Crisis Counseling Assistance and Training Program Data Toolkit
SUPPORTING STATEMENT – Part A

A.   JUSTIFICATION

1.   Circumstances of Information Collection

The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS) is requesting approval for a reinstatement from the Office of Management and Budget (OMB) for the Crisis Counseling Assistance and Training Program (CCP) Data Toolkit. The current forms in the toolkit (OMB No. 0930-0270) expired on September 30, 2018. The CCP Data Toolkit contains seven continuing forms:

    a) Individual/Family Crisis Counseling Services Encounter Log – Revised
    b) Group Encounter Log – Revised
    c) Weekly Tally Sheet – Revised (burden statement added)
    d) Adult Assessment and Referral Tool – Revised
    e) Child/Youth Assessment and Referral Tool – Revised
    f) Participant Feedback Form - Revised
    g) Service Provider Feedback Form - Revised

The CCP (commonly referred to as the Crisis Counseling Program) is funded by the Federal Emergency Management Agency (FEMA) through the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Public Law 93-288, as amended by Public Law 100-707). Please refer to the SAMHSA website (https://www.samhsa.gov/dtac/ccp) for more information and resources regarding the CCP.

Data collected using this toolkit will be reported in the aggregate and will be used to report summary statistics that will support the improvement of CCP service provision and to discuss the services within the disaster behavioral health scientific community.

Services offered by the CCP involve direct interventions to individuals and groups affected by a major disaster or its aftermath. Educational activities and public information on disaster behavioral health issues are another component of the CCP. Additionally, disaster behavioral health consultation and training are also provided. If FEMA declares a state eligible for the CCP, FEMA will look to the Director of the National Institute of Mental Health, as the delegate of the Secretary of the Department of Health and Human Services (HHS), to oversee the program (44 CFR 206.171 [f[a]). As such, SAMHSA CMHS (embedded within HHS) has become the designated representative for monitoring the CCP; providing consultation, technical assistance, and guidance; and serving as point of contact to HHS for program matters.

Funded by FEMA and administered by SAMHSA's CMHS, the CCP provides supplemental funding for individual and community crisis intervention services to U.S. states, territories, and federally recognized tribes (hereinafter referred to as "states"). States may apply for the Immediate Services Program (or ISP, which operates for the first 3 months after a disaster) and the Regular Services Program (or RSP, which operates for the next 9 months). The CCP has provided disaster behavioral health services to millions of disaster survivors since its inception

and, as a result of 30 years of accumulated expertise, it has become an important model for federal response to a variety of catastrophic events. Recent CCPs include responding to Hurricane Harvey and Hurricane Irma, as well as to flooding, mudslides, and wildfires. These CCPs have primarily addressed the short-term behavioral health needs of communities through these services:

a) Individual and group counseling
b) Outreach and public education
c) Referral

Individual and group crisis counseling assists survivors in coping with current stress and symptoms to return to pre-disaster functioning. It relies largely on "active listening," and crisis counselors also provide psycho-education (especially about the nature of responses to trauma) and help clients build coping skills. Outreach and public education serve primarily to normalize reactions and to engage people who might need further care. These roles are often, though not exclusively, performed by paraprofessionals who work throughout the community at sites including schools, churches, and workplaces. Although there are no formal limits to the number of sessions a person receives, crisis counseling typically involves no more than a few sessions. Because crisis counseling is time limited, referral is the third important function of CCPs. Counselors are expected to refer people to formal treatment if they have developed more serious psychiatric problems, including substance use disorders.

Regardless of their cause, disasters damage local infrastructures and strain the ability of local systems to meet the population's basic needs. For the survivors, disasters may engender an array of stressors, including threat to one's own life and safety, exposure to the dead and dying, bereavement, profound loss, social and community disruption, and ongoing hardship. As a result of both the high prevalence and highly stressful nature of disasters, the question of whether they affect behavioral health has been of interest for decades, and a substantial literature has developed that identifies and explains these effects. Based on a comprehensive literature review, the range of consequences experienced by disaster survivors is broad, including various psychological problems, such as depression, anxiety, and posttraumatic stress disorder (PTSD); physical health problems, such as sleep disruption, somatic complaints, and impaired immune function; chronic problems in living, such as troubled interpersonal relationships and financial stress; and resource loss, such as declines in perceived control and perceived social support. The data collected using the currently approved OMB CCP tools bear out these findings. According to crisis counselors completing the Individual/Family Crisis Counseling Services Encounter Log form, the most common event reactions among survivors were feeling anxious or fearful (11 percent), sadness or tearful (10 percent), and despair or hopeless (9 percent). Similarly, individuals who completed the Participant Feedback Form most frequently reported consequences of the disaster that included being bothered by bad memories, nightmares, or reminders of what happened; feeling down or depressed; and finding other stressful things harder to deal with because of what happened.

CCPs have been required to collect data related to their program throughout the length of the program (44 CFR 206.171 [F][3]). However, until September 2005 there was no systematic mechanism for collecting the required data due to differences between disasters, programs, and

states. In September 2005, OMB approved the CCP Data Toolkit (OMB No. 0930-0270) developed by SAMHSA's CMHS with the assistance of the Department of Veterans Affairs' National Center for PTSD. In August 2008, OMB approved the revised CCP Data Toolkit (OMB No. 0930-0270) to include minor revisions and the addition of a data collection form (Child/Youth Assessment and Referral Tool). In August 2012 we added a family/household component to the Individual Crisis Counseling Services Encounter Log to reduce the burden for crisis counselors who before that time needed to complete separate forms for interactions with various relatives or household members actively engaged during a single visit. At that time the form was renamed Individual/Family Crisis Counseling Services Encounter Log. In August 2015 we added minor revisions to these forms including the addition of mobile app questions to the Service Provider Feedback Form and minor revisions to the gender question on the Participant Feedback Form and Service Provider Feedback Form.

The current OMB approval expired in September 2018; hence SAMHSA CMHS is requesting the approval of the revised CCP Data Toolkit for another three-year period.

2. **Purpose and Use of Information**

CCPs by nature are delivered in a rapidly evolving environment in which decisions need to be made quickly based on limited information. The prejudice is toward action, not deliberation. During the crisis, there may be little interest in collecting systematic information on how the program is working. This shortcoming makes it difficult to monitor program progress and provides limited data with which to evaluate program implementation or outcomes. Without a systematic data collection process, programs have limited means of assessing what they have discovered from experience in a way that can be communicated to other people planning responses to future events.

The toolkit relies on standardized forms. Data will be collected throughout the program period about services delivered and users of services. On the program level, the data can be entered quickly and easily via paper forms or a mobile app into a cumulative database that will be set up in advance to yield summary tables for both quarterly and final reports for the program. Because the data will be collected in a consistent way from all programs, data can be uploaded into an ongoing national database that likewise provides SAMHSA CMHS with a way of producing summary reports comparing the services provided across all programs funded.

