



WISCONSIN DEPARTMENT
of **HEALTH SERVICES**

DIVISION OF CARE AND TREATMENT SERVICES
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Definitions of Evidence-Based Practices (EBPs) for the 2018 CSP and CCS Program Surveys

INSTRUCTIONS: The 2018 CSP and CCS Program Surveys ask you to report which evidence-based practices (EBPs) your program offered and how many consumers received those EBPs during the past year. This document provides information about each EBP to help you determine which EBPs you offered.

- Any EBP that you report should match the description on the following pages as well as the description in the formal EBP toolkits found through the web links listed for each EBP in this document. Complete details about implementing an EBP also can be found at the web links.
- Please report whether your program fully implemented, partially implemented, or did not offer each EBP during 2018: any EBP that you report on the survey as being “**fully**” implemented should meet **all** the *critical elements* specified on the following pages; an EBP that you report as being “**partially**” implemented should meet **some** of those *critical elements*. Report “No” for those EBPs you did not implement last year.
- If specific EBPs including Integrated Dual Disorders Treatment (IDDT), Supported Employment and Permanent Supportive Housing—EBPs are provided by your program as a component of ACT, participants receiving them should be reported under both ACT and **separately** under the other specific EBPs.
- Some survey questions ask whether your program monitors the fidelity of each EBP you’ve implemented. To determine if you formally monitor fidelity, refer to the description of fidelity tools and methods through the web links listed for each EBP in this document.

Adult EBPs Your Program May Use:

Please refer to these toolkits if deciding whether or not to list the following interventions in your survey responses.

ASSERTIVE COMMUNITY TREATMENT (ACT)

Definition

A team based approach to the provision of treatment, rehabilitation, and support services. ACT/PACT models of treatment are built around a self-contained multi-disciplinary team that serves as the fixed point of responsibility for all patient care for a fixed group of clients. In this approach, normally used with clients with severe and persistent mental illness, the treatment team typically provides all client services using a highly integrated approach to care. Key aspects are low caseloads and the availability of the services in a range of settings. The service is a recommended practice in the PORT study (Translating Research Into Practice: The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations. Lehman, Steinwachs, and Co-Investigators of Patient Outcomes Research Team, *Schizophrenia Bulletin*, 24(1):1-10, 1998) and is cited as a practice with strong evidence based on controlled, randomized effectiveness studies in the Surgeon General's report on mental health (U.S. Department of Health and Human Services, (1999). Chapter 4; "Adults and mental health." In *Mental Health: A report of the Surgeon General.*). Additionally, CMS (Centers for Medicare and Medicaid Services [formerly the Health Care Financing Administration (HCFA)]) recommended that state Medicaid agencies consider adding ACT to their State Plans in the HCFA Letter to State Medicaid Directors, Center for Medicaid and State Operations, June 07, 1999.

Fidelity Measure

<http://store.samhsa.gov/product/SMA08-4345>

Critical Elements of Assertive Community Treatment (ACT):

- **Small caseload:** Client/ provider ratio of 10:1 or fewer is the ideal
- **Multidisciplinary team approach:** ACT is a team approach rather than an approach that emphasizes services by individual providers. The team should be multidisciplinary and could include a psychiatrist, nurse, and substance abuse specialist. For reporting purposes, there should be at least 3 FTE on the team.
- **Includes clinical component:** In addition to case management, the program directly provides services such as: psychiatric services, counseling/psychotherapy, housing support, substance abuse treatment, employment/rehabilitative services.
- **Services provided in community settings:** Program works to monitor status, and develop community living skills in the community rather than the office.
- **Responsibility for crisis services:** Program has 24-hour responsibility for covering psychiatric crises.

