NSW GOVERNMENT Family & Community Services

Review of the evidence for intensive family service models

Appendix 2: Intervention details

This review by the Parenting Research Centre and The University of Melbourne identifies interventions for improving outcomes for families with a range of identified vulnerabilities. The findings will help inform the service reformation process.

Report commissioned by the NSW Government Department of Family and Community Services

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Disclaimer

The Parenting Research Centre and The University of Melbourne do not endorse any particular intervention presented here. This review of the evidence drew largely on reliable secondary sources rather than primary sources of evidence. The searches were conducted in early 2015. Readers are advised to consider new evidence arising since the publication of this review when selecting and implementing interventions with vulnerable families.

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Contents

1. Well Supported

Please note: It is assumed that all dollars are given in US dollars. However, this was not clearly stated by the organisations.

1.1. Nurse-Family Partnership (NFP)

Nurse-Family Partnership (NFP)	
Intervention description	'The *Nurse-Family Partnership (NFP)* program provides home visits by registered nurses to first-time, low-income mothers, beginning during pregnancy and continuing through the child's second birthday.'
Population	'First-time, low-income mothers (no previous live births) For children/adolescents ages: 0 – 5 For parents/caregivers of children ages: 0 – 5'
Target outcomes	• Child development • Child behaviour • Safety and physical wellbeing • Child maltreatment • Family functioning • Support networks • Systems outcomes
Intervention details	• 'Clients: ▪ Voluntary ▪ First time mothers ▪ Low income ▪ Enrolled early in pregnancy • Intervention context:

Nurse-Family Partnership (NFP)	
	▪ Within a 1:1 therapeutic relationship ▪ Visits are in the clients home ▪ Visit schedule per guidelines and client's needs • Nurses and Supervisors: ▪ Complete all NFP core education • Application of the intervention: ▪ Nurses use their judgment to apply the *NFP* visit guidelines across 6 domains: o Personal Health o Environmental Health o Life Course Development o Maternal Role o Family and Friends o Health and Human Services ▪ Nurses apply the three theories through current strategies: o Self-Efficacy o Human Ecology o Attachment ▪ Nurses carry manageable caseloads, no more than 25 families • Reflection and Clinical Supervision: ▪ 1:1 weekly clinical supervision for each nurse with the nurse supervisor ▪ Case conferences are structure, at least 2 times a month ▪ Nurse supervisors conduct joint home visits with each nurse three times a year • Program Monitoring and Use of Data:

Nurse-Family Partnership (NFP)	
	▪ Nurses collect data as specified by the *Nurse-Family Partnership* National Service Office (NFP NSO), and all data is sent to the *NFP* NSO's national database called Efforts to Outcomes (ETO) ▪ ***NFP*** NSO reports data to agencies to assess and guide program implementation ▪ Agencies use these reports to monitor, identify and improve variances, and assure fidelity to the *NFP* model • Agency: ▪ Is networked with other services in the community ▪ Has community support for sustainability.' Components identified by PRC (Macvean *et. al.*, 2013) Delivery level : individual Delivery: • Service linkage • Individual plan • Family goals • Praise for parents • Structured sessions Content: • Parent mental and physical health • Child care skills/caregiving • Problem-solving skills • Life skills, continuity of life course: family economics, nutrition, education, employment, relationships
Delivery setting	• Birth Family Home

Nurse-Family Partnership (NFP)	
	• Community Agency
Dose	‘*Recommended Intensity:* Ideally, nurses begin 60-90 minute visits with pregnant mothers early in their pregnancy (about 16 week’s gestation). Registered nurses visit weekly for the first month after enrolment and then every other week until the baby is born. Visits are weekly for the first six weeks after the baby is born, and then every other week through the child's first birthday. Visits continue on an every-other-week basis until the baby is 20 months. The last four visits are monthly until the child is two years old. Nurses use their professional nursing judgment and increase or decrease the frequency and length of visits based on the client's needs. *Recommended Duration:* Clients are able to participate in the program for two-and-a-half years and the program is voluntary.’
Staffing	‘*Nurse home visitors*: Registered Nurse with a Bachelor's Degree in nursing, as a minimum qualification *Nurse Supervisor*: Registered Nurse with a Bachelor's Degree in nursing, as a minimum qualification, and a Master's Degree in Nursing preferred.’
Resources or supporting tools	‘The typical resources for implementing the program are: • Office space that facilitates confidentiality related to clients and health care records • Computer and telecommunication capabilities • Cell phones • 1 FTE Nurse Supervisor per 4 FTE nurse home visitors • 0.50 FTE clerical/data entry support for each 4-nurse team serving 100 families • Adequate travel expense reimbursement (mileage) for home visitors In addition, a community advisory board and strong, stable, and sustainable funding for agency operations is recommended.’
Cost information	‘Program Benefits (*per individual*): $27,174

Nurse-Family Partnership (NFP)	
	Program Costs (*per individual*): $9,842 Net Present Value (*Benefits minus Costs, per individual*): $17,332 Measured Risk (*odds of a positive Net Present Value*): 71%'
PRC rating	Well supported
Primary source	CEBC
Date last reviewed	June 2013

1.2. Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)	
Intervention description	'*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 hybrid treatment model 'that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles.'
Population	'Target Population: Children with a known trauma history 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. For children/adolescents ages: 3 – 18 For parents/caregivers of children ages: 3 – 18'
Target outcomes	• Child behaviour • Family functioning • Child development • Safety and physical wellbeing

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)	
	• Support networks
Intervention details	'The intervention includes: • 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: The child learns to understand the relationships between thoughts, feelings and behaviors and think in new and healthier ways. • T – Trauma narrative and processing: Gradual exposure exercises including verbal, written and/or symbolic recounting (i.e., utilizing dolls, art, puppets, etc.) of traumatic event(s) so the child learns to be able to discuss the events when they choose in ways that do not produce overwhelming emotions. Following the completion of the narrative, clients are supported in identifying, challenging and correcting cognitive distortions and dysfunctional beliefs. • 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, but maybe initiated earlier when children have significant behavior problems so parents can be coached in the use of behavior management skills. Sessions generally 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.'
Delivery setting	'This program is typically conducted in a(n): • Birth Family Home

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)	
	• Community Agency • Community Daily Living Settings • Outpatient Clinic • Residential Treatment Center’
Dose	‘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.’
Staffing	• ‘Master's degree and training in the treatment model. • Experience working with children and families. Training is obtained: National Conferences; CARES Institute, Allegheny General Hospital and onsite by request. Number of days/hours: Introductory Overview: 1–8 hours; Basic Training: 2–3 days; Ongoing Phone Consultation (twice monthly for 6-12 months): groups of 5-12 clinicians receive ongoing case consultation to implement TF-CBT for patients in their setting; Advanced Training: 1–3 days’
Resources or supporting tools	‘The typical resources for implementing the program are: • Private space to conduct sessions • Waiting area for children when parents are being seen • Therapeutic books and materials’
Cost information	No information available
PRC rating	Supported
Primary source	CEBC
Date last reviewed	March 2014

2. Supported

2.1. Attachment and Biobehavioral Catch-up (ABC)

Attachment and Biobehavioral Catch-up (ABC)	
Intervention description	‘*ABC* targets several key issues that have been identified as problematic among children who have experienced early maltreatment and/or disruptions in care. These young children often behave in ways that push caregivers away. The first intervention component helps caregivers to re-interpret children's behavioral signals so that they provide nurturance even when it is not elicited. Nurturance does not come naturally to many caregivers, but children who have experienced early adversity especially need nurturing care. Thus, the intervention helps caregivers provide nurturing care even if it does not come naturally. Second, many children who have experienced early adversity are dysregulated behaviorally and biologically. The second intervention component helps caregivers provide a responsive, predictable environment that enhances young children's behavioral and regulatory capabilities. The intervention helps caregivers follow their children’s lead with delight. The third intervention component helps caregivers decrease behaviors that could be overwhelming or frightening to a young child. Program Goals: The program goals of *Attachment and Biobehavioral Catch-up (ABC)* are: • Increase caregiver nurturance, sensitivity, and delight • Decrease caregiver frightening behaviors • Increase child attachment security and decrease disorganized attachment • Increase child behavioral and biological regulation’
Population	‘Caregivers of infants 6 months to 2 years old who have experienced early adversity, such as due to maltreatment or disruptions in care.’
Target outcomes	• Child behaviour • Child maltreatment prevention

