Five Examples of Programs Supported by Evidence
As Reported on the Website of the California Evidence-Based
Clearinghouse for Child Welfare
(long version)

FIVE PROGRAMS

- Example #1: Triple P – Positive Parenting (Parent Training)
- Example #2: Project Connect (Reunification Services)
- Example #3: Motivational Interviewing (Substance Abuse Treatment)
- Example #4: Trauma-Focused Cognitive Behavioral Therapy (Trauma treatment for Children)
- Example #5: Independent Living Program-Lighthouse (Training for Youth Transitioning to Adulthood)

SOURCE
http://www.cachildwelfareclearinghouse.org/search/topical-area

RATING SCALES

Scientific Scale
1. Well Supported - Effective Practice
2. Supported - Efficacious Practice
3. Promising Practice
4. Acceptable/Emerging Practice
5. Fails to Demonstrate Effect
6. Concerning Practice

Relevance Scale
1. High: The program was designed, or is commonly used, to meet the needs of children, youth, young adults, and/or families receiving child welfare services.

2. Medium: The program was designed, or is commonly used, to serve children, youth, young adults, and/or families who are similar to child welfare populations (i.e., in history, demographics, or presenting problems) and likely include current and former child welfare services recipients.
3. Low: The program was designed, or is commonly used, to serve children, youth, young adults, and/or families with little or no apparent similarity to the child welfare services population.

**Relevance to Child Welfare Outcomes** is judged based on peer-reviewed studies (published or in press):
- The program evaluation had measures relevant to safety.
- The program evaluation had measures relevant to permanency.
- The program evaluation had measures relevant to child and family well-being.
Example #1: Triple P - Positive Parenting Program

Scientific Rating: 1 - Well Supported - Effective Practice

Relevance to Child Welfare Rating: 2 - Medium


Type of Maltreatment: Emotional abuse and Physical abuse

Target Population: Parents and other caregivers of children from birth through age 18.

Brief Description:
The Triple P-Positive Parenting Program is a Parent Training program. The Triple P-Positive Parenting Program is a multi-level system of parenting and family support. It aims to prevent severe behavioral, emotional and developmental problems in children by enhancing the knowledge, skills, and confidence of parents. It can be provided individually, in a group, or a self-directed format. It incorporates five levels of intervention on a tiered continuum of increasing strength for parents of children and adolescents from birth to age 16. The multi-disciplinary nature of the program allows utilization of the existing professional workforce in the task of promoting competent parenting. The program targets five different developmental periods from infancy to adolescence. Within each developmental period, the reach of the intervention can vary from being very broad (targeting an entire population) to quite narrow (targeting only high-risk children). Triple P-Positive Parenting Program enables practitioners to determine the scope of the intervention given their own service priorities and funding.

Essential Components
1. Prevention oriented with age-specific interventions timed developmentally to maximize impact (e.g. preschool, early teen)
   ○ Program designed for preschoolers and primary school children, as well as a distinct program for early teens.
   ○ Tip sheets available for distinct age groups (infants, toddlers, preschoolers, primary school children, teens).
2. Uses an explicit self-regulatory framework
   ○ Includes principles of: Self sufficiency, self-efficacy, self management, and problem solving.
   ○ Parents are taught how to monitor behavior and asked to set specific, observable goals.
   ○ Self-management and self-sufficiency are enhanced by prompting the parent to review their implementation of parenting strategies and reflect on aspects that are strengths and set specific goals for any weaknesses.
   ○ The flexible program uses many examples and teaches parents how to solve problems in a self-sufficient manner, applying the principles they have learned.
3. Uses the principles of sufficiency to ensure cost effectiveness
Multiple levels of intervention enable tailoring of intervention intensity to individual family needs, ensuring cost-effectiveness.

Families with lowest level of risk are provided with lower intensity interventions, while families at higher levels of risk receive higher intensity interventions.

The practitioner determines the level of risk using the assessment information (e.g., intake interview, questionnaires, monitoring, observation) and then chooses the most appropriate intervention intensity.

Following completion of an intervention level, assessments are used to determine whether a family needs additional levels of intervention.

