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Trauma-Focused Cognitive Behavioral Therapy (TFCBT)

The following brief was obtained from the National Resource Center for Permanency and Family Connections of the Silberman School of Social Work at Hunter College, at the following website:
http://nrcpfc.org/ebp/downloads/CommonlyUsedEPBs/Trauma-FocusedCognitive-BehavioralTherapy(TF-CBT).pdf
The overview *is from information available in The Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP) at* http://nrepp.samhsa.gov/AdvancedSearch.aspx

What is it?

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" is used for the components of the treatment model, which are: **P**sychoeducation and parenting skills; **R**elaxation skills; **A**ffect expression and regulation skills; **C**ognitive coping skills and processing; **T**rauma narrative; **I**n vivo exposure (when needed); **C**onjoint parent-child sessions; and, **E**nhancing 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.

Who is it for? What presenting problems does it address?

Children/adolescents ages 3-18 years old with a known trauma history who are experiencing significant Post-Traumatic Stress Disorder (PTSD) symptoms, as well as other emotional and behavioral difficulties related to traumatic exposure.

What outcomes are addressed in the research?

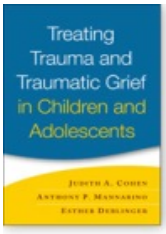
1. Family/relationships
2. Mental health
3. Social functioning
4. Trauma/injuries

Training Resources: The following was retrieved from the National Crime Victims Research and Treatment Center at the following web site: https://academicdepartments.musc.edu/projectbest/tfcbt/tfcbt.htm

Who can deliver TF-CBT?

This treatment can be used by a variety of mental health professionals including clinical social workers, professional counselors, psychologists, psychiatrists, or clinical counselors.

Treatment Manual



Cohen, J.A., Mannarino, A.P., & Deblinger, E. (2006). Treating Trauma and Traumatic Grief in Children and Adolescents. New York: The Guilford Press.

Where can I get more information about TF-CBT and child trauma?

- Description of TF-CBT and ratings of its level of empirical research support and relevance to child welfare populations by the California Evidence-Based Clearinghouse for Child Welfare.
- TF-CBT Fact Sheet from the NCTSN: Brief description of TF-CBT developed by the NCTSN.
- Review of TF-CBT from the Child Welfare Information Gateway: Description of TF-CBT and its use with sexually abused children.
- NREPP description of TF-CBT
- The Center for Traumatic Stress in Children and Adolescents
- CARES Institute
- Online Training Resources Brochure

What is TF-CBT*Web*?

TF-CBT*Web* is a web-based course for learning Trauma-Focused Cognitive-Behavioral Therapy. It covers all of the procedures of TF-CBT, and includes streaming video demonstrations and many other learning resources. TF-CBTweb is designed to allow you to learn at your own pace, and use the learning experiences when it is convenient for you. Once you have completed TF-CBT*Web*, you can return as often as you like to "brush up" on techniques, watch demonstrations, or download the resources.

Other websites for training information include the following:
http://www.nctsn.org/resources/training-and-implementation
https://learn.nctsn.org/

Trauma Informed Child-Parent Psychotherapy (TI-CPP)

The following brief was obtained from the National Resource Center for Permanency and Family Connections of the Silberman School of Social Work at Hunter College, at the following website:

http://nrcpfc.org/ebp/downloads/CommonlyUsedEPBs/Child-Parent_Psychotherapy(CPP)_8.22.13.pdf

What is it?

Child-Parent Psychotherapy (CPP) is an intervention for children and their parents who have experienced at least one form of trauma (e.g., maltreatment, the sudden or traumatic death of someone close, a serious accident, sexual abuse, exposure to domestic violence) and are presenting with different problems as a result. The primary goal is to support and strengthen the relationship between a child and his or her parent (or caregiver) in order to repair the child's sense of safety, attachment, and appropriate affect to ultimately improve the child's cognitive, behavioral, and social functioning. The type of trauma and the child's age/developmental status determine the structure of CPP sessions. For example, if the child is an infant, the focus is on helping the parent(s) understand the trauma's potential impact on development and or functionality. Older children often take an active role in the treatment, which often involves play to facilitate communication between child and parent.