Attachment and Biobehavioral Catch-up (ABC)	
	• Family functioning
Intervention details	‘Targets three key issues: ▪ Child behaves in ways that push caregiver away: The caregiver is helped to override tendencies to respond “in kind” and to provide nurturance regardless. ▪ Child is dysregulated at behavioral and biological levels: Caregiver is helped to provide environment that helps child develop regulatory capabilities. This includes parent following child's lead and showing delight in child. ▪ Caregiver is helped to decrease behaviors that may be frightening or overwhelming to the child. • While *ABC* is a manualized intervention that also incorporates video-feedback and homework, the most crucial aspect of the intervention is the parent coach’s use of “In the Moment”’ comments that target the caregiver behaviors of nurturance, following the lead, delight, and non-frightening behaviors. These are used throughout the home visiting session while working with the parent.’ Components identified by PRC (Macvean *et. al.*, 2013) Delivery level: Individual Delivery: • Structured sessions • Written material • Discussions • Feedback Content: • Child behaviour and behaviour management • Nurturance in response to child distress • Parent-child interactions • Predictable environment for child, explain rules/expectations/use of routines/ setting limits

Attachment and Biobehavioral Catch-up (ABC)	
Delivery setting	Adoptive Home Birth Family Home Foster/Kinship Care
Dose	‘Recommended Intensity: Weekly one-hour sessions Recommended Duration: 10 sessions’
Staffing	‘There is no educational level requirement for parent coaches. Potential parent coaches participate in a screening prior to training. If they pass the short screening, coaches attend a 2-3 day training and a year of supervision.’
Resources or supporting tools	‘A/V: Laptop computer Video camera Webcam for supervision Personnel: Clinician with excellent interpersonal skills Space: Must be conducted at caregivers’ homes; this can include shelters or other temporary living situations.’
Cost information	No information provided
PRC rating	Supported

Attachment and Biobehavioral Catch-up (ABC)	
Primary source	CEBC
Date last reviewed	September 2014

2.2. Be Proud! Be Responsible!

Be Proud! Be Responsible!	
Intervention description	'*Be Proud! Be Responsible!* is designed to decrease the frequency of risky sexual behavior and related HIV/STD infection among minority (African American, Latino) adolescents. Based on cognitive-behavior theory, the program uses group discussions, videos, games, brain-storming, experiential exercises, and skill-building activities to improve teens knowledge about HIV and STDs, and to increase self-efficacy and skills that might help to avoid risky sexual behavior (e.g., abstinence, condom use).'
Population	'Minority (mostly African American and Latinos) adolescents (age 11-19) of both genders. At risk teens living in low SES environments.'
Target outcomes	• Child behaviour • Safety and physical wellbeing
Intervention details	'Based on cognitive-behavior theory, the program uses group discussions, videos, games, brain-storming, experiential exercises, and skill-building activities to improve teens knowledge about HIV and STDs, and to increase self-efficacy and skills that might help to avoid risky sexual behavior (e.g., abstinence, condom use).'
Delivery setting	School
Dose	'The intervention includes six sessions, of 60-minute length. The program can be implemented in a six-day, two-day, or one-day format.'
Staffing	Teachers and school nurses
Resources or supporting tools	'*Be Proud! Be Responsible!* offers a two-day onsite training of educators, from 8:30-4:30, at an estimated $6,000 plus travel. Educators are trained to implement the curriculum with fidelity, model how to answer

Be Proud! Be Responsible!	
	sensitive questions, do some values clarifications, and make fidelity-based adaptations. Training also include practice in conducting the lessons. Training Certification Process: A 5-day train the trainer, offered on-site, for 8 trainees costs an estimated $25,000 plus travel. The five-day training includes fidelity monitoring, evaluation training, and training of facilitators. Participants who complete the training are certified to train others to be facilitators of the program.'
Cost information	Training '…estimated $6,000 plus travel.' 'Training certification process: A 5-day train the trainer, offered on-site, for 8 trainees costs an estimated $25,000 plus travel.'
PRC rating	Supported
Primary source	Blueprints
Date last reviewed	Date last reviewed not indicated but last study was dated 2009

2.3. Coping Power

Coping Power	
Intervention description	'*Coping Power* for parents and their at-risk children consists of two components (Parent Focus and Child Focus) designed to impact four variables that have been identified as predicting substance abuse (lack of social competence, poor self-regulation and self-control, poor bonding with school, and poor caregiver involvement with child). The program's Child component emphasizes problem-solving and conflict management techniques, coping mechanisms, positive social supports, and social skill development. The Parent component teaches parents skills to manage stress, identify disruptive child behaviours, effectively discipline and reward their children, establish effective communication structures, and manage child behaviour outside the home. *Coping Power* is a 16-month program delivered during the 5th and 6th grade school years. Children attend 22 group sessions in 5th grade and 12 group sessions in 6th grade. Groups are led by a school-family program specialist and a guidance counsellor. Children also receive half hour individual sessions once every two months. Parents attend 11 group sessions during their children's 5th grade year and 5 sessions during the 6th grade year.'

Coping Power	
	‘There is also a universal intervention, known as Coping with Middle School Transitions. This program consists of Parent Meetings and Teacher In-service Meetings. Three parent meetings are held during 5th grade and one parent meeting is held in 6th grade. Teachers participate in five 2-hour meetings during the 5th grade year. These two components are designed to promote home-school involvement, address parents' upcoming concerns about the transition to middle school, and address the four identified predictors of substance use.’ ‘A stand-alone universal version adapts the program for all elementary-school children. It uses 24 sessions, one each week, based on the child component of the program but with some changes in activities to encourage participation of all children in the classroom. A certified *Coping Power* Program psychologist and teacher deliver the intervention. The program does not include the parent component and makes changes to fit the whole classroom but otherwise is said to be essentially the same as the original.’
Population	For children aged 5 – 11 years at risk of substance abuse and their parents. ‘Parents and their at-risk children)’ Age: Late Childhood (5 – 11) – K/Elementary Gender: Male and Female Race/Ethnicity: All Race/Ethnicity
Target outcomes	• Child development • Child behaviour • Family functioning • Support networks
Intervention details	*Coping Power* for parents and at-risk children: ‘The program's Child component emphasizes problem-solving and conflict management techniques, coping mechanisms, positive social supports, and social skill development. The Parent component teaches parents skills to manage stress, identify disruptive child behaviours, effectively discipline and reward their children, establish effective communication structures, and manage child behaviour outside the home’ Universal intervention: as Coping with Middle School Transitions:

Coping Power	
	'…promote home-school involvement, address parents' upcoming concerns about the transition to middle school, and address the four identified predictors of substance use.' Stand-alone universal intervention: 'The program does not include the parent component and makes changes to fit the whole classroom but otherwise is said to be essentially the same as the original.'
Delivery setting	School
Dose	16-month program delivered during the 5th and 6th grade school years. 'Child - children attend 22 group sessions in 5th grade and 12 group sessions in 6th grade. Groups of 5-8 children meet for 40-50 minutes. Additionally, each student receives a half hour individual session once every two months.' 'Parent - The Parent component is delivered over the same 16-month period as the Child component. Groups of 12 or more parents meet in 16 sessions during their children's 5th grade year and 5 sessions during the 6th grade year.'
Staffing	School-family program specialist and a guidance counsellor. For the stand-alone universal intervention: 'A certified *Coping Power* Program psychologist and teacher deliver the intervention.'
Resources or supporting tools	'Training in the *Coping Power* Program is conducted in a workshop format and is generally completed over a 2 or 3 day period. Training includes hands-on opportunities for participants to learn and practice intervention techniques, as well as presentations, discussions, and videotape modeling on the intervention. The workshops also cover the developmental model upon which *Coping Power* is based and a review of empirical evidence supporting the program. Workshops are offered twice per year on the University of Alabama campus. The program will also arrange on-site trainings for interested agencies and school systems on an individual basis. Ongoing consultation and technical assistance can be arranged as needed.'
Cost information	'Initial Training and Technical Assistance: In-person training is available at the implementation site and at the University of Alabama campus at a cost for a 2-day training for up to 30 participants starting at $1,500. Additional costs may be incurred for more extensive planning and preparation, to be determined based on the individual needs of the group to be trained. Travel for the trainees or trainers would be an extra expense.