4. Specifically incorporates identifiable program elements to promote generalization or transfer of learning.
   - Flexible training, using multiple examples.
   - Explicit process of teaching techniques that are able to be generalized and maintained across time, situations, and different children.
   - Teaching parents strategies for managing high-risk situations (e.g., going shopping) to ensure generalization across contexts.

5. Flexible delivery methods available and evaluated.
   - Individual delivery
   - Group delivery
   - Self-directed program delivery with or without telephone support
   - Media based delivery (e.g., television series)

Group Format
Triple P - Positive Parenting Program was designed to be conducted in a group. Triple P - Positive Parenting Program has been tested for use in a group setting. The recommended group size is: 10-12 parents.

Testing references


Recommended Parameters
- Recommended intensity: Sessions last up to one hour. The number of sessions varies according to the level of intervention required by the family: Level 2 - approximately
one to two sessions delivered via seminars or individual brief consultations. Level 3 - up to four brief 20-minute consultation sessions. Level 4 - eight to ten sessions. Level 5 - on average an additional three sessions per parent.

- Recommended duration: This varies by the level of intervention required by the family. For example, Level 2 is one to two weeks in duration, while Level 5 can be up to twelve weeks.

**Homework**
Triple P - Positive Parenting Program includes a homework component.

- **Description:** Homework varies depending on the level of intervention but could include: monitoring of child behavior, monitoring of parent behavior, implementation of positive parenting strategies (e.g. behavior charts) and discipline routines, practice sessions with child, viewing videos, reading parent workbooks, problem solving exercises, planned discussion with spouse or partner.

**Delivery Setting**
- Triple P - Positive Parenting Program is typically conducted in a(n): Adoptive Home, Birth Family Home, Community Agency, Foster Home, Hospital, Outpatient Clinic, Residential Care Facility, and School.

**Parent Component**
- Triple P - Positive Parenting Program was designed with a Parent Component.
- Triple P - Positive Parenting Program addresses the following presenting problems and symptoms: Attribution and anger management issues.

**Child Component**
- Triple P - Positive Parenting Program was designed with a Child Component.
- Triple P - Positive Parenting Program addresses the following presenting problems and symptoms: Conduct problems, ADHD, oppositional defiant disorders, eating problems, pain syndromes.
- **Age range(s):** 0-16
  - Triple P - Positive Parenting Program was developed for children with developmental delays.
  - Triple P - Positive Parenting Program has been tested for children with developmental delays.

**Relevant research studies**


**Racial/Ethnic Diversity**

- Triple P - Positive Parenting Program was not designed for specific racial/ethnic/cultural groups.
- Triple P - Positive Parenting Program was tested in specific racial/ethnic/cultural groups.

**Relevant research studies**

**Studies with Chinese populations**


**Studies with indigenous populations**


**Studies with European populations**


**Education and Training Resources**

- There is a manual that describes how to implement this program.
- There is training available for Triple P - Positive Parenting Program.
- Training contact: For training inquiries within USA www.triplep-America.com. For all other training inquiries www.triplep.net (international).
- Number of days/hours: 2-5 day training plus 1 day accreditation depending on level of intervention.
• Training is obtained: It can be provided on-site within an agency or other convenient location.
• There currently are additional qualified resources for training.
• List of additional qualified resources: All training is conducted by an accredited trainer with doctoral or similar level qualifications.

Identified Resources Necessary to Implement Program
The typical resources for implementing Triple P - Positive Parenting Program are: An economic analysis been completed and is currently under review for publication. Please contact the developer for more information.

Minimum Provider Qualifications
A professional qualified in a helping discipline who has gone through the training and been accredited.

Relevant Research

Randomized controlled trial using wait list in highly controlled setting (same population as Sanders, Markie-Dadds, Tully & Bor, 2000). At post-intervention, Triple P group had significantly lower levels of parent-reported child behavior problems, lower levels of dysfunctional parenting, and greater parental competence than the wait list condition. The gains achieved at post-intervention were maintained at one-year follow-up.


