Sonja and her mother were struck broadside at an intersection by a truck. Sonja, age 7, had a broken arm. Her mother was seriously injured and will have a long recovery in a rehab center two hours from where Sonja and her father live. Sonja is refusing to go to school and she screams and sob if she is required to ride anywhere in a car.

James was sexually abused by a youth leader at his church over several years. Now 14, James is quiet and shy, has few friends, and avoids involvement in activities at school or in the community. He has nightmares.

Jenna, age 5, witnessed her parents’ substance abuse and fighting on a routine basis. She was placed in foster care after the drug task force raided the home and arrested the parents. Jenna’s foster parents say that she is ‘a handful.’ She is rowdy, does not attend well to directions, argues, and lies. However, if the foster parents have any sort of disagreement, Jenna becomes scared and retreats to her room and she won’t come out.

Phil’s father was killed in Afghanistan during a tour of duty. Phil was only 10 years old. Since this sudden loss, Phil’s grades have dropped and he appears depressed. He does not often get together with his friends and had a ‘falling out’ with his best buddy. He stays in his room and plays video games or watches a little television.

Trauma-based treatments are designed to serve many children who are impacted by a wide variety of traumatic experiences. Children who are victims in motor vehicle accidents, who have experienced war, who have lived with domestic violence, who have experienced the loss of a parent to illness or to an accident, and those who have been maltreated all might benefit from interventions designed to alleviate symptoms of traumatic stress.

Children in the foster care system have often experienced deprivation or trauma such as child maltreatment that led to their placement in care. Child trauma victims of sudden parental loss, natural disasters, refugee children, or children who are immigrating to the United States with their families from war-torn countries may be living with their families of origin and may or may not be served by child welfare systems. The trauma interventions described in this article can be appropriate for both children in foster care and children living with their families.

The term ‘maltreatment’ encompasses many diverse experiences. Maltreatment does not result in a specific set of symptoms. Further, maltreatment may or may not be experienced as traumatic. Thus, interventions for maltreated children need to be matched to that child’s needs. For example, a young child abuse victim with separation anxiety needs a different sort of intervention than an older maltreated child who is showing oppositional and aggressive behaviors. Since only a subsection of maltreated children later develop traumatic stress, not all child victims of maltreatment will be appropriate for a treatment designed to reduce trauma symptoms (Damashek & Chaffin, 2012).

The term ‘evidence-based treatment’ is reserved for interventions that have been tested in more than one scientifically rigorous study (such as randomized control trials) and have consistently been shown to work better than a placebo or no treatment. Most evidence-based treatments have a manual and are time-limited.

Trauma is a relatively frequent occurrence. More than half of children and adolescents in the United States have experienced an event that is potentially traumatic. These events include: child maltreatment; witnessing domestic violence; exposure to community violence; being a victim of bullying; being involved in a serious accident, fire, or disaster; medical trauma; or the sudden loss of a loved one (Cohen, Berliner & Mannarino, 2010). Not all children who experience trauma develop significant symptoms, however. It is thought that approximately a quarter of children exposed to trauma will...
Evidence-based treatments are interventions that have been proven to be effective through research studies. Criteria for labeling a treatment as “evidence-based” differ. Some typical criteria are:
- The treatment has a sound theoretical basis;
- A substantial research literature indicates the treatment’s effectiveness with the targeted population of children, their parents, and/or families;
- The treatment is generally accepted as appropriate;
- There is no indication of substantial risk of harm;
- There is written guidance on the components of the treatment or on the treatment protocol;
- There are randomized, controlled, experimental studies that have found the treatment to be effective.

The Substance Abuse Mental Health Services Administration (SAMSHA) has identified three trauma treatment principles that evidence-based treatments should embody. First, behavioral health treatment providers must understand the dynamics and impact of trauma on children’s lives. Secondly, children and their caregivers receiving treatment should be involved in the design, delivery, and evaluation of the services. Third, providers should be culturally sensitive when offering services.

Evidence-based treatments are a particularly good match for service systems such as child welfare, according to Chaffin & Friedrich (2004). Evidence-based treatments are designed to address specific goals. Overt and concrete changes (such as cessation of maltreatment, an improved home environment, reduction of child trauma symptoms) are precisely the goals of the child welfare system. As a service purchaser, child welfare systems might be interested in services that achieve positive child welfare outcomes.

Those seeking evidence-based treatments may need to be persistent and selective. According to the American Psychological Association, only 45% of graduate programs and 51% of internships train psychology students to treat abused or otherwise traumatized children using evidence-based interventions. For those using providers who are not trained psychologists, the likelihood that these providers have received rigorous training in how to administer evidence-based treatments may be much lower. In particular, PsyD programs and unaccredited internships were likely to teach students treatments with limited or no research backing. The study identified 27 empirically-supported treatments for trauma, including Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), the approach meeting the highest standard of evidence. The authors surveyed 201 graduate programs. A second survey of 137 internship programs found that about half of internship programs offered training in 13 empirically-supported treatments as determined by the California Evidence-Based Clearinghouse for Child Welfare (Sigel & Silovsky, 2011). Sigel and Silovsky’s findings underscore gaps in basic training that can affect the availability of evidence-based treatments.

It is, of course, possible that providers can receive training after graduation and retool to offer evidence-based interventions. Available data, however, suggests that this process is slow and evidence-based interventions have not been broadly adopted in the United States (Rotheram-Borus, Swendeman, & Chorpita, 2012). VCPN staff hope that the following introduction to some of the evidence-based treatments for trauma that are currently available will encourage providers and purchasers of treatment to seek and select effective and proven interventions when feasible.

Examples of Evidence-based Treatments

Prior to describing some of the evidence-based treatments now available for children who have experienced trauma, it might be beneficial to note that not all children and families will meet criteria to engage in these treatments. The treatments generally require active participation of a motivated parent or caregiver. Thus, children whose parents or caregivers are unstable or unmotivated will not be likely to complete the treatments described below or benefit from them. Some treatments assume that the child has clear, specific memories of the traumatic event. Children who lack such memories or who are unable to verbalize these memories will not be able to complete some treatments. If behavioral problems of the child are severe or if the family is unstable due to constant crises, it is less likely that the child and family will be able to focus on the components of trauma-based therapy. In cases where the child or the family appear inappropriate for trauma-based treatment, an alternative approach can be taken and trauma-based therapy can wait until the child and family are better stabilized (Ford & Cloitre, 2009).

Goals of trauma-based interventions are several. In order to manage distress, the intervention must help the child and caretaker increase affect regulation and impulse control. Children who have experienced trauma may show difficulty in sustaining attention, in remembering events, and in thinking clearly when making decisions or trying to plan actions. There may be difficulty in sustaining consistent motivation other than avoidance and hypervigilant self-protection. Avoidance and self-protection can progress into dissociative reactions. There can be persistent physical discomfort and illness symptoms. Relationships can become dysregulated and the child can show disorganized patterns of attachment. Thus, all domains of functioning can be affected (Ford & Cloitre, 2009).
One treatment for children with PTSD that has considerable research support is **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)**. TF-CBT is supported by studies conducted specifically with abused children, and with those who have witnessed domestic violence or who have experienced a traumatic loss. The studies have been conducted by independent investigators and include follow up. TF-CBT is considered the best-supported treatment model in the child maltreatment field (Damashek & Chaffin, 2012). The California Evidence-Based Clearinghouse for Child Welfare rates TF-CBT as a “1” (well-supported by research).

TF-CBT has been validated in 10 randomized controlled trials, three quasi-controlled trials, two open studies and one cross site validation conducted among many sites of the SAMHSA-funded National Child Traumatic Stress Network (Cohen & Mannarino, 2010). The studies found that more than 80 percent of children who complete treatment show marked improvement in symptoms within 12 to 16 sessions (Cohen & Mannarino, 2010). Additionally, TF-CBT is superior to usual community treatment in improving PTSD and other symptoms in multiply-traumatized children and for improving PTSD, behavior problems and placement disruption among foster children. It has been shown to be superior to child-centered therapy for improving domestic violence-related PTSD. Its effectiveness has also been demonstrated for improving children’s PTSD symptoms after community disasters and terrorist attacks and for improving traumatic grief symptoms in children (studies cited in Cohen & Mannarino, 2010).

TF-CBT is often clinic-based but has also been implemented in homes, schools, state hospitals and residential treatment settings. The treatment offered in clinics is designed as a short-term therapy with results expected in 12 to 16 weeks. Treatment in other settings may require a longer intervention (Mannarino, personal communication).

TF-CBT was originally developed for children who had experienced sexual abuse. However, the treatment has also proven effective for children who have been exposed to domestic violence, natural disasters, terrorism, and traumatic loss. The treatment has been utilized with children from diverse cultures (see below for some examples of cultural adaptations) and the treatment manual has been translated into several languages (Cohen & Mannarino, 2010). Not every child or adolescent is appropriate for TF-CBT. The treatment is designed for children and youth ages 3 to 17 whose presenting problems relate directly to their traumatic life experiences. These children present with some combination of PTSD, depression, anxiety, shame, negative self-esteem, or behaviors that are clearly related to the traumatic experience. TF-CBT may not be the best choice for children who have seri-
Treatments continued from page 3

ous and long-standing behavioral problems or other serious psychiatric symptoms, even if there is a background of trauma exposure (Cohen & Mannarino, 2010). While the treatment also requires participation of a parent or caregiver who was not abusive to the child (Cohen et al., 2007), Dr. Mannarino notes that research results have demonstrated significant improvements in PTSD symptoms even in the absence of parent participation. Assessment is necessary to help clinicians focus the intervention. The assessment should specifically address PTSD, symptoms of anxiety and depression, and sexually inappropriate behaviors, as these have been found to be most responsive to TF-CBT (Cohen et al., 2007). Difficult behaviors can be examined through a functional behavioral analysis (FBA). There is a brief description of this process on the VCNP website for those readers who would like a description.