Coping Power	
	Additional training days can be added based upon the experience of trainees. Web-based training is also available. Curriculum and Materials: • Child Group Facilitator's Guide: $59.95 • Parent Group Facilitator's Guide: $47.95 • Child Group Workbooks (pack of 8): $67.50 • Parent Group Workbooks (pack of 8): $98.50 Licensing: none. Intervention Implementation costs: Ongoing Curriculum and Materials: Each parent-child pair needs a set of workbooks that cost $20.75 per set. In addition, it is estimated that each student will need materials costing $53. These include things like prizes, puppets, dominoes, etc. Staffing: Two facilitators are required for groups of six parent-child pairs. One should be a master's degree or Ph.D. clinician. A co-facilitator is often at a bachelor's level. Although the developers calculate costs on an hourly basis, typically *Coping Power* would be implemented by staff already employed by the sponsor organization. Since the program has been most often implemented in schools, qualified guidance staff, perhaps paired with teachers as co-leaders, could conduct the groups. *Coping Power* can also be provided in community agencies and outpatient mental health centers, again likely using existing qualified staff. Groups meet for one hour (child) and 90 minutes (parents). In addition, there is preparation and documentation time needed. This requires 1-2 hours for each group session. Other Implementation costs: Some programs include home visits by clinicians to recruit participants. These visits could represent an additional cost. Implementation Support and Fidelity Monitoring Costs: Ongoing Training and Technical Assistance: After the initial training, *Coping Power* training staff provides ongoing consultation, typically through twice-monthly, one-hour conference calls at $100 per hour. The cost of this TA is estimated to be $283 per parent-child pair. Fidelity Monitoring and Evaluation: *Coping Power* staff are available to review for quality audio or video tapes of sessions at $100 per hour. This typically costs $150 per parent-child pair.

Coping Power	
	Ongoing License Fees: none. Other Cost Considerations: Using unlicensed facilitators would require supervision, possibly from an outside consultant charging fees for their time. Year One Cost Example: This cost example will include 15 teams of two facilitators each serving two groups of six parent-child pairs during Year One of implementation. Thus, 180 parent-student pairs will be served. It will be assumed that the facilitators are already employed by the sponsor organization and that no home visits would be made. On-site 2-day training for 30: $1,500 Trainer travel: $2,000 Facilitator Guides-30 sets: $5,400 Workbooks for 180 parent-child pairs: $3,735 Materials for each student: $9,540 Consultation from *Coping Power* @ $283/parent-child pair: $50,940 Quality monitoring of recordings @ $150/parent-child pair: $27,000 Total Year One Cost: $100,115 The cost per parent-child pair in Year One would be $556.’
PRC rating	Supported
Primary source	Blueprints
Date last reviewed	Date last reviewed not indicated but last cited paper is dated 2014

2.4. DARE to be You

DARE to be You	
Intervention description	‘*DARE to be You (DTBY)* is a multilevel prevention program aimed at high-risk families with children ages 2–5. The program is designed to lower children’s risk of future substance abuse and other high-risk activities by improving aspects of parenting that contribute to children’s resiliency. *DTBY* combines three supporting aspects—educational activities for children, strategies for the parents or teachers, and environmental structures—to enable program participants to learn and practice the desired skills. Originally, the community-based *DTBY* curriculum concentrated on youths, their parents, and community professionals. The training was aimed toward the multiagency community teams who provided services to youth. The parent training of the current *DTBY* program evolved from the community trainings. The objectives of the parent–child workshops include improving self-efficacy and self-esteem; increasing internal locus of control; enhancing decision-making skills through effective reasoning; mastering effective child-rearing strategies, particularly communication skills; learning effective stress management; learning developmental norms to reduce frustration with children’s behavior and increase empathy; and strengthening peer support. Families engage in parent-child workshops that focus on developing the parents' sense of competence and satisfaction with the parent role, providing knowledge of appropriate child management strategies, improving parents' and children's relationships with their families and peers, and contributing to child developmental advancement. *DTBY* seeks to improve parent and child protective factors by improving parents’ sense of competence and satisfaction with being parents, providing them with knowledge and understanding of a multilevel, primary prevention program that targets Native American, Hispanic, African American, and white parents and their preschool children.’
Population	High-risk families (including substance abuse and mental illness) with children 2 to 5 years old
Target outcomes	• Child development

DARE to be You	
	• Child behaviour • Family functioning • Support networks
Intervention details	‘Families engage in parent-child workshops that focus on developing the parents' sense of competence and satisfaction with the parent role, providing knowledge of appropriate child management strategies, improving parents' and children's relationships with their families and peers, and contributing to child developmental advancement.’ ‘The objectives of the parent–child workshops include: • improving self-efficacy and self-esteem; • increasing internal locus of control; • enhancing decision-making skills through effective reasoning; • mastering effective child-rearing strategies, particularly communication skills; • learning effective stress management; • learning developmental norms to reduce frustration with children’s behavior and increase empathy; • and strengthening peer support.’
Delivery setting	No information provided
Dose	‘Sessions are ideally given in 2½-hour increments over 10–12 weeks and include a 10- to 30-minute joint activity for parents and children to practice skills learned in the session. ‘ ‘After completing the program, parents are welcome to attend annual reinforcement workshops. These boosters are given with a minimum of two series of four 2-hour sessions and are designed to enhance skills learned without duplicating previous activities. The boosters are intended to foster supportive networks and to consolidate the skills gained from DTBY.’
Staffing	Multiagency community teams
Resources or supporting tools	‘The program includes a preschool activity book for children ages 2–5 and developmentally appropriate curricula for children in kindergarten through second grade, in grades 3–5, and in grades 6–8’

DARE to be You	
Cost information	• 'Implementation manuals: Included in cost of training; additional manuals are $65 each. • Activity kit for children's program: $225. • 20 hours of on-site training (includes evaluation manual with process and content instruments): $5,500 for up to 35 participants, plus travel expenses. • 20 hours of off-site training (includes evaluation manual with process and content instruments): $500 for the first participant, $250 for each additional participant from the same agency. • Phone or email consultation (up to three calls or emails): Free. • Additional technical assistance: $50 per hour.'
PRC rating	Supported
Primary source	SAMHSA
Date last reviewed	November 2006

2.5. Early Risers "Skills for Success"

Early Risers "Skills for Success"	
Intervention description	'*Early Risers "Skills for Success*" is a developmentally focused, competency-enhancement program that targets 6- to 12-year-old elementary school students who are at high risk for early development of conduct problems, including substance use (who display early aggressive, disruptive, or nonconformist behaviors). *Early Risers* is based on the premise that early, comprehensive, and sustained intervention is necessary to target multiple risk and protective factors. The program uses integrated child-, school-, and family-focused interventions, coordinated by a family advocate, to move high-risk children onto a more adaptive developmental pathway.'
Population	'6- to 12-year-old elementary school students who are at high risk for early development of conduct problems, including substance use'

Early Risers “Skills for Success”	
Target outcomes	• Child behaviour • Family functioning • Support networks • Systems outcomes
Intervention details	Child-focused component: ‘The child-focused component has three parts: summer camp, school year friendship groups, and school support. The summer camp consists of 24 hours each of social-emotional skills training, reading enrichment and motivation, and creative activities, all supported by behavioral management protocols to build and support social, emotional, problem-solving, and peer friendship skills. The social-emotional skills training is implemented using a program such as *Promoting Alternative THinking Strategies (PATHS), Second Step*, or *Incredible Years*, each of which was reviewed by NREPP separately. The school year friendship group is offered during or after school and promotes advancement and maintenance of skills learned over the summer. School support, which occurs throughout each school year during the school day, is intended to promote academic skill building, such as task organization and home-school communication, as well as to address children's behavior while in school, through case management, consultation, and mentoring activities.’ Family-focused component: ‘The family-focused component has two parts: family nights with parent education (called *Parents Excited About Kids, or PEAK*) and family support. At family nights, held in a center or school five times per year during the evening, children participate in fun activities while their parents meet in small groups for parenting-focused education and skills training. Family support involves the implementation of an individually designed case plan for each family to address its specific needs, strengths, and maladaptive patterns through goal setting, brief interventions, referrals to community supports, continuous monitoring, and, if indicated, more intensive and tailored parent skills training.’
Delivery setting	Child-focused – school and summer camp

Early Risers "Skills for Success"	
	Family-focused – school or a centre
Dose	Information not provided
Staffing	'The family advocate must have a bachelor's degree in child or family education and experience working with parents or children.'
Resources or supporting tools	Information not provided
Cost information	• '3-day, on-site training (includes implementation manual, curriculum with CD-ROM, fidelity checklists, and consultation and technical assistance on topics such as suggested outcome measures): $7,000 for up to 20 participants (includes travel expenses). • Social-emotional skills training curriculum: Varies, depending on program selected by implementer. • Phone and email consultation and technical assistance: Included in the cost of training for 1 year; fee based after the first year. • Phone and email support: Free. • On-site technical assistance: Varies depending on the assistance needed, plus travel expenses.'
PRC rating	Supported
Primary source	SAMHSA
Date last reviewed	July 2012

2.6. Healthy Families America (Home Visiting for Child Well-Being) (HFA)

Healthy Families America (Home Visiting for Child Well-Being) (HFA)	
Intervention description	'*HFA* is a home visiting program model designed to work with overburdened families who are at-risk for child abuse and neglect and other adverse childhood experiences. It is designed to work with families who may have histories of trauma, intimate partner violence, mental health issues, and/or substance abuse issues.