Randomized controlled trial conducted in Hong Kong using wait list control in usual care setting. The results showed that Triple P was effective in reducing disruptive child behavior problems, reducing dysfunctional parenting style, increasing a parent's sense of competence and reduced conflict over parenting.


Randomized controlled trial using wait list in highly controlled setting. The intervention group had lower levels of parent-reported disruptive child behavior, lower levels of dysfunctional parenting, greater parental competence, and higher consumer satisfaction than the wait list condition.
References


California application(s)
Triple P - Positive Parenting Program has been implemented with fidelity in California. Locations: Mendocino County.

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Date reviewed: March 2006
Example #2: Project Connect

Scientific Rating: 3 - Promising Practice

Relevance to Child Welfare Rating: 1 - High


Type of Maltreatment: Emotional abuse, Exposure to domestic violence, Physical abuse, Physical neglect, and Sexual abuse

Target Population: High-risk, substance-affected families involved in the child welfare system. Family risks may include the following: Poly-substance abuse and dependence, domestic violence, child abuse and neglect, criminal involvement and behavior, poverty, inappropriate housing, lack of education, poor employment skills, and impaired parenting. Most of the families served are ethnically diverse, have a low household income, and are headed by single mothers.

Brief Description:
Project Connect is a Reunification program. Project Connect works with high-risk families who are affected by parental substance abuse and are involved in the child welfare system. The program offers home-based counseling, substance abuse monitoring, nursing, and referrals for other services. The program also offers home-based parent education, parenting groups, and an ongoing support group for mothers in recovery. While the goal for most Project Connect families is maintaining children safely in their homes, when this is not possible, the program works to facilitate reunification.

Essential Components
1. Family Centered, Community Based Services
   - Staff members focus on encouraging families to use their strengths to work on the concerns in their lives.
   - The program works to connect families with, and help them to manage, the larger systems in their lives (i.e., schools; courts; child welfare systems; treatment programs for substance abuse, mental health issues, medical problems, and domestic violence; homeless shelters; Social Security; AFDC etc.).
   - Staff members work within these systems to advocate for families and to empower families to overcome the barriers to effective functioning.
2. Enhancing Parent/Child Relationships; Decreasing Parental Substance Abuse and Dependence
   - The program developed the Risk Inventory for Substance Abuse-Affected Families to assist in determining the level of risk and service needs for the families. There are eight scales that measure the following: commitment to recovery, patterns of use, effect on childrearing, effect on lifestyle, supports
for recovery, parent's self-efficacy, parent's self-care, and neighborhood safety.

- Visits to the family can take place in the family's primary place of residence, in the community, or at the office, based on the family's needs.
- Group parenting sessions are offered to families to improve specific parenting skills.
- Follow-up visits at the home encourage the application of new skills. Parent/child groups work to enhance the attachment and bond between adults and children.
- Frequent recreational events are held in order to support and encourage positive interactions, and for families to have fun safely.
- Observed visitation provides opportunities to offer feedback to the parent and the child when appropriate. This visitation also provides opportunities for collaterals to best determine service needs.
- The program works to enhance communication between foster parents and biological parents, in order to provide consistency and continuity of care for the children.
- In order to facilitate effective communication and interventions, family-driven case conferencing occurs frequently between various providers and family members.
- Individual supportive counseling is offered on a weekly basis to address individual issues and develop problem-solving strategies.
- The program helps families overcome barriers by providing concrete services. These services include using the program's emergency assistance fund, providing transportation when necessary by cabs and/or program van, and making referrals for service linkage.

**Group Format**

- Project Connect was not designed to be conducted in a group.
- Project Connect has not been tested for use in a group setting.

**Recommended Parameters**

- Recommended intensity: At least 2 home visits a week. Intensity is determined by the family's needs and the level of risk to the children.
- Recommended duration: Program services last an average of 13 months for families that complete the program. Home visits are typically one to two hours per visit, adding up to four to six hours of services per week.

**Homework**

Project Connect does not include a homework component.