The data collection tools seek to gather information to better understand program reach, quality, and consistency. Additionally, since January 2016 SAMHSA DTAC staff members have developed and implemented a mobile application that offer CCP crisis counselors/program staff a more efficient alternative to the paper forms as they document their encounters in the field. The mobile data entry was implemented for the: (1) Individual/Family Crisis Counseling Services Encounter Log; (2) Group Encounter Log; (3) Weekly Tally Sheet; (4) Adult Assessment and Referral Tool and (5) Child/Youth Assessment and Referral Tool. These forms were tied directly into the existing desktop system's back-end database and front-end functionality such as reporting, analysis, and quality control features. In order to maintain anonymity of the providers and participants completing the survey, we did not utilize the mobile app for the Service Providers Feedback Form and Participants Feedback Form.

Program reach refers to the number of encounters crisis counseling staff have with disaster survivors. Program quality refers to whether the services were perceived as appropriate and beneficial by both service recipients and crisis counseling staff. Program consistency refers to the variability in service provision across geographical areas and whether this variability can be explained by differences in the areas and their populations. State CCPs will use the following components of the toolkit for data collection throughout the life of the program:

Encounter Logs. These forms document all services provided. Completion of these logs is required by the crisis counselors during both the ISP and RSP. Minimal changes are recommended to the encounter logs from the previous OMB approved encounter logs (OMB NO. 0930-0270, Expiration date 09/30/2018). There are three types of encounter logs:

> Individual/Family Crisis Counseling Services Encounter Log *(see **Attachment A: Revised***)*. Crisis counseling is defined as an interaction that lasts at least 15 minutes and involves participant disclosure. This form is completed by the crisis counselor for each service recipient or each family, defined as the person or persons who actively participated in the session (for example, by verbally participating), not someone who is merely present. Information collected includes demographics, service characteristics, risk factors, event reactions, and referral data. The Individual/Family Crisis Counseling Services Encounter Log can be used for individual encounters or for family encounters (though an encounter of either type must be 15 minutes or longer for crisis counselors to use this form). Family data are aggregated and analyzed separately from individual data. When the crisis counselor completes the form, he or she completes it for either an individual encounter or a family encounter, not both. Since data are reported at the aggregate level, the data collected provides valuable information to the program. In the period September 2015 until end of March 2018 we have completed 293,485 Individual/Family Crisis Counseling Services Encounter Logs.

> **Individual and Family Crisis Counseling Services Encounter Log changes include updates to the gender, race, and disability questions/sections in order to modernize the language and bring them into line with standard practice (see References in Appendix A). The burden statement was also added.**

> Group Encounter Log (**see Attachment B: Revised***)*. This form is used to identify either a group crisis counseling encounter or a group public education encounter. The person completing the form uses a check mark at the top of the form to identify the class of activities (that is, counseling or education). Information collected includes service characteristics, group identity and characteristics, and the focus or foci of the group's activities. In the period September 2015 until end of March 2018 we have completed 32,216 Group Encounter Logs.

> **Group Encounter Log changes include updates to the race and disability questions/sections in order to modernize the language and bring them into line with standard practice (see References in Appendix A). The burden statement was also added.**

Weekly Tally Sheet (**see Attachment C***). This form documents brief educational and supportive encounters not captured on any other form. Information collected includes service characteristics, daily tallies and weekly totals for brief educational or supportive contacts, and material distribution with minimal or no interaction, including social networking and mass media advertising efforts. The Weekly Tally Sheet is used to measure reach, as it assesses the number of materials distributed and types of contacts. It also addresses program consistency in that it is used to capture data that in turn will be used to understand weekly trends and other phenomena within and across programs.

The following variables on the Weekly Tally Sheet are intended to capture the reach of the program through its less-than-15-minute interactions: brief educational contacts, telephone contacts, email contacts, material handed to people, material left at people's homes, material left in public places, and community networking and coalition building. In the period September 2015 until end of March 2018 we have completed 33,241 Weekly Tally Sheets. **No changes to this form other than adding the burden statement.**

Programs are encouraged to review the data using the "Weekly Trends" reporting features of the online system in order to ensure consistency of the program's implementation with the intended service plan. Weekly Tally Sheets do not address the quality of the program.

Assessment and Referral Tools. Generally, these forms are used as an interview guide with adults or children and youth who have received individual crisis counseling on two or more occasions and who may need referral to further and more intensive services. However, these tools may be used at any time that a crisis counselor suspects that an individual is experiencing serious reactions to the disaster.

These Assessment and Referral Tools have been used by CCPs in their current forms and validated (see Appendix A for references).

Adult Assessment and Referral Tool (**see Attachment D: Revised**). This tool ensures the collection of information on characteristics of the encounter, risk categories, and demographics. The tool also includes the **S**hort **P**TSD **R**ating **Int**erview: **E**xpanded Version, also known as the SPRINT-E, an 11-item measure of post-disaster distress including but not limited to symptoms of PTSD.

- Script for instructions is provided for clarity. The script reads as follows:

  "READ ALOUD: Occasionally, we find it helpful to ask survivors a few specific questions about how they were affected by the disaster and how they are feeling now. Your name or address is not being recorded on this form, and any information will be kept private to the extent of the law. You may choose not to answer any question. May I ask you these questions? My first questions are about various experiences you have had in the disaster. Do any of the following apply to you?"

Adult Assessment and Referral Tool changes include updates to the gender, race, and disability questions/sections in order to modernize the language and bring them into line with standard practice (see References in Appendix A). In addition, the former question about suicidality has been removed and updated to align with the Ask Suicide-Screening Questions to Everyone in Medical Settings (ASQ-EM) tool (see References in Appendix A). The burden statement was also added.

Child/Youth Assessment and Referral Tool (**see Attachment E: Revised**). This tool ensures collection of information on risk factors and demographics, and it includes items to assess post-disaster symptoms, as well as items for parents to rate their child's feelings and behavior. When this form was developed, the symptom (or reaction) section of the tool was adapted from the University of California at Los Angeles (UCLA) Post-traumatic Stress Disorder Reaction Index with inclusion of additional items related to depression and functioning (Steinberg, Brymer, Decker, & Pynoos, 2004). Drs. Pynoos and Steinberg granted permission for this modification for use by the CCP Project Liberty after the terrorist attacks on September 11, 2001. This tool was then adapted by National Child Traumatic Stress Network in 2005 for use by the Louisiana Spirit Specialized CCP after Hurricanes Katrina and Rita.

Child/Youth Assessment and Referral Tool changes include updates to the gender, race, and disability questions/sections in order to modernize the language and bring them into line with standard practice (see References in Appendix A). In addition, the former question about suicidality has been removed and updated to align with the Ask Suicide-Screening Questions Toolkit (ASQ) for youth (see References in Appendix A). The burden statement was also added.

■ The following instructions are provided on the form for clarity.

It is recommended that this form be used with all children or youth who are intensive users of services. Intensive users are people who are participating in their third individual crisis counseling visit with any crisis counselor from the program or who continue to suffer severe distress that may be impacting their ability to perform routine daily activities. This form should be used as an interview guide (1) with children receiving individual crisis counseling on the third and fifth occasions OR (2) with any child at any time if you suspect the child may be experiencing serious reactions to the disaster.