Healthy Families America (Home Visiting for Child Well-Being) (HFA)	
	HFA services are offered voluntarily, intensively, and over the long-term (3 to 5 years after the birth of the baby). The goals of *Healthy Families American (HFA)* are to: • Build and sustain community partnerships to systematically engage overburdened families in home visiting services prenatally or at birth. • Cultivate and strengthen nurturing parent-child relationships. • Promote healthy childhood growth and development. • Enhance family functioning by reducing risk and building protective factors.'
Population	'Families with children aged 0 – 5 years who are at-risk for child abuse and neglect. Families may be at risk due to substance abuse, mental illness, or parental history of abuse in childhood.'
Target outcomes	• Child development • Child behaviour • Safety and physical wellbeing • Maltreatment prevention • Family functioning • Support networks • Systems outcomes
Intervention details	'They can be broken into three broad areas: Service initiation, service content, and staff characteristics and supervision. Service Initiation: ▪ Initiate services prenatally or at birth. ▪ The screening and assessment should occur within two weeks after the birth of the baby. ▪ The first home visit should occur within three months after the birth of the baby – preferably prenatally. ▪ Administer a standardized (i.e., in a consistent way for all families) assessment

Healthy Families America (Home Visiting for Child Well-Being) (HFA)	
	▪ The Parent Survey (formerly the Kempe Family Stress Checklist) is conducted to identify the family strengths as well as family history and/or issues related to higher risk of child maltreatment and/or poor childhood outcomes. ▪ *HFA* staff must be well-trained in how to administer and score the assessment. ▪ Offer services voluntarily and use positive outreach efforts to build family trust. ▪ Services must be voluntary. ▪ Program staff must identify positive ways to establish a relationship with a family and keep families interested and connected over time because many participants are often reluctant to engage in services and may have difficulty building trusting relationships. Service Content: ▪ Offer services intensively with well-defined criteria for increasing or decreasing frequency of service and over the long-term. ▪ Services should be offered AT LEAST WEEKLY during the 1st six months after the birth of the baby. ▪ The family's progress is used for determining service intensity – as the family's confidence and self-sufficiency increases, the frequency of visits decrease. ▪ *HFA* offers services for a minimum of three years and up to five years after the birth of the baby. ▪ Provide services that are culturally sensitive. ▪ Ethnic, racial, language, demographic, and other cultural characteristics identified by the program must be taken into account in overseeing staff-family interactions. ▪ Staff receives training designed to increase understanding and sensitivity of the unique characteristics of the service population. ▪ The program analyzes the extent to which all aspects of its service delivery system (assessment, home visitation, and supervision) are culturally sensitive. ▪ Provide services that focus on supporting the parent as well as supporting parent-child interaction and child development. ▪ Home visiting staff discuss and review, in supervision and with families, issues identified in the initial assessment during the course of home visiting services. ▪ Program services to families are guided by the Individual Family Support Plan (IFSP).

Healthy Families America (Home Visiting for Child Well-Being) (HFA)	
	▪ The program promotes positive parent-child interaction, child development skills, and health and safety practices with families through the use of curriculum or other educational materials. ▪ The program monitors the development of participating infants and children with a standardized developmental screening, tracks children who are suspected of having a developmental delay, and follows through with appropriate referrals and follow-up. ▪ Link all families to a medical provider to assure optimal health and development (e.g., timely immunizations, well-child care, etc.) Depending on the family's needs, they may also be linked to additional services such as financial, food, and housing assistance programs, school readiness programs, child care, job training programs, family support centers, substance abuse treatment programs, and domestic violence shelters. ▪ Participating Target Children are linked to a medical/health care provider ▪ The program ensures immunizations are up-to-date for target children and provides information, referrals, and linkages to available health care resources for all participating family members. ▪ Families are connected to additional services in the community. ▪ Limit staff caseloads ▪ No more than 15 families who are currently being seen weekly ▪ No more than 25 families per caseload Staff Characteristics: ▪ Select service providers based on their personal characteristics (i.e., non-judgmental, compassionate, ability to establish a trusting relationship, etc.), their willingness to work in or their experience working with culturally diverse communities, and their skills to do the job. Service providers have a framework, based on education or experience, for handling the variety of situations they may encounter when working with at-risk families. ▪ Provide basic training for service providers in areas such as cultural competency, substance abuse, reporting child abuse, domestic violence, drug-exposed infants, and services in their community. ▪ All staff must receive Orientation training prior to working with families. ▪ All staff must receive training in Wraparound topics within 6 months and 12 months of hire (distance learning modules and/or in person). ▪ Provide intensive training to Service providers specific to their role.

Healthy Families America (Home Visiting for Child Well-Being) (HFA)	
	▪ All staff must receive in-person Core Training in either Parent Survey (Assessment) or Integrated Strategies (Home Visitors) within six months of hire. ▪ Supervisors also receive in-person training based on the track (assessment or home visiting) they supervise and administrative, clinical, and reflective practice training within six months of hire. ▪ Provide ongoing, effective, accountable, clinical, and reflective supervision to all service providers. ▪ Direct service providers must receive weekly, individualized supervision. ▪ Full-time supervisors are to have 6 or fewer direct services staff. ▪ Direct service staff must receive skill development and professional support and be held accountable for the quality of their work. ▪ Supervisors and Program Managers are also held accountable for the quality of their work and provided with skill development and professional support. ▪ Additionally, it is very important that materials be presented in a lower grade level of reading, typically 5th grade or lower.'
Delivery setting	Birth Family Home
Dose	'Recommended Intensity: Families are to be offered weekly home visits for a minimum of six months after the birth of the baby. Home visits typically run 50-60 minutes. Upon meeting the defined criteria for family functioning, visit frequency is reduced to biweekly visits, monthly visits, and quarterly visits and services are tapered off over time. Typically, during pregnancy, families receive 2-4 visits per month. During times of crisis, families may be seen 2 or more times in a week. Recommended Duration: Services are offered prenatally or at birth until the child is at least three years of age and can be offered until he/she is five years of age.'
Staffing	'Program staff is selected because of a combination of personal characteristics, experiential, and educational qualifications. Direct Service Staff should have qualifications including, but not limited to: • Experience in working with or providing services to children and families.

Healthy Families America (Home Visiting for Child Well-Being) (HFA)	
	• An ability to establish trusting relationships. • Acceptance of individual differences. • Experience and willingness to work with the culturally diverse populations that are present among the program's target population. • Knowledge of infant and child development. Supervisors should have qualifications including, but not limited to: • A solid understanding of and experience in supervising and motivating staff, as well as providing support to staff in stressful work environments. • Knowledge of infant and child development and parent-child attachment. • Experience with family services that embrace the concepts of family-centered and strength-based service provision. • Knowledge of maternal-infant health and dynamics of child abuse and neglect. • Experience in providing services to culturally diverse communities/families. • Experience in home visitation with a strong background in prevention services to the 0-3 age population. • Bachelor's degree in human services or related field required (Master's degree preferred). Program managers should have qualifications including, but not limited to: • A solid understanding of and experience in managing staff. • Administrative experience in human service or related program(s), including experience in quality assurance/improvement and program development. • A bachelor's degree in human services administration or related field required (Master's degree preferred).'
Resources or supporting tools	'The typical resources for implementing the program are: • A host agency or a collaboration of host agencies that provide office space with confidentiality related to participant files/records • Computer and email

Healthy Families America (Home Visiting for Child Well-Being) (HFA)	
	• Data or tracking system • Cell phones • Program Manager • 1 FTE Supervisor per 5-6 FTE home visitors • 1 FTE Supervisor per 5-6 FTE assessment staff • Travel expense reimbursement (mileage) for home visitors • A community advisory board • Diversified, and sustainable funding.'
Cost information	No information provided
PRC rating	Supported
Primary source	CEBC
Date last reviewed	June 2014

2.7. Incredible Years (IY)

Incredible Years (IY)	
Intervention description	'The Incredible Years is a series of three separate, multifaceted, and developmentally based curricula for parents, teachers, and children. This series is designed to promote emotional and social competence; and to prevent, reduce, and treat behavior and emotional problems in young children. The parent, teacher, and child programs can be used separately or in combination. There are treatment versions of the parent and child programs as well as prevention versions for high-risk populations.'
Population	Families with children aged 4-8 years with behavior or conduct problems. Also used with children at high risk. 'Parents, teachers, and children