**Delivery Setting**

Project Connect is typically conducted in a(n): Birth Family Home, Community Agency, and Foster Home.
Parent Component
• Project Connect was designed with a Parent Component.
• Project Connect addresses the following presenting problems and symptoms:
  Substance abuse, mental health problems

Child Component
• Project Connect was designed with a Child Component.
• Project Connect addresses the following presenting problems and symptoms: Parental
  substance abuse, neglect, abuse
• Age range(s): 0-17
Project Connect was not developed for children with developmental delays.
Project Connect has not been tested for children with developmental delays.

Racial/Ethnic Diversity
• Project Connect was not designed for specific racial/ethnic/cultural groups.
• Project Connect was not tested in specific racial/ethnic/cultural groups.

Education and Training Resources
• There is not a manual that describes how to implement this program.
• There is training available for Project Connect.
• Training contact: Valentina Laprade, 401-721-9237, vlaprade@cfsri.org
• Number of days/hours: Varies
• Training is obtained: Varies
• There currently are not additional qualified resources for training.

Identified Resources Necessary to Implement Program
The typical resources for implementing Project Connect are: Office space, transportation

Minimum Provider Qualifications
• A Master's degree in social work, or a related field, and experience with at-risk
  families. A Bachelor's degree with extensive experience with at-risk, substance
  abuse-affected families, and/or those with child welfare involvement may also be
  acceptable.
  The clinical supervisor of the program should be a Master’s level, licensed clinical
  social worker with supervisory experience and experience with at-risk families.
  The manager should be a Master’s level, licensed independent clinical social worker
  with supervisory and management experience.

Relevant Research

  A generalist approach to social work practice with families affected by parental
  addiction is presented. Data from two state reports on Project Connect are
  reported (same sample as Olsen, 1995). The data shows that 60% of Project
Connect's families successfully completed services, resulting in significant reductions in family risk factors. In addition, Project Connect children were more likely to be returned home, and were returned home more quickly, than children whose parents did not receive services.

Details on the design of the study are not presented, although it appears that randomization did not occur. Families completing Project Connect were compared to other child welfare-involved families with chemical dependency problems who did not receive Project Connect services.


Data of families with chemical dependency problems are presented for 66 parents with 176 children, one group receiving Project Connect services and one not. Project Connect children were more likely to be reunited with their parents (45% vs 13%) and were returned to their parents sooner (5 months vs. 11 months) as compared to the other families. Randomization of families did not occur and comparison data on the two groups are not presented.

References


California application(s)
Project Connect has not been implemented with fidelity in California.

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Date reviewed: July 2006
Example #3: Motivational Interviewing (MI)

Scientific Rating: 1 - Well Supported - Effective Practice

Relevance to Child Welfare Rating: 2 - Medium

Child Welfare Outcomes: Safety

Type of Maltreatment: Not specified

Target Population: Caregivers of children referred to the child welfare system.

Brief Description:
Motivational Interviewing (MI) is a Substance Abuse program. MI is a client-centered, directive method designed to enhance client motivation for behavior change. It focuses on exploring and resolving ambivalence by increasing intrinsic motivation to change. MI has been shown to be effective in improving substance abuse outcomes by itself, as well as in combination with other treatments.

Essential Components
The overarching goals of MI are:
1. to enhance internal motivation to change;
2. to reinforce this motivation; and
3. to develop a plan to achieve change.

MI emphasizes two essential dimensions related to an individual's ambivalence to change: the importance of the change and the confidence that the change can be accomplished.

MI includes a number of open-ended questions encouraging the client to talk about circumstances surrounding his or her referral for evaluation as opposed to the standard substance abuse evaluation that includes administering a number of structured interviews asking closed-ended questions. Examples of the types of open-ended questions that might be used are as follows:
- What do you think are the reasons your caseworker referred you here today?
- What worries you about your substance use?
- How has your use of substances presented problems for you in the past?
- What kinds of things would need to happen to make you consider changing your substance use?
- What are the things that would prevent you from changing your substance use?
- What are your concerns about entering substance abuse treatment at this time?

Group Format
- Motivational Interviewing (MI) was designed to be conducted in a group.
- Motivational Interviewing (MI) has been tested for use in a group setting.
Testing references


Recommended Parameters
- Recommended intensity: Usually 1-3 individual sessions. There is some evidence that 2-3 sessions are more effective than a single session. Less is known about the optimal intensity when delivered in a group format.
- Recommended duration: 30-50 minutes each session.
- The recommended group size is: 5-7 participants

Homework
Motivational Interviewing (MI) does not include a homework component.