Who is it for? What presenting problems does it address?

1. Children: Birth–5 years old that:

a. 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,

b. Are experiencing behavior, attachment, and/or mental health problems, including posttraumatic stress disorder (PTSD) because of experienced trauma.

2. Parent(s)/Caretaker(s) of traumatized child.

What outcomes are addressed in the research?

1. Child PTSD symptoms
2. Child behavior problems
3. Children's representational models
4. Attachment security
5. Maternal PTSD symptoms
6. Maternal mental health symptoms other than PTSD symptoms

This overview *of Child-Parent Psychotherapy is from information available in The Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP) at* http://nrepp.samhsa.gov/AdvancedSearch.aspx

Training Resources

http://childtrauma.ucsf.edu/child-parent-psychotherapy-training

http://www.nrepp.samhsa.gov/.

https://learn.nctsn.org/

Multisystemic Therapy (MST)

The following information was retrieve
at http://nrepp.samhsa.gov/AdvancedSearch.aspx#aLegacyPrograms

Family Integrated Transitions Multisystemic Therapy (MST-FIT)

Program Description

Family Integrated Transitions Multisystemic Therapy (MST-FIT) provides individual and family services to help incarcerated youth or youth out of home in placements (ages 12 to 17½) with co-occurring mental health and substance use disorders transition back into their home communities. The goals of the FIT program include lowering the youth's risk for recidivism, connecting the family with appropriate community supports, helping the youth achieve abstinence from alcohol and other drugs, improving the mental health status of the youth, and increasing the youth's prosocial behavior.

The program is an intensive, 6-month family- and community-based treatment program, which begins during the last 2 months of a youth's residence in a residential facility. The next 4 months of treatment occur while the youth transitions back to their home community. The program focuses on addressing all environmental systems that impact the youth, including home, family, school and teachers, vocational goals and employment, neighborhood, use of free time, and friends. The youth and family work on transitional needs (mental and physical health, academic, housing, safety, support structure and monitoring, etc.) to increase the success of the transition from the residential facility to home.

FIT uses the multisystemic therapy model with elements of dialectical behavior therapy, motivational interviewing, and relapse prevention. Core components include the following:
• MST-FIT clinicians go to where the child is and are on call 24 hours a day, 7 days a week.
• MST-FIT clinicians work intensively with parents and caregivers to put them in control.
• The therapist works with the caregivers to keep the adolescent focused on school and gaining job skills.
• The therapist, youth, and caregivers identify prosocial activities for youth.

Training Resources
http://mstservices.com/training/overview

http://mstservices.com/teams/become-a-provider

Functional Family Therapy (FFT)

The following description of FFT was obtained on the Penn State Evidence-Based Prevention and Intervention Support Center website: http://www.episcenter.psu.edu/ebp/familytherapy

Functional Family Therapy (FFT) is an empirically grounded family intervention program for dysfunctional and at-risk youth aged 11-18 and their families, including youth with problems such as conduct disorder, violent acting-out, and substance abuse. Youth often also present with additional comorbid challenges such as depression. Intervention is conducted in clinic settings, as outpatient therapy, and as a home-based model, including delivery in schools, child welfare, probation, parole/aftercare, and mental health, and as an alternative to incarceration or out-of-home placement. Treatment ranges from, on average, 8-12 one-hour sessions up to 30 sessions of direct service for more difficult situations. Treatment has specific phases that serve to organize intervention in a coherent manner, thereby allowing clinicians to maintain focus in the context of considerable family and individual disruption.
Clinical trials have demonstrated that FFT is capable of effectively treating adolescents with Conduct Disorder, Oppositional Defiant Disorder, Disruptive Behavior Disorder, alcohol and other drug abuse disorders, and those who are delinquent and/or violent. FFT interrupts the matriculation of these adolescents into more restrictive, higher-cost services, reduces their penetration of social services and the adult criminal system, and prevents younger siblings from entering the system of care.

