Provide child survivor & guardian with concrete information about what will happen next
* Educate child survivor & guardian about typical stress reactions & stress management techniques
* Provide child survivor & guardian with information to increase coping & resiliency
* Use puppets, toys, encourage picture drawings of feelings or event, clay worry object, make a “shield of faith”

* Read books: A Terrible Thing Happened; Brave Bart; Don’t Pop Your Cork on Monday
Action Step 3: C-A-R-E
Educate Practice

* Make your “shield of faith”
"I am Safe & Strong" Song

I am safe & I am strong,
Take a breath & sing this song.
I’m growing stronger every day,
I know I will be okay.
I am safe & I am strong,
Take a breath & sing along.
(Source: Association of Play Therapy)
Activity 6: Child C³ARE Model of Disaster Behavioral Health First Aid Protocol

Related Learning Objective: Describe & demonstrate the Child C³ARE Model of Disaster Behavioral Health First Aid protocol.

Time: 30 minutes

Instructions:
* View the Child C³ARE Model demonstration video. (15 minutes)
* Identify & describe the steps, stages, & techniques of the Child C³ARE Model that were demonstrated in the video. (5 minutes)
* Share your unique individual responses with the large group. (5 minutes total)
* Discuss: (5 minutes total)
  * What did the helper do well?
  * What interventions could the helper try?
Activity 6: Child C³ARE Demonstration Video
Activity 7: Child C³ARE Model Role-Play

Related Learning Objective: Describe & demonstrate the Child C³ARE Model of Disaster Behavioral Health First Aid protocol.

Time: 30 minutes

Instructions:
* Assemble in pairs.
* Each participant will take a turn at role-playing the following: (10 minutes each role)
  * Behavioral first aid specialist (BFAS)
  * Child disaster survivor
* After each role-play, the participants will assess & offer feedback to each other. (5 minutes each)
Module 4

Structured Group
Disaster Behavioral Health Interventions
with Children & Adolescents
Learning Objective

* Describe & demonstrate group behavioral health interventions for managing & reducing disaster related stress with children & adolescent survivors of disasters.
Structured Group Intervention Goals

* Share experiences & feelings
* Boost children’s sense of mastery & control
* Share ways of solving common problems
* Screening
* Psycho-education
* Stress & anxiety management / coping
10 Curative Factors of Group Intervention

1. Imparting information
2. Instilling hope
3. Altruism
4. Universality
5. Corrective recapitulation
6. Develop socializing techniques
7. Imitative behavior
8. Interpersonal learning
9. Group cohesiveness
10. Catharsis

(Yalom, 1995)
Structured Group Interventions for Children

* Cognitive behavioral therapy
* Systematic desensitization / relaxation
* Crisis management briefing
* Small group defusing
* Psychological debriefing
Crisis Management Briefing with Children

* Structured group process
* Four phases
* Designed for large groups of children & parents (10 - 300), who experienced the same disaster or event
* Conducted any time after the event
* 45-75 minutes duration
Crisis Management Briefing with Children Protocol (Cont.)

1. Gather large group of children & parents
2. Have credible authority give facts of event
3. Use puppets to convey accurate information & answer questions
4. Use puppets, bubbles & art supplies to teach stress management strategies
Crisis Management Briefing for Elementary School Children

* Explain why you are there
* Puppet play
  * One scared puppet and one wise puppet
  * Address children’s fears & questions
* Let each child hug puppet
Small Group Defusing

* Brief, 3-phase, small group process
* Goals: to reduce children survivors' intense reactions, normalize their responses, accelerate their recovery & assess need for further intervention
* Conducted in private place located away from the disaster scene
* Administered within first 3 to 12 hours following incident
* 20-45 minutes duration
* Use puppets, stuffed animals, art supplies, bubbles
Small Group Defusing Protocol

1. Introduction
   * Give reason for gathering
   * Review guidelines
   * Encourage children survivors’ support & participation

2. Exploration
   * Ask children survivors to discuss the experience
   * Draw a picture of experience & what will help

3. Information
   * Normal stress reactions / responses
   * Practical stress survival skills
   * Accept & summarize
Small Group Defusing
for Elementary School Children

* My Memory Story
  * My name is ____.
  * Something terrible happened & I feel ____.
  * Two good things I will always remember are ____.
* To make myself feel better I will ____.
* Hold onto hope. (Draw rainbow.)

* Card for survivors
  My heart is with you.
Activity 8: Small Group Defusing with Children Role-Play

Related Learning Objective: Describe & demonstrate group behavioral health interventions for managing & reducing disaster related stress with children & adolescent survivors of disaster & trauma.

Time: 30 minutes

Instructions:
* Assemble into groups of six to seven members.
* Select & read your role. (5 minutes)
* Prepare to role-play your selected role for the small group defusing.
  * Child: Identify typical trauma responses & concerns for assigned child.
  * Leader: Prepare to conduct the defusing.
* Participate in a small group defusing. (20 minutes)
* Debrief the small group defusing. (5 minutes)
Psychological Debriefing with Children

* A formal, 7-step, small group process
* Goals: To mitigate or resolve children survivors’ distress through education, ventilation, reassurance & screening
* Conducted 1-10 days after disaster event
* Led by a person trained in CISD & a licensed mental health professional
* Establish a set time in a quiet, private room away from disaster scene
  * 60-120 minutes duration
* Effectiveness of intervention in question
Psychological Debriefing with Children Protocol

1. Introduction phase
2. Fact phase
3. Thought phase
4. Reaction phase
5. Symptoms’ phase
6. Teaching phase
7. Re-Entry phase

(Originally developed by Mitchell & Everly, 1996; adapted for children by McPherson, 2003)
Psychological Debriefing with Children (Cont.)