TF-CBT includes skill-based components that include gradual exposure followed by the trauma narrative and processing which incorporate more intense gradual exposure interventions. Foundations of the intervention are gradual exposure (rather than prolonged exposure or ‘flooding’) integrated into the treatment and the use of desensitization techniques to de-condition anxiety or fear responses to abuse-related thoughts or stimuli. The treatment requires a collaborative approach between the therapist and the family, and recounting of the traumatic event by developing a narrative account of the traumatic experiences (Allen & Johnson, 2011; Damashek & Chaffin, 2012). Parallel individual sessions for the child and for parents are used at the start of treatment with conjoint child-parent sessions included later in the treatment. Dr. Mannarino notes that sometimes conjoint sessions can occur early in the treatment as well if needed to address safety planning or behavioral difficulties. During the individual sessions, the therapist carefully increases the intensity and duration of exposure to the child’s traumatic experience during each TF-CBT progressive component. The child and parent are able to gradually increase their abilities to tolerate exposure to the traumatic memories. Each individual session builds the therapeutic relationship while providing skills and a safe environment for addressing and processing the traumatic memories. Joint parent-child sessions help the parent and child practice the skills and foster more effective parent-child communication (Cohen et al., 2007).

The components of TF-CBT can be remembered using the acronym ‘PPRAC-TICE.’ These letters stand for:
- Psychoeducation (information about trauma and reactions to trauma);
- Parenting skills (such as behavior management);
- Relaxation skills (managing the physical reactions to stress);
- Affective modulation skills (managing affective reactions to trauma);
- Cognitive coping skills (understanding the connections between thoughts, feelings, and behaviors);
- Trauma narrative and processing (recounting the narrative about the trauma and correcting cognitive distortions related to the trauma);
- In vivo mastery of trauma reminders (overcoming fears related to the trauma);
- Conjoint parent-child sessions; and
- Enhancing safety and planning for the future (Cohen et al., 2010).

Psychoeducation is evident throughout TF-CBT. Children may feel less isolated after learning that many children experience similar events. Parents may be more understanding of their child’s symptoms if they are aware of typical reactions to traumatic events. Written information and brochures allow parents and children a reference between sessions. Clinicians can raise hope by relating that 80% of children experience symptom remission after 12 sessions (Cohen & Mannarino, 2010).

Parents are viewed as active members of the treatment team and they need to implement what they have learned at sessions in their homes. The work is a partnership with therapists providing skills and parents guiding the therapist in how to optimally implement the treatment with their child. The parenting skills component of TF-CBT include application of standard behavioral management and skills training that increases positive parent-child encounters, reinforces positive child behaviors, ignores minor irritating behaviors, offers children effective instructions, and teaches parents how to use consequences for misbehaviors effectively. Parents are taught how to monitor child behavior and how to develop explicit behavior management plans. Teaching problem solving and communication is central both to the parent component and to the child intervention. Helping parents assist their child in emotional and behavioral regulation empowers parents to feel capable and effective in helping their child move towards recovery (Cohen et al., 2010; Cohen & Mannarino, 2010).

Relaxation can effectively reverse physiological changes that can occur following a traumatic experience. Children with trauma histories may not sleep well, may be hyper-alert, and may be hyper-responsive to danger. The particular relaxation strategies utilized should depend upon the child’s age and preferences for activities (Cohen & Mannarino, 2010).

Affect modulation skills help children learn to accurately identify, express, and manage feelings. A wide variety of techniques can assist, including: drawing; feeling expression games; problem-solving skills; or the use of humor, optimism, and faith. Children can be taught specific techniques for dealing effectively with trauma reminders (such as seeing the person who harmed them; hearing news stories about similar trauma; having a bad dream about the trauma) (Cohen & Mannarino, 2010).

Cognitive coping skills teach children the connections between thoughts, feelings, and behaviors. The child is taught to replace inaccurate and/or ineffective thoughts or reactions with more accurate or more helpful thoughts and feelings (Cohen & Mannarino, 2010).

Once the child and parents have mastered the skills components of TF-CBT (which typically takes 4 to 8 sessions), therapists begin the trauma narrative and processing. The next sessions will involve talking more specifically about the child’s trauma experiences. If the skills components have been executed successfully, each prior session will have gradually increased the intensity and duration of addressing trauma reminders. Therefore, the child and parent have developed some tolerance and ability to be exposed to the traumatic memories (Cohen & Mannarino, 2010).

During the trauma narration and processing component, the child develops a narrative about their personal trauma experiences. A written narrative—either book, poem, or song—is commonly the medium. For younger children or those who have trouble writing, the therapist can record the child’s verbal statement or behaviors, acting out what happened. The trauma narrative generally occurs over 3 to 5 sessions. It begins with life prior to the trauma, describes the traumatic experiences, and ends with what messages the child might offer other children. As the narrative is developed, it is shared with the child’s permission in parallel parent sessions. Parents may learn details about the trauma for the first time and parent sessions allow the parent to express and process feelings prior to conjoint sessions with the child (Cohen & Mannarino, 2010).

The component of in vivo mastery uses gradual exposure to help children who have developed specific fears (such as being afraid to use the bathroom because abuse occurred there or being afraid to travel in automobiles because of an accident). In vivo mastery is not initiated if true danger still exists (Cohen & Mannarino, 2010).

Conjoint sessions (child and parent together) are undertaken as therapy draws to a close. The goal is to improve direct child-parent communication about the trauma and other important issues that may not yet have been addressed. In the conjoint sessions the


Trauma-Focused CBT for Children and Adolescents facilitates implementation of trauma-focused cognitive-behavioral therapy (TF-CBT) in a range of contexts. It demonstrates how assessment strategies and treatment components can be tailored to optimally serve clients’ needs while maintaining overall fidelity to the TF-CBT model. Coverage includes ways to overcome barriers to implementation in residential settings, foster placements, and low-resource countries. Contributors also describe how to use play to creatively engage youth of different ages, and present TF-CBT applications for adolescents with complex trauma, children with developmental challenges, military families struggling with the stresses of deployment, and Latino and Native American children. There are a wealth of clinical examples featured.

CONTINUUM OF ADOPTING EVIDENCE-BASED PRACTICE

- Pre-contemplation Phase: These practitioners are unaware of the advantages of evidence-based practice and have no plans to incorporate these proven methods into their work.
- Contemplation Phase: These practitioners are aware of evidence-based practices and are considering incorporating these therapies into their work. They must overcome inertia and a lack of training.
- Preparation Phase: These individuals have made the decision to learn and apply the best practice methods and concepts. They are seeking in-depth training and consultation in order to make changes in their practices.
- Action Phase: These practitioners are starting to apply what they have learned. They are offering therapy that has, at least, been influenced by best practices principles.
- Maintenance Phase – Those in this phase have fully integrated best practices and are using them as intended.

Source: the Kauffman report, 2004

Treating Trauma and Traumatic Grief in Children and Adolescents, edited by Judith Cohen, Anthony Mannarino, and Esther Deblinger, 2006, 256 pages, $32.00.

Available from The Guilford Press, 27 Spring Street, New York, NY 10012 (212) 966-6708, FAX: (212) 966-6708, Web site: www.guilford.com

Treating Trauma and Traumatic Grief in Children and Adolescents describes trauma-focused cognitive behavioral therapy for children affected by posttraumatic stress disorder, depression, and anxiety. The book is divided into three parts. The first section focuses on the impact of trauma and describes the trauma-focused cognitive behavioral therapy model. The second section introduces trauma-focused components of the model. These include: psycho education; relaxation; affective expression; cognitive coping; in vivo mastery; ensuring safety. The volume then explores the grief-focused components, including: education; resolving ambivalent feelings; preserving positive memories; and committing to present relationships. The authors provide a troubleshooting section at the end of almost every chapter, offering questions with answers regarding applying the knowledge just learned in the chapter. Also, useful handouts and information on obtaining additional training are provided in the appendix.
Evidence-based Treatments
continued from page 5

Parent-Child Interaction Therapy (PCIT)

PCIT dates to the 1970’s. Conceived by Shelia Eyberg, Ph.D. while at the Oregon Health Sciences Center, the treatment was later refined at the University of Florida. The intervention was originally created for oppositional children who have negative interactions with parents and do not comply with parental requests. Studies on these children (who are not maltreated) show that improvements are maintained for three-fourths of those treated for three to six years after treatment ends (Chaffin et al., 2004).

PCIT has been adapted for parents who physically abuse children ages 4 to 12 years. Studies with this population demonstrate that PCIT is effective in decreasing subsequent abuse reports, in lowering child behavioral problems, in reducing parental stress, in increasing parental warmth, and in decreasing risk for future abuse (Chaffin et al., 2004; Damashek & Chaffin, 2012). At least 30 research studies have found PCIT to be effective in treating at-risk families and children with behavioral problems (Chaffin, Taylor, Wilson, & Ingelman, 2007).

The PCIT intervention teaches parents or caregivers how to engage in positive interactions with children, how to use contingent praise, how to avoid coercive or negative parenting behaviors, and how to apply a consistent behavioral time-out discipline strategy. A defining feature of the PCIT is direct coaching of the parent by use of a wireless earphone while the parent and child interact (Damashek & Chaffin, 2012). PCIT is based on developmental theory and holds that authoritative parenting – a combination of nurturance, good communication and behavioral regulation – produces optimal mental health outcomes for children. By providing caregivers with skills to respond selectively to child behavior, the caregiver becomes more sensitive to the child, responds with greater warmth, becomes more emotionally available and creates a secure caregiver-child attachment which reduces stress (‘N’zi & Eyberg, in press).

PCIT includes two sequential phases and requires an average of 15 weekly outpatient sessions. Goals of the first phase, the Child-Directed Interaction, are to improve the quality of the parent-child relationship and strengthen the parent’s ability to attend to and reinforce positive child behavior. Parents learn to ‘follow the child’s lead’ in one-on-one play, to provide positive attention and to actively ignore minor misbehaviors. Parents are taught to use PRIDE skills (Praise; Reflection; Imitation; Description; Enjoyment) to reinforce positive child behaviors. Parents also learn to avoid intrusive or leading behaviors.

In the second phase of PCIT, the Parent-Directed Interaction, parents learn to give effective instructions and to follow through with consistent consequences, including praise for compliance and a timeout procedure for noncompliance. Live skill coaching is the primary intervention method in both treatment phases. The parent and child interact in the therapy room while the therapist coaches from an observation room using a wireless microphone.