National Site: Functional Family Therapy

Additional Training Resources:
http://www.fftllc.com/about-fft-training/clinical-model.html
https://www.ncjrs.gov/pdffiles1/ojjdp/184743.pdf
https://www.strengtheningfamilies.org/html/programs_1999/01_FFT.html

Multi-Dimensional Treatment Foster Care (MDTFC)

The following overview of MDTFC is from the National Council of Juvenile and Family Court Judges: http://www.ncjfcj.org/multi-dimensional-treatment-foster-care-mtfc

Multi-Dimensional Treatment Foster Care (MTFC)
Intervention Basics Multi-Dimensional Treatment Foster Care (MTFC) is an alternative to group home treatment or State facilities for youth who have been removed from the home due to substance use and/or involvement in the juvenile justice system. MTFC typically comes after previous family preservation efforts have failed. Referrals come from the juvenile courts, mental health and child welfare agencies. The treatment program works to keep the youth living successfully in their communities and helps prepare their caregivers for a successful reunification.

MTFC is based on social learning theory and has four key elements, which are targeted during foster care placement and aftercare:

1. Providing youth with a consistent, reinforcing environment where they are mentored and encouraged to develop academic and positive living skills
2. Providing youth with daily structure that includes clear expectations, limits, and specified consequences delivered in a teaching-oriented manner
3. Providing close supervision
4. Helping youth to avoid deviant peer associations while providing them with the support and assistance needed to establish pro-social peer relationships.

MTFC is a cost effective alternative to traditional foster care, group or residential treatment and incarceration for problematic adolescents. MTFC can be implemented by any agency or organizations providing services to children with serious behavior problems and their families.
Expectation of Sessions:
Number of sessions varies, dependent on the intensity of the treatment. Sessions are created to closely mirror normative life. Typically lasts 6-9 months and includes interventions conducted in the foster home, continuing care works with both the family and with the adolescent individually.

Recommended Populations

1. Youth ages 13-17
2. Girls & Boys
3. American Indian or Alaska Native; Asian; Black or African American; Hispanic or Latino; and White
4. Residential; Outpatient; Correctional; Home; School; Workplace; and Other community settings
5. Urban; Suburban; and Rural and/or frontier

Special Considerations for Juvenile Drug Courts
Because the criteria for inclusion in this intervention are youth who have been separated from their families, with the goal of establishing permanency or family reunification, this program would only apply to a small population of youth in juvenile drug courts. These youth are often referred as cross-over youth and would be involved in both family dependency court and the juvenile drug court. Youth who have received/are receiving MTFC are more likely to be involved with their biological family in family dependency court and the juvenile justice system; however in a situation where a youth is involved with

their family in a family dependency court and in a juvenile drug court, there could be a number of cross-systems issues to navigate.

Engagement Strategies
Engagement of youth involved among multiple systems can be extremely difficult and great care must be taken when coordinating services. If the JDC does accept a youth involved in multiple systems, the JDC team members will have to be cognizant of the youth's time, as there will be multiple requirements (i.e., several different court appearances, as well as treatment requirements). JDC programs are generally very intensive and require a huge time commitment, so it is important NOT to set these youth and families up for failure. In addition, there will be a tendency for families, both biological and foster, to confound the efforts of the courts and agencies involved and will want to make sure the dual process is beneficial for the youth, as well as the families.

The Department of Social Services/Child Protective Services will likely be the lead agency in decision making for these youth, and memorandums of understanding or working agreements between the court and social service agencies should be in place before the youth enters the JDC program.

Implementation and Training
JDC teams should consider visiting another court that has implemented this treatment and involved in a multi-system approach, as well as undergo an intensive training component.

Contact Gerard J. Bouwman, (541) 343-2388, gerardb@mtfc.com to research costs and training opportunities.

For more detailed information regarding research and replications associated with MTFC, visit: SAMHSA's National Registry of Evidence-Based Programs and Practices.