Assertive Community Treatment (ACT) is Not:

Intensive Case Management

**INTEGRATED TREATMENT FOR CO-OCCURRING
MENTAL HEALTH & SUBSTANCE ABUSE DISORDERS:
INTEGRATED DUAL DISORDERS TREATMENT (IDDT)**

Definition

Dual diagnosis treatments combine or integrate mental health and substance abuse interventions at the level of the clinical encounter. Hence, integrated treatment means that the same clinicians or teams of clinicians, working in one setting, provide appropriate mental health and substance abuse interventions in a coordinated fashion. In other words, the caregivers take responsibility for combining the interventions into one coherent package. For the individual with a dual diagnosis, the services appear seamless, with a consistent approach, philosophy, and set of recommendations. The need to negotiate with separate clinical teams, programs, or systems disappears. The goal of dual diagnosis interventions is recovery from two serious illnesses.

Fidelity Measure

<http://store.samhsa.gov/product/SMA08-4367>

Critical Elements of Integrated Dual Disorders Treatment (IDDT):

- **Multidisciplinary team:** A team of clinical professionals working in one setting and providing MH and SA interventions in a coordinated fashion.
- **Stagewise interventions:** That is, treatment is consistent with each client's stage of recovery (engagement, motivation, action, relapse prevention).

Integrated Dual Disorders Treatment (IDDT) is Not:

Coordination of clinical services across provider agencies

Delivered as a Component of ACT:

If this EBP is provided by your program as a component of ACT, participants receiving them should be reported in the CSP survey under both ACT and **separately** under this EBP.

FAMILY PSYCHOEDUCATION

Definition

Family psycho-education is offered as part of an overall clinical treatment plan for individuals with mental illness to achieve the best possible outcome through the active involvement of family members in treatment and management and to alleviate the suffering of family members by supporting them in their efforts to aid the recovery of their loved ones. Family psycho-education programs may be either multi-family or single-family focused. Core characteristics of family psycho-education programs include the provision of emotional support, education, resources during periods of crisis, and problem-solving skills.

Fidelity Measure

<http://store.samhsa.gov/product/SMA09-4423>

Critical Elements of Family Psychoeducation:

- A structured curriculum is used.
- Psychoeducation is a part of clinical treatment.

Family Psychoeducation is Not:

Several mechanisms for family psycho-education exist. The evidence-based model, promoted through SAMHSA's EBP implementation resource kit ("toolkit") involves a clinician. For URS reporting, do not include family psycho-education models not involving a clinician as part of clinical treatment.

Note: Some states are providing NAMI's Family-to-Family program and not the family psychoeducation EBP described above. If a state is providing NAMI's Family-to-Family program, this should be reported under family psychoeducation with an asterisk and a note indicating that the numbers reflect the NAMI program and not the EBP described above.

Delivered as a Component of ACT:

If this EBP is provided by your program as a component of ACT, participants receiving them should be reported in the CSP survey under both ACT and **separately** under this EBP.

ILLNESS SELF-MANAGEMENT AND RECOVERY (IMR)

Definition

Illness Self-Management and Recovery (also called illness management or wellness management) is a broad set of rehabilitation methods aimed at teaching individuals with mental illness strategies for collaborating actively in their treatment with professionals, for reducing their risk of relapses and re-hospitalizations, for reducing severity and distress related to symptoms, and for improving their social support. Specific evidence-based practices that are incorporated under the broad rubric of illness self-management are psychoeducation about the nature of mental illness and its treatment, "behavioral tailoring" to help individuals incorporate the taking of medication into their daily routines, relapse prevention planning, teaching coping strategies to managing distressing persistent symptoms, cognitive-behavior therapy for psychosis, and social skills training. The goal of illness self-management is to help individuals develop effective strategies for managing their illness in collaboration with professionals and significant others, thereby freeing up their time to pursue their personal recovery goals.

Fidelity Measure

<http://store.samhsa.gov/product/SMA09-4463>

Critical Elements of Illness Self-Management and Recovery (IMR):

Service includes a specific curriculum that includes mental illness facts, recovery strategies, using medications, stress management, and coping skills. It is critical that a specific curriculum is being used for these components to be counted for reporting.

Illness Self-Management and Recovery (IMR) is Not:

Advice related to self-care, but a comprehensive, systematic approach to developing an understanding and a set of skills that help a consumer be an agent for his or her own recovery.

Delivered as a Component of ACT:

If this EBP is provided by your program as a component of ACT, participants receiving them should be reported in the CSP survey under both ACT and **separately** under this EBP.