Motivation and engagement are very important, according to Dr. Eyberg. One of several motivational methods to encourage parents is to chart the child’s progress. Data is gathered regularly from the parents, and a parent completes a behavior rating on their child each week. The results are graphed and discussed with the parents. If the data suggest behavioral deterioration or areas of concern, those difficulties can be problem-solved.

When the graph indicates improvement, the graph is used to praise the parent for doing a good job of implementing the skills at home.

The benefits of PCIT have been established in numerous research studies. Gains are durable over time, generalize to untreated children within the family, and generalize from home to school settings. A recent study that piloted the effectiveness of using PCIT in a group format showed promising results (Nieter, Thornberry & Brestan-Knight, 2012). The mounting evidence has spurred national and international interest in dissemination. One cultural adaptation for PCIT is described later in the article.

Dissemination is a concern. Distance from training sites, training costs, and therapist and agency readiness have been barriers. Trainers have worked to develop training that reduces barriers to implementation and maintenance of the treatment. The Learning Collaborative methodology (described elsewhere in this issue) is one promising model. Telemedicine technology has also been used to allow trainers to consult with trainees from a distance while providing live, immediate feedback (Nie, Eyberg, & Chase, 2012).

Rhea Chase, Ph.D. of Duke University is a PCIT International Master Trainer. With generous funding from The Duke Endowment, Dr. Chase and the PCIT team at Duke University Medical Center conducted the first Learning Collaborative focused on the dissemination of PCIT. Results suggest that the Learning Collaborative is a promising training methodology for PCIT. Participating clinicians conduct PCIT with high levels of fidelity and report high levels of satisfaction with the training. Families receiving PCIT through the Learning Collaborative report significant improvements in child behavior.

The first Collaborative was a success, with 25 agencies applying to have their staff trained. Due to the demand for the training and the early success of the program, PCIT

PRINCIPLES OF TREATMENT WITH BEHAVIORALLY DISORDERED CHILDREN

Sheila M. Eyberg discusses the following principles in a recent article:

- Establish rapport
- Address parent motivation
- Consider the child’s developmental level
- Use assessment to guide treatment
- Maintain treatment integrity
- Abide by the treatment theory
- Plan for treatment generalization

of the Carolinas was granted continued training funding through the Duke Endowment. The Learning Collaborative has been repeated and Dr. Chase is now preparing to train a third cohort of clinicians.

Dr. Chase described several challenges in community dissemination of PCIT, including the intensity of the model and the costs associated with the necessary space and equipment. The live coaching component of PCIT requires a one-way mirror or closed circuit monitor that allows the therapist to observe the parent and child from a separate room. The space also requires audio equipment to allow the clinician to hear the parent and child while they are playing and an assistive listening devise to allow the clinician to speak to the parent in ‘real time.’ Case consultation is an important aspect of PCIT training; therefore, while a clinician is in training, therapy sessions are recorded.

The significant cost and specific requirements related to offering PCIT highlight the importance of agency involvement in PCIT training. Agency involvement is a key feature in the Learning Collaborative model and is one of the reasons that Dr. Chase believes that using a Learning Collaborative for dissemination is optimal for PCIT. It is her hope that families throughout North and South Carolina will have access to high quality PCIT services if public mental health agencies can be equipped to offer the intervention. PCIT is powerful and robust, according to Dr. Chase. “PCIT is designed primarily for younger children ages two and a half to six. However, research at the University of Oklahoma Health Sciences Center has supported the use of PCIT in reducing recidivism rates of physical abuse in families with children through age 12 when none of the children had conduct disorders.” She adds that several researchers have explored cultural adaptations of PCIT (some are described later in this article). One example is an adaptation for Mexican-American families by Dr. Kristen McCabe at the University of San Diego (McCabe & Yeh, 2009). Dr. Chase described the intervention. “Kristen McCabe created an adaptation for Mexican American families. She compared the effectiveness of a culturally-modified version of PCIT to both ‘treatment as usual’ and to regular PCIT. The culturally-modified version and standard PCIT were both equally effective and both were superior to ‘treatment as usual.’” Dr. Chase notes that if clinicians can adapt treatments to be culturally sensitive, that is an ethical practice, even if the regular model is equally effective.

Dr. Chase concludes, “I am completely spoiled by PCIT. A clinician can see change in just an hour! Even under very adverse circumstances, we see positive change. Even before a parent completely masters the skills, there is change. The change is rapid and dramatic. Many clinicians work their entire careers and do not see the kind of change that we see every day.”

WHAT CAN CHILD WELFARE WORKERS DO TO OFFER TRAUMA-INFORMED SERVICES?

The National Child Traumatic Stress Network offers ideas of how child welfare staff can better serve children who have experienced trauma. Consult their Child Welfare Trauma Training Toolkit (www.nctsnet.org/products/child-welfare-trauma-training-toolkit-2008). The following points are extracted:

- Understand the impact of trauma on the child and integrate that understanding into your work.
- Maximize the child’s sense of safety. Help caregivers maintain consistent, predictable environments with routines, clear expectations, consistent feedback and positive reinforcement.
- Help children effectively manage their emotions. Encourage physical activities, involvement in expressive activities such as music and art, animal-assisted activities, and other active involvement in the community. Help the child label emotions and understand what is happening when trauma reminders occur.
- Coordinate services with other agencies.
- Perform a comprehensive assessment of the child’s trauma experiences and use it to guide service provision.
- Support and promote positive and stable relationships in the child’s life. Identify people who are important to the child and consider how to strengthen these relationships.
- Provide support and guidance to the child’s family and caretakers. Encourage their involvement in the child’s therapy. Provide training and information to them about the effects of trauma.
- Engage in self-care and manage professional and personal stress. Be part of a support system for coworkers.

The Child and Family Traumatic Stress Intervention (CFTSI)

This intervention was designed by Steven Marans, Ph.D. and Steven Berkowitz, MD at the Childhood Violent Trauma Center (CVTC) at the Yale Child Study Center. The developers drew upon two decades of collaborative work with law enforcement and child protective services partners in providing acute and on-the-scene interventions to children and families who had been exposed to violence and other potentially traumatic events. CFTSI is an early intervention and secondary prevention model that is implemented immediately following a potentially traumatic event of the disclosure of physical or sexual abuse. The intervention aims to reduce early post-traumatic stress reactions, to decrease the likelihood of the child developing longer-term post-traumatic psychiatric disorders, and to identify children who may need longer-term mental health care. As a brief, early intervention, CFTSI fills a gap between crisis intervention and evidence-based treatments that are designed to address traumatic stress symptoms or disorders that have become established. Intended for children ages 7 to 18, CFTSI is strengths-based, capitalizes on protective factors, and is focused simultaneously on decreasing symptoms and on improving communication between the child victim and a non-offending caregiver.

continued on page 8
Evidence-based Treatments

continued from page 7

The intervention involves four sessions. During an intake appointment that is conducted by a trained staff member other than the designated CFTSI provider, the child and the parent or caregiver are screened separately for symptoms of post-traumatic stress to determine if the child is in need of trauma-focused treatment and to create a baseline measurement of symptoms. At the first CFTSI session the treatment provider meets with the parent or caregiver alone. A psycho-educational approach is taken with explanations given about typical child reactions to trauma. A series of questionnaires are completed with the parent to assess both the parent’s and the child’s trauma symptoms. In addition, case management and care coordination issues are considered and a case management plan is created.

The CFTSI provider begins the second session by meeting with the child. Education is provided to the child about trauma and trauma reactions, and a series of questionnaires, similar to those completed by the parent, are completed with the child to assess the child’s trauma symptoms. During the second half of the session, the caregiver joins the CFTSI provider and the responses to the questionnaires are compared. Areas of agreement are praised and areas of discrepancy are discussed as opportunities to improve communication by helping the child better inform the parent about his or her symptoms and feelings so the caretaker is more aware, receptive, and supportive. The CFTSI provider determines symptoms to target and coping skills are taught and practiced with the caregiver and child. Coping skills focus on specific symptom clusters which include but are not limited to sleep disturbance, depressive withdrawal, aggressive behaviors, tantrums, intrusive thoughts, and anxiety.

The third and fourth CFTSI sessions are conducted conjointly with the caregiver and the child. In these sessions, the child completes the questionnaires together with the caregiver indicating areas of agreement and sharing additional observations. The main focus is on practicing the coping skills, increasing the communication efforts and increasing the family’s sense of self-efficacy. During the fourth session, the CFTSI provider also discusses case disposition and makes recommendations for additional treatment or services. Following the final session, the child and caregiver complete a brief interview to track symptom reduction and caregiver satisfaction. Where agency capacity permits, a six-week follow up assesses symptom levels.

Berkowitz, Stover, and Marans (2010) conducted a randomized trial at the Child- 

hood Violent Trauma Center at the Child Study Center at the Yale University School of Medicine. Youth (n= 106) were randomly assigned to either the intervention (n=53) or to a similar four-session supportive comparison condition (n= 53). At follow up, the intervention group showed significantly fewer full or partial PTSD diagnoses than the comparison group. Children who received CFTSI were 65% less likely than comparison youth to meet criteria for full PTSD at three month follow up and were 73% less likely than comparison youth to meet combined criteria for partial and full PTSD. CFTSI has also been evaluated in Child Advocacy Center settings. In a recently completed analysis of 134 CFTSI cases at the Safe Horizon CACs in New York City (Berkowitz, Stover, & Marans, 2011), the trauma symptoms of children who received CFTSI decreased 54%. Caregiver satisfaction was extremely high with over 98% of the 64 caregivers saying that they would recommend the CFTSI intervention to a friend. Staff was satisfied as well and reported an increased sense of efficacy after the introduction of the model. (Readers should note however, that there was no control or comparison group in this preliminary report.)

Treatments in Preliminary Stages

Many of the treatments described in this section build upon or borrow components from evidence-based treatments with proven effectiveness. Damashek & Chaffin (2012) note that “borrowing” has benefits. Since modifications of evidence-based treatments appear to be robust, there may not be a need for the separate development of specialized models for each particular population. Rather, effectiveness with one population may generalize, even with adaptations to the original procedure (such as described below), for other groups. If this thinking is accurate, the time and expense of validating an adaptation might be forgone in favor of more rapid adaptations that continue to yield positive results. Thus, some of the treatments in this section may quickly prove efficacious and become regarded as well-established options.