What does the Research Tell us about Services for Children in Therapeutic/ Treatment Foster Care with Behavioral Health Issues? https://store.samhsa.gov/shin/content/SMA14-4842/SMA14-4842.pdf

Training Resources

The following is from http://www.blueprintsprograms.com/factsheet/treatment-foster-care-oregon.

MDTFC ENDORSEMENTS
Blueprints: Model
Coalition for Evidence-Based Policy: Top Tier
Crime Solutions: Effective
OJJDP Model Programs: Effective
SAMHSA: 2.8-3.1

PROGRAM INFORMATION CONTACT
TFC Consultants, Inc.
John D. Aarons, President
12 Shelton McMurphey Blvd.
Eugene, Oregon 97401
Telephone: 541-343-2388 ext. 204

johna@tfcoregon.com
Website: www.tfcoregon.com
PROGRAM DEVELOPER/OWNER
Patricia Chamberlain, Ph.D.
Oregon Social Learning Center

Example of Oregon Program:
Potential foster parents undergo a more intensive screening process prior to training than families interested in "regular" foster care. Once eligibility is determined, an application is completed and home visit is conducted, where parents learn about the program in detail, and the expectations and training certification requirements are explained. TFCO parents must be willing to work with a more difficult population of adolescents, and take a more active treatment perspective, including a program that is more intensely structured for day-to-day activities. Parents are part of a therapeutic team, with ongoing monitoring and assistance. Foster parents receive 20 hours of preservice training, where they are indoctrinated with an overview of the program model. They learn to analyze behavior, implement the individualized daily program, methods for working with the biological family, and understand TFCO policies and procedures. During training, an emphasis on learning techniques for reinforcing and encouraging are stressed. During screening and training, TFCO personnel learn more about the family and make assessments about matching them with a program youth. Demographics are considered (i.e., youth with histories of sexual acting out or problems getting along with other children are carefully placed).
All program staff attend a three-day orientation on the program model, which includes a combination of didactic instruction, role plays, and case examples. Therapists and program supervisors receive an additional day of training in the TFCO therapy approach, and program supervisors receive a fifth day of training specific to their role. All clinical staff also attend the next scheduled TFCO parent training session. For new clinical staff (therapists and case managers), instruction on the point and level system and how to implement it is completed, case examples are used to explain how the program can be individualized for each case and to address specific types of problems. New staff also receive an orientation on the roles and duties of each member of the TFCO team and how these roles coordinate with each other in the treatment process. New staff also attend relevant clinical supervision and the weekly TFCO parent meetings to get practical information on how the program is implemented. They then sit in on ongoing cases or watch videotapes of treatment sessions (both individual and family).
Training Certification Process
There is no training of trainers model.

Other Resources:
http://www.ncjfcj.org/multi-dimensional-treatment-foster-care-mtfc
http://cayugacenters.org/resources/acronyms/mtfc-multi-dimensional-treatment-foster-care/

Dialectical Behavior Therapy (DBT)

The following overview was taken from the SAMSHA National Registry of Evidence-based Programs and Practices at the website http://legacy.nreppadmin.net/ViewIntervention.aspx?id=36 .

Dialectical Behavior Therapy (DBT) is a cognitive-behavioral treatment approach with two key characteristics: a behavioral, problem-solving focus blended with acceptance-based strategies, and an emphasis on dialectical processes. "Dialectical" refers to the issues involved in treating patients with multiple disorders and to the type of thought processes and behavioral styles used in the treatment strategies. DBT has five components: (1) capability enhancement (skills training); (2) motivational enhancement (individual behavioral treatment plans); (3) generalization (access to therapist outside clinical setting, homework, and inclusion of family in treatment); (4) structuring of the environment (programmatic emphasis on reinforcement of adaptive behaviors); and (5) capability and motivational enhancement of therapists (therapist team consultation group). DBT emphasizes balancing behavioral change, problem-solving, and emotional regulation with validation, mindfulness, and acceptance of patients. Therapists follow a detailed procedural manual.