Delivery Setting
Motivational Interviewing (MI) is typically conducted in a(n): Community Agency, Hospital, Outpatient Clinic, and Residential Care Facility.

Parent Component
- Motivational Interviewing (MI) was designed with a Parent Component.
- Motivational Interviewing (MI) addresses the following presenting problems and symptoms: Substance abuse or dependence and other health/lifestyle behavior change issues.

Child Component
- Motivational Interviewing (MI) was not designed with a Child Component.
- Motivational Interviewing (MI) was not developed for children with developmental delays.
- Motivational Interviewing (MI) has not been tested for children with developmental delays.

Racial/Ethnic Diversity
- Motivational Interviewing (MI) was not designed for specific racial/ethnic/cultural groups.
- Motivational Interviewing (MI) was tested in specific racial/ethnic/cultural groups.
Relevant research studies
MI appears to produce higher effect sizes when used with minority populations. It has been particularly tested with African-American, Hispanic and Native American populations. See meta-analysis: Hettema, J., Steele, J., & Miller, W. R. (2005). Motivational interviewing. Annual Review of Clinical Psychology, 1, 91-111.

Education and Training Resources
- There is a manual that describes how to implement this program.
- There is training available for Motivational Interviewing (MI).
- Training contact: Our website, www.motivationalinterview.org, contains a list of trainers and Dr. Theresa Moyers at the University of New Mexico, email: tmoyers@unm.edu.
- Number of days/hours: Training can be provided on-site. Follow-up feedback and coaching can be delivered effectively by telephone.
- Training is obtained: Training can be provided on-site. Follow-up feedback and coaching can be delivered effectively by telephone.
- There currently are additional qualified resources for training.
- List of additional qualified resources: Mike Clark trains CPS staff in Motivational Interviewing Assetbuilding@aol.com, www.motivationalinterview.org

Identified Resources Necessary to Implement Program
The typical resources for implementing Motivational Interviewing (MI) are: A room to conduct the session.

Minimum Provider Qualifications
None. Efficacy does not appear to be related to the level of practitioner degree.

Relevant Research

Carroll and colleagues used a single MI assessment at treatment intake and showed a large and significant increase in entry into at least one session of regular treatment (59% versus 29%) even with only 60 clients randomized. Once regular treatment began and no further MI was implemented, both groups disengaged from treatment at similar rates.


Another study randomized 71 subjects to MI implemented by the substance abuse treatment provider; no significant differences were shown in treatment outcomes in eight weeks. Several reasons were posited for the lack of positive finding,
including a small sample and an active control condition (education and home visit).


This article contains a meta-analysis of over 70 controlled trials of motivational interviewing. The review shows particularly strong evidence for the efficacy of MI with alcohol/drug abuse.

References


California application(s)
Motivational Interviewing (MI) has been implemented with fidelity in California. Locations: It has been used extensively by Kaiser-Permanente. Also by Mental Health Systems in San Diego.

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Website: http://www.motivationalinterview.org

Date reviewed: August 2006
Example #4: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Scientific Rating: 1 - Well Supported - Effective Practice

Relevance to Child Welfare Rating: 1 - High

Child Welfare Outcomes: Child/family well-being

Type of Maltreatment: Exposure to domestic violence and Sexual abuse

Target Population: Children who are experiencing significant Post-Traumatic Stress Disorder (PTSD) symptoms, whether or not they meet full diagnostic criteria. In addition, children with depression, anxiety, and/or shame related to their traumatic exposure. Children experiencing Childhood Traumatic Grief can also benefit from the treatment.

Brief Description:
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a Trauma Treatment for Children program. TF-CBT is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles.