MEDICATION MANAGEMENT (MedTEAM)

Definition

In the toolkit on medication management, there does not appear to be any explicit definition of medication management. However, the critical elements identified for evidence-based medication management approaches are the following:

- Utilization of a systematic plan for medication management;
- Objective measures of outcome are produced;
- Documentation is thorough and clear; and
- Consumers and practitioners share in the decision-making.

Fidelity Measure

MedTEAM is one example of an EBP for medication management and it can be found here:

<http://store.samhsa.gov/product/MedTEAM-Medication-Treatment-Evaluation-and-Management-Evidence-Based-Practices-EBP-KIT/SMA10-4549>

Critical Elements of Medication Management (MedTEAM):

- Treatment plan specifies outcome for each medication.
- Desired outcomes are tracked systematically using standardized instruments in a way to inform treatment decisions.
- Sequencing of antipsychotic medication and changes are based on clinical guidelines.

Medication Management (MedTEAM) is Not:

Medication prescription administration that occurs without the minimum requirements specified above.

Delivered as a Component of ACT:

If this EBP is provided by your program as a component of ACT, participants receiving them should be reported in the CSP survey under both ACT and **separately** under this EBP.

SUPPORTED EMPLOYMENT

Definition

Mental health Supported Employment (SE) is an evidence-based service to promote rehabilitation and return to productive employment for persons with serious mental illnesses. SE programs use a team approach for treatment, with employment specialists responsible for carrying out all vocational services from intake through follow-along. Job placements are: community-based (i.e., not sheltered workshops, not onsite at SE or other treatment agency offices), competitive (i.e., jobs are not exclusively reserved for SE clients, but open to public), in normalized settings, and utilize multiple employers. The SE team has a small client to staff ratio. SE contacts occur in the home, at the job site, or in the community. The SE team is assertive in engaging and retaining clients in treatment, especially utilizing face-to-face community visits, rather than phone or mail contacts. The SE team consults/works with family and significant others when appropriate. SE services are frequently coordinated with Vocational Rehabilitation benefits.

Fidelity Measure

<http://store.samhsa.gov/product/SMA08-4365>

Critical Elements of Supported Employment:

- **Competitive employment:** Employment specialists provide competitive job options that have permanent status rather than temporary or time-limited status. Employment is competitive so that potential applicants include persons in the general population.
- **Integration with treatment:** Employment specialists are part of the mental health treatment teams with shared decision making. They attend regular treatment team meetings (not replaced by administrative meetings) and have frequent contact with treatment team members.
- **Rapid job search:** The search for competitive jobs occurs rapidly after program entry.
- **Eligibility based on consumer choice (not client characteristics):** No eligibility requirements such as job readiness, lack of substance abuse, no history of violent behavior, minimal intellectual functioning, and mild symptoms.
- **Follow-along support:** Individualized follow-along supports are provided to employer and client on a time-unlimited basis. Employer supports may include education and guidance. Client supports may include crisis intervention, job coaching, job counseling, job support groups, transportation, treatment changes (medication), and, networked supports (friends/family).

Supported Employment is Not:

- Prevocational training
- Sheltered work
- Employment in enclaves (that is, in settings where only people with disabilities are employed)

Delivered as a Component of ACT:

If this EBP is provided by your program as a component of ACT, participants receiving them should be reported in the CSP survey under both ACT and **separately** under this EBP.

PERMANENT SUPPORTIVE HOUSING

Definition

Permanent supportive housing is defined as services to assist individuals in finding and maintaining appropriate housing arrangements. This activity is premised upon the idea that certain clients are able to live independently in the community only if they have support staff for monitoring and/or assisting with residential responsibilities. These staff assists clients in selecting, obtaining, and maintaining safe, decent, affordable housing while maintaining a link to other essential services provided within the community. The objective of permanent supportive housing is to help obtain and maintain an independent living situation.

Permanent supportive housing is a specific program model in which a consumer lives in a house, apartment or similar setting, alone or with others, and has considerable responsibility for residential maintenance, but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities. Criteria identified for permanent supportive housing programs include: housing choice, functional separation of housing from service provision, affordability, integration (with persons who do not have mental illness), and right to tenure, service choice, service individualization and service availability.