Descriptive Information

For additional information and resources on Dialectical Behavior Therapy, visit:

1. *SAMHSA's National Registry of Evidence-based Programs and Practices: Dialectical Behavior Therapy*

   http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=36

2. Behavioral Tech, LLC
   http://www.behavioraltech.org

3. University of Washington: Behavioral Research & Therapy Clinics
   http://blogs.uw.edu/brtc/

Training and Implementation Resources:

Kathryn E. Korslund, Ph.D., ABPP • (206) 616-7324 • korslund@uw.edu
Behavioral Tech, LLC • (206) 675-8588 • information@behavioraltech.org
Research:
Marsha M. Linehan, Ph.D., ABPP • (206) 543-9886 • linehan@uw.edu

Multidimensional Family Therapy (MDFT)

The following brief was obtained from the National Resource Center for Permanency and Family Connections of the Silberman School of Social Work at Hunter College, at the following website: http://nrcpfc.org/ebp/downloads/CommonlyUsedEPBs/Multidimensional%20Family%20Therapy%20(MDFT)_8.22.13.pdf

What is it?

Multidimensional Family Therapy (MDFT) is a comprehensive and multi-systemic family-based outpatient or partial hospitalization (day treatment) program for substance-abusing adolescents, adolescents with co-occurring substance use and mental disorders, and those at high risk for continued substance abuse and other problem behaviors such as conduct disorder and delinquency. Working with the individual youth and his or her family, MDFT helps the youth develop more effective coping and problem-solving skills for better decision making and helps the family improve interpersonal functioning as a protective factor against substance abuse and related problems.

Delivered across a flexible series of 12 to 16 weekly or twice weekly 60- to 90-minute sessions, MDFT is a manual-driven intervention with specific assessment and treatment modules that target four areas of social interaction:

1. the youth's interpersonal functioning with parents and peers
2. the parents' parenting practices and level of adult functioning independent of their parenting role
3. parent-adolescent interactions in therapy sessions
4. communication between family members and key social systems (e.g., school, child welfare, mental health, juvenile justice)

Who is it for? What presenting problems does it address?

Families with youth ages 6-17 with co-occurring substance use and mental disorders, substance-abusing adolescents, and those at high risk for continued substance abuse and other problem behaviors (e.g. conduct disorder and delinquency).

What outcomes are addressed in the research?

1. Substance use
2. Substance use-related problem severity
3. Abstinence from substance use
4. Treatment retention
5. Recovery from substance use
6. Risk factors for continued substance use and other problem behaviors
7. School performance
8. Delinquency

Seven Challenges

The information in this program outline is provided by the program representative and edited by the California Evidence-Based Clearinghouse staff. http://www.cebc4cw.org/program/the-seven-challenges/

The Seven Challenges® program, specifically for young people with drug problems, is designed to motivate a decision and commitment to change and to support success in implementing the desired changes. The program simultaneously aims to help young people address their drug problems as well as their co-occurring life skill deficits, situational problems, and psychological problems. The challenges provide a framework for helping youth think through their own decisions about their lives and their use of alcohol and other drugs. Counselors use the program to teach youth to identify and work on the issues most relevant to them. In sessions, as youth discuss the issues that matter most, counselors seamlessly integrate The Seven Challenges® as part of the conversation.

The Seven Challenges® are:

1. We decided to open up & talk honestly about ourselves & about alcohol and other drugs.
2. We looked at what we liked about alcohol and other drugs, and why we were using them.
3. We looked at our use of alcohol/drugs to see if it has caused harm or could cause harm.
4. We looked at our responsibility and the responsibility of others for our problems.
5. We thought about where we were headed, where we wanted to go, & what we wanted to accomplish.
6. We made thoughtful decisions about our lives & about our use of alcohol & other drugs.
7. We followed through on our decisions about our lives and drug use. If we saw problems, we went back to earlier challenges and mastered them.