Essential Components
- P- Psycho-education and parenting skills
- R- Relaxation techniques: Focused breathing, progressive muscle relaxation, and teaching the child to control their thoughts (thought stopping).
- A- Affective expression and regulation: To help the child and parent learn to control their emotional reaction to reminders by expanding their emotional vocabulary, enhancing their skills in identification and expression of emotions, and encouraging self-soothing activities
- C- Cognitive coping and processing or cognitive reframing: Through this component, the child learns to think in new and healthier ways about the abuse and their role in it.
- T- Trauma narrative: Gradual exposure exercises including verbal, written and/or symbolic recounting (i.e., utilizing dolls, art, puppets, etc.) of abusive event(s) so the child learns to be able to discuss the events when they choose in ways that do not produce overwhelming emotions.
- I- In vivo exposure: Encourage the gradual exposure to innocuous (harmless) trauma reminders in child's environment (e.g., basement, darkness, school, etc.) so the child learns they can control their emotional reactions to things that remind them of the trauma, starting with non-threatening examples of reminders.
- C- Conjoint parent/child sessions: Held typically toward the end of the treatment. Sessions deal with psycho-education, sharing the trauma narrative, anxiety management, and correction of cognitive distortions. The family works to
enhance communication and create opportunities for therapeutic discussion regarding the trauma.

- E- Enhancing personal safety and future growth: Provide training and education with respect to personal safety skills and healthy sexuality/interpersonal relationships; encourage the utilization of skills learned in managing future stressors and/or trauma reminders.

**Group Format**

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) was not designed to be conducted in a group.
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) has been tested for use in a group setting.
- The recommended group size is: 6-10 children and their caregivers

**Testing references**


**Recommended Parameters**

- Recommended intensity: Sessions are conducted once a week.
- Recommended duration: For each session: 30-45 minutes for child; 30-45 minutes for parent. The program model also includes conjoint child-parent sessions toward the end of treatment that last approximately 30-45 minutes. Treatment lasts 12-18 sessions.

**Homework**

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) includes a homework component.
  Description: Parents are given weekly assignments to practice the treatment components at home, both alone and to reinforce and practice these with their children. Children are also given homework during certain sessions to reinforce and practice skills learned in therapy sessions.

**Delivery Setting**

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is typically conducted in a(n): Community Agency and Outpatient Clinic.

**Parent Component**

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) was designed with a Parent Component.
• Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) addresses the following presenting problems and symptoms: Inappropriate parenting practices and parental trauma-related emotional distress.

**Child Component**
• Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) was designed with a Child Component.
• Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) addresses the following presenting problems and symptoms: Feelings of shame, distorted beliefs about self and others, acting out behavior problems, and PTSD and related symptoms.
• Age range(s): 4-8
• Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) was not developed for children with developmental delays.
• Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) has not been tested for children with developmental delays.

**Racial/Ethnic Diversity**
• Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) was designed for specific racial/ethnic/cultural groups.
• Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) was tested in specific racial/ethnic/cultural groups.
• Specific Groups: Caucasians, African Americans, and biracial populations

**Relevant research studies:**
TF-CBT has been adapted and tested with Hispanic children


**Education and Training Resources**
• There is a manual that describes how to implement this program.
• There is training available for Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).
• Training contact: Judith Cohen, M.D. jcohen1@wpahs.org or Esther Deblinger, Ph.D. deblines@umdnj.edu.
• Number of days/hours: Introductory Overview 1-8 hours
  Basic Training 2-3 days
  Advanced Training 1-3 days
• Training is obtained: National Conferences; CARES Institute, Allegheny General Hospital and onsite by request
• There currently are additional qualified resources for training.
• List of additional qualified resources: Ten-hour basic web-based training free of charge at www.musc.edu/tfcbt.

Identified Resources Necessary to Implement Program
The typical resources for implementing Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) are: Private space to conduct sessions; waiting area for children when parents are being seen; therapeutic books and materials

Minimum Provider Qualifications
• Master's degree and training in the treatment model.
  Experience working with children and families.

Relevant Research

Randomized controlled trial (RCT) demonstrating superiority of TF-CBT over nondirective supportive therapy for 68 sexually abused children ages 3-7 and their non-offending parents in improving posttraumatic stress and internalized, externalized, and sexual behavior problems. Measures included the *Child Behavior Checklist (CBCL), Child Sexual Abuse Inventory, and Weekly Behavior Report*.