Preschool Children

Preschool children whose verbal skills are just beginning to develop can pose a special challenge to therapists. Since parents or caretakers are present when issues surface, an approach that trains parents and caretakers to respond to the preschool child’s immediate needs may be preferred over traditional therapy approaches where the clinician works with the child. Salloum and Storch (2011) have piloted such an approach which they term parent-led, therapist-assisted, trauma-focused cognitive behavioral therapy (PTA-TF-CBT).
Alison Salloum, Ph.D., Assistant Professor at the University of South Florida, is one of the developers of PTA-TF-CBT. In a recent interview with VCPN staff, she noted that TF-CBT (above) was first developed with preschool children. While the traditional TF-CBT model is quite effective for preschool children, Dr. Salloum felt that she could use the principles from TF-CBT, teach them to parents, and develop a treatment that is efficient and less costly. “One of the barriers to therapy for very young children is that parents want to be the source of help for their child,” says Dr. Salloum. “If we can give parents the correct empirical tools and support, then they can be effective in helping their child heal.”

The treatment model consists of three face-to-face meetings over a 6-week time period, supplemented by telephone support weekly and a parent workbook called Stepping Together. Stepping Together is based on the Preschool PTSD Manual that was tested in a randomized clinical trial (Scheeringa, Weems, Cohen, Amaya-Jackson, & Guthrie, 2011). During each meeting, the parent is given one of three parts of the workbook and the therapist explains what is to be completed. The weekly phone calls encourage the parent to complete the assignments and problem-solve any difficulties.

There can be several advantages to PTA-TF-CBT. In a case study application, the treatment was acceptable and satisfactory to the parent. Therapist time was limited, thus conserving resources. Clinical improvements were reported post treatment and at a five-week follow up (Salloum & Storch, 2011). Dr. Salloum notes that the total treatment time for PTA-TF-CBT is similar to TF-CBT but much of the treatment is done by the parent at the child’s home.

If a child does not respond to the PTA-TF-CBT, then the usual TF-CBT can be undertaken. “The child can ‘step up’ to the full treatment if the PTA-TF-CBT is not sufficient,” explains Dr. Salloum. “Step 2 is a nine-session TF-CBT to enhance the first step.” A recent clinical trial, funded by the National Institute of Mental Health, is underway to compare standard TF-CBT to PTA-TF-CBT. “We are examining differential characteristics that might predict which children respond to the PTA-TF-CBT and which children might need the standard care.


Available from: www.childrens-bureau.com ($25 plus shipping) or contact Paulette Carter, MPH, LCSW, President/CED, Children’s Bureau of New Orleans, Inc. at pcarter@childrens-bureau.com

GTI for children was based on a framework in which practice informed the research and the research informed the practice. The development and evaluation of GTI began in 1997. A community-based non-profit agency, Children’s Bureau of New Orleans Inc., was providing intervention to low-income urban African-American children who had witnessed multiple types of violence and many of whom had had a loved one murdered. The intervention was based on experiences with these children.

GTI has been tested with children experiencing posttraumatic stress due to witnessing or being a direct victim of violence (often multiple types of violence), death of a loved one (including homicide) and disasters (specifically Hurricane Katrina). The intervention utilizes cognitive behavioral and narrative therapy strategies to effectively and significantly reduce symptoms of posttraumatic stress, depression, and traumatic grief in children. GTI has been implemented in various community-based settings, including schools, afterschool programs and community centers, and may be provided individually or in a group setting.

The GTI treatment manual includes several specific features: 1) a fidelity checklist for each session and a section for notes to document the process of implementing GTI; 2) a section on evaluation that explains screening and lists the recommended evaluation tools along with where these tools can be obtained; 3) case vignettes to illustrate implementation of specific activities, and; 4) all of the worksheets that are needed.

GTI is to be implemented by mental health clinicians, preferably with a master’s degree in a mental health related field.

A two-day training on implementing GTI is recommended for first-time users. All training requests may be made to Dr. Alison Salloum at: asalloum@usf.edu


This publication from the U.S. Departments of Justice and Health and Human Services summarizes findings from Federal reviews of research studies and program evaluations to help communities improve outcomes for children exposed to violence. It cites evidence-based practices that practitioners and policymakers can use to implement prevention services and activities for children. In reviewing the research literature on evidence-based programs, common characteristics have emerged that have been shown to either support success or reduce the effectiveness of programs. This paper highlights two types of service characteristics. The first lists facilitators’ characteristics that are common across a range of programs that are associated with better outcomes. The second lists barriers, or those characteristics that can prevent programs from being successful. A third list includes common service and system gaps documented as practical implications discussed in the research literature. Data were collected from the following databases prepared by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and the Substance Abuse and Mental Health Services Administration (SAMHSA): SAMHSA’s National Registry of Evidence-Based Programs and Practices; SAMHSA’s National Child Traumatic Stress Network; OJJDPs Model Programs Guide; and OJJDPs Children Exposed to Violence Evidence-Based Guide.
INVEST FOR CHILDREN:
A COMMUNITY-BASED LEARNING COLLABORATIVE

Several energetic people have combined forces to bring training in evidence-based trauma treatments for children to Virginia. INVEST for Children stands for INcreasing Virginia’s Evidence-Supported Treatments for Children. The INVEST for Children Project is headquartered at the Children’s Hospital of The King’s Daughters (CHKD). It is supported, in part, by a grant from the National Children’s Alliance, written and administered by Carole Campbell Swiecicki, Ph.D., a clinical psychologist.

Three Virginia Child Advocacy Centers and their affiliated professionals are currently participating in the first INVEST for Children community-based learning collaborative. Foothills Child Advocacy Center (in Charlottesville), Greater Richmond Stop Child Abuse Now (SCAN) and CHKD Child Abuse Program were selected to receive the training that is funded by the grant. Clinicians are learning Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and brokers of services are being trained in how to screen children and refer them.

Each participating site and their affiliated professionals formed a ‘Community Change Team’ (CCT) which was comprised of participants from three groups: clinicians; brokers; and administrators. Dr. Swiecicki notes that training is essential for all three components in order to arrive at a functional system of screening, referral, and intervention.

The first of two face-to-face learning sessions occurred in May, 2012. The first training covered the basics of TF-CBT. A certified trainer, Elissa Brown, Ph.D. conducted the session with clinicians. In an interview with VCPN staff, Dr. Brown said she was able to take the training to a more sophisticated level because the clinicians in the group arrived with a solid understanding of trauma-informed treatment. “They are a talented, dedicated group,” she remarked.

Dr. Brown is a clinical psychologist based in New York City. She operates the Child HELP Partnership, an organization that promotes Healing after trauma, Empowering multi-cultural communities, offering a Learning center to train professionals and dedicated to Preventing child abuse and in-jury. Her organization offers affordable trainings twice a year for independent practitioners (see web article on available training for professionals).

 While the clinicians were being trained by Dr. Brown, the brokers of services were being trained by Libby Ralston, Ph.D., a founding director of the Dee Norton Low-country Children’s Center, a CAC in South Carolina, and a co-developer of the community-based learning collaborative model. The brokers of services included case managers, child protective services workers, CAC administrators, forensic interviewers, and family advocates. These individuals interact with the children early in the process. The brokers can implement screening practices, learned through the collaborative training, to determine whether or not the child is showing trauma symptoms and if so, refer the child for treatment. The brokers also work closely with investigators.

After the training, 12 consultation calls with clinicians offer supervision and reinforce the training. These one-hour calls occur every two weeks and allow clinicians to present cases and receive feedback. There have already been several consultation calls, and the clinicians are enthusiastic about the interaction. The calls deepen knowledge and enhance the clinician’s level of competence, says Dr. Swiecicki.

Lisa Wright is the Mental Health Program Coordinator for Greater Richmond SCAN. She comments, “The clinical consultation calls have been very helpful. The calls help clinicians understand how to implement TF-CBT protocols. For example, during a recent consultation call, we reviewed a case where there is a caregiver who dislikes her child. We first discussed how to engage the caregiver. Then we talked about how to use the TF-CBT skill of psycho-education to help her to better understand and respond to the child’s acting out behaviors.”

Jennifer Kline, Program Coordinator for Foothills Child Advocacy Center, agrees. She adds, “I obtained many ideas for the case manager position that we just hired. I’m using what I learned in the sessions to create her job descriptions and the protocols.”

Foothills brought some of their community partners into the Collaborative. Shannon Noe, LPC, CTS, a counselor at Child and Family Services is excited about applying the information. She is part of the Foothills multidisciplinary team. “Our team has benefitted from the training in many ways,” she comments. “We are a committed team with strong leadership.”

There will be one additional learning session in mid-November. Brokers also are scheduled for consultation calls, but theirs are monthly rather than every other week. The consultation calls will continue through the end of January, 2013. At that time, the grant that is funding the current learning collaborative will be completed.

Dr. Swiecicki notes that there are several evidence-based treatments and the model is an efficient and effective way to increase the availability of evidence-based treatments. Wright agrees. She commented, “We have been offering evidence-supported trauma treatment at our CAC for seven and a half years.”

Recently, Dr. Swiecicki received exciting news! She and her colleagues were awarded a SAMHSA grant that will fund the INVEST for Children project for 4 years. This funding will provide PCIT (Parent Child Interaction Therapy) and AF-CBT (Abuse-Focused Cognitive Behavioral Therapy) training to the staff at CHKD as well as training for CPS and Department of Human Services workers on screening and referral procedures, including how to identify the best type of treatment. She is thrilled with the new learning opportunities.

The need for training is great, according to the proponents of INVEST. “We have treatments available that have been shown to be effective. Even so, it is difficult to say to professionals, ‘You have skills but there is a better model than what you are offering.’ It can be expensive and time-consuming to learn new methods. If a practitioner is comfortable with their current offerings, that person may not feel the need to acquire new skills” notes Dr. Brown. Also, many graduate programs do not have faculty trained in evidence-based treatments, which means that current gradu-
WHAT IS A COMMUNITY BASED LEARNING COLLABORATIVE?

A Community Based Learning Collaborative (CBLC) uses methods designed to allow participants to make dramatic improvements in a focused area over a short time period. The CBLC is intended to close the gap between what science has identified as best practice and what is actually offered in the field. Sometimes agency policies endorse best practices but for various reasons evidence-based interventions are not being implemented in day-to-day practice. The CBLC tries to bridge the gap between what is known and what is practiced.