Program Goals *The Seven Challenges®* are:

1. Decrease drug use
2. Improve overall mental health
3. Improve relationships
4. Improve school/work performance
5. Increase awareness of past and present issues and how they relate to societal issues (discrimination, etc.) to help young people put their problems into a societal context and then take control of their lives and move past problems

Contact Information:
Name: Sharon Conner, Director of Program Services

Agency/Affiliation: The Seven Challenges, LLC
Website: www.sevenchallenges.com
Email: sconner@sevenchallenges.com
Phone: (520) 405-4559

Adolescent Community Reinforcement (ACR)

The following brief was obtained from the National Resource Center for Permanency and Family Connections of the Silberman School of Social Work at Hunter College, at the following website: http://nrcpfc.org/ebp/downloads/AdditionalEBPs/Adolescent_Community_Reinforcement_Approach(A-CRA)_8.22.13.pdf and the SAMHSA National Registry of Evidence-based Programs and Practices. http://www.nrepp.samhsa.gov/landing.aspx

The Adolescent Community Reinforcement Approach (A-CRA) is a behavioral intervention that seeks to replace environmental contingencies that have supported alcohol or drug use. This outpatient program uses pro-social activities and behaviors that support recovery and has guidelines for three types of sessions: adolescents alone, parents/caregivers alone, and adolescents and parents/caregivers together. There are 17 different A-CRA procedures that address, for example, problem-solving skills to cope with day-to-day stressors, communication skills, and active participation in pro-social activities with the goal of improving life satisfaction and eliminating alcohol and substance use problems. Role-playing/behavioral rehearsal is a critical component of the skills training used in A-CRA, particularly for the acquisition of better communication and relapse prevention skills. Homework between sessions consists of practicing skills learned during sessions and participating in prosocial leisure activities.

A-CRA has been adapted for use with Assertive Continuing Care (ACC), which provides home visits to youth following residential treatment for alcohol and/or other substance dependence. It also has been adapted for use in a drop-in center for street-living, homeless youth to reduce substance use, increase social stability, and improve physical and mental health.

Who is it for? What presenting problems does it address?

Youth and young adults 12-22 years old with DSM-IV cannabis, alcohol, and/or other substance use disorders.

What outcomes are addressed in the research?

1. Abstinence from substance use
2. Recovery from substance use
3. Cost effectiveness
4. Linkage to and participation in continuing care services
5. Substance use
6. Social stability
7. Depression symptoms

8. Internalized behavior problems

For additional information and resources on Adolescent Community Reinforcement Approach, visit:

☐ *SAMHSA's National Registry of Evidence-based Programs and Practices: Adolescent Community Reinforcement Approach (A-CRA)*

http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=41

☐ *The California Evidence-Based Clearinghouse for Child Welfare: Adolescent Community Reinforcement Approach (A-CRA)*

http://www.cebc4cw.org/program/adolescent-community-reinforcement-approach/detailed

This webpage provides detailed information about A-CRA, including its scientific rating on the CEBC's Scientific Rating Scale.

Education and Training Resources

The following is taken from The California Evidence-Based

Clearinghouse for Child Welfare at http://www.cebc4cw.org/program/adolescent-community-reinforcement-approach/detailed

Chestnut Health Systems, ACRA-ACC Home Page

There is a manual that describes how to implement this program, and there is training available for this program.

Training Contacts:

Brandi Barnes
bbarnes

- @chestnut.org
  phone: (309) 451-7791
- Mark Godley
  mgodley@chestnut.org
  phone: (309) 451-7800

Training is obtained:

Centralized training is provided for both clinicians and supervisors. It is expected that each clinician will work with a supervisor who is pursuing certification or is already certified as a supervisor in the model, followed by a certification process that requires uploading digital

recordings to a secure website for expert review and feedback, and attending cross-site coaching calls. Once a supervisor achieves certification, it is possible to train and certify clinicians at his/her own site with verification from Chestnut Health Systems.

Number of days/hours:

The initial training is 28 hours. The certification process requires recording treatment sessions (so this occurs during actual treatment hours); the average coaching and feedback review time is 14 hours. So on average, basic certification is 42 hours. After individuals have made progress in certification, additional training workshops are available for training in how to use the procedures to address other co-occurring disorders and for supervisors.