NOTE: Prior to administration of the Child/Youth Assessment and Referral Tool, make sure that consent has been obtained from a parent/caregiver for the child's or youth's participation. Children over the age of 7 may answer on their own behalf (with parental consent). For children 0–7, it is recommended that a parent/caregiver be interviewed with the child present. When there are concerns about the ability of a child over the age of 7 to understand and accurately answer the questions, it is advisable for the parent/caregiver to assist in answering the questions. Adolescents may not want to be interviewed in front of their parents. If

a parent/caregiver is present, ask the adolescent if he or she wishes to be interviewed alone. See your program manager or CCP Evaluation Guidance and Administration document for further details.

- This tool contains a script for verbal consent, which instructs the person administering the tool to: READ: "Occasionally, we find it helpful to ask children/adolescents or their parents/caregivers a few specific questions about how they were affected by the disaster and how they are feeling now. May I ask you these questions? My first questions are about various experiences you have had in the disaster."

Crisis counselors, although paraprofessionals, receive training on how to use these forms in the required CCP trainings and have been administering them for years. According to the developers (Dr. Fran Norris and Dr. Melissa Brymer), these tools were developed for use by paraprofessionals. However, CCPs must have a protocol in place regarding what the crisis counselor should do if a referral is warranted and if a person being interviewed responds to the question "Is there any possibility that you might hurt or kill yourself?" with an answer of yes. The following guidance is provided to programs on the actual forms:

Many CCPs have team leaders or other staff with a mental health background to administer this tool to ensure that proper assessment and referral is carried out. All crisis counseling staff using this tool should have detailed training and guidance on use of the tool and when to make a referral for more intensive services. Prior to use of this tool, the CCP should have identified an organization or agency that is willing to accept referrals from the CCP for more intensive mental health or substance abuse intervention services.

The references in Appendix A provide support for the idea that an individual other than a licensed professional can effectively administer these tools.

Additionally, the following guidance is provided to the programs in the CCP Data Toolkit regarding referrals for children and youth:

For children over the age of 10 (or if the crisis counselor or parent/caregiver is concerned about a younger child), the [crisis] counselor may ask, 'Have you had any thoughts or plans about either hurting or killing yourself?' If the respondent answers 'YES' to this item, then the crisis counselor should immediately refer the child/youth for psychiatric or mental health professional intervention. The CCP should have protocols or procedures in place for how a crisis counselor should respond and who should be notified of this safety concern.

Many CCPs have team leaders or other staff with a mental health background to ensure that proper assessment and referral is carried out. All crisis counseling staff using this tool should have detailed training and guidance on use of the tool and when to make a referral for more intensive services. Prior to use of this tool, the CCP should have identified an organization or agency that is willing to accept referrals from the CCP for more immediate psychiatric intervention.

If the total number is four or higher, the counselor should discuss appropriate referral options for the child/youth and/or family. This includes being prepared to offer youth and parents the name at an organization that has agreed to accept CCP referrals and a contact at that organization.

As described above, the CCP must have a referral resource/center/agency for situations in which the crisis counselor has identified a child/youth as in need of immediate services. It is typically the case that the referral resource/center/agency has a licensed mental health professional on staff. Suggested licenses are clinical/counseling professionals with independent licensure, such as licensed psychiatrists (MD) or psychiatric nurses, licensed psychologists (PhD or PsyD), licensed clinical social workers (LCSW or equivalent) or licensed professional counselors, or licensed marriage and family therapists (LMFT).

Participant Feedback Form (**see Attachment F: Revised***).* These forms are completed by and collected from a sample of adult service recipients, not every recipient. A time sampling approach (e.g., soliciting participation from all counseling encounters during 1-week period 6 months and 1-year post-event) will be used. Information collected includes satisfaction with services, usefulness of the services provided, perceived improvements in one's own functioning, types of exposure, and event reactions. In this application, we added a question about annual household income "What is your annual gross household income?" with preset categories to select from as studies have shown that socioeconomic status as defined by income can be related to survivors' stress.

Participant Feedback Form changes include the new question about annual household income and changes to the gender and race questions/sections in order to modernize the language and bring them into line with standard practice (see References in Appendix A). The burden statement was also added.

The Participant Feedback Form is the only one used to collect information directly from adult service recipients, and the primary tool for collecting information on the quality of the program (the Service Provider Feedback Form is the other). It is used to inform program services at the local, state, and federal level. The questions about services relate directly to the goals of crisis counseling, such as reassurance and being helped to find ways to cope. There is a section on the ways in which the respondent was exposed to the disaster, and on event reactions, such as posttraumatic stress, depression, impaired functioning, and perceived need for additional help. (This is the SPRINT-E, described earlier as part of the Adult Assessment and Referral Tool).

The SAMHSA Disaster Technical Assistance Center (DTAC) provides the following template to programs prior to adminstering the Participant Feedback Form, with instructions that it be customized to the program and provided as a cover sheet to the Participant Feedback Form:

[Date]

Dear friend:

[Name of or reference to disaster] caused many challenges and problems for many people. Our crisis counseling project, [Name of project], tries to help people cope with the stress of recovery. To do our jobs well, we need to know more about how people are doing now and if our crisis counselors are finding the best ways to be helpful.

Inside this packet is a very brief survey. It will take you only a few minutes to fill out but will be very helpful to us. Your answers will help us to help others.

The packet has a pen in it for you to use and keep. It also has a stamped envelope for you to mail in your survey after you are done. The survey does not ask for your name and is completely anonymous. No one will know which survey you filled in. Your answers will be used together with the answers of other people who are also kind enough to help us this week.

Please send your survey in by [Date]. Of course, it is fine if you choose not to participate. Also, you should feel free to leave any question blank that you don't want to answer.

Your opinions are important to us. Thank you for taking the time to complete this survey.

Sincerely,

[Name of Project Director]
[Name of Project]

Service Provider Feedback Form (**see Attachment G: Revised***).* These forms are completed by and collected from the CCP service providers (i.e., crisis counselors) anonymously at approximately 6 months and 1-year post-event. The items on this form relate to the training, work environment, and level of job stress experienced by the crisis counselor. Crisis counselors can complete the Service Provider Feedback Form online, ensuring confidentiality. The form will be coded on several program- and worker-level variables to be shared with program management for review. The Service Provider Feedback Form provides additional information on the quality of the program. In this application the different types of CCP training and the extent of their usefulness have been updated to improve capturing training feedback. In addition, the Service Provider Feedback Form changes include rewording of the questions about the different types of CCP training and the extent of their usefulness to capture training feedback, incorporation into the delivery of services, and give more clarity to program administrators. The sections of items relating to the providers' feedback on work, supervision, support and the scale of response options to these items has also been reworded. Additionally, we have added questions for the providers about their personal experience with the disaster, as they are typically members of the affected community prior to beginning their work with the CCP. **Changes also include updates to the gender and race questions/sections in order to modernize the language and bring them into line with standard practice (see References in Appendix A).**

The burden statement was also added. Also, we have added a new section to address mobile technology and data entry, and the questions in this section were updated from the previous form. Finally, we have added questions related to the counselors' income information and personal experience(s) with the disaster as they are typically members of the affected community prior to employment by the CCP and program leadership is responsible for monitoring the counselors' stress levels. With the addition of these items we still expect the crises counselors to complete the form within the 15 – 25 minutes timeframe.