Incredible Years (IY)	
	For children/adolescents ages: 4 – 8 For parents/caregivers of children ages: 4 – 8’
Target outcomes	• Child development • Child behaviour • Family functioning • Support networks
Intervention details	• ‘The Incredible Years BASIC Parent Training Program targets parents of high-risk children and those displaying behavior problems. Highlighted parenting skills include: ▪ How to build strong relationships with children through child-directed play interactions ▪ How to be a social, emotional and academic coach for children ▪ How to provide praise and incentives to build social and academic competency ▪ How to set limits and establish household rules ▪ How to handle misbehavior • The Incredible Years ADVANCE Parent Training Program addresses interpersonal skills such as: ▪ How to effectively communicate with your children and other adults ▪ How to handle stress, anger and depression management issues ▪ How to problem solve between adults ▪ How to help children learn to problem solve ▪ How to provide and receive support • The Incredible Years Child Training Program (Dina Dinosaur Social Skills and Problem-Solving Curriculum) - The Child Training program promotes social competency and reduces conduct problems. Children are trained in four areas: ▪ Emotion Management o How to talk about feelings

Incredible Years (IY)	
	○ How to understand and detect feelings in others ○ How to self-regulate and manage upsetting feelings ▪ Social Skills ○ How to talk to and make friends ○ How to work in teams ○ How to cooperate and help others ○ How to effectively communicate ○ How to follow rules ○ How to play with others and enter into groups ▪ Problem Solving ○ How to deal with anger ○ How to solve problems step-by-step ○ How to be friendly ▪ Classroom Behavior ○ How to listen ○ How to follow school rules ○ How to stop-look-think-check’
Delivery setting	• Birth Family Home • Community Agency • Community Daily Living Settings • Foster/Kinship Care • Hospital • Outpatient Clinic • Religious Organization

Incredible Years (IY)	
	• School • Workplace • Pediatric Primary Care Setting
Dose	'Recommended Intensity: One two-hour session per week. Classroom program offered 2-3 times weekly for 60 lessons. Teacher sessions can be completed in 5-6 full-day workshops or 18-21 two-hour sessions. Recommended Duration: The Basic Parent Training Program is 14 weeks for prevention populations, and 18 - 20 weeks for treatment. The Child Training Program is 18-22 weeks. For treatment version, the Advance Parent Program is recommended as a supplemental program. Basic plus Advance takes 26-30 weeks. The Child Prevention Program is 20 to 30 weeks and may be spaced over two years. The Teachers Program is 5 to 6 full-day workshops spaced over 6 to 8 months.'
Staffing	Master's level (or equivalent) clinicians
Resources or supporting tools	• TV/DVD or Computer with projector • Room for 16 people • Two group leaders for the group, etc.
Cost information	No information available
PRC rating	Supported
Primary source	Primary Source CEBC
Date last reviewed	June2013

2.8. Multidimensional Family Therapy (MDFT)

Multidimensional Family Therapy (MDFT)	
Intervention description	‘MDFT is a family-based treatment system for adolescent substance use, delinquency, and related behavioral and emotional problems. Therapists work simultaneously in four interdependent domains: the adolescent, parent, family, and community. Once a therapeutic alliance is established and youth and parent motivation is enhanced, the MDFT therapist focuses on facilitating behavioral and interactional change. The final stage of MDFT works to solidify behavioral and relational changes and launch the family successfully so that treatment gains are maintained.’ ‘ The goals of Multidimensional Family Therapy (MDFT) are split into four domains: • Adolescent Domain: ▪ Address identity formation, improve self-awareness, and enhance self-worth and confidence ▪ Develop meaningful short-term and long-term life goals ▪ Improve emotional regulation, coping, and problem solving skills ▪ Improve expressive and communication skills ▪ Promote success in school/work ▪ Promote pro-social peer relations and activities ▪ Reduce drug use and problem behaviors ▪ Improve and stabilize mental health problems • Parent Domain: ▪ Strengthen parental teamwork ▪ Improve parenting skills & practices ▪ Rebuild emotional bonds with teen ▪ Enhance parents individual functioning • Family Domain:

Multidimensional Family Therapy (MDFT)	
	▪ Improve family communication and problem solving skills ▪ Strengthen emotional attachments and feelings of love and connection among family members ▪ Improve everyday functioning of the family unit • Community Domain: ▪ Improve family member's functional relationships with social systems such as school, court, legal system, child welfare workplace, and neighborhood Build family member capacity to actively reach out to access and actualize needed resources necessary for stress reduction or daily life needs'
Population	'Target Population: Adolescents 11 to 18 with the following symptoms or problems: substance abuse or at risk, delinquent/conduct disorder, school and other behavioral problems, and both internalizing and externalizing symptoms For children/adolescents ages: 11 – 18 For parents/caregivers of children ages: 11 – 18'
Target outcomes	• Child development • Child behaviour • Family functioning • Support networks • Systems outcomes
Intervention details	• 'Being an integrated family therapy approach that attempts to improve: ▪ Parenting practices ▪ Family problem solving skills ▪ Parental teamwork ▪ Parent functioning by motivating them to obtain substance abuse or mental health treatment for themselves, if needed. ▪ Adolescent communication, emotion regulation and coping skills

Multidimensional Family Therapy (MDFT)	
	▪ Adolescent functioning by reducing substance use and delinquency, and improving school bonding and performance, and family relationships. • Emphasizing parental self-care throughout treatment to ensure that parents are maximally available to and effective with their teens • Following these intervention parameters: ▪ Number of sessions per week: 1-3 with an average of 2 ▪ Length of treatment: 3-6 months ▪ A mix of individual youth, parent, and family sessions of approximately 40% youth, 20% parent, and 40% family ▪ Use of telephone calls with youth and family in between face-to-face sessions ▪ Community sessions with school, juvenile justice, child welfare, etc. ▪ MDFT has specific clinical supervision protocols; each therapist receives: o Weekly case review supervision o Either DVD/video or live supervision each month ▪ Case and supervision information entered into in the web-based MDFT Clinical Portal by MDFT therapists and supervisors which facilitates adherence to the approach ▪ In programs serving youth and families with few resources and high need, a therapist assistant/family advocate an added benefit to the MDFT program; works to reduce barrier to treatment participation and facilitate access to community resources'
Delivery setting	• Adoptive Home • Birth Family Home • Community Agency • Day Treatment Program • Foster/Kinship Care • Hospital • Residential Care Facility

Multidimensional Family Therapy (MDFT)	
	• School • Juvenile detention facility
Dose	‘Recommended Intensity: For at-risk and early intervention, therapists typically provide 1-2 sessions per week, with sessions lasting between 45 and 90 minutes. More severe cases will require sessions 1- 3 times per week (average of 2) with each session lasting 45-90 minutes. For all cases, the dose titrates down as the treatment progresses. The dose is more intense in the first third of treatment and is gradually reduced to 1 session per week during the last 4-6 weeks. Recommended Duration: 3-4 months for at-risk and early intervention youth and families. 5-6 months for youth with a substance abuse and/or conduct disorder diagnosis.’
Staffing	‘Therapists must have Master's Degree in counseling, mental health, family therapy, social work, or a related discipline. Therapist assistants can have a Bachelor's Degree or relevant experience.’
Resources or supporting tools	‘The typical resources for implementing the program are: • Clinic treatment rooms large enough to accommodate a family • Cell phones for therapists, case managers/therapist assistants, and supervisors to call each other and clients. • Equipment to record therapy session for supervision (DVD, videotape), and equipment to play back sessions for supervision. • Capacity to conduct live supervision sessions. • If serving a drug-using or high-risk population, funds to pay for instant urine screen testing that is incorporated into ongoing treatment.’
Cost information	Information not available
PRC rating	Supported

Multidimensional Family Therapy (MDFT)	
Primary source	CEBC
Date last reviewed	May 2014

2.9. Multisystemic Therapy (MST)

Multisystemic Therapy (MST)	
Intervention description	'*Multisystemic Therapy (MST*) is an intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues and their families. The primary goals of *MST* are to decrease youth criminal behavior and out-of-home placements. Critical features of *MST* include: (a) integration of empirically based treatment approaches to address a comprehensive range of risk factors across family, peer, school, and community contexts; (b) promotion of behavior change in the youth's natural environment, with the overriding goal of empowering caregivers; and (c) rigorous quality assurance mechanisms that focus on achieving outcomes through maintaining treatment fidelity and developing strategies to overcome barriers to behavior change.'
Population	'Target Population: Youth, 12 to 17 years old, with possible substance abuse issues who are at risk of out-of-home placement due to antisocial or delinquent behaviors and/or youth involved with the juvenile justice system. For children/adolescents ages: 12 – 17 For parents/caregivers of children ages: 12 – 17'
Target outcomes	• Child behaviour • Family functioning • Support networks • Systems outcomes
Intervention details	'Delinquent or antisocial youth who are 12 to 17 years old and may also meet the following criteria: • Youth at Imminent risk of out-of-home placement due to criminal offenses