Additional Resources:

There currently are additional qualified resources for training:

- Robert J. Meyers, RJM & Associates, Email: bmeyers@unm.edu

Assertive Continuing Care (ACC)

The following outline is from the SAMHSA National Registry of Evidence-based Programs and Practices. http://nrepp.samhsa.gov/AdvancedSearch.aspx

Adolescent Community Reinforcement Approach (A-CRA)/Assertive Continuing Care (ACC) (A-CRA/ACC)

Program Description

Adolescent Community Reinforcement Approach/Assertive Continuing Care (A-CRA/ACC) is an outpatient program for youths and young adults between the ages of 12 and 24 who have substance use and co-occurring mental health disorders. A-CRA uses both behavioral and cognitive–behavioral techniques to replace environmental settings and cues that have supported alcohol or drug use with prosocial activities and new social skills that support recovery. A-CRA is the main component within Assertive Continuing Care (ACC), which provides home, school, or other community visits to youths following residential treatment for substance use disorders.

A-CRA is administered by a behavioral health clinician through three types of sessions: 1) for adolescents alone, 2) for parents/caregivers alone, and 3) for adolescents and parents/caregivers together. According to the youth's needs and self-assessment of happiness in multiple areas of life functioning, the therapist chooses from among 21 procedures for developing problem-solving skills to cope with day-to-day stressors,[WU1] and priming new prosocial activities with the goal of improving life satisfaction and eliminating alcohol and substance use problems. A-CRA skills training involves coaching, practice, and feedback, particularly to support the acquisition of better family relationship skills, anger management, and relapse prevention skills. Homework is assigned between sessions and consists of practicing skills learned during sessions and participating in prosocial leisure activities. The A-CRA intervention is typically delivered over 12 to 14 weeks and generally includes 10, 1-hour individual sessions; two, 1-hour sessions with parents/caregivers; and two, 1-hour sessions with both adolescents and parents/caregivers together.

ACC is a continuing care intervention specifically designed for adolescents following a period of residential, intensive outpatient, or regular outpatient treatment. It stresses rapid initiation of continuing care services after discharge to promote recovery and prevent relapse. ACC is delivered primarily through home visits where clinicians offer A-CRA procedures in accordance with the information the adolescent provides in terms of his or her reinforcers, strengths, and needs. Clinicians also provide typical case-management services, including linkage to other needed community services, home/community therapy sessions, and midweek telephone calls between the therapist and the adolescent.

A-CRA/ACC has also been implemented with juvenile-justice-involved youths within a drop-in center, and with youths in residential treatment.

Web Resources
https://www.omh.ny.gov/omhweb/ebt/web_resources.html

- The Children, Youth and Family Mental Health Evidence-Based Practice Project (EBPP) is a collaborative effort between the School of Social Work at the State University of New York at Buffalo and the New York State Office of Mental Health (OMH) Division of Child & Family Services. Since its inception in 2002, it provides assessment, training, and consultation services to the more than 400 affiliated agencies in the 19 counties of OMH's Western Region.
  The EBPP provides training and other support services to agencies in implementing recognized evidence-based practices in mental health services for children and families.

- Focus on Integrated Treatment (FIT) offers free online courses designed to help programs implement integrated treatment for co-occurring disorders (COD). Integrated mental health and substance use treatment is a proven strategy for helping people achieve and maintain recovery. Developed for the real-world environment, FIT's practical approach features concise, half-hour modules that allow clinicians to choose when and where to take their training. FIT is a project of the Center for Practice Innovations which provides technical assistance in the implementation of best practices.

- The National Registry of Evidence-based Programs (NREPP) of the federal Substance Abuse and Mental Health Services Administration (SAMHSA) is a searchable online listing of mental health and chemical dependency interventions with have been designated as best practices for independent reviewers. NREPP's purpose is to assist the public in finding evidence-based treatments and improve access to these programs.