Crisis counselors are the essential link between the program and the consumer. Crisis counselors and their supervisors are in a unique position to judge the quality of the services being provided and the extent to which they match the needs of the community. The Service Provider Feedback Form yields a standardized assessment of providers' opinions and reactions to their work.

Ongoing program monitoring and information gathering will continue to increase the knowledge base established with the previous CCP Data Toolkit (approved in 2005, 2008, 2012, and 2015). This knowledge base persists to inform and guide the program at the federal level. From the systematic collection of data, it is possible to interpret the factors responsible for differences in CCP implementation—that is, whether they derive from variations in setting (e.g., rural versus urban community) or program design variables that contribute to more successful outreach. By collecting data across future programs more completely and systematically, SAMHSA CMHS may be able to look at program data trends and make better judgments about program-level factors that influence service delivery. This goal requires a set of standardized tools that are useful for program monitoring and that feed into a cumulative national database.

For each CCP grant that is awarded, two quarterly progress reports and one final report for the 9-month RSP grant are submitted to FEMA and CMHS project officers and a SAMHSA DTAC technical assistance specialist. Quarterly reports are due 30 days after the end of the 3-month reporting period. The final program report is due to the FEMA and CMHS project officers 90 days after the final day of program services. Program monitoring data are required in the quarterly reports and the final program report. Below, we provide a website link and login to our current CCP Online Data Collection and Evaluation System (ODCES) demonstration and training website so that OMB may view some of the reporting options available for data entered into the system that are accessible in real time at multiple levels (i.e., local service provider, state or territory, and federal). This website is a replica of the real CCP ODCES website, but it houses test data and is used for demonstration and training purposes. The login provided is for the state and territory level. After logging in, please view the reporting section (on the left-hand menu) to access the various reports offered to users. The website is maintained and managed by SAMHSA DTAC.

For a demonstration or questions regarding this website, please contact SAMHSA staff either Dr. Nikki Bellamy at 240-276-2418, nikki.bellamy@samhsa.hhs.gov or Captain Erik Hierholzer, 240-276-0408, erik.hierholzer@samhsa.hhs.gov.

In summary, whether the questions concern how to improve the reach of the service delivery system or how to improve the efficacy of the services themselves, systematic program monitoring provides a basis for the answers. Our proposed methodology for future CCP data

collection processes, via the use of the CCP Resource/Data Toolkit, attempts to improve practice in a way that adheres to the goals and standards of program evaluation science while supporting the goals and standards of SAMHSA CMHS for delivering the highest possible caliber of disaster behavioral health program during a crisis.

3.   Use of Information Technology

The forms, as well as the ability to submit the forms, are available to all CCPs both electronically as well as in hardcopy. Following the completion of the data collection forms, data are entered into an online database, the CCP ODCES. This system, created in 2009, allows real-time data entry and reporting. All instruments will be available for download and printing from the SAMHSA DTAC website and the ODCES. Most of the forms, including the Individual/Family Crisis Counseling Services Encounter Log, Group Encounter Log, Weekly Tally Sheet, Child/Youth Assessment and Referral Tool, and Adult Assessment and Referral Tool are also available via a mobile app for counselors to download onto a program-supplied device. Service recipients (that is, disaster survivors) will also complete a paper-based version of the Participant Feedback Form, while crisis counselors may complete the Service Provider Feedback Form via paper or a secure electronic link. Data from all of the forms are entered into an online secure database, maintained according to federal security standards.

4.   Effort to Identify Duplication

These forms are specific to this program, and no other programs are collecting these data.

5.   Involvement of Small Entities

The information requested will not have a significant impact on small entities.

6.   Consequences If Information Collected Less Frequently

The Individual/Family Crisis Counseling Services Encounter Log will be completed by the crisis counselor for 100 percent of individuals or families who access crisis counseling services for 15 minutes or longer. The Group Encounter Log will be completed by the crisis counselor for 100 percent of groups that meet for crisis counseling or for public education. The Weekly Tally Sheet will be completed by the crisis counselor for 100 percent of other brief educational or supportive encounters **not captured by any other form**.

The Adult and Child/Youth Assessment and Referral Tools will be completed by a trained crisis counselor for 100 percent of service recipients who access the individual crisis counseling component multiple times (recommended on the third and fifth visit) or as deemed necessary. It is predicted that this will be less than 5 percent of all service users.

The Participant Feedback Form will be completed by service recipients. It will be made available at least twice during the CCP ISP and/or RSP grant to users of crisis counseling and education services and encounters. The sampling strategy will be determined by the state but will involve a target of at least two sampling occurrences during the program period.

The Service Provider Feedback Form will be administered to all CCP service providers (that is, crisis counselors and team leaders) at approximately 6 months and 1 year after a disaster incident.

The data being collected on the forms are already required per 44 CFR 206.171 (f)(a). The introduction of these forms will provide a more systematic method for data collection that will improve data quality and integrity, thereby helping to better inform practice in a way that adheres to the goals and standards of the program and SAMHSA CMHS for delivering the highest caliber possible of behavioral health programs during a crisis. If CCPs do not collect the data at the prescribed data points, this will decrease SAMHSA CMHS's ability to fully assess service delivery and make program improvements, in particular by losing measurement of intermediate and long-term disaster effects.

7. Consistency with the Guidelines in 5 CFR 1320.5(d)(2)

This information collection fully complies with 5 CFR 1320.5(d)(2).

8. Consultation Outside the Agency

The notice required by 5 CFR 1320.8(d) was published in the *Federal Register* On November 7, 2018 (83 FR 55733). No comments were received.

Key updates in this submission include minor revisions to include the burden statement and updates to the language in questions about gender, race, and disability questions/sections in all the applicable forms (Individual and Family Crisis Counseling Services Encounter Log: Attachment A, Group Encounter Log: Attachment B, Adult Assessment and Referral Tool: Attachment D, Child/Youth Assessment and Referral Tool: Attachment E, Participant Feedback Form: Attachment F, and Service Provider Feedback Form: Attachment G). In addition, the Child/Youth and Adult Assessment and Referral Tools have been revised to update the questions about suicidality. The Service Provider form has also been revised to include rewording some of the questions to enhance their clarity and additional questions about a counselor's disaster exposure as well as updates to the gender and race questions, and the Participant feedback form to include rewording some of the questions, a new question about annual income, and updates to the gender and race questions.