Multisystemic Therapy (MST)	
	• Physical aggression at home, at school, or in the community • Verbal aggression, verbal threats of harm to others • Substance abuse in the context of problems listed above Programs will need to exclude: • Youth living independently or youth for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends, and other potential surrogate caregivers • Youth referred primarily due to concerns related to suicidal, homicidal, or psychotic behaviors • Youth referred primarily for problem sexual behavior. *MST*–Problem Sexual Behavior (*MST-PSB*), however, is an adaptation of *MST* that is available for youth with externalizing, delinquent behaviors, including aggressive (e.g., sexual assault, rape) and non-aggressive (e.g., molestation of younger children) sexual offenses • Youth with pervasive developmental delays Intervention Context: • Services are provided in the family's home or other places convenient to them and at times convenient to the family. • Services are intensive, with intervention sessions being conducted from once per week to daily. • A 24 hour/7 day/week on-call schedule is utilized to provide round-the-clock availability of clinical services for families. Therapists and Supervisors: • *MST* staff members work on a clinical team of 2-4 therapists and a supervisor. • *MST* therapists are Masters-prepared (clinical-degreed) professionals. • *MST* clinical supervisors must be at least 50% part-time and may supervise 1-2 teams only. • *MST* clinical supervisors are, at minimum, highly skilled Master's-prepared clinicians with training in behavioral and cognitive behavioral therapies and pragmatic family therapies (e.g., Structural Family Therapy and Strategic Family Therapy). Application of the Intervention:

Multisystemic Therapy (MST)	
	• Interventions are developed using an analytical model that guides the therapist to assess factors that are driving the key clinical problems, and then in designing interventions that are applied to these driving factors or "fit factors." • All intervention techniques are evidence-based or evidence-informed. • Each therapist carries a maximum caseload of 6 families and case length ranges from 3 to 5 months. Clinical Supervision: • The *MST* clinical supervisor conducts on-site weekly team clinical supervision, facilitates the weekly *MST* telephone consultation, and is available for individual clinical supervision for crises. Program Monitoring and Use of Data: • Agencies collect data as specified by *MST* Services, and all data are sent to the *MST* Institute (MSTI) which is charged with keeping the national database system. • MSTI data reports are used to assess and guide program implementation. • Agencies use these reports to monitor and assure fidelity to the *MST* model. Agency: • The agency must have community support for sustainability. • With the buy-in of other organizations and agencies, *MST* is able to "take the lead" for clinical decision-making on each case. • Stakeholders in the overall *MST* program have responsibility for initiating these collaborative relationships with other organizations and agencies while *MST* staff sustain them through ongoing, case-specific collaboration.'
Delivery setting	• Adoptive Home • Birth Family Home • Foster/Kinship Care • School
Dose	'Recommended Intensity:

Multisystemic Therapy (MST)	
	Services are intensive, with intervention sessions being conducted from three times per week to daily. However, there is no expectation on a specific number of contact hours as staff contact is based on the clinical needs of the families. Session length also depends on the treatment needs of the family and may range from 50 minutes to 2 hours. Multiple types of sessions may be conducted in one day (e.g., parental drug screening and session; family communication and problem solving). Recommended Duration: 3-5 months'
Staffing	• 'The supervisor must have an understanding of the Juvenile Justice System, and experience with family therapy and cognitive-behavioral therapy. The supervisor must have experience in managing severe family crises that involve safety risk to the family. • Supervisors are, at minimum, highly skilled Master's-prepared clinicians with training in behavioral and cognitive behavioral therapies and pragmatic family therapies (i.e., Structural Family Therapy and Strategic Family Therapy). • At least 66% of the therapists must have a Master's degree in counselling or social work.'
Resources or supporting tools	'Office space to house the team and conduct consultation and supervision is required as well as laptops and cell phones for all staff.'
Cost information	Information not available
PRC rating	Supported
Primary source	CEBC
Date last reviewed	June 2013

2.10. Multisystemic Therapy for Youth with Problem Sexual Behaviours (MST-PSB)

Multisystemic Therapy for Youth **w**ith Problem Sexual Behaviors (MST-PSB)	
Intervention description	‘*Multisystemic Therapy for Youth With Problem Sexual Behaviors (MST-PSB)* is a clinical adaptation of *Multisystemic Therapy (MST)* that is specifically targeted to adolescents who have committed sexual offenses and demonstrated other problem behaviors. *MST-PSB* is suitable for use with male and female youth, although the youth included in the studies reviewed for this summary were primarily male. The primary objectives of *MST-PSB* are to decrease problem sexual and other antisocial behaviors and out-of-home placements. Based in principle on an ecological model, the intervention is directed at youth and their families, with the collaboration of community-based resources such as case workers, probation/parole officers, and school professionals. Services to youth include a functional assessment in the context of their families, school, community, and social networks and a subsequent treatment plan including individual therapeutic sessions. The specific treatments provided depend on the factors driving the youth's behavior but typically address deficits in overall family relations and the youth's cognitive processes, peer relations, and school performance. Parents participate in family therapy, gain skills to provide guidance to youth, and are encouraged to develop social support networks. *MST-PSB* is delivered in the youth's natural environment (i.e., home, school, community) by master's-level therapists trained in a clinical area of the human service field. Each therapist provides approximately 5 to 7 months of intensive services to three to five families at a time. Many families require two to four sessions per week during the most active parts of treatment, with some families requiring a higher frequency of sessions based upon clinical need.’ Outcomes addressed: • ‘Problem sexual behaviour • Incarceration and other out-of-home placement • Delinquent activities other than problem sexual behaviors • Mental health symptoms • Family and peer relations • Substance use’

Multisystemic Therapy for Youth **w**ith Problem Sexual Behaviors (MST-PSB)	
Population	'Adolescents aged 13-17 who have committed sexual offenses and demonstrated other problem behaviors'
Target outcomes	• Child behaviour • Family functioning • Support networks • Systems outcomes
Intervention details	'*MST for Problem Sexual Behavior (MST-PSB)* is an adaptation of *MST* that was developed for 10- to 17.5-year-old youth with sexually related externalizing delinquent behaviors, including aggressive (e.g., sexual assault, rape) and non-aggressive (e.g., molestation of younger children) sexual offenses. Youth may also exhibit the following characteristics: • At imminent risk of out-of-home placement due to criminal offenses. • Physical aggression at home or school or in the community. • Verbal aggression and threats of harm to others. • Substance abuse in the context of the problems listed above. Programs will need to exclude: • Youth living independently or youth for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends, and other potential surrogate caregivers. • Youth referred primarily due to concerns related to suicidal, homicidal, or psychotic behaviors. • Youth with pervasive developmental delays.' 'Services to youth include a functional assessment in the context of their families, school, community, and social networks and a subsequent treatment plan including individual therapeutic sessions. The specific treatments provided depend on the factors driving the youth's behavior but typically address deficits in overall family relations and the youth's cognitive processes, peer relations, and school performance. Parents participate in family therapy, gain skills to provide guidance to youth, and are encouraged to develop social support networks.'

Multisystemic Therapy for Youth **w**ith Problem Sexual Behaviors (MST-PSB)	
	'Intervention Context: • Services are provided in the family's home or other convenient places and at times convenient to the family. • Services are intensive, with intervention sessions conducted from once a week to every day. • A 24 hour/7 day per week on-call schedule is utilized to provide round-the-clock availability of clinical services for families. Therapists and Supervisors: • *MST-PSB* staff members work on a clinical team of 2-4 therapists and a supervisor. • *MST-PSB* therapists are Master's-prepared (clinical-degreed) professionals. • *MST-PSB* clinical supervisors must be allocate at least 50% of their time to each *MST-PSB* team and may supervise 1-2 teams only. • *MST-PSB* clinical supervisors are, at minimum, highly skilled Master's-prepared clinicians with training in behavioral and cognitive-behavioral therapies and pragmatic family therapies (i.e., Structural Family Therapy and Strategic Family Therapy). Application of the Intervention: • Interventions are developed using an analytical model that guides the therapist to assess factors that are driving the key clinical problems, and then in designing interventions that are applied to these driving factors or "fit factors." • Each therapist carries a maximum caseload of 4 families and case length ranges from 5 to 7 months. Clinical Supervision: • The *MST-PSB* clinical supervisor conducts on-site weekly team clinical supervision, facilitates the weekly *MST-PSB* telephone consultation, and is available for individual clinical supervision for crises. Program Monitoring and Use of Data:

Multisystemic Therapy for Youth **w**ith Problem Sexual Behaviors (MST-PSB)	
	• Agencies collect data as specified by MST Services/MST Associates, and all data are sent to the MST Institute (MSTI), which is charged with keeping the national database system • MSTI data reports are used to assess and guide program implementation. • Agencies use these reports to monitor and assure fidelity to the *MST-PSB* model. Agency: • The agency must have community support for sustainability. • With the buy-in of other organizations and agencies, *MST-PSB* staff is able to "take the lead" for clinical decision-making on each case. • Stakeholders in the overall *MST-PSB* program have responsibility for initiating these collaborative relationships with other organizations and agencies while *MST-PSB* staff sustains them through ongoing, case-specific collaboration.' (CEBC)
Delivery setting	'*MST-PSB* is delivered in the youth's natural environment (i.e., home, school, community)'
Dose	'Therapists provide 5 to 7 months of intensive services to three to five families at a time. Many families require two to four sessions per week during the most active parts of treatment, with some families requiring a higher frequency of sessions based upon clinical need.'
Staffing	Delivered 'by master's-level therapists trained in a clinical area of the human service field.'
Resources or supporting tools	'Office space to house the team and conduct consultation and supervision is required. All team members must also have cell phones and access to computers. Each team must have at least one video camera (for training and quality assurance purposes).' (CEBC)
Cost information	• 'Implementation materials and licensing fees: $4,000 per site and $2,500 per team. • Start-up support, site assessment, and all system consultation (includes 2-day, on-site orientation training): $11,000 plus travel expenses. • Ongoing support (includes quarterly on-site booster training): $38,000 per year plus travel expenses. • Quality assurance data collection support: $10,800 per team.'