Fidelity Measure <http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510>

Critical Elements of Permanent Supportive Housing:

- **Target population:** Targeted to persons who would not have a viable housing arrangement without this service.
- **Staff assigned:** Specific staff are assigned to provide supported housing services.
- **Housing is integrated:** That is, Supported Housing is provided for living situations in settings that are also available to persons who do not have mental illnesses.
- **Consumer has the right to tenure:** The ownership or lease documents are in the name of the consumer.
- **Affordability:** Supported housing assures that housing is affordable (consumers pay no more than 30-40% on rent and utilities) through adequate rent subsidies, etc.

Permanent Supportive Housing is Not:

- Residential treatment services
- A component of case management

Delivered as a Component of ACT:

If this EBP is provided by your program as a component of ACT, participants receiving them should be reported in the CSP survey under both ACT and **separately** under this EBP.

TOBACCO CESSATION *BUCKET APPROACH* (page 1 of 3)

Definition

More than one in three adults with a mental illness smoke cigarettes (compared to one in five for adults with no mental illness (see the University of Wisconsin-Center for Tobacco Research and Intervention (UW-CTRI): <http://www.ctri.wisc.edu/providers-behavioral-health.htm>). The Tobacco Cessation “Bucket Approach” was developed at UW-CTRI in collaboration with NAMI-Wisconsin as a set of tobacco reduction interventions tailored to the user’s willingness to move toward quitting. As a *promising* interventional approach founded upon the established stages of change model, it holds considerable promise in helping persons with mental illness approach and achieve tobacco cessation. For the purposes of the definition of the five bucket categories, “tobacco” refers to *any* use of tobacco products (including combustible products such as cigarettes, cigars, and pipes, but also snuff, chew, snuz, and e-cigarettes). While other chemicals are dangerous as well (e.g., marijuana, crack, cocaine, heroin, methamphetamine, PCP, DMT, 5-Meo-DMT), for the purposes of this definition, these should not be included except in the “other smoking” category.

Critical Elements of Tobacco Cessation *Bucket Approach*:

- Utilization of a systematic plan for program-wide implementation of the Tobacco Cessation *Bucket Approach* (in accordance with the definition below);
- Inquiry and assessment of each participant’s readiness for change according to the *Bucket Approach*;
- Treatment and Recovery Plans identify individualized assessed need for, specific interventions to be provided, and desired outcomes in accordance with the individual’s *Bucket* assignment;
- Proper application of interventions appropriate to each *Bucket* in where participants are categorized;
- Outcomes are tracked systematically using standardized definitions to establish a metric of progress.

Delivered as a Component of ACT:

If this EBP is provided by your program as a component of ACT, participants receiving them should be reported in the CSP survey under both ACT and **separately** under this EBP.

TOBACCO CESSATION *BUCKET APPROACH* (page 2 of 3)

Tobacco Cessation Bucket Approach Definition—Pending Development of a Toolkit

A toolkit is being developed based upon successful pilot studies which will guide implementation and replication of the model involving standardization and ability to measure fidelity. A fidelity measure is pending but these definitions should be self-evident and lend themselves to easy categorization based on the participant's self-report and staff concurrence. Current data are being gathered as baseline attempts to be used to refine toolkit development.

Tobacco Use Buckets

Programs that are utilizing the *Bucket Approach* are to categorize the number of program participants into the following categories (or buckets). Please see the next page for "A Simple Graphic of the Bucket Approach."

For all individuals who were open within the program at any time during the survey year, assign each to only one bucket based upon their stage of change "bucket" as determined at the end of the survey year. For those who quit tobacco use during the survey year, categorize as "quit." For participants who were discharged from the program during the survey year, assign them to the "bucket" that characterizes their stage of change at the date of discharge.