Demonstrated that initial differences between TF-CBT and Non-Directive Supportive Therapy (NST) treatment groups were maintained at 6-and 12-month follow-ups, with TF-CBT remaining superior to NST in multiple domains of outcome. Measures included the *Child Behavior Checklist (CBCL), Child Sexual Abuse Inventory, and Weekly Behavior Report*.


Eighty-two sexually abused children, 8-15 years old, and their primary caretakers were randomly assigned to TF-CBT or NST. The results demonstrated the superior effectiveness of TF-CBT in reducing self-reported depression and improving social competence.

Eighty-two sexually abused children, 8-15 years old, and their primary caretakers were randomly assigned to TF-CBT or NST. Measures included the Children's Depression Inventory (CDI), Trauma Symptom Checklist for Children (TSCC), State-Trait Anxiety Inventory for Children (STAIC), Child Sexual Behavior Inventory (CSBI), and the Child Behavior Checklist (CBCL). Among treatment completers, TF-CBT resulted in significantly greater improvement in anxiety, depression, sexual problems and dissociation at 6-month follow-up and in PTSD and dissociation at 12-month follow-up. Intent-to-treat analysis indicated group X time effects in favor of TF-CBT on measures of depression, anxiety, and sexual problems.


A multi-site RCT for 229 children with sexual abuse-related PTSD symptoms; more than 90% had experienced multiple types of traumas in addition to sexual abuse. Measures included Schedule for Affective Disorders and Schizophrenia for School-Age Children- Present and Lifetime Version (K-SADS), (for this study, the PTSD, Psychosis, and Substance Use Disorders sections were used); Children's Depression Inventory (CDI); State-Trait Anxiety Inventory for Children (STAIC); and Children's Attributions and Perceptions Scale (CAPS). TF-CBT was superior to Child Centered Therapy (CCT) in improving PTSD, depressive, anxiety, shame, and behavioral symptoms as well as abuse-related cognitions in children; and in improving depression, parenting skills, parental distress about the child's abuse, and support of the child among parents who participated in treatment.


RCT for 100 sexually abused children 8-14 years old and their non-offending parents, assigned to TF-CBT for child only, parent only, parent and child, or to community treatment as usual (TAU). Children receiving TF-CBT experienced significantly greater improvement in PTSD symptoms; children whose parents received TF-CBT treatment experienced significantly greater improvement in depression and behavior problems and their parents experienced significantly greater improvement in parenting skills. Measures included the Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS-E); Children's Depression Inventory (CDI); State-Trait Anxiety Inventory for Children (STAIC); Child Behavior Checklist (CBCL); and Parenting Practices Questionnaire.

Improvements in PTSD, depression, and externalizing behaviors that were found at post-treatment were maintained across groups at 3 and 6 months and one and two year follow-ups with TF-CBT retaining its advantage over TAU.


RCT for 44 children ages 2-8 years old and their mothers demonstrated that mothers participating in TF-CBT groups reported greater improvements in intrusive thoughts and parental emotional distress related to their children's abuse than those participating in supportive groups. Children participating in the TF-CBT groups demonstrated greater improvement in their knowledge regarding body safety skills than children who participated in supportive groups.


RCT for 36 Australian 5-17 year old sexually abused youth assigned to child-only, child+family, or wait list control condition (WL). Results indicated that both treatment conditions improved equally on PTSD; both were superior to WL; child-only condition improved more on depression and child-only improved more child+family on anxiety at post-treatment. At 3-month follow-up, child+family improved more on fear than child-only condition.

References


California application(s)
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) has been implemented with fidelity in California.
Locations: Chadwick Center for Children and Families - San Diego

Contact Information
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Date reviewed: May 2006
**Example #5: Independent Living Program-Lighthouse**

Scientific Rating: 4 - Acceptable/Emerging Practice - Effectiveness is Unknown

Relevance to Child Welfare Rating: 1 - High

Type of Maltreatment: Not specified

Target Population: Target population is youth of any race or gender between the ages of 16-19, who are aging out of the child welfare or juvenile justice systems and cannot return to live with their families. Youth with developmental delays have participated in the program. In addition, the program is designed to allow teen parents and their child(ren) to participate.