The following experts reviewed the toolkit and found that it was written clearly and the language was concise and accurate. Further, the experts as well as previous users of the toolkit agreed that there should be a decrease in overall burden with the revised tools. **More information on the rationale for the revised burden table is provided in Item 12 of this supporting statement.** Based on estimates of revised burden, individuals completing the forms should need no more than 8 minutes for the Individual/Family Crisis Counseling Services Encounter Log; 5 minutes for the Group Encounter Log; 12 minutes for the Weekly Tally Sheet; 15 minutes each for the Adult Assessment and Referral Tool and Child/Youth Assessment and Referral Tool, 15 minutes for the Participant Feedback Survey, and 25 minutes for the Service Provider Feedback Form.

The experts that were consulted included the following individuals:

1) Lamyaa Yousif, Ph.D., M.Sc., M.B.Ch.B.
   Lead Research Analyst
   SAMHSA Disaster Technical Assistance Center
   c/o IQ Solutions, Inc.
   11300 Rockville Pike, Suite 901
   Rockville, MD 20852
   Phone: 240-221-4346
   LYousif@IQSolutions.com

2) Everly Macario, Sc.D., M.S., Ed.M.
   Senior Evaluation Research Director
   SAMHSA Disaster Technical Assistance Center
   c/o IQ Solutions, Inc.
   11300 Rockville Pike, Suite 901
   Rockville, MD 20852
   Phone: 224-244-3965
   EMacario@IQSolutions.com

3) Mary Kay Dugan, M.A.
   Managing Director and Principal Research Scientist
   IMPAQ International, LLC
   400 North 34th Street, Suite 320
   Seattle, WA 98103
   Phone: 206-939-4970
   Mdugan@impaqint.com

4) Abigail Woodroffe, Ph.D.
   Senior Program Evaluator
   SAMHSA Disaster Technical Assistance Center
   C/O IMPAQ International
   60 William St, Suite 100
   Wellesley, MA 02481
   Tel. 781-772-3742
   awoodroffe@impaqint.com

9.   Payment to Respondents

No remuneration will be provided to any respondents. The crisis counselor respondents will not receive any additional payment, as completion of the forms in the toolkit is part of their regular work responsibilities within the CCP. These forms are the Individual/Family Crisis Counseling Services Encounter Log, Group Encounter Log, Weekly Tally Sheet, both the Adult and Child/Youth Assessment and Referral Tools, and, as needed, the Service Provider Feedback Form. The hourly cost associated with the completion of the Participant Feedback Form is the processing cost for these forms to be completed by service recipients. Service recipient

respondents will not receive any remuneration.

10.   Assurance of Confidentiality

SAMHSA CMHS and its contractors or consultants will not receive personally identifiable client or participant records. Service Provider-level information will be aggregated to at least the program level.

Service providers and service recipients will be assured that protection of data is maintained throughout the data collection and data storage period. All data will be closely safeguarded, and no individual identifiers will be used in reports, in which only aggregated data will be reported. The online database developed and maintained by SAMHSA CMHS adheres to all applicable IT security requirements using electronic and physical safeguards. In 2017, SAMHSA's Information Technology office assessed the system and determined that it is fully compliant with security standards and granted an official Authority to Operate certificate.

The following Paperwork Reduction Act Statement appears on all data collection forms that crisis counselors complete:

Paperwork Reduction Act Statement
This information is being collected to assist the Substance Abuse and Mental Health Services Administration (SAMHSA) with program monitoring of FEMA's Crisis Counseling Assistance and Training Program. Crisis counselors are required to complete this form following the delivery of crisis counseling services to disaster survivors (44 CFR 206.171 [F][3]). Information collected through this form will be used at an aggregate level to determine the reach, consistency, and quality of the Crisis Counseling Assistance and Training Program. Under the Privacy Act of 1974, any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0270. Public reporting burden for this collection of information is estimated to average X minutes per encounter, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 5600 Fishers Ln, Room 15E57B, Rockville, MD 20857.

For the Participant Feedback Form and the Service Provider Feedback Form, both of which are voluntary and anonymous, the statement will read as follows:

Paperwork Reduction Act Statement
This information is being collected to assist the Substance Abuse and Mental Health Services Administration (SAMHSA) with program monitoring of FEMA's Crisis Counseling Assistance and Training Program (44 CFR 206.171 [F][3]). This voluntary information collected will be used at an aggregate level to determine the reach, consistency, and quality of the Crisis Counseling Assistance and Training Program. Under the Privacy Act of 1974, any personally

identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0930-0270. Public reporting burden for this collection of information is estimated to average 15 to 25 minutes per form, including the time for reviewing instructions and completing responses. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 5600 Fishers Ln, Room 15 E57B, Rockville, MD 20857.

11.   __Questions of a Sensitive Nature__

The questions about mental health and behavioral health issues such as substance use could be considered sensitive, but they are either asked or discussed in the context of a disaster behavioral health program by trained personnel who undergo training and are instructed in the manner to approach the service recipient to normalize the encounter. Crisis counselors are instructed to explain the purpose of the data tools and data being collected and if a service recipient declines permission, to deliver services without completing a data collection tool. The question about annual income can be considered sensitive, but it is being asked in an anonymous form and cannot be tracked back to the survey respondent.

12.   __Estimates of Annualized Hour Burden__

The revised adjusted figures are based upon a review of data trends among recent and currently active CCPs and the utilization of the Individual/Family Crisis Counseling Services Encounter Log, Group Encounter Log, and Adult and Child/Youth Assessment and Referral Tools, which are used at a lower rate than previously reported. Thus, the revised total amount of time that is estimated for completion of the CCP Data Toolkit, record management by provider staff, and entry into an online database by the CCPs is 7,638 hours. The annualized hourly costs to respondents are estimated to be $152,760.00. It is estimated from previous CCP reports that crisis counselors (that is, outreach workers, paraprofessionals; estimated wage $20/hour) are expected to complete most data collection forms, and the hourly cost for the Participant Feedback Form is associated with processing costs. The revised burden estimates summarized in the Table 1 below and the associated table footnotes are based on the reported experience of SAMHSA CMHS CCP grantees and contractors in compiling, completing, and reporting on the previously approved CCP Data Resource Toolkit forms.

Table 1: Annualized Hour Burden Estimates for Respondents for Each Data Collection Instrument

Data Collection Instrument	Estimated Number of respondents	Responses per Respondent	Total Responses	Hours per Response	Total Hour Burden	Hourly Rate	Total Hour Cost
Individual/Family Crisis Counseling Services Encounter Log	600[1]	196[2]	117,600	0.08	9,408	20.00	$188,160.00
Group Encounter Log	100[3]	33[3]	3,300	0.05	165	20.00	$3,300.00
Weekly Tally Sheet	600[1]	52[4]	31,200	0.15	4,860	20.00	$93,600.00
Assessment and Referral Tools	600[1]	9.77	5,860[5]	0.17	1,482	20.00	$28,560.00
Participant Feedback Form	1,000	1	1,000	0.25	250	20.00	$5,000.00
Service Provider Feedback Form	100[6]	1	100	0.41	41	20.00	$820.00
Total	3,000		161,600		16,206		$319,440.00

[1] 200 is based on typical average of 30 crisis counselors (or 30 full-time equivalent) per grant with an approximate average of 20 grants per year (i.e., 30 x 20 = 600).