- A. **Quit:** Participant quit using tobacco and stayed quit during the survey year. (Do not assign this category if the individual states they've quit in the face of clear evidence to the contrary.)
- B. **Quit Now:** Participant is actively trying to quit completely.
- C. **Talk and Prepare:** Participant is not trying to quit completely, but is making efforts toward that goal (reducing, practice quit attempts, pre-quit use of cessation medicines, recording smoking, etc.).
- D. **Just Talk:** Participant is not willing to make any efforts toward quitting, but is willing to talk about their tobacco use.
- E. **Not Right Now:** Participant is not even willing to talk about their tobacco use at this time.

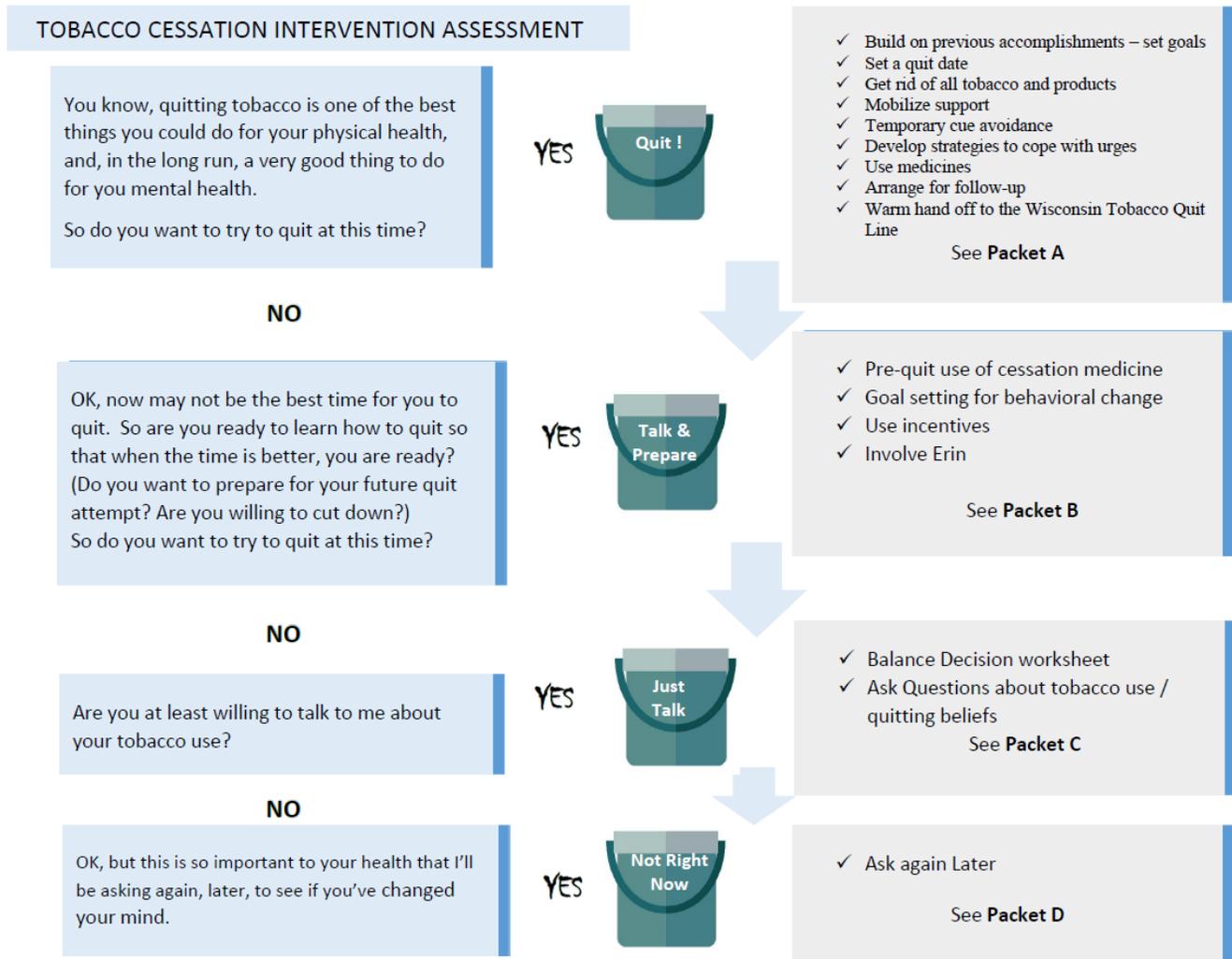
Other Categories

For individuals who never used tobacco or quit previously, please categorize those participants in their respective categories but *not* in one of the five buckets. Assign program participants to the "other smoking" category for any smoking activity during the survey year involving chemicals that were not tobacco products.

