

GENERAL INFORMATION

<p>Treatment Description</p>	<p>Designed for implementation by school teachers or counselors, Support for Students Exposed to Trauma (SSET) is a cognitive-behavioral, skills-based, support group aimed at relieving symptoms of child traumatic stress, anxiety, depression, and functional impairment among middle school children (ages 10-16) who have been exposed to traumatic events. It is used most commonly for children who have experienced or witnessed community, family, or school violence, or who have been involved in natural disasters, accidents, physical abuse, or neglect. It includes 10 lessons in which children learn about common reactions to trauma, practice relaxation, identify maladaptive thinking and learn ways to challenge those thoughts, learn problem solving skills, build social support, and process the traumatic event. Between sessions, children practice the skills they have learned.</p> <p>Developed as an adaptation of the Cognitive-Behavioral Intervention for Trauma in Schools program (CBITS; Stein et al., 2003; Kataoka et al., 2003; Jaycox et al., 2010), SSET contains many of the same therapeutic elements but is designed to be implemented by school staff members without clinical training, with the back-up of a clinician who can help with clinical decision-making related to screening and intervention, provide emergency back-up, and advise on high-risk students. The SSET adaptation of CBITS does not include individual or group imaginal exposure to the traumatic event, and is designed to be more like a school lesson, written in lesson plan format.</p>
<p>Target Population</p>	<p>Schools are one of the natural environments that can support health and mental health. Delivery of mental health programs through schools can overcome logistical barriers (transportation, scheduling) as well as reduce stigma.</p> <p>SSET is designed for children in late elementary school through early high school (ages 10-16) who have experienced events such as witnessing or being a victim of family, school, or community violence, being in a natural or man-made disaster, being in an accident or fire, or being physically abused or injured, and who are experiencing moderate to severe levels of post-traumatic stress symptoms. SSET was developed and tested in middle schools serving diverse, multicultural, and multilingual students—predominantly Latino, African American, Caucasian, and Asian. It is designed to be used in schools with children from a variety of ethnic and socio-economic backgrounds and acculturation levels.</p>
<p>Essential Components</p>	<p>SSET includes cognitive-behavioral coping strategies and skills and trauma narrative.</p> <p>Key components:</p> <ul style="list-style-type: none"> • Psychoeducation • Relaxation training • Cognitive coping • Gradual exposure to trauma reminders • Trauma narrative • Problem Solving

GENERAL INFORMATION

<p>Essential Components continued</p>	<p>Parental permission is sought for children to participate. A handout is sent home to parents, followed by screening of students.</p> <p>A screening procedure is recommended for use in the general school population to assist in identifying children who have been exposed to traumatic events and have current moderate to severe post-traumatic stress symptoms, including guidelines for consultation with the back-up clinician to advise on cases in which child abuse is detected or the child discloses intent to harm self or others. A call or in-person meeting with parents/caregivers is recommended at the beginning of treatment to answer questions and review expectations for child and parent involvement. A step-by-step guide lesson plan, including scripts and examples for activities, is available for use by the group leader, as well as a workbook with all of the parent letters, handouts, and materials needed for each session.</p>
<p>Clinical & Anecdotal Evidence</p>	<p>Are you aware of any suggestion/evidence that this treatment may be harmful? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Uncertain</p> <p>Extent to which cultural issues have been described in writings about this intervention (scale of 1-5 where 1=not at all to 5=all the time). 5</p> <p>This intervention is being used on the basis of anecdotes and personal communications only (no writings) that suggest its value with this group. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Are there any anecdotes describing satisfaction with treatment, drop-out rates (e.g., quarterly/annual reports)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, please include citation:</p> <p>Jaycox LH, Langley AK, Stein BD, Wong M, Sharma P, Scott M, Schonlau M, Support for Students Exposed to Trauma: A Pilot Study, <i>School Mental Health</i>, 1(2):49–60, 2009</p> <p>Has this intervention been presented at scientific meetings? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are there any general writings which describe the components of the intervention or how to administer it? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, please include citation:</p> <p>Jaycox LH, Kataoka SH, Stein BD, Wong M and Langley A, Responding to the needs of the community: A stepped care approach to implementing trauma-focused interventions in schools, <i>Report on Emotional and Behavioral Disorders in Youth</i>, 5(4):85-88, 100-103, 2005</p> <p>Jaycox LH, Langley AK and Dean KL, Support for Students Exposed to Trauma: The SSET Program—Lesson Plans, Worksheets, and Materials, Santa Monica: RAND Corporation, TR-675, 2009.</p> <p>Jaycox LH, Langley AK, Stein BD, Wong M, Sharma P, Scott M, Schonlau M, Support for Students Exposed to Trauma: A Pilot Study, <i>School Mental Health</i>, 1(2):49–60, 2009</p>