[2] On average, each crisis counselor will complete 196 forms over the course of the grant.

[3] Average of one form per week for a pair of crisis counselors (i.e., 2 counselors completing 1 form = 100 crisis counselors) at 33 weeks that includes both ISP and RSP (1 x 33 = 33).

[4] Average of 52 weeks for each grant that includes both ISP and RSP.

[5] On average 5 percent of the individuals encountered will result in the use of this tool (i.e., 117,200 individual x 5% = 5,860).

[6] On average 50 percent of service providers/crisis counselors may complete or use this tool.

13.   Estimates of Annualized Cost Burden to Respondents

There are neither capital or startup costs nor are there any operation and maintenance costs to respondents as these costs are assumed under the CCP grant funding to the states/territories or federally recognized tribes.

14.   Estimates of Annualized Cost to Government

The cost to the government will include approximately 0.5 full-time equivalent (FTE) senior staff at a General Schedule 14, or GS-14 (129,869.00) which level for a total of approximately $64,934.00 annualized cost.

15.   Changes in Burden

This is a reinstatement.

16.   Time Schedule, Publication, and Analysis Plans

16.a. Time Schedule

No timetable can be given at this time due to the nature of this data collection effort. A crisis (that is, natural or human-caused disaster such as a terrorist attack) must occur before a time schedule can be established. CCPs are initially funded to a state for 3 months (Immediate Services Program, ISP), and then the state may receive funding for 9 months based on need (Regular Services Program, RSP). Collection of toolkit data will begin as soon as the CCP is established, and this information will be used to inform the program progress reports filed at 3, 6, and 9 months. A final report will be generated at the end of the program, typically 1 year after the initial application for the ISP grant.

The state CCPs will determine when they will collect the forms from crisis counselors for review and entry into the online database. The typical timeline is as follows:

1. Individual/Family Crisis Counseling Services Encounter Log and Group Encounter Log forms will be collected on an ongoing basis as service recipient contact is made. These logs will be submitted to the CCP staff member responsible for reviewing them on a regular basis (typically, at the end of each day, but depending on the CCP and the context of the event, this may occur once a week).

2. Weekly Tally Sheets will be completed at least once per week for each county visited and submitted to the CCP staff member responsible for their review.

3. Assessment and Referral Tools when completed will be collected on a daily or weekly basis and submitted to the CCP staff member responsible for their review.

4. Participant Feedback Forms will be collected twice, at 6 months and 1 year post-disaster.

5. Service Provider Feedback Forms will be collected twice, at 6 months and 1 year post-disaster.

16.b. Publication

Service recipient data will be collected through the CCPs. Data will be used to monitor and provide feedback to the CCP while the program is active as well as to SAMHSA CMHS and FEMA project officers and program staff. Copies of quarterly and final reports for each CCP will be maintained by SAMHSA CMHS. In addition, presentations will be made at grantee or professional meetings and/or conferences, at which time aggregate data will be provided about the performance of the CCP that is hosting the meeting. Feedback regarding the CCP's performance during that event will also be discussed in the context of other CCPs that bear comparison on some single variable or set of variables. Future uses of the data may include submission to present or publish aggregate-level findings to professional scientific organizations or journals in or related to disaster behavioral health to help improve service delivery through lessons learned. Any such presentation or submission for publication will adhere to the

appropriate federal guidelines and policies.

16.c. Analysis Plan

Once a crisis occurs and a CCP is established, collected data will be used to monitor and provide feedback to the CCP while the program is active as well as to SAMHSA CMHS and FEMA project officers and federal staff. These data will be uploaded or entered into an online database that will be set up in advance to yield summary tables for both quarterly and final reports for the program. Quarterly reports are used to monitor delivery of services by each program throughout the life of the program, thus giving the project officers an opportunity to determine if service implementation is sufficient to meet the needs of the community and whether service recipients are appropriately identified and reached. This process helps to shape the response in vivo, or on an ongoing basis. The final reports will provide a comprehensive tracking mechanism to show how the CCPs were established and how they changed over time, lessons learned from the process of establishing and maintaining the CCP, numbers of service recipients reached, how and what services were used over time, and other program factors that will be used to inform the state as to how it can better respond to future disasters. Collected data will also become a part of an ongoing national database to produce summary reports of services across all funded CCPs. Because data at the program level will be collected systematically, it will be possible to perform analyses across system variables (for example, variations in setting such as urban versus rural or variations in program design that lead to more effective outreach). This will enable SAMHSA CMHS to make better judgments about program-level factors that influence service delivery. The primary intent of the collection of data is to use the data internally for monitoring, evaluative, and training purposes.

There are three primary analysis components or objectives described below.

The first objective relates to a descriptive analysis to summarize the information from all of the tools and forms. This analysis will be descriptive in nature to address such questions as the following:

1. How many service recipients were seen in this program?
2. What were the demographic characteristics of the service recipients seen in this program?
3. What were the demographic characteristics of the service providers in this program?
4. What were the levels of exposure to the event for service recipients?
5. What were the levels of stress associated with the event for service providers?
6. Where were services provided?
7. What services were provided?

The second objective relates to the outcome analysis. This analysis will be descriptive in nature and will address the following questions:

1. Did the services meet the needs of the service recipients?
2. What were the reactions of service recipients to the disaster?

3. How adequately did the CCP serve the providers in the areas of training, workload, resource availability, supervision, support, and stress management and compassion fatigue (self-care)?
4. Were there differences in reactions of service recipients to disasters based on geographic or demographic characteristics?
5. How did the disaster risk vary between service recipient and service providers?

The third and final objective relates to trend analysis of the tools over time. Each CCP grant has been required to collect data related to the program throughout the length of the program (44 CFR 206.171 [F][3]). However, until September 2005, there was no systematic mechanism for collecting the required data due to differences among disasters, programs, and states. In September 2005, OMB approved the CCP Data Toolkit (OMB No. 0930-0270), which was developed by SAMHSA CMHS with the assistance of the Department of Veterans Affairs' National Center for PTSD. For the original 2005 OMB approval, the major objective proposed and achieved was to have consistent data collection processes, forms and tools for use, and administration across all awarded CCP grants in both the ISP and RSP timeframes. In 2008, OMB approved the second iteration of CCP data collection forms with the same OMB number and an expiration date of January 2012. This second iteration approved by OMB also had major objectives that were proposed and achieved, including the addition of event reactions on the Individual/Family Crisis Counseling Services Encounter Log, the provision for a Child/Youth Assessment and Referral Tool, and an online data entry and reporting system accessible 24 hours a day, 7 days a week, that could be utilized by all awarded CCP grants throughout ISP and RSP timeframes. The third iteration, again with the same OMB number and an expiration date of August 2015, added a family/household component to the Individual/Family Crisis Counseling Service Encounter Log. The fourth iteration with the same OMB number and an expiration date of August 2018, added minor revisions to the gender question on the Adult Assessment and Referral Tool (**Attachment D**), Child/Youth Assessment and Referral Tool (**Attachment E**), Participant Feedback Form (**Attachment F**), and Service Provider Feedback Form (**Attachment G**). The current request for OMB approval represents the fifth iteration of these CCP data forms. The major objectives with this current fourth iteration are as follows:

- Renew the forms with minimal changes to align language around gender, race, and disability with best practices.
- Maintain continuity of data to promote efficient and quality analysis across programs and years.