- **Never Used Tobacco:** Participant never smoked nor used any tobacco products.
- **Ex-Users of Tobacco:** Participant stopped use of tobacco prior to involvement in CSP or CCS, or prior to the current survey year.
- **Other Smoking:** During the survey year smoked other chemicals that are not tobacco products. Include those individuals who may be categorized into buckets above as well. (This is the *only* category that can be assigned along with another category.)

TOBACCO CESSATION *BUCKET APPROACH* (page 3 of 3)

A Simple Graphic of the Bucket Approach



MOTIVATIONAL INTERVIEWING

Definition: Motivational Interviewing (MI) is a “collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person’s own reasons for change within an atmosphere of acceptance and compassion.”¹

Fidelity: there is “no reliable and valid way to measure MI fidelity other than through the direct coding of practice samples”.² Fidelity is defined in terms of basic and advanced standards (see¹) for skill measures which include percentage of open questions (of total questions), percentage of complex reflection (of total reflection), ratio of reflections to questions, and percentage of MI-adherent behaviors (of total other behaviors). Additionally, there are global measures to assess overall MI practice.³

Critical Elements:

- A “spirit” or way of being with people which is:
 - Collaborative;
 - Evocative;
 - Accepting and respectful of autonomy; and
 - Compassionate
- Core skills which include:
 - Asking open-ended questions;
 - Looking for strengths and affirming these strengths;
 - Careful listening and reflection; and
 - Summarizing
 - Providing information using the “elicit-provide-elicit” procedure
- Core skills are applied specifically within 4 processes, including:
 - **Engaging** the person and building the relational foundation;
 - **Focusing** in which the agenda for the conversation is collaboratively developed and a specific “target behavior” is selected;
 - **Evoking** in which the person’s ideas and motivations for change are explored; the practitioner listens for change talk, proactively draws it out, and differentially responds to it in an effort to enhance motivation; and
 - **Planning** in which a goal and support plan is collaboratively developed

What Motivational Interviewing is Not: stages of change; a technique; a manipulative way of tricking people into change; just client-centered therapy; what practitioners are already doing; easy to learn.⁴

Delivered as a Component of ACT:

- If this EBP is provided by your program as a component of ACT, participants receiving them should be reported in the CSP survey under both ACT and **separately** under this EBP.

¹ Miller, W. R., & Rollnick, S. (2013, p. 29, p. 400). *Motivational interviewing: Helping people change* (3rd ed.). New York: Guilford Press.

² Miller, W. R., & Rose, G. S. (2009, p. 530). Toward a theory of motivational interviewing. *American Psychologist*, 64(6), 527-537.

³ Moyers, T. B., Martin, T., Manuel, J. K., Miller, W. R., & Ernst, D. (January 2010). *Revised global scales: Motivational interviewing treatment integrity 3.1.1 (MITI 3.1.1)*. University of New Mexico: Unpublished manual.

⁴ Miller, W. R., & Rollnick, S. (2009). Ten things that motivational interviewing is not. *Behavioural and Cognitive Psychotherapy*, 37(2), 129-140.

Other Adult EBPs Your Program May Use:

Please refer to these toolkits if deciding whether or not to list the following interventions in your survey responses.