GENERAL INFORMATION

<p>Clinical & Anecdotal Evidence continued</p>	<p>Has the intervention been replicated anywhere? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other countries? <i>(please list)</i> The intervention has been implemented in Los Angeles, CA; Lawndale, CA; Pittsburgh, PA.</p>	
<p>Research Evidence</p>	<p>Sample Size (N) and Breakdown <i>(by gender, ethnicity, other cultural factors)</i></p>	<p>Citation</p>
<p>Randomized Controlled Trials</p>	<p>N=76, 6th and 7th graders (age 11.5, SD=0.7) of two large middle schools in urban Los Angeles during two school years (2005-6 and 2006-7). Most students were Hispanic (96%). The sample was evenly split in terms of gender (51% female, 49% male) and of lower socioeconomic status, with parents reporting 8th grade education on average and 80% reporting a family income of \$25,000 or less.</p>	<p>Jaycox LH, Langley AK, Stein BD, Wong M, Sharma P, Scott M, Schonlau M, Support for Students Exposed to Trauma: A Pilot Study, <i>School Mental Health</i>, 1(2):49–60, 2009.</p>
<p>Outcomes</p>	<p>This study used a randomized design to compare students who participated in SSET immediately (between baseline and 3-month followup assessment) or on a delayed schedule (between the 3-month and 6-month followup assessments)</p> <p>Process measures & results:</p> <ol style="list-style-type: none"> <i>Participant satisfaction & attendance</i> Parent satisfaction scores were 4.50 out of 6, indicating that parent satisfaction was between “very good” and “excellent.” Student satisfaction was high as well with an average score of 2.52 out of 3, between “mostly true” and “very true.” On average, students attended approximately 8 of the 10 lessons. <i>Fidelity of the intervention as delivered by school staff</i> A random subset of audiotapes were rated for fidelity to the manual. The average coverage rating was 2.39 out of 3 with all implementers in the acceptable range of fidelity. The average quality rating was 2.37 out of 3. <p>Participant screening & outcomes measures utilized:</p> <ol style="list-style-type: none"> <i>Modified Life Experiences Survey (LES; Singer et al., 1995; Singer, Miller, Guo, Slovak, & Frierson, 1998)</i> to assess exposure to violence through direct experience and witnessing of events at home, at school, and in the neighborhood for the purpose of screening children for the program. <i>Child PTSD Symptom Scale (CPSS; Foa, Treadwell, Johnson, & Feeny, 2001)</i>, to assess PTSD symptoms for both screening into the program and for use in examining child outcomes over time. 	

GENERAL INFORMATION

Outcomes continued

3. *Children's Depression Inventory* (CDI; Kovacs, 1981). This 27-item measure assesses children's cognitive, affective and behavioral depressive symptoms
4. *Strengths and Difficulties Questionnaire—Parent Report, and Teacher Report* (SDQ, Goodman, 1997; Goodman, Meltzer, & Bailey, 1998).

Results:

Between group effect sizes (ES):

Between baseline and the first follow-up, during which the immediate SSET group participated in the lessons, we observed decreases in PTSD (treated ES = -.39, control ES = -.16, difference ES = -.23) and depression (treated ES = -.25, control ES = .07, difference ES = -.32) scores that were more pronounced than in the comparison group. However, changes in parent reported behavior problems were negligible (treated ES = -.39, control E = -.28, difference ES = -.10). Changes in teacher reports showed a small effect size ((Treated ES= .006, control ES= .28, difference ES =-.28), with the immediate intervention group showing slight decreases whereas the delayed intervention group showed slight increases in behavior problems by teacher report. During the time period between the first and second follow-up, when the delayed SSET group participated in the lessons and the immediate group did not, we observed that the immediate SSET group scores stayed about the same, and that there was some decrease in self-reported scores for PTSD and depression as well as parent reported behavior problems in the delayed group

Regression Analyses:

The regression analysis examining depression and PTSD scores at the first follow-up, controlling for scores at baseline, revealed a significant intervention group effect for depression scores (Estimate=0.65; T=-1.99, p=.046) and a non-significant trend for PTSD scores (Estimate = 0.58, T=-1.89, p=.058). These estimates of the intervention effect remained stable with comparable levels of significance when school or group leader were controlled as fixed effects. Neither teacher nor parent reports of behavior problems showed a significant intervention effect (T=-0.19 and T=-1.22, respectively).