As such, we expect that the ability will increase for federal partners and state CCPs to conduct extensive trend analysis with the Individual/Crisis Counseling Services Encounter Log and other forms in the CCP Data Toolkit from 2005 to present. Moreover, we believe that this increased ability will support the purpose of continued collection of standardized information for appropriate processing, analysis, and reporting. In these analyses, we will identify breaks in trend analyses by major revision of a given instrument, and provide separate trend lines for individual, youth, and family data.

17.   Display of Expiration Date

The expiration date for OMB approval will be displayed on all data collection instruments.

18.   Exceptions to Certification Statement

This collection of information involves no exceptions to the Certification for Paperwork Reduction Act Submissions. The certifications are included in this submission.

B. STATISTICAL METHODS

1.   Sampling Methods

Ruggiero, K.J., Davidson, T.M., McCauley, J., Gros, K.S., Welsh, K., Price, M., . . . Amstadter, A.B. (2015). Bounce Back Now! Protocol of a population-based randomized controlled trial to examine the efficacy of a web-based intervention with disaster-affected families. *Contemporary Clinical Trials, 40*,138–149.

Efforts used to inform this section of the OMB Supporting Statement include the following: (1) a retrospective evaluation of the CCP, 2) a cross-site evaluation of CCP grants funded as a result of the 2005 Gulf Coast hurricanes, and (3) analysis of the data from 2009 to 2011. The first two studies were performed by the National Center for PTSD as an interagency agreement with SAMHSA CMHS.

The retrospective evaluation involved an archival analysis of all available reports for crisis counseling grants implemented in the 50 United States that closed out over a 5-year interval. As such, all crisis counseling projects that closed out between October 1, 1996, and September 30, 2001, and were administered by states rather than territories, were eligible for analysis. Reports from 44 grants covering 28 disaster events were included in the quantitative analysis for the retrospective evaluation.

Given the catastrophic nature of the 2005 Gulf Coast hurricanes, a disaster-specific cross-site evaluation of funded CCPs was supported by SAMHSA CMHS. The cross-site evaluation of the 2005 Gulf Coast hurricane programs consisted of 22 grants in 17 states active between November 2005 and February 2007, thus 3 to 18 months after Hurricane Katrina. These grants utilized the 2005 OMB-approved CCP data collection forms.

The means (or averages) from these studies, combined with a review of the data trends from the past 2 years and consideration of the current CCP grants, were used to inform this section of the OMB Supporting Statement. The average number of respondents from 2016-2017 is 145,200 per year for the CCPs, distributed as follows:

1. Individual/Family Crisis Counseling Services Encounter Log = 117,200
    a. Service providers (i.e., crisis counselors/program staff) will be required to complete this form for all service recipients who access individual or family crisis counseling services of 15 minutes or more.

2. Group Encounter Log = 15,000
    a. Service providers will be required to complete this form for each group of service recipients who access group crisis counseling services and/or group public education services.

3. Weekly Tally Sheet = 11,100
    a. Service providers will be required to complete this form for all contacts for whom data are not captured on either the Individual/Family Crisis Counseling Services or Group Encounter Logs.

4. Assessment and Referral Tools = 400
    a. These tools (Adult or Child/Youth) are intended for intense users of services, defined as all individuals receiving a third or fifth individual crisis counseling visit, or those experiencing serious reactions to the disaster. This tool will be administered by the services providers during encounters with all eligible service recipients during beginning 3 months after the disaster.

5. Participant Feedback Form = 1,200
    a. These forms will be collected from a sample of service recipients, not every recipient. The use of a time sampling approach is recommended, e.g., soliciting participation from all counseling encounters 1 week per quarter.

6. Service Provider Feedback Form = 300
    a. These forms will be administered to all service providers, and data will be collected anonymously at least once at 6 months and/or 1 year after the disaster.

Most CCPs will collect client information using mobile app for fast, timely and reliable data entry into the online system and analysis, the CCP forms can also be collected on paper and then forwarded for central location for online data entry. The completion of forms is a part of the daily work requirements for service providers and does not interfere with ongoing program operations.

2. Information Collection Procedures

CCP crisis counselors and outreach workers will be responsible for completing the Individual/Family Crisis Counseling Services Encounter Log and the Group Encounter Log during the encounter or after the service recipient(s) has/have left the encounter location. Service providers will select appropriate response categories to items on the log based on their own perceptions of the service recipient or on information that recipients provide during the encounter. The Weekly Tally Sheet will be completed by the CCP crisis counselor or outreach worker at the end of the designated "week" period (for example, Sunday through Saturday as determined by the CCP and the SAMHSA CMHS project officer).

The Individual/Family Crisis Counseling Services Encounter Log will be completed by the service provider for all individuals who access this service. The Group Encounter Log will be completed by the service provider for all groups that meet for crisis counseling or for public education. The Weekly Tally Sheet will be completed by the service provider for all brief educational or supportive encounters **not captured by any other form**.

The Assessment and Referral Tools will be administered by CCP service providers and used as a checklist with the service recipient present. The Assessment and Referral Tools are intended to be completed by a trained service provider for all service recipients who access individual crisis counseling for the third or fifth time or express a strong need for intensive services. These tools will be read aloud to the recipient by the crisis counselor, and the recipient will be asked to respond to questions accordingly.

Both the Service Provider and Participant Feedback Forms will be completed in a location of the respondent's choosing (for example, home or office) and anonymously. The Service Provider Feedback Form will be administered online, and the Participant Feedback Form will be returned by mail. No individual identifying information will be collected on the forms to assure the anonymity of the respondent. The SAMHSA CMHS project officer along with FEMA staff will provide guidance to the state in determining the most appropriate method for the collection, processing, and sharing of findings from these forms.

3.   Methods to Maximize Response Rates

The following logs/tools will be completed by a trained service provider as part of their job requirements:

- Individual/Family Crisis Counseling Services Encounter Log
- Group Encounter Log
- Weekly Tally Sheet
- Assessment and Referral Tools (Adult and Child/Youth)

To maximize response rates and compliance with the completion of these tools, all crisis counselors will be trained on the requirements of completing these forms as well as administration protocols. Procedures will be put in place for the oversight of the crisis counselors ensuring that they are monitored for compliance in completing all required forms. As such, our targeted response rates for the encounter logs (that is, Individual/Family Crisis Counseling Services Encounter Log, Group Encounter Log, and Weekly Tally Sheet) and the Assessment and Referral Tools is 100 percent. However, it is acknowledged that a 100 percent completion rate may not always be possible for various reasons (for example, the counselor may fail to complete a form as required, a form may not be available at the time of the encounter, or a form may be lost. Therefore, we estimate there may be a non-completion rate of between 2 to 5 percent yielding a completion rate of approximately 95 percent these forms.