**Brief Description:**
The Independent Living Program-Lighthouse is a Youth Transitioning into Adulthood program. The Independent Living Program, developed by Lighthouse Youth Services, is designed to provide housing, life-skills training, case management, mental health counseling, and other support services to youth nearing adulthood. These youth could be aging out of the child welfare or juvenile justice systems, at risk of homelessness, or unable to return to biological families. The goal is to provide them with the knowledge and skills necessary to live self-sufficiently. To this end, the youth are provided referrals and case management support to enable them to complete their education, gain employment, and move toward becoming responsible and productive members of the community.

**Essential Components**

1. Housing
   - Apartment acquired
   - Security deposit paid
   - Lease signed (by agency)
   - Monthly rent paid
   - Apartment furnished
   - Basic supplies purchased

2. Financial Support
   - Weekly allowance
   - Utilities paid
   - Phone bill paid

3. Life-Skills Training
   - Assessment of living skills
   - Chance to earn "nest egg"
   - Completed one-on-one visits

4. Emotional Support/Guidance
   - On-call 24 hours a day
   - Ongoing informal counseling
   - Bi-weekly meetings with social worker
• Crisis counseling
• Weekly support groups

5. Case Management/Planning
• Frequent meetings with referring agency caseworkers
• Referrals to community services-employment assistance
• Planning for termination

6. Outreach
• Year-round self-sufficiency workshops
• Foster parent training
• Training and consultation
• Training materials development

Group Format
• Independent Living Program-Lighthouse was not designed to be conducted in a group.
• Independent Living Program-Lighthouse has not been tested for use in a group setting.

Recommended Parameters
• Recommended intensity: An average of one face-to-face visit per week with the youth with phone contact in between visits.
• Recommended duration: Youth stay in the program for an average of 10.5 months. The length of the weekly face-to-face visit varies.

Homework
• Independent Living Program-Lighthouse includes a homework component.
• Description: The youth have 12 life skills packets to complete while in the program.

Delivery Setting
Independent Living Program-Lighthouse is typically conducted in: Not specified.

Parent Component
Independent Living Program-Lighthouse was not designed with a Parent Component.

Child Component
• Independent Living Program-Lighthouse was designed with a Child Component.
• Independent Living Program-Lighthouse addresses the following presenting problems and symptoms: Emancipating from the foster care system
• Age range(s): 16, 17, and 18
  o Independent Living Program-Lighthouse was not developed for children with developmental delays.
  o Independent Living Program-Lighthouse has not been tested for children with developmental delays.
**Racial/Ethnic Diversity**
- Independent Living Program-Lighthouse was not designed for specific racial/ethnic/cultural groups.
- Independent Living Program-Lighthouse was not tested in specific racial/ethnic/cultural groups.

**Education and Training Resources**
- There is not a manual that describes how to implement this program.
- There is training available for Independent Living Program-Lighthouse.
- Training contact: Mark J. Kroner, LISW, Lighthouse Youth Services, 513-487-7130
- Number of days/hours: Informal training/consultation is available to those who are interested.
- Training is obtained: Via phone consultation
- There currently are not additional qualified resources for training.

**Identified Resources Necessary to Implement Program**
The typical resources for implementing Independent Living Program-Lighthouse are:
- Apartments for youth, money (for rent, moving costs, deposits, etc.), phones, household furnishings, staff office, and insurance.

**Minimum Provider Qualifications**
Bachelor’s degree. Some are licensed social workers and a few have LISWs, which refers to a Master's of Social Work graduate who has passed an advanced licensing test.

**Relevant Research**

Non-randomized study which tracked youth leaving the child welfare system from foster homes, supervised Individual Learning Plans (ILPs), and the Lighthouse Youth Services' program of scattered-site apartments. The youth from the Lighthouse scattered-site apartments did better than the other two groups on a multiple-choice inventory used to gauge life-skills knowledge.

**References**


California application(s)
Independent Living Program-Lighthouse has not been implemented with fidelity in California.

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