A CBLC offers:

- Multiple learning sessions
- Ongoing consultation
- Guidance to make and test the impact of small changes
- Sharing success
- Offering methods and support to overcome barriers
- Ways to sustain the practices

Sources: Saunders & Ralston, 2012; 2012 INVEST for Children Community Based Learning Collaborative on TF-CBT Orientation Guide

Training Resources

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) Web
Medical University of South Carolina
National Crime Victims Research & Treatment Center
MSC 861, Ste 207, 2nd floor Institute of Psychiatry
67 President Street
Charleston, SC 29425 (29403 for express mail)
Phone: (843) 792-8151
Website: http://tfcbt.musc.edu/
Email: tfcbt@musc.edu

TF-CBT Web is a web-based course for Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT). The free course is the first step in training for clinicians and those successfully completing the training can earn 10 CEUs (Continuing Education Credit). Credits are awarded on a module-by-module basis; however, all modules must be completed in order to receive credit.

Children’s Hospital of the King’s Daughters

Children’s Hospital of the King’s Daughters Child Abuse Program
601 Children’s Lane
Norfolk, VA 23507
Website: http://www.chkd.org/services/childabuse
Contact: Carole Campbell Swiecicki, Ph.D.
Phone: (757) 668-6100
Email: carole.swiecicki@chkd.org

The Child Abuse Program at Children’s Hospital of the King’s Daughters brings multidisciplinary professionals together to coordinate investigations and interventions for each child abuse case, with the goal of reducing trauma and time in the legal system. The program provides a supportive, child-friendly environment in order to minimize further stress for child victims. Their mission is to identify and provide services for child victims of abuse and neglect in a safe, supportive environment while reducing secondary trauma. All services are based on the highest professional standards and evidence-based practices shown to reduce the impact of trauma and generate positive outcomes. The CHKD’s program has also added a trained service dog who can accompany children during interviews, medical exams, and therapy appointments to lessen a child’s anxiety level. Dr. Swiecicki is a supervisor for TF-CBT and she is the coordinator for an initiative to improve access to evidence-based treatment for child victims of maltreatment in Virginia. She is available to discuss agency training needs.
intervention,” explains Dr. Salloum. The results will be published. While Dr. Salloum was not able to offer an estimate, she indicated that the numbers of children who respond well to the more efficient and less costly PTA-TF-CBT was encouraging and higher than she had expected.

**Combined Parent-Child Cognitive-Behavioral Therapy for Families that Physically Abuse (CPC-CBT)**

CPC-CBT developer Melissa K. Runyon, Ph.D., Professor of Psychiatry at The University of Medicine & Dentistry of New Jersey-School of Osteopathic Medicine (UMDNJ-SOM) and Treatment Services Director at the CARES Institute started her career at the University of Miami School of Medicine Child Protection Team (CPT). In many of the cases of child physical abuse seen by the CPT, judges ordered the parent alone to parenting classes and there generally was no treatment ordered for the child. Parents frequently attended the class and then presented their certificate of completion to the court. The child was placed back in the home or the child protection case was closed. The recidivism rates among these cases were very high with many returning to the CPT within a few months. Dr. Runyon comments, “If the child is not treated, there can be an interaction effect. Parents who abuse frequently interpret their children’s behavior incorrectly, often perceiving symptoms of trauma as disobedience. This inaccurate perception escalates the coercion between the parent and the child. If the child is not treated for trauma, the interaction will not likely improve, leaving the child to suffer with trauma symptoms and at-risk for further abuse.”

CPC-CBT consists of four phases of therapy. The Engagement & Psychoeducation phase involves the use of engagement strategies, motivational interviewing and goal setting to initiate change talk and to motivate parents who are not contemplating changing their parenting style or interactions with children. A key component to the success of the intervention is engagement and obtaining the parents’ commitment to the therapy process. Dr. Runyon notes that in the first controlled trial, the attrition rate was only 12% if families attended the first three sessions with the primary focus of these sessions being engagement.

Phase 2 of the intervention teaches both parents and children effective coping skills. Dr. Runyon explains that while CPC-CBT assists the child in healing from the traumatic experience of abusive or coercive parenting, CPC-CBT also teaches the parents skills (how to cope; how to regulate affect; how to remain calm; positive parenting skills; interaction and communication skills). A parent-child interaction coach assists the parent in implementing these skills. Parent sessions also focus on increasing social support, reducing isolation, and assisting parents in developing healthy emotional outlets.

Phase 3 helps families develop a Family Safety Plan. The plan helps families learn how to identify when parent-child interactions are escalating and how to ensure safety and communication in the family.

The Abuse Clarification process is the final phase of therapy. A trauma narrative is developed with the child over several sessions. Simultaneously, the parent writes a clarification letter where he or she takes responsibility for the abusive or coercive actions. The final step involves the parent hearing and responding to their child’s narrative about the abuse and cohesive interactions.

“It is a very powerful moment when a parent says to a child, ‘I’m so glad you told because I hit you’ remarks Dr. Runyon. Dr. Runyon summarizes, “In the simplest terms, CPC-CBT clinicians are helping parents to create positive family environments to enjoy their children and to enjoy being parents.”

A priority of CPC-CBT is to closely monitor the family and continually reassess for recurrence of corporal punishment or physical abuse. In addition to lowering the risk of violence, goals are to help parents correct unrealistic expectations and misinterpretations of child behavior, to increase positive interactions and to improve children’s overall emotional adjustment. The treatment utilizes modeling, role plays, behavioral rehearsal, praise, corrective feedback, and homework assignments.

Dr. Runyon explained that she and her colleague, Dr. Esther Deblinger, developed CPC-CBT through a series of research studies. An initial pilot study was conducted to address the feasibility of a 16-week CBT group approach that incorporated the child into the parents’ therapy (Runyon, Deblinger, & Schroeder, 2009). The group format was chosen because of a belief that guarded populations (such as parents who physically abuse) may benefit from suggestions and interactions with peers rather than from input from the therapist alone. In this pilot study with 12 parents and 21 children, both parents and children reported pre to post treatment improvements after their participation in CPC-CBT. Specifically, parents and children reported reductions in the use of physical punishment and improvements in parental anger towards their children. There were reductions in children’s PTSD symptoms and behavioral problems. However, there was no follow-up so it is unclear if the positive changes at the end of the 16-week treatment were maintained over time.

In their 2010 study, Runyon, Deblinger, and Steer compared the relative efficacy of CPC-CBT (24 parents, 34 children) to Parent-only CBT (20 parents, 26 children). Children were assessed on emotional and behavioral functioning prior to treatment, after 15 treatment sessions, and 3 months after completion of the treatment. The children and parents in the CPC-CBT group demonstrated greater improvements in resolving PTSD symptoms and improving parenting skills when compared to the Parent-only CBT group. A three-month follow-up demonstrated that the treatment gains after the 16-session treatment were maintained.

Dr. Runyon relates that CPC-CBT is...
being disseminated both nationally and internationally. For example, agencies in four cities across the Southern portion of Sweden have implemented CPC-CBT with positive results and plan to conduct a large-scale clinical trial. Dr. Runyon said that researchers in Sweden have replicated the findings of the initial CPC-CBT pilot study (i.e., Runyon et al., 2009) with most participants receiving individual CPC-CBT (Kjellgren, Svedin & Nilsson, in press). She continued, “In their pilot study, they examined pre to post treatment changes for 26 parents and 25 children. After their participation in CPC-CBT, there was a significant decrease in parent-reported depression, violent parenting tactics, and inconsistent parenting as well as significant improvements in children’s reports of trauma and depressive symptoms. Children also reported significant decreases in violent parenting tactics and improvements in positive parenting.”

According to Dr. Runyon, four agencies in Mississippi participated in a CPC-CBT Learning Collaborative in 2010 through 2011 that was supported by funding from Gulf Coast Mental Health Center, a member of the National Child Traumatic Stress Network. Data collected from the clients of participating clinicians demonstrated significant pre to post-treatment improvements for both children and parents.

Training programs for clinicians who want to offer CPC-CBT are described in the article on training opportunities on VCPN’s website. Their training model includes a motivational enhancement procedure and places emphasis on teaching clinicians how to engage families. To read more about the details of CPC-CBT, see additional information on VCPN’s website.

**Treatment for Child Sexual Behavioral Problems**

*Jane Silovsky, Ph.D.*
*Developer of SBP-CBT*

Some child victims of sexual abuse develop sexual behavioral problems (SBP). Preschool children who have been sexually abused are at particular risk with about a third demonstrating some SBP, compared to school-aged children where about 6% demonstrate SBP (Kendall-Tackett, Williams & Finkelhor, 1993; Silovsky, Swisher, Widiffield, Jr. & Burris, in press). In a meta-analysis (Amand, Bard & Silovsky, 2008), 11 studies were located that evaluated

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**QUESTIONS TO ASK TREATMENT PROVIDERS**

- What is the nature of their training in evidence-based treatments?
- Does the therapist use a standardized assessment process to gather information on the child and family and to monitor progress over time?
- What techniques will the therapist use to help the child manage his or her emotions and behaviors?
- Will the therapist use a combination of individual and joint parent-child sessions?
- Is the practitioner experienced with families of similar cultural background?
- Is there any harm associated with the treatment?

Sources: Cohen et al., 2007; Child Welfare Information Gateway

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This guide is intended to provide a foundation of information for child welfare administrators. It offers a brief overview of evidence-based practice. There are sections on identifying and selecting treatments with scientific support as well as discussions about implementation and adoption of evidence-based practices. An appendix outlines classification systems.
Evidence-based Treatments

continued from page 13

18 different treatments for SBP in children under age 12. It is interesting that the results emphasized that the primary change agent for children’s sexual behavior problems appears to be the parent or the caregiver. Parent competence in learning behavioral management skills was the practice element that was most strongly associated with reductions in child sexual behavior problems. However, Dr. Silovsky notes that parent training alone has not been evaluated as a treatment for SBP. Rather, programs augmented by behavior parent training addressing abuse prevention skills, sexual education and rules about sexual behavior appeared most promising. The authors note that SBP treatment has only begun to be evaluated and few randomized clinical trials have been conducted.