The Participant Feedback Form will be completed by of adult service recipients (for whom individual or group crisis counseling services were provided). The form will be administered at 6 and 12 months after an event. At 6 and 12 months after the event, the program chooses a 1- or 2-week period during which selected sample members are asked to complete the Participant Feedback Form anonymously. The response rate will be calculated by comparing the total number of forms received and completed to the total number of forms that were distributed separately at 6 and 12 months. Methods to increase response rates include: (1) providing a stamped return envelope; and, (2) providing an accompanying letter from the program director encouraging participation and the need for the information to be returned to help improve the experiences of future service delivery. Furthermore, pre-testing of the form has helped to ensure that form is easily comprehensible and brief enough to facilitate completion.

A review of previous data collected in the ODCES indicates that the typical response rate for the Participant Feedback Form is approximately 10 percent. We anticipate the same response rate for the current collection request. However, we may have a slight increase in reporting from previous years, as we are requiring CCPs to administer this form if a longer ISP grant is requested and at least once during the RSP grant period.

Given this low response rate, it is likely that people who complete the Participant Feedback Form differ in program-important ways from people who do not. When findings are reported, the response rate and the likelihood of bias in the findings will be communicated clearly, and aggregate level characteristics of responders as they relate to the program will be provided.

The Service Provider Feedback Form will be made available via an online link or paper distribution to all CCP service providers at 6 months and/or 1 year after the disaster. Response rates will be calculated separately for the 6 month and 1 year collection efforts. Methods to increase response rates among the service providers will include: (a) a letter to encourage completion of these forms.

4.   Tests of Procedures

No new tests of procedures will be undertaken. Many instruments in the CCP Data Toolkit have been taken from established data collection tools that have already been tested for validity and reliability. In addition, SAMHSA CMHS staff members have had an opportunity to review the revised tools and all agree with the data items. The Assessment and Referral Tools, the Participant Feedback Form, and the Service Provider Feedback Form contain elements of the Short PTSD Rating Interview, or SPRINT, and the SPRINT-E, an expanded version of this form, both of which have been determined in research to be reliable and internally consistent. The Child/Youth Assessment and Referral Tool has items from the UCLA Posttraumatic Stress Disorder Reaction Index. Other items on these three forms, as well as on the Individual/Family Crisis Counseling Services Encounter Log and Group Encounter Log Forms, evolved directly from previous studies (for example, retrospective and cross-site evaluation of 2005 Gulf Coast hurricanes), and through site visits, interviews, and focus groups with states, direct service providers, and federal staff. Demographics collected across all forms are considered standard items for collection in the research literature and speak directly to the goals of the CCP.

5.   Statistical Consultants

The names and phone numbers of project officers and the consultant are as follows:

Federal Project Officers

>   Nikki D. Bellamy, Ph.D.
>   Center for Mental Health Services
>   Division of Prevention, Traumatic Stress, and Special Programs
>   Emergency Mental Health and Traumatic Stress Services Branch
>   5600 Fishers Lane, Room 14E05D
>   Rockville, MD 20857
>   Phone: 240-276-2418
>   Cell: 202-744-9042
>   Fax: 301-480-8966
>   nikki.bellamy@samhsa.hhs.gov
>
>   Erik Hierholzer
>   Captain, United States Public Health Service
>   Substance Abuse and Mental Health Services Administration
>   Lead Public Health Advisor
>   Emergency Mental Health and Traumatic Stress Services Branch
>   Center for Mental Health Services
>   5600 Fishers Lane, Room 14E01D
>   Rockville, MD 20857
>   Phone: 240-276-0408
>   Cell: 240-499-5859
>   erik.hierholzer@samhsa.hhs.gov

Statistical Consultants

>   Lamyaa Yousif, Ph.D., M.Sc., M.B.Ch.B.
>   Lead Research Analyst
>   SAMHSA Disaster Technical Assistance Center
>   c/o IQ Solutions, Inc. |
>   11300 Rockville Pike, Suite 901
>   Rockville, MD 20852
>   240.221.4346 Voice
>   LYousif@IQSolutions.com
>
>   Everly Macario, Sc.D., M.S., Ed.M.
>   Senior Evaluation Research Director
>   SAMHSA Disaster Technical Assistance Center
>   c/o IQ Solutions, Inc. |
>   11300 Rockville Pike, Suite 901
>   Rockville, MD 20852

Phone: 224-244-3965
EMacario@IQSolutions.com

Mary Kay Dugan, M.A.
Managing Director and Principal Research Scientist
IMPAQ International, LLC
400 North 34th Street, Suite 320
Seattle, WA 98103
Phone: 206-939-4970
Mdugan@impaqint.com

ATTACHMENTS

A. Individual/Family Crisis Counseling Services Encounter Log

B. Group Encounter Log

C. Weekly Tally Sheet

D. Assessment and Referral Tool (Adult)

E. Assessment and Referral Tool (Child/Youth)

F. Participant Feedback Form

G. Service Provider Feedback Form

APPENDIX A
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Encounter Logs

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APPENDIX B:

SAMPLE DATA TABLES

Disaster Outreach Services: Primary Services

Primary Service	Population Served	Percentage
Individual Crisis Counseling		
Group Counseling/Public Education		
Brief Educational/Supportive Contact		

Disaster Outreach Services: Primary Services – County Name

Primary Service	Population Served	Percentage
Individual Crisis Counseling		
Group Counseling/Public Education		
Brief Educational/Supportive Contact		

Individual Encounter by Age

Age	County	Population Served
preschool		
child		
adolescent		
adult (18–39)		
adult (40–64)		
adult (65+)		

Material Distribution

County	Handed to People	Mailed to People	Left in Public

Individual Crisis Counseling Monthly Trends

Year-Month	County	Total

Group Encounter Monthly Trends

Year-Month	County	Total

Telephone Contact Monthly Trends

Year-Month	County	Total

Risk Factors Monthly Trends

Year-Month	Risk	Total
	family missing/dead	
	friend missing/dead	
	pet missing/dead	
	home damaged or destroyed	
	vehicle or major property loss	
	other financial loss	
	disaster unemployed (self or household member)	
	injured or physically harmed (self or household member)	
	life was threatened (self or household member)	
	witnessed death/injury (self or household member)	
	assisted with rescue/recovery (self or household member)	
	prolonged separation from family	
	evacuated quickly with no time to prepare	
	displaced from home 1 week or more	
	sheltered in place or sought shelter due to immediate threat of danger	
	past substance use/mental health problem	
	preexisting physical disability	

	past trauma	
	N/A	