- TF-CBT Web is a free, web-based course which provides ten continuing education credits. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based practice for children with posttraumatic symptoms. It is a components-based treatment that incorporates trauma-sensitive interventions with cognitive behavioral treatment. Children and parents learn to process thoughts and feelings related to the traumatic event(s), resolve distressing thoughts, feelings and behaviors, and enhance safety. Multiple research studies and much clinical evidence indicate that TF-CBT is effective in helping children, adolescents, and their parents overcome many of the difficulties associated with abuse and trauma.

  TF-CBT has proven effective in addressing posttraumatic stress disorder, depression, anxiety, externalizing behaviors, sexualized behaviors, feelings of shame, and mistrust. The parental component increases the positive effects for children by reducing parents' own levels of distress about their child's abuse and improving parenting practices and support of their child.

https://www.omh.ny.gov/omhweb/ebt/
https://www.ojjdp.gov/mpg
https://www.crimesolutions.gov/TopicDetails.aspx?ID=98

Children, Youth and Families

MJ Evidence Based Practice Project

Selected EBP Links

http://www.omhmentalhealthebpwny.org/selected/index.htm

The following are links to other evidence-based practice web sites that discuss evidence-based treatments that deal with mental health issues.

American Academy of Child and Adolescent Psychiatry
Commonly Used EBP's in Child Welfare
Effective Child Therapy Evidence-based mental health treatment for children and adolescents
Evidence Based Practices for the Helping Professionals
Evidence-Based Practices in Child Welfare
Free Online Course on Trauma Focused CBT with Children and their Families
National Child Traumatic Stress Network Empirically Supported Treatments and Promising Practices
NYS OMH Division of Children & Family Services Evidence Based Treatment Dissemination Center and Training Information
Promising Practices for children with serious emotional disturbance
Research in Practice for Children and Families
Virginia Commission on Youth
Note- See "Youth & Family Programs" and "Child and Adolescent Mental Health Treatments"

National Resource Center for Permanency and Family Connections (NRCPFC)

Silberman School of Social Work at Hunter College

NRCPFC Evidence-Based Practice (EBP) Overviews

http://nrcpfc.org/ebp/CommonlyUsedEBPs.html

The purpose of these outlines developed by NRCPFC is to provide a brief overview of some specific evidence-based practices that are utilized in the field of child welfare, based on the information available in The Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP) and The California Evidence-Based Clearinghouse for Child Welfare's (CEBC) database. The content presented in the following briefs was retrieved from either SAMHSA's NREPP or the CEBC's database, as cited in the briefs. (Last updated June 2013)

The following is a list of commonly used EBPs in child welfare. To view overviews of additional EBPs, click here.

- Brief Strategic Family Therapy (BFST)
- Child-Parent Psychotherapy (CPP)
- Cognitive Behavioral Therapy (CBT) for Adolescent Depression
- Family Behavior Therapy (FBT)
- Family Connections (FC)
- Multidimensional Family Therapy (MDFT)
- Nurse-Family Partnership (NFP)
- Nurturing Parenting Program (NPP)
- Parent-Child Interaction Therapy (PCIT)
- Solution-Based Casework
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Triple P- Positive Parenting Program

Below is a list of additional EBPs. To see overviews of commonly used EBPs in child welfare, click here.

- Adolescent Community Reinforcement Approach (A-CRA)
- Coping Cat
- Dialectical Behavioral Therapy (DBT)
- Guiding Good Choices (GGC)
- HOMEBUILDERS
- Incredible Years
- Keepin' it REAL

- LifeSkills Training (LST)
- Living in Balance (LIB)
- Matrix Model
- Moral Reconation Therapy (MRT)
- Parents Anonymous
- Parents as Teachers (PAT)
- Promoting Alternative Thinking Strategies (PATH)
- SafeCare
- Seeking Safety
- Strengthening Families Program (SFP)
- Trauma Recovery and Empowerment Model (TREM)
- Traumatic Incident Reduction (TIR)

Wellness Recov http://www.omhmentalhealthebpwny.org/support/index.htm ery Action Plan (WRAP)