1. Introduction Phase
   * Helper & warrior/athlete role
   * Decorate name plates or tags
Psychological Debriefing with Children (Cont.)

2. Fact Phase
   * News broadcast
   * Drawing
Psychological Debriefing with Children (Cont.)

3. Thought Phase

* Puppet sentence completion
* Cartoon thought bubbles

This is scary!
Psychological Debriefing with Children (Cont.)

4. Reaction Phase

* Color your feelings
* Feelings faces
Psychological Debriefing with Children (Cont.)

5. Symptoms' Phase

* Symptom charades
* Puppet's symptoms
Psychological Debriefing with Children (Cont.)

6. Teaching Phase

* Brave Bart or A Terrible Thing Happened
* Bubbles
* Balloons
* Clay worry object
* "Tense like a tin-man & relax like a rag doll"
* "Shield of Faith"
Psychological Debriefing with Children (Cont.)

7. Re-Entry Phase

* Group cheer
* “High fives”
Module 5

Strategies for Helping Families Respond to the Behavioral Health Needs of Child & Adolescent Trauma Survivors
Learning Objective

* Describe strategies for helping families respond to the needs of child & adolescent trauma survivors.
Benefits of Family Involvement to Child Survivor

* Accelerates child survivor’s recovery
* Reduces secrecy & shame
* Promotes child survivor’s self-acceptance
* Improves child’s attachment to parent or caring adult

(James, 1989)
The key ingredient for children survivors recovering from trauma is...

*How children see their parents respond!*
Providing Consultation with Families of Children Survivors

* Family Support:
  * Provide reassurance, information on typical reactions & appropriate responses

* Referrals:
  * Develop list of community resources & trained play therapists
Guidelines for Parents’ Interaction with Children

* Talk calmly & openly at child’s level
* Ask about child’s thoughts & fears
* Share your own fears & reassure child
  * Acknowledge parts of the disaster that were frightening to you
  * Do not falsely minimize the danger
  * Admit your concerns & stress your ability to cope

(Braden & Duchin, 2002; Speier, 2000)
Guidelines for Parents’ Interaction with Children (Cont.)

* Provide physical affection
* Emphasize the normal routine
* Limit media re-exposure
* Allow expression in private ways (e.g., playing, drawing)
* Encourage positive coping, not blaming
* Foster social support from teachers & classmates

(Braden & Duchin, 2002)
Guidelines for Parents’ Interaction with Children (Cont.)

Develop a Family Disaster Plan:

* Discuss procedures for likely disasters
* Arrange for two places to meet
  * Right outside of your home
  * Outside of your neighborhood – write down address & phone number
* Ask out-of-state friend to be your “family contact”
* Discuss what to do in evacuation – pets, important papers, things
Guidelines for Parents’ Interaction with Children (Cont.)

Develop a Family Crisis Kit:

* Water – 1 gallon/person/day
* Food – 3 day supply of non-perishables
* First Aid Kit & Medications
* Clothing – 3-day supply
* Bedding – blankets, sleeping bags, pillows
* Tools & Supplies – can opener; cash; map
* Hygiene & Sanitation – toilet paper, soap, bleach
* Fun Stuff – crayons, playing cards, books, games
Wrap-Up

* Questions???
* Learning Objectives’ Review
Learning Objectives

1. Recognize the purpose, principles, practices & protocol of systematic, theory-based interventions with children & adolescents.
2. Discuss examples of potentially traumatic events for children & adolescents.
3. Describe children's & adolescents' common responses to trauma.
4. Identify risk & resiliency factors of children & adolescents experiencing trauma.
5. Identify the signs, symptoms & syndromes of children & adolescents who need follow-up intervention.
6. Identify appropriate referral resources & services for children & adolescents who need further intervention.
7. Describe & demonstrate the Child C³ARE Model of Disaster Behavioral Health First Aid protocol.
9. Describe strategies for helping families respond to the needs of child & adolescent trauma survivors.
Reflection Exercise

* What sticks out the most? (What are you taking away?)
* What can you use? How?
Next Steps

* FCPHP C-FAST Recommended Distance Learning Programs
  * Assuring Cultural Competence in Disaster Response
  * Understanding Compassion Fatigue
  * Critical Incident Stress Management & Public Health Emergency Readiness & Response
* Additional Disaster Behavioral Health First Aid Specialist Trainings
  * R-FAST (Responder) - Spring 2006
  * S-FAST (Special Populations) - Fall 2006
  * T-FAST (Trainer) - Fall 2006
Documentation

*Post Assessment
*Program Evaluation
*Continuing Education Credit Application
*Program Certificate
Photo Credits

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The Florida Center for Public Health Preparedness

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