Multisystemic Therapy for Youth **w**ith Problem Sexual Behaviors (MST-PSB)	
PRC rating	Supported
Primary source	SAMHSA
Date last reviewed	December 2009

2.11. Oregon Model, Parent Management Training (PMTO)

Oregon Model, Parent Management Training (PMTO***)***	
Intervention description	'*PMTO* refers to a set of parent training interventions developed over forty years, originating with the theoretical work, basic research, and intervention development of Gerald Patterson and colleagues at Oregon Social Learning Center. *PMTO* can be used in family contexts including two biological parents, single-parent, re-partnered, grandparent led, and foster families. *PMTO* can be used as a preventative program and a treatment program. It can be delivered in many formats, including parent groups, individual family treatment, books, audiotapes and video recordings. *PMTO* interventions have been tailored for specific clinical problems, such as antisocial behavior, conduct problems, theft, delinquency, substance abuse, and child neglect and abuse. The goals of *PMTO* include: • Improving parenting practices • Reducing family coercion • Reducing and preventing internalizing and externalizing behaviors in youth • Reducing and preventing substance use and abuse in youth • Reducing and preventing delinquency and police arrests in youth • Reducing and preventing out-of-home placements in youth • Reducing and preventing deviant peer association in youth • Increasing academic performance in youth • Increasing social competency in youth

Oregon Model, Parent Management Training (PMTO)	
	• Increasing peer relations in youth'
Population	'Parents of children 2-18 years of age with disruptive behaviors. Versions adapted for children with conduct disorder, delinquency, substance abuse, and child neglect and abuse.'
Target outcomes	• Child behaviour • Maltreatment prevention • Family functioning • Support networks • Systems outcomes
Intervention details	'Parents being the focus of the *PMTO* intervention because they are the presumed agents of change;, however, parents, focal youth, and the family should all benefit from the intervention Core components of *PMTO*: • Encouragement of positive behavior • Systematic, mild consequences for negative behavior • Monitoring • Problem-solving • Positive involvement Supporting components of *PMTO*: • Giving good directions • Observing and recording behavior • Identifying and regulating emotions • Fostering communication through cooperation • Promoting school success Important therapeutic strategies in *PMTO* focused on:

Oregon Model, Parent Management Training (PMTO)	
	• Supporting and encouraging the development of parenting skills • Helping to prevent and manage resistance to change • Using sophisticated clinical practices to build therapeutic alliance and provide a supportive environment for change • Providing active teaching that includes modelling, role play and other experiential exercises that provide opportunity for practice with coaching • Incorporating a problem solving process that focuses on specifying future-oriented goals • Placing an emphasis on eliciting goal behavior from parents rather than direct teaching • When administered in parent groups, the recommended group size is 12-15 participants'
Delivery setting	• Adoptive Home • Birth Family Home • Community Agency • Community Daily Living Settings • Foster/Kinship Care • Outpatient Clinic
Dose	'Recommended Intensity: 1.5 to 2-hour weekly parent group sessions and 60-minute weekly individual/family sessions Recommended Duration: 14 group sessions and 20-25 individual/family sessions, depending on severity; individual family treatment is not typically provided together with group treatment. The time frame can be 5-6 months or longer, depending on circumstances'
Staffing	'Bachelor's degree with 5 years appropriate clinical experience or Master's Degree in relevant field'
Resources or supporting tools	'All sessions are video recorded and uploaded to HIPAA-compliant website for coaching/supervision and certification. Thus, video recording equipment, computer, and high speed internet access are required.'

Oregon Model, Parent Management Training (PMTO)	
Cost information	Information not provided
PRC rating	Supported
Primary source	CEBC
Date last reviewed	April 2014

2.12. ParentCorps

ParentCorps	
Intervention description	'*ParentCorps* is a culturally informed, family-centered preventive intervention designed to foster healthy development and school success among young children (ages 3-6) in families living in low-income communities. *ParentCorps* helps parents promote their children's social, emotional, and self-regulatory skill development and effectively partner with early childhood educators to advance their children's behavioral and academic functioning, mental health, and physical development. The parent groups are facilitated by trained mental health professionals who present a specific set of parenting strategies: establishing structure and routines for children, providing opportunities for positive parent-child interactions during nondirective play, using positive reinforcement to encourage compliance and social and behavioral competence, selectively ignoring mild misbehaviors, and using effective forms of discipline for misbehavior (e.g., timeouts, loss of privileges). As part of the collaborative group process, facilitators help parents tailor and adopt strategies so they are meaningful and relevant given their family's cultural background, values, and goals. Participants are introduced to the parenting strategies through group discussions, role-plays, an animated video series portraying a day in the life of families from one community, and a photography-based book of *ParentCorps* family stories and homework. In a manner that is sensitive to and respectful of the parents' readiness for change, facilitators' help parents anticipate barriers and generate solutions so that families can successfully implement the strategies. Parents share their progress and experiences as they attempt the new parenting strategies at home, and they engage in open discussions about the difficulties of parenting under stressful conditions. These group experiences create a sense of belonging to a community of parents working together toward shared goals for their children. The child groups are led by trained classroom teachers who promote social, emotional, and self-regulatory skills through interactive lessons, experiential activities, and play. In support of the individualized goals that

ParentCorps	
	parents set for their children, the teachers promote skills and shape behaviors using strategies that complement the parenting strategies being introduced to parents. Additionally, the teachers communicate with parents after each session to provide feedback regarding the child's progress in skill development and goal attainment. ‘
Population	‘Young children (ages 3-6) in families living in low-income communities.’
Target outcomes	• Child development • Child behaviour • Family functioning
Intervention details	Parent groups: • ‘Establishing structure and routines for children, • providing opportunities for positive parent-child interactions during nondirective play, • using positive reinforcement to encourage compliance and social and behavioral competence, • selectively ignoring mild misbehaviors, and using effective forms of discipline for misbehavior (e.g., timeouts, loss of privileges). • … facilitators help parents tailor and adopt strategies so they are meaningful and relevant given their family's cultural background, values, and goals. • Participants are introduced to the parenting strategies through group discussions, role-plays, an animated video series portraying a day in the life of families from one community, and a photography-based book of *ParentCorps* family stories and homework. • …facilitators help parents anticipate barriers and generate solutions so that families can successfully implement the strategies. • Parents share their progress and experiences as they attempt the new parenting strategies at home, and they engage in open discussions about the difficulties of parenting under stressful conditions.’ Child groups:

ParentCorps	
	• Promotion of: 'social, emotional, and self-regulatory skills through interactive lessons, experiential activities, and play. • …teachers promote skills and shape behaviors using strategies that complement the parenting strategies being introduced to parents. • … teachers communicate with parents after each session to provide feedback regarding the child's progress in skill development and goal attainment. '
Delivery setting	School Other community settings - early childhood education or child care settings
Dose	Fourteen weekly 2-hour group sessions, which occur concurrently for parents and children. Groups include approximately 15 participants
Staffing	Trained mental health professionals The child groups are led by trained classroom teachers
Resources or supporting tools	• '*ParentCorps* training and start-up materials (includes leader's manuals and resource guides for use with the child and parent groups; props, puppet, and music CD for use with the child group; and DVD for use with the parent group). • Family group materials (includes parent workbooks, parent toolkit, and wordless picture book).'
Cost information	• '*ParentCorps* training and start-up materials (includes leader's manuals and resource guides for use with the child and parent groups; props, puppet, and music CD for use with the child group; and DVD for use with the parent group): $2,000 (for up to 4 child group leaders and 1 parent group leader). • Family group materials (includes parent workbooks, parent toolkit, and wordless picture book): $30 per family. • *ParentCorps* 101: Web-based training: $50 per user. • 5-day training at New York University: $5,000 per site (for up to 4 participants). • 2-day, on-site consultation: $5,000 plus travel expenses. • Group leader coaching (14 hours during the first cycle of implementation): $2,000.