Subgroup analyses:

Among students with higher symptoms at the beginning of the study, intervention effects were more pronounced, with a 10-point reduction in PTSD symptoms, 5-point reduction in depressive symptoms, and 5-point reduction in behavioral problems in the immediate intervention group between baseline and first follow-up assessment, though the delayed intervention group also showed more modest reductions. In contrast, in the low symptoms group, we observed little or no change across time in either group

Adverse Events: No adverse reactions to the intervention were noted. Some children disclosed child abuse, which was reported to authorities following school guidelines.

Conclusions:

Findings support the feasibility, acceptability, and promise of SSET as delivered by school staff for children with traumatic stress. Additional testing is warranted.

GENERAL INFORMATION

<p>Implementation Requirements & Readiness</p>	<p>Full support of the school principal and administration should be obtained prior to initiating SSET.</p> <ul style="list-style-type: none"> • A whiteboard or large writing pad and extra copies of the activity worksheets are used for each session. • Active parental consent is usually required for participants. • A back-up clinician of record is required so as to work with SSET implementers should any students be identified who require more intensive services or who remain symptomatic at the end of the group. <p>SSET is not a crisis intervention. If an entire school is affected by a disaster or violence, it is recommended that school counselors wait at least a month after the trauma before identifying those children in need of SSET.</p>
<p>Training Materials & Requirements</p>	<p>SSET is designed as lesson plans for teachers or school counselors. However, a clinician of record is required to serve as back up to the SSET group leader. One back-up clinician can support SSET implementers at several schools.</p> <p>Training consists of reading background materials and the manual, attending a 1.5-day, in-person training, and then receiving ongoing consultation from a local clinician with expertise in CBT and/or child trauma treatment. Guidelines are provided both in the manual and during the training regarding: consultation with the back-up clinician, protecting student confidentiality, forming groups of children, handling disclosure by students, limiting group leader self-disclosure, and self-care for the group leader. This training also addresses issues related to successful delivery of a mental health program in a school setting.</p> <p>The manual is available at http://www.rand.org/pubs/technical_reports/TR675.html. An on-line training course and implementation support materials can be found at www.ssetprogram.org. To arrange virtual or in-person live training, contact Pamela Vona at pamela@safeandresilient.org.</p>
<p>Pros & Cons/ Qualitative Impressions</p>	<p>What are the pros of this intervention over others for this specific group (e.g., addresses stigma re. treatment, addresses transportation barriers)? Implementation in schools enables clinicians to reach underserved students who might not otherwise receive mental health care. It also reduces barriers to care such as transportation, and SSET is typically delivered at no cost to the family. Not all schools have on-site clinicians, and so SSET can fill a need by being designed for delivery by non-clinically trained school staff.</p> <p>What are the cons of this intervention over others for this specific group (e.g., length of treatment, difficult to get reimbursement)? Not all students are permitted by parents to participate in screening or intervention in schools. Thus, some students are missed. Some students will need additional treatment above and beyond this early intervention group treatment, so SSET implementers need to work with a clinician to make appropriate referrals after or in parallel to SSET.</p> <p>Other qualitative impressions: Interviews with parents, students, and educators indicate that the program is well tolerated and that users are generally satisfied.</p>

GENERAL INFORMATION

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<p>References</p>	<p>Jaycox LH, Kataoka SH, Stein BD, Wong M and Langley A, Responding to the needs of the community: A stepped care approach to implementing trauma-focused interventions in schools, <i>Report on Emotional and Behavioral Disorders in Youth</i>, 5(4):85-88, 100-103, 2005</p> <p>Jaycox LH, Langley AK and Dean KL, Support for Students Exposed to Trauma: The SSET Program—Lesson Plans, Worksheets, and Materials, Santa Monica: RAND Corporation, TR-675, 2009.</p> <p>Jaycox LH, Langley AK, Stein BD, Wong M, Sharma P, Scott M, Schonlau M, Support for Students Exposed to Trauma: A Pilot Study, <i>School Mental Health</i>, 1(2):49–60, 2009.</p> <p>Kataoka S, Stein BD, Jaycox LH, Wong M, Escudero P, Tu W, Zaragoza C and Fink A, A school-based mental health program for traumatized Latino immigrant children, <i>Journal of the American Academy of Child and Adolescent Psychiatry</i>, 42(3):311-18, 2003.</p> <p>Stein BD, Jaycox LH, Kataoka SH, Wong M, Tu W, Elliott MN and Fink A, A mental health intervention for schoolchildren exposed to violence: A randomized controlled trial, <i>Journal of the American Medical Association</i>, 290(5):603-11, 2003.</p> <p>Jaycox LH, Cohen JA, Mannarino AP, Langley AK, Walker DW, Gegenheimer K, Scott M, Schonlau M, Children’s mental health care following Hurricane Katrina : A field trial of trauma-focused psychotherapies, <i>Journal of Traumatic Stress</i>, 23(2):223-31, 2010.</p>