- Treatment of Depression in Older Adults
 - <http://store.samhsa.gov/product/Treatment-of-Depression-in-Older-Adults-Evidence-Based-Practices-EBP-KIT/SMA11-4631CD-DVD>
- Interventions for Disruptive Behavior Disorders
 - <http://store.samhsa.gov/product/Interventions-for-Disruptive-Behavior-Disorders-Evidence-Based-Practices-EBP-KIT/SMA11-4634CD-DVD>
- Consumer-Operated Services
 - <http://store.samhsa.gov/product/Consumer-Operated-Services-Evidence-Based-Practices-EBP-KIT/SMA11-4633CD-DVD>
- Medication Algorithms - Schizophrenia
 - <http://schizophreniabulletin.oxfordjournals.org/content/30/3/627.full.pdf>
- Medication Algorithms – Bipolar Disorders
 - <http://www.psychiatrist.com/JCP/article/Pages/2005/v66n07/v66n0710.aspx>

Youth EBPs Your Program May Use:

Please refer to these toolkits if deciding whether or not to list the following interventions in your survey responses.

MULTISYSTEMIC THERAPY (MST)

Definition

Multisystemic Therapy (MST) is an intensive family- and community-based treatment that addresses the multiple determinants of serious antisocial behavior. The multisystemic approach views individuals as being nested within a complex network of interconnected systems that encompass individual, family, and extra-familial (peer, school, neighborhood) factors. Intervention may be necessary in any one or a combination of these systems. The goal is to facilitate change in this natural environment to promote individual change. The caregiver is viewed as the key to long-term outcomes.

Toolkit

<http://store.samhsa.gov/shin/content/SMA11-4634CD-DVD/EBPsPromisingPractices-IDBD.pdf>

(Pages 95-106)

Fidelity Measure

Not available

Critical Elements of Multisystemic Therapy (MST):

- Services take into account the life situation and environment of the child / adolescent and involve peers, school staff, parents, etc.
- Services are individualized.
- Services are provided by MST therapists or masters-level professionals.
- Services are time-limited.
- Services are available 24/7.

**THERAPEUTIC FOSTER CARE (TFC)
and MULTIDIMENSIONAL TREATMENT FOSTER CARE (MTFC)**

Definition

Children are placed with foster parents who are trained to work with children with special needs. Usually, each foster home takes one child at a time, and caseloads of supervisors in agencies overseeing the program remain small. In addition, therapeutic foster parents are given a higher stipend than traditional foster parents, and they receive extensive pre-service training and in-service supervision and support. Frequent contact between case managers or care coordinators and the treatment family is expected, and additional resources and traditional mental health services may be provided as needed.

Toolkit

<http://store.samhsa.gov/shin/content/SMA11-4634CD-DVD/EBPsPromisingPractices-IDBD.pdf>

(Pages 113-118)

Fidelity Measure

Not available

Critical Elements of Therapeutic Foster Care (TFC):

- There is an explicit focus on treatment
- There is an explicit program to train and supervise treatment foster parents
- Placement is in the individual family home

Therapeutic Foster Care is Not:

An enhanced version of regular foster care

FUNCTIONAL FAMILY THERAPY (FFT)

Definition

Functional Family Therapy (FFT) is an outcome-driven prevention/intervention program for youth who have demonstrated the entire range of maladaptive, acting out behaviors, and related syndromes. Treatment occurs in phases where each step builds on one another to enhance protective factors and reduce risk by working with both the youth and their family. The phases are engagement, motivation, assessment, behavior change, and generalization.

Toolkit

<http://store.samhsa.gov/shin/content/SMA11-4634CD-DVD/EBPsPromisingPractices-IDBD.pdf>

(Pages 107-112)

Fidelity Measure

Not available

Critical Elements of Functional Family Therapy (FFT):

- Services are provided in phases related to engagement, motivation, assessment, behavior change, etc.
- Services are short-term, ranging from 8-26 hours of direct service time.
- Flexible delivery of service by one and two person teams to clients in the home, the clinic, juvenile court, and at time of re-entry from institutional placement.

PARENT-CHILD INTERACTION THERAPY (PCIT)

Definition

Parent-Child Interaction Therapy (PCIT) is a treatment program for young children with disruptive behavior disorders that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. PCIT was developed for children ages 2-7 years with externalizing behavior disorders. In PCIT, parents are taught specific skills to establish or strengthen a nurturing and secure relationship with their child while encouraging prosocial behavior and discouraging negative behavior. This treatment has two phases, each focusing on a different parent-child interaction: child-directed interaction (CDI) and parent-directed interaction (PDI).