The University of Oklahoma (OU) Cognitive Behavioral Therapy for Childhood Sexual Behavior Problems (SBP-CBT) is a short-term (12 to 16 sessions) outpatient treatment that focuses on teaching younger children with sexual behavior problems (boys and girls ages 6 to 12 years) clear and specific rules about sexual behavior, self-control skills (stopping and thinking before acting) and child sexual abuse prevention skills. The treatment is family-oriented and incorporates cognitive-behavioral treatment such as TF-CBT, psycho-educational components, and supportive group treatment.

According to a review by to Damashek & Chaffin (2012), children respond well to SBP-CBT and long-term follow up (10 years) showed reduced rates of future sex crimes and sexual abuse perpetration reports. In the 10-year follow up from the original randomized clinical trial (Bonner, Walker, & Berlinger, 1999) children randomized to the SBP-CBT had long-term sexual offense rates similar to children with disruptive behavior problems but no known previous sexual behavior problems (2% and 3% respectively). In contrast, children randomized to dynamic play therapy had an 11% sexual offense rate (Carpentier, Silovsky, & Chaffin, 2006). The California Evidence-Based Clearinghouse for Child Welfare (CEBC) rates the treatment a “2” (supported by research evidence). OU also has a SBP-CBT program developed for preschool age children that is rated as a “3” (promising) by CEBC.

In an interview with VCPN staff, Jane Silovsky, Ph.D., director of the SBP-CBT program at OU, noted that in the meta-analy-

sis (Amand, et al., 2008), SBP-CBT has been found more effective than both dynamic play therapy and non-directive supportive therapy for reducing sexual behavior problems. The intervention has been found effective when offered either as a family-based treatment or in a group format. The parent or caregiver must be involved; treating children without parent participation is not likely to be effective.

Dr. Silovsky expressed that the lack of outpatient programs for SBP, along with myths about the affected youth, hinder the dissemination of evidence-based treatments and can result in a system that can be detrimental to children and families. “Many programs continue to use practices based on treatment for adults or adolescents with illegal sexual behaviors rather than offer developmentally-appropriate services. Youth with SBP may be removed from homes and placed in foster or residential care as a standard practice rather than based on an assessment of safety and risk. Treatment for family members typically is fragmented and not coordinated. If developmentally-appropriate outpatient care is available, some children and youth can safely remain in the community,” she explains. Dr. Silovsky adds, “While there are a few unsafe youth who do require separation from families, these are the exception rather than the rule. There is little justification for using adult practices and components of treatments for adults. We need to realize that children are not adult sex offenders or sexual predators. They are first and foremost children.”

Dr. Silovsky and her colleagues at OU are currently working with the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and three sites (Los Angeles, Omaha, Nebraska, and New Jersey) to provide outpatient SBP-CBT and more coordinated services, targeting late childhood and early adolescent youth.

Dr. Silovsky and the OU SBP-CBT training team have trained five other teams. Since successful implementation requires support from community and service providers such as child welfare, schools, and juvenile justice, training applicants must show indication of community readiness to adopt the treatment approach. While there currently is no official certification, there are requirements to be trained to fidelity. These include a week of intensive training and follow up consultation that includes reviewing of recorded sessions. The community collaboration approach is similar to the Learning Collaborative approach (discussed elsewhere in this issue).

Multisystematic Therapy (MST) for Youth with Problem Sexual Behaviors (MST-PSB) is an adaptation of MST (see article on VCPN’s website) which is an intervention for delinquent adolescents. MST works through primary caregivers and other important individuals in the youth’s social ecology to change the youth’s behaviors. Short-term (4 to 6 months) intensive services are delivered by licensed professionals. Risk factors are assessed and practical, action-oriented activities and techniques are implemented to achieve goals. The California

Children with Sexual Behavior Problems Cognitive-Behavioral Treatment Program: School-Age Group

Website: http://www.cebc4cw.org/program/children-with-sexual-behavior-problems-cognitive-behavioral-treatment-program-school-age-group/

Contact: Jane F. Silovsky, Ph.D.
Phone: (405) 271-8858
Email: jane-silovsky@ouhsc.edu
Website: http://www.oumedicine.com/csbp

The Children with Sexual Behavior Problems Cognitive-Behavioral Treatment Program: School Age Group is a family-oriented, cognitive-behavioral, psychoeducational, and supportive treatment group designed to reduce or eliminate incidents of sexual behavior problems. The program is for boys and girls ages 6 to 12 who have sexual behavior problems and their caregivers. It is an outpatient group treatment program, however it can be provided to individual families when group is not an option. The treatment is provided as an open-ended group, where children are able to graduate in four or five months. Children in the program acknowledge their previous breaking of sexual behavior rules; learn coping and self-control strategies; and develop a plan of how they’re going to keep these rules in the future. Caregivers are advised on how to supervise children; implement rules in the home; communicate about sex education; and reduce behavior problems. In addition to the school-age program, an SBP-CBT program developed for preschool age children is also available. Training is available from the University of Oklahoma team. Jane F. Silovsky, Ph.D. is the contact.
Evidence-Based Clearinghouse on Child Welfare has rated this program as a “1” or “Established.” According to Damashek & Chaffin (2012), MST-PSB is the only treatment model for juvenile sex offenders with research support. Most alternative models are adaptations of adult sex offender programs and have not yet published outcome studies with juveniles. MST-PSB may, according to Damashek & Chaffin (2012), be well-suited to sexually abusive youth who also have serious antisocial and delinquent problems and may be more intensive than necessary for youth with more limited general problems.

Risk Reduction for Substance Abuse in Adolescents

Risk Reduction through Family Therapy (RRFT) is a multi-component treatment that integrates principles and interventions from existing empirically-supported interventions. It builds upon Multisystemic Therapy (MST) and TF-CBT. The authors say the intervention can function either as an intervention or as a risk-reduction tool (Danielson et al., 2010).

In a recent interview with VCPN staff, Carla Kmett Danielson, Ph.D. explained that, as an intern at the Medical University of South Carolina, she saw a lack of effective treatment for traumatized teenagers whose primary presenting problems included acting out behaviors such as cutting themselves, engaging in risky sexual behaviors, using alcohol and illicit drugs, and running away. There was a ‘myth’ that one could not treat trauma until the substance abuse was under control. However, the substance abuse and other destructive behaviors were often in response to the trauma. “We are finding that integrated treatment that addresses both the substance abuse and the adolescent’s background of trauma is an effective approach,” says Dr. Danielson.

Dr. Danielson applied for funding to test her ideas. She received an early career development award from the National Institute on Drug Abuse (NIDA) and a second grant from NARSAD (now the Brain & Behavior Research Foundation). She used the funding to develop her treatment model and to evaluate it through two pilot studies described below.

RRFT combines psycho-education with teaching of coping skills and family communication. It combines treatment for substance abuse and for PTSD symptoms. It addresses healthy dating and sexual decision-making and contains components for risk reduction for sexual assault and other traumatic events. Dr. Danielson notes that risk reduction can mean an increase in positive activities with the teen’s family and/or increased monitoring from parents. “We help the families improve communication and develop rules such as a curfew. We can teach parents to be very behaviorally specific and to tie privileges such as cell phone use to positive behaviors,” she explains.

A pilot open trial was completed through a 6-month post-treatment follow up with 10 youth (Danielson, et al., 2010). Treatment length ranged from 14 to 34 sessions. Reductions were reported in substance use and in substance-use risk factors. There were modest improvements in family cohesion and conflict levels. Large effects were found for improvements in PTSD and depressive symptoms. Treatment gains were maintained through the 6-month post-treatment follow up. There was no control condition and the sample size was very small. Danielson and colleagues recently published the results from a randomized, controlled trial (RCT) with 30 adolescents comparing RRFT to ‘treatment as usual.’ Youth in the RRFT condition showed significantly greater reductions in substance use, in specific substance use risk factors (e.g. family functioning), and parent-reported PTSD symptoms, depression and internalizing symptoms (Danielson et al., 2012).

A NIDA-funded study is currently underway under the direction of Dr. Danielson and colleagues to evaluate RRFT’s efficacy in a much larger sample of adolescents. While the model is not quite ready for dissemination, Dr. Danielson has offered some training workshops at major national conferences. She summarizes, “We know that trauma is directly related to substance use among adolescents. In the youth we have treated thus far, it has been very effective to integrate the trauma treatment with the interventions for substance abuse.”

Culturally-Modified Treatments

There are efforts to modify interventions for specific cultural groups, although little research was found to document the success of these efforts.

Culturally Modified Trauma-Focused Treatment (CM-TFT)

The National Child Traumatic Stress Network describes a Culturally Modified Trauma-Focused Treatment (CM-TFT-CBT) being piloted by Michael A. de Arellano, Ph.D. and Carla K. Danielson, Ph.D. of the Medical University of South Carolina. They are adapting TF-CBT for use with Latino children.

Dr. de Arellano was interviewed by VCPN staff. He is a professor at the Medical University of South Carolina and Director of the Mental Health Disparities and Diversity Program that is part of the National Crime Victims Research and Treatment Center at the Department of Psychiatry and Behavioral Sciences.

Dr. de Arellano exudes enthusiasm as he describes how he has adapted TF-CBT for Latino populations. When he arrived in South Carolina 17 years ago, he was the only Spanish-speaking psychologist in the entire state. He had many referrals of Spanish-speaking clients to his clinic. “I was using evidence-based treatments, but cultural themes and concerns kept being interjected into the treatment process. Being bilingual and bicultural, I began to integrate these into the treatment. As people learned about my work, I was encouraged to write about my adaptations so others might consider these effective modifications for Latino populations,” he explained.

Dr. de Arellano’s clinic is for underserved populations and he supervises six bilingual clinicians. He notes that Latino youth have been found to experience higher rates of trauma than other ethnic groups. He serves children who have been exposed to horrendous traumatic events such as having their parents kidnapped, seeing their parents killed, or having their parents simply disappear as well as children who have been exposed to abuse, neglect, or sexual abuse. Additionally, Latino youth may face additional stressors such as limited access to community resources, poverty, and acculturation issues. “The model is very effective in reducing trauma symptoms. Further, families rarely drop out of treatment which is perhaps the most potent element of success,” he adds.