Toolkit

<http://store.samhsa.gov/shin/content/SMA11-4634CD-DVD/EBPsPromisingPractices-IDBD.pdf>

(Pages 61-65)

Fidelity Measure

Not available

Other Resources

- PCIT International: <http://www.pcit.org>

Critical Elements of Parent-Child Interaction Therapy (PCIT):

- Staff received initial and continued training in PCIT to demonstrate adequate and sensitive coaching;
- Meets young children's dual needs for nurturance and limits.

TRAUMA-FOCUSED COGNITIVE BEHAVIOR THERAPY (TF-CBT)

Definition

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a psychosocial treatment model designed to treat posttraumatic stress and related emotional and behavioral problems in children and adolescents. Initially developed to address the psychological trauma associated with child sexual abuse, the model has been adapted for use with children who have a wide array of traumatic experiences, including domestic violence, traumatic loss, and the often multiple psychological traumas experienced by children prior to foster care placement. The treatment model is designed to be delivered by trained therapists who initially provide parallel individual sessions with children and their parents (or guardians), with conjoint parent-child sessions increasingly incorporated over the course of treatment. The acronym PRACTICE reflects the components of the treatment model: Psychoeducation and parenting skills, Relaxation skills, Affect expression and regulation skills, Cognitive coping skills and processing, Trauma narrative, In vivo exposure (when needed), Conjoint parent-child sessions, and Enhancing safety and future development. Although TF-CBT is generally delivered in 12-16 sessions of individual and parent-child therapy, it also may be provided in the context of a longer-term treatment process or in a group therapy format (SAMHSA, 2015).

Toolkit

Not available

Fidelity Measure

Not available

Other Resources

- SAMHSA. (2015). National Registry of Evidence-Based Programs and Practices: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=135>
- SAMHSA's Trauma and Justice Strategic Initiative. (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. <http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf>
- Cohen, J.A., Mannarino, A.P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: The Guilford Press. <http://www.guilford.com/books/Treating-Trauma-Traumatic-Grief-Children-Adolescents/Cohen-Mannarino-Deblinger/9781593853082>
- *TF-CBTWeb*, a web-based learning course for Trauma-Focused Cognitive Behavior Therapy: <https://tfcbt.musc.edu/>

Critical Elements of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT):

- Training delivered through learning collaboratives (12 months) with consultation with national trainers on model to be followed.

TRAUMA-INFORMED CHILD-PARENT PSYCHOTHERAPY (TI-CPP)

Definition

Trauma-Informed Child-Parent Psychotherapy (TI-CPP) is an evidence-based, parent-child therapeutic treatment for children from birth to age 6 who have experienced trauma and, as a result, are experiencing emotional, behavior, attachment, and/or mental health problems.

Child-Parent Psychotherapy (CPP) is an intervention for children from birth through age 5 who have experienced at least one traumatic event (e.g., maltreatment, the sudden or traumatic death of someone close, a serious accident, sexual abuse, exposure to domestic violence) and, as a result, are experiencing behavior, attachment, and/or mental health problems, including posttraumatic stress disorder (PTSD). The primary goal of CPP is to support and strengthen the relationship between a child and his or her parent (or caregiver) as a vehicle for restoring the child's sense of safety, attachment, and appropriate affect and improving the child's cognitive, behavioral, and social functioning (SAMHSA, 2015).

Toolkit

Not available

Fidelity Measure

Not available

Other Resources

- SAMHSA. (2015). National Registry of Evidence-Based Programs and Practices: Child-Parent Psychotherapy (CPP).
<http://legacy.nreppadmin.net/ViewIntervention.aspx?id=194>
- University of Wisconsin-Madison, School of Medicine and Public Health, Department of Psychiatry, Infant, Early Childhood, and Family Mental Health Capstone Certificate Program: Trauma Informed Child-Parent Psychotherapy (TI-CPP).
http://infantfamilymentalhealth.psychiatry.wisc.edu/?page_id=44

Critical Elements of Trauma -Informed Child-Parent Psychotherapy (TI-CPP):

- Training is delivered through learning collaboratives (18 months) and consultation with national trainers on model to be followed.