Dr. de Arellano further refined his approach through research funded by a ‘K’ grant and a grant from the National Child Trauma Center. He did focus groups with providers and Latino parents and asked them to discuss what modifications were needed to TF-CBT in order to make the treatment culturally relevant for them. His first focus group was comprised of recent immigrants from Mexico. He later did focus groups in Colorado, Texas and Florida.

A description of the culturally-modified TF-CBT for children of Latino descent is published in a recent volume, Trauma-Focused CBT for Children and Adolescents: Treatment Applications by Judith A. Cohen, Anthony P. Mannarino & Esther Deblinger (see book review, page 5). Dr. de Arellano considers his adaptation to the TF-CBT pro-continued on page 16
Evidence-based Treatments

continued from page 15

tocol as a method to accommodate language, culture and family values in a way that makes the treatment compatible with the families’ world view.

Some examples of modifications are including a broad range of caregivers and extended family members in the treatment. Since Latino clients are more likely to express distress through somatic complaints, assessment and monitoring of these symptoms is a priority. Any aspects of spiritual beliefs that help the child relax (such as prayer or meditation) can be integrated into treatment. Engagement strategies rely on emphasis on cultural constructs such as a preference for punishment over reward for child management. Methods such as ‘time-out’ can be framed as ‘la esquina de aburrimiento’ (corner of boredom) or ‘la esquina de castigo’ (corner of punishment). Behavioral interventions can be framed as a means to achieve greater respeto (respect) from the child. Praise can be reworded as pointing out the desired behaviors. The use of cuentos (stories) that are known to the children can present information. Concepts such as machismo (Men should be strong) for boys or marianismo (Suffering is a ‘cross to bear’) for girls may require reframing the concepts so that children feel comfortable discussing negative emotions and events. The chapter details ways that these and other cultural aspects can be utilized to make the TF-CBT relevant and meaningful for the child and family.

Dr. de Arellano stresses that the Latino population is varied and originates in many countries with disparate beliefs and practices. Therefore, assessment of cultural beliefs at the outset of therapy is essential. Assessment strategies are also considered in the book chapter mentioned above. Another resource is two prior VCPN issues (Volumes 62 and 90) that describe issues and methods for enabling culturally-competent treatment.

Native American Indian and Alaska Native Populations

VCPN staff spoke to Dolores Subia Bigfoot, Ph.D., member of the Caddo Nation of Oklahoma and Associate Professor in the Department of Pediatrics at the University of Oklahoma Health Sciences Center. She is co-Director of the Indian Country Child Trauma Center.

In 2003, Dr. BigFoot received funding from the National Child Traumatic Stress Network to work with trauma in native populations. She and her colleagues immediately began examining how to enhance evidence-based treatments to make them relevant to American Indian and Native Alaska populations. “I began by examining universal truths. Using the understandings that we have developed within our indigenous world view, how can we use that wisdom within the cognitive-behavioral model?”

Dr. BigFoot continued, “What we have done is to use the core understandings of our cultural ways to show how the concepts of cognitive-based therapies work. For example, with PCIT (Parent-Child Interaction Therapy- see above), the relationship and attachment of the child to the caregiver is important. We have a similar concept of ‘Making Relatives’ which can be described but is not limited to when a person steps in to replace relatives.”

Dr. BigFoot uses the different theories embedded in American Indian and Alaska Native cultures to bring a better understanding of PCIT to life for these culturally diverse populations. “American Indian and Alaska Native people recognize the cultural teaching such as the living tree, the medicine wheel, the teachings of the canoe or the teachings of the cradleboard. Elements such as these can be incorporated into evidence-based interventions. For example, relaxation is a key element of some therapies. We have ‘smudging’ which is a relaxation method.” She summarizes, “We still do the very same things as the proven therapy methods, but the rationale and reasons given are different.”

BigFoot and Funderburk (2012) have published an article ‘Honoring Children, Making Relatives: The Cultural Translation of Parent-Child Interaction Therapy for American Indian and Alaska Native Families’ that describes a model using the fundamentals of PCIT within the context of American Indian and Alaska Native philosophies by applying Circle Theory and Old Wisdom. The article discusses how to reframe the core concepts in PCIT by using Old Wisdom principles to help clients understand that the core concepts and underlying premises of PCIT are consistent with traditional teachings and beliefs about raising children. They suggest maintaining the integrity of the PCIT evidence-based elements while incorporating American Indian and Alaska Native concepts (such as the child as the center of the circle; the use of storytelling; ceremony). The basic tenets of PCIT are unchanged but simply reframed, using concepts and understandings that honor the teachings and practices of generations of American Indian and Alaska Native peoples.

In addition to enhancing PCIT, the Indian Country Child Trauma Center offers two other modifications of evidence-based interventions. Honoring Children, Mending the Circle is a modification of TF-CBT and Honoring Children, Respectful Ways is a treatment for children with sexual behavioral problems.

Dr. BigFoot recognizes that she does not have the means to perform controlled clinical trials. “However, we see families improve. We have families that have experienced horrendous events. Once clinicians have provided treatment in the culturally-enhanced PCIT, children and families show improved assessment scores and also report that they are no longer triggered by trauma reminders” comments Dr. Bigfoot.

Dr. BigFoot relates that there are approximately 4 million American Indians and Alaska Native people according to the last census with about 30% living on reservations. An additional 30% of the total Native population is located in urban areas close to reservations.

The Indian Country Child Trauma Center at the University of Oklahoma’s Project Making Medicine has offered clinical training in the treatment of child physical and sexual abuse since 1994 and has had a training grant since 2008 to offer culturally-enhanced TF-CBT trainings. They train 40 to 45 therapists a year in TF-CBT. These individuals come from tribal behavioral health, Indian Health Service, public schools on reservations, or tribally-controlled boarding schools. They are licensed professionals, mainly offering services on reservations, but some are in urban centers. The clinicians undergo four days of training and then return for supervision sessions or use weekly telephone consultations as well as booster sessions. Dr. BigFoot and the Center plan to continue to train clinicians as long as they have funding. Presently, they have a grant through 2014.

continued on page 18
Where to Find Information About Evidence-based Treatments

**The California Evidence-Based Clearinghouse for Child Welfare (CEBC)**
Chadwick Center for Children and Families
Rady Children’s Hospital - San Diego
3020 Children’s Way, MC 5131
San Diego, CA 92123
Phone: (858) 576-1700 x3213
Email: cebc@rchsd.org
Website: http://www.cebc4cw.org/

The California Evidence-Based Clearinghouse for Child Welfare (CEBC) provides information and resources for child welfare professionals. Their primary task is to inform the child welfare community about research evidence for programs being used or marketed in California. However, the CEBC also lists programs that may be less well-known in California, but were recommended by the expert for a specific topic area. The CEBC provides guidance on evidence-based practices to statewide agencies, counties, public and private organizations, and individuals.

There are two different rating scales that the CEBC uses on their website. The Scientific Rating Scale is a 1 to 5 rating of the strength of research evidence supporting a practice or program. A rating of 1 represents a program with the strongest research evidence, while a 5 is a concerning program that appears to pose substantial risk to children and families. If programs do not have strong enough research to be rated on the scale, they are classified as Not able to be Rated (NR). The Screening and Assessment Tools Rating Scale is a three-level rating on the level of psychometrics of a tool used for screening or assessment found in published, peer-reviewed journals. The A, B, and C levels are based on whether reliability and validity, or no reliability or validity has been established.

**National Child Traumatic Stress Network (NCTSN)**
Website: http://www.nctsn.org/
National Center for Child Traumatic Stress (NCCTS)
NCCTS — University of California, Los Angeles
11150 W. Olympic Blvd., Suite 650
Los Angeles, CA 90064
Phone: (310) 235-2633
Fax: (310) 235-2612
Robert S. Pynoos, Co-Director
Email: rpynoos@mednet.ucla.edu

NCCTS — Duke University
411 West Chapel Hill Street, Suite 200
Durham, NC 27701
Phone: (919) 682-1552
Fax: (919) 613-9898
John Fairbank, Co-Director
Email: john.fairbank@duke.edu

**Program Office of the National Child Traumatic Stress Initiative**
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
Department of Health and Human Services
5600 Fishers Lane
Parklawn Building, Room 17C-26
Rockville, MD 20857

The National Child Traumatic Stress Network (NCTSN) works to raise the standard of care and increase the access to services for traumatized children, their parents, and communities throughout the country. In order to achieve this goal, the NCTSN is raising public awareness about the impacts of traumatic stress on children; creating trauma-informed developmentally and culturally appropriate programs; working with established systems of care to ensure accessible care; and fostering a community dedicated to working together and sharing knowledge about child traumatic stress. There are a number of resources provided on the website including: training and education resources; public awareness; funding opportunities; and policy issues. The website also provides resources for online research related to NCTSN, resources regarding different topics related to child traumatic stress, and resources for specific audiences. These audiences include: parents, caregivers, school personnel, and professionals. The NCTSN provides resources to guide individuals choosing interventions for abused and neglected children and children who experience other traumatic stress.

**Promising Practices Network on Children, Families, and Communities**
RAND Corporation
1776 Main Street
Santa Monica, CA 90401
Phone: (310) 393-0411 ext. 7172
Fax: (310) 260-8161
Email: promisingpractices@rand.org
Website: http://www.promisingpractices.net

The Promising Practices Network (PPN) is a group of individuals and organizations that work together to publish accessible, high-quality evidence-based information about what works to improve the lives of children, families, and communities. The network helps decision-makers at all levels understand what approaches and programs have been shown in scientific literature to improve outcomes for children and families in various areas related to child and family well-being. Summaries of effective programs are included on the website based on three evidence level categories: proven, promising, and other reviewed programs. Additional resources such as databases and implementation tools are linked to the site.
Evidence-based Treatments

continued from page 16

Implementation

The development of evidence-based treatments is only one aspect in service delivery. Once effective treatments are available, how can they be implemented? For treatments to be available to the children and families who need them, there must be qualified, trained and enthusiastic providers who actually use the evidence-based treatment with fidelity (Wilson, 2012).

Awareness of the availability of effective treatments is prerequisite to learning how to deliver such treatments. Unfortunately, many practitioners are unaware of supported intervention models (Chaffin & Friedrich, 2004). For example, a study of 262 clinicians serving maltreated children determined that the clinicians were generally unable to identify which treatments were evidence-based. Master’s-level clinicians were more likely to identify treatments without empirical support as being evidence-based. Many clinicians were able to identify TF-CBT as an evidence-base treatment but no more than a third could identify any other evidence-based treatments (Allen et al., 2012).

Some past efforts to train providers and encourage use of evidence-based treatments have been disappointing. For example, the SafeCare parenting model is one of the few parent training programs that addresses child neglect, the most common form of child maltreatment. This program focuses on home safety, child health, and parent-child interactions using behavioral techniques and a structured approach to parent training. The program addresses risk factors for both child abuse and child neglect. According to Chaffin and Friedrich (2004), the model is among the more widely studied and is the best-supported model. A large-scale implementation effort in 2009 and 2010 in one state trained 295 individuals from 50 agencies in the model. Follow up data indicated that overall levels of implementation were low with relatively few providers (about a quarter) conducting any SafeCare sessions and even fewer receiving certification (Whitaker et al., 2012).

Chaffin & Friedrich (2004) also discuss dissemination. They note that publishing a manual and research results may go unnoticed since few front-line workers read journals of peer-reviewed scientific articles. Even once there is awareness, retooling and implementing new models may require a period of skill development and consultation or supervision, rather than simply attending a workshop or purchasing and reading a manual. Practical difficulties and expense mean that practitioners may feel more comfortable with the methods they are currently using as opposed to learning new ways of operation.

Several studies have examined the variables that affect implementation of evidence-based programs. Several researchers concur that in addition to a workforce willing and able to implement the evidence-based program, there must be an organizational structure that supports the new practices and system-level support to allow and encourage the evidence-based practices (Allen, Gharagozlou & Johnson, 2012; Chaffin & Friedrich, 2004; Shapiro, Printz & Sanders, 2012; Whitaker, 2012). For example, likelihood of use of evidence-based techniques is increased if providers believe the use of evidence-based treatment is required by a supervisor, by their agency or by the state.

If providers perceive themselves as successful in using the evidence-based practice, they are more likely to use the intervention in the future. Once a decision is made to adopt an evidence-based treatment approach, high-quality training that results in imparting skills and self-confidence for the providers is necessary. The post-training environment such as reinforcement, supervision, and case consultation will influence the use of the evidence-based program (Self-Brown et al., 2012; Shapiro et al., 2012). Free training and support will not likely be sufficient without addressing the organizational and systems-level variables (Whitaker et al., 2012).

Increasing Access to Evidence-based Treatments

While many children in the child welfare system would benefit from evidence-based treatments, most traumatized children receive no treatment or receive treatments without strong support of effectiveness. Indeed, as noted above, many clinicians are unable to even identify which treatments are evidence-based (Allen et al., 2012; Chaffin & Friedrich, 2004). It should be noted that the wide gap between availability of proven treatments and the use of these treatments in practice is not unique to the child trauma field but exists in medicine and other intervention areas.

In addition to lack of awareness or resistance to change, there are practical reasons why practitioners do not retool and adopt more effective treatment models. There can be difficulty or expense in obtaining training (Allen et al., 2012; Chaffin & Friedrich, 2004). Clinicians trained in a nondirective approach, or those who believe that children lack the verbal ability to describe their experiences may use evidence-based approaches less frequently (Allen & Johnson, 2011). Provider turnover, poor provider participation in consultation, and lack of referral or system infrastructure support can impact use of evidence-based treatments (Self-Brown et al., 2012).

There are a few methods being piloted that aim to increase the likelihood that children who need a proven and effective trauma treatment might be able to find a provider who offers evidence-based treatment. In addition to the Learning Collaborative (described in a separate article, this issue), several efforts are described below.

A Utah Primary Children’s Medical Center evaluated a protocol employed by nurses with parents to determine whether use of a standardized protocol that introduced parents to the concept of evidence-based treatment might increase parents’ access to EBT. Parents of children who received an outpatient forensic examination also received a booklet about EBT that was reviewed with them. Parents were asked to rate a 29-item checklist of factors that have been shown to be associated with potential barriers and assets to access EBT. Parents in the protocol condition were more likely than parents in the control condition to report discussing EBT during a mental health appointment. Nurses who implemented the protocol viewed it favorably and additionally, parents in the protocol condition expressed greater satisfaction with the forensic examination (Gulley, Price & Johnson, 2008).

A second effort to increase the use of EBT has been undertaken by the North Carolina Practice Improvement Collaborative (see separate block, page 19). The NCPIC has been established by the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services. Their mission is ensure that each time a consumer comes into contact with the DMHDDSAS system, he or she will receive excellent care that is consistent with a scientific understanding of what interventions are effective. They have identified 170 licensed clinicians in 60 North Carolina counties who are trained in TF-CBT. They have information on their website about TF-CBT. They have identified sources of training for clinicians, as well.

The National Child Traumatic Stress Network (NCTSN) has produced numerous online training programs, has conducted multiple in-person training programs on the use of various evidence-based interventions, and disseminates multiple guides on the availability and implementation procedures for empirically-supported treatments (Allen et al., 2012). There are several ‘clearinghouses’ available that review and feature evidence-based treatments. These include the California Evidence-Based Clearinghouse, the Promising Practices Network, the Office of Juvenile Justice and Delinquency Prevention (OJJDP), the Substance Abuse and Mental Health Services Administration (SAMSA), and the U.S. Department of Health and Human Services (see blocks, this issue for descriptions and visit VCPN’s website).
Two states, North Carolina and South Carolina, have established projects to help clinicians in their respective states become competent in evidence-based treatments. These projects are trying to ensure that citizens of their state receive the best possible mental health care.

North Carolina Practice Improvement Collaborative

The mission of the collaborative, founded in 2005, is to ensure that when any citizen of North Carolina comes into contact with the Divisions of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS), that person will receive excellent care that is consistent with what is scientifically supported. Noting that some of the most popular approaches to treatment do not have scientific support, the Collaborative supports use of proven treatment models and encourages that treatments be administered with fidelity.

Some authors have suggested that graduate programs need to teach evidence-based treatments in their curriculum. Also, national organizations and licensing boards could require training each year in evidence-based methods, similar to requirements for yearly training in ethics and legal issues (Allen et al., 2012; Chaffin & Friedrich, 2004; Self-Brown, Whitaker, Berlinger, & Kolko, 2012).

Other ideas for accelerating the use of evidence-based treatments include:
- Keying funding to outcomes rather than only services rendered with differential payment for best practices delivered with fidelity and competency.
- Targeted funding for projects that provide agencies with start-up costs for adopting evidence-based treatments.
- Improved marketing for evidence-based treatments.
- Countering misperceptions that evidence-based treatments are sterile and inflexible or impersonal.
- Increased advocacy and social demand for best practices.

Composed of representatives from all three areas (mental health; developmental disabilities; substance abuse services), the NCPIC meets quarterly to review and discuss interventions. Yearly, the group presents a report of prioritized program recommendations to the Division Director at a public forum.

The website contains a wealth of information about evidence-based practice. It can be accessed at: www.ncpic.net/

South Carolina’s Project Best

Project Best is a state-wide collaborative effort to use innovative community-based dissemination, training, and implementation methods that will increase the capacity of every community in South Carolina to deliver evidence-supported mental health treatments to every abused and traumatized child who requires treatment. The Dee Norton Lowcountry Children’s Center, an accredited Children’s Advocacy Center, and the National Crime Victims Research and Treatment Center are the coordinating partners for Project BEST.

Janis Koenig, M.ED., Program Coordinator II at the National Crime Victims Research and Treatment Center explains Project BEST, “Project BEST, through a grant from the Duke Endowment, is providing clinicians in South Carolina with training in evidence-supported treatments. We also train brokers of mental health services to identify and refer appropriate children for treatment.”

The Community-Based Learning Collaborative (CBLC) is a 12 to 14-month training effort that is structured through Child Advocacy Centers (CAC) to enhance their Multi-disciplinary Teams and to integrate mental health services into the CAC response. Each community CAC creates a Community Change Team that is dedicated to learning skills and implementing evidence-based treatment. Project BEST provides the training and ongoing consultation needed to build the knowledge and skills to deliver the evidence-supported treatments. Koenig explains that the initial treatment being implemented is Trauma-Focused Cognitive Behavioral therapy (TF-CBT). Project BEST is in the second 3-year phase of offering CBLC.

For more information, contact Janis Koenig at: koenigjs@musc.edu or visit the website at: http://academicdepartments.musc.edu/projectbest

SAMHSA’s National Registry of Evidence-based Programs and Practices (NREPP)

Phone: (866) 436-7377
Email: nrepp@samhsa.hhs.gov
Website: http://www.nrepp.samhsa.gov

The National Registry of Evidence-based Programs and Practices (NREPP) is a searchable online registry of mental health and substance abuse interventions that have been reviewed and rated by individual reviewers. The purpose is to assist the public in identifying scientifically-based approaches to preventing and treating mental and substance use disorders that can be distributed to the field. The registry is continuing to grow as new intervention summaries are continually being added. Each summary contains general information about an intervention; a description of the research outcomes; a list of studies and materials reviewed; quality of research and readiness for distribution ratings; and contact information. The registry does not provide a rating of the intervention’s effectiveness.
Children who have experienced significant trauma deserve our best response and deserve to have effective interventions. Evidence-based treatments are proven to be effective. A higher percentage of children experience symptom relief with the use of EBT than obtained from alternative treatments. In many cases, EBTs require fewer sessions and are less costly for the purchaser than alternatives. Families recognize and appreciate the more rapid results and they are less likely to terminate treatment prematurely. VCPN salutes the treatment developers and the clinicians who are embracing the most effective treatments!

References Available on the Website

• Meet the Developers
• Training Resources
• Promising Treatments
• Clearinghouses
• More about TF-CBT
• More about CPC-CBT
• Virginia’s Child Advocacy Centers
• Resource Reviews
• Practice Principles
• References and more

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If you prefer an electronic notice when VCPN is published rather than a hard copy, please e-mail your preference to Joann Grayson at graysojh@jmu.edu

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