ParentCorps	
	• Phone and email support: $150 per hour. • Technical support for *ParentCorps* 101: Included in cost of Web-based training. • Quality assurance measures: Included in cost of implementation materials.'
PRC rating	Supported
Primary source	SAMHSA
Date last reviewed	November 2011

2.13. Parent-Child Interaction Therapy (PCIT)

Parent-Child Interaction Therapy (PCIT)	
Intervention description	'*Parent-Child Interaction Therapy (PCIT)* is a dyadic behavioral intervention for children (ages 2.0 – 7.0 years) and their parents or caregivers that focuses on decreasing externalizing child behavior problems (e.g., defiance, aggression), increasing child social skills and cooperation, and improving the parent-child attachment relationship. It teaches parents traditional play-therapy skills to use as social reinforcers of positive child behavior and traditional behavior management skills to decrease negative child behavior. Parents are taught and practice these skills with their child in a playroom while coached by a therapist. The coaching provides parents with immediate feedback on their use of the new parenting skills, which enables them to apply the skills correctly and master them rapidly. *PCIT* is time-unlimited; families remain in treatment until parents have demonstrated mastery of the treatment skills and rate their child's behavior as within normal limits on a standardized measure of child behavior. Therefore treatment length varies but averages about 14 weeks, with hour-long weekly sessions.'
Population	'Target Population: Children ages 2.0 - 7.0 years old with behavior and parent-child relationship problems. May be conducted with parents, foster parents, or other caretakers. For children/adolescents ages: 2 – 6 For parents/caregivers of children ages: 2 – 6'

Parent-Child Interaction Therapy (PCIT)	
Target outcomes	• Child behaviour • Family functioning • Child development
Intervention details	‘Child Directed Interaction (CDI): • Parent-child dyads attend treatment sessions together and the parent learns to follow the child's lead in play. • The parent is taught how to decrease the negative aspects of their relationship with their child and to develop positive communication. • The parent is taught and coached to use CDI skills. These skills help the parents give positive attention to the child following positive (e.g. non-negative) behavior and ignore negative behavior. • By learning CDI skills, the parent is taught: ▪ To give labeled praise following positive child behavior. ▪ To reflect or paraphrase the child's appropriate talk. ▪ To use behavioral descriptions to describe the child's positive behavior. ▪ To avoid using commands, questions, or criticism because these verbalizations are intrusive and often give attention to negative behavior. • The parent is observed and coached through a one-way mirror at each treatment session. • After the first session, at least half of each session is spent coaching the parent in CDI skills utilizing a 'bug in the ear’. A wireless communications set consisting of a head set with microphone that the therapist wears and an ear receiver that the parent wears. • The parent's CDI skills are observed and recorded during the first five minutes of each session to assess progress and to guide skills learned through coaching during session. • Behaviors are tracked and charted on a graph at each session to provide the parent with immediate feedback regarding progress in positive interactions and the achievement of skill mastery. • The parent is provided with homework between sessions to enhance skills learned in the session.

Parent-Child Interaction Therapy (PCIT)	
	• Dyads do not proceed to the Parent Directed Interaction (PDI) until the parent demonstrates mastery of the CDI. Parent Directed Interaction (PDI): • Parent-child dyads attend treatment sessions together and the parent learns skills to lead the child's behavior effectively. • The parent is taught how to direct the child's behavior when it is important that the child obey their instruction. • The parent is observed and coached through a one-way mirror at each treatment session. • After the first session, at least half of each session is spent coaching the parent in PDI utilizing a 'bug in the ear,' a wireless communications set consisting of a head set with microphone that the therapist wears and an ear receiver that the parent wears. • Parent's PDI skills are observed and recorded during the first five minutes of each session to assess progress and guide the coaching of the session. • The parent learns to incorporate the effective instructions and commands (e.g. commands that are direct, specific, positively stated, polite, given one at a time, given only when essential, and accompanied by a reason that either immediately precedes the command or accompanies the praise for compliance) learned during the CDI component. • The parent learns to follow through on direct commands by giving labeled praise after every time the child obeys and beginning a time-out procedure after every time the child disobeys. • The parent learns a time-out procedure to use in the event that the child disobeys a direct command. The parent begins by issuing a warning, which will lead to the time-out chair, and then to the time-out room if the child continues disobeying. • The parent is coached to use the PDI algorithm, which gives the child an opportunity to obey and stop the time-out procedure at each step. • Behaviors are tracked and charted on a graph at each session to provide the parent with immediate feedback regarding progress in their PDI skills. • Once the parent demonstrates mastery of the procedures, she/he is given homework that gradually increases the intensity of the situations as the child learns to obey.

Parent-Child Interaction Therapy (PCIT)	
	• Treatment does not end until the parent meets pre-set mastery criteria for both phases of treatment and the child's behavior is within normal limits on a parent-report measure of disruptive behavior at home. ***PCIT*** can be delivered in a group format as well. When done so, small groups of 3 or 4 families in 90-minute sessions are recommended. This will allow adequate time for individual coaching of each parent-child dyad while other parents observe, code, and provide feedback in each session. For additional information, please check the ***PCIT*** website homepage at www.pcit.org and select "*PCIT* Integrity Checklists and Materials."' Components identified by PRC (Macvean *et. al.*, 2013) Delivery level: Individual Delivery: • Praise for parents • Structured sessions • Coaching while parents interact with child/ active skills training • Remediation of inappropriate response to child • Mastery skills attainment Content: • Child behaviour and behaviour management • Predictable environment for child, explain rules/expectations/use of routines/ setting limits • Descriptive for child behaviour/descriptive/labelled praise for child • Praise for desired child behaviour • Avoids commands, questions, criticism

Parent-Child Interaction Therapy (PCIT)	
	• Follow through on commands • Time out
Delivery setting	'This program is typically conducted in a(n): • Community Agency • Outpatient Clinic'
Dose	'Recommended Intensity: One or two 1-hour sessions per week with the therapist Recommended Duration: The average number of sessions is 14, but varies from 10 to 20 sessions. Treatment continues until the parent masters the interaction skills to pre-set criteria and the child's behavior has improved to within normal limits'
Staffing	'A firm understanding of behavioral principles and adequate prior training in cognitive-behavior therapy, child behavior therapy, and therapy process skills (e.g., facilitative listening) is required. For training in this treatment protocol outside an established graduate clinical training program, the equivalent of a master's degree and licensure as a mental health provider is required. It is recommended that the 40 hours of intensive skills training be followed by completion of two supervised cases prior to independent practice. For within program supervisors, it is recommended that they complete a minimum of 4 prior cases and complete a within program trainer training.' 'Training is obtained: On-site and off-site Number of days/hours: 5 days for a total of 40 hours. Follow-up consultation through the completion of two cases.'
Resources or supporting tools	'The typical resources for implementing the program are: • Two connected rooms with a one-way mirror on the adjoining wall (one room for client, other room for coach) or another method for the therapist to unobtrusively observe the parent. • A wireless communications set consisting of a head set with microphone and an ear receiver (i.e., "bug in the ear") • A VCR and television monitor to tape record sessions for supervision, training, and research purposes'
Cost information	Information not available

Parent-Child Interaction Therapy (PCIT)	
PRC rating	Well supported
Primary source	CEBC
Date last reviewed	June 2013

2.14. Project SUCCESS

Project SUCCESS	
Intervention description	'*Project SUCCESS* (Schools Using Coordinated Community Efforts to Strengthen Students) is designed to prevent and reduce substance use among students 12 to 18 years of age. The program was originally developed for students attending alternative high schools who are at high risk for substance use and abuse due to poor academic performance, truancy, discipline problems, negative attitudes toward school, and parental substance abuse. In recent years, *Project SUCCESS* has been used in regular middle and high schools for a broader range of high-risk students. '
Population	'Students 12 to 18 years of age attending alternative high schools who are at high risk for substance use and abuse due to poor academic performance, truancy, discipline problems, negative attitudes toward school, and parental substance abuse.'
Target outcomes	• Child behaviour • Systems outcomes
Intervention details	• 'The Prevention Education Series (PES), an alcohol, tobacco, and other drug program conducted by *Project SUCCESS* counselors (local staff trained by the developers) who help students identify and resist pressures to use substances, correct misperceptions about the prevalence and acceptability of substance use, and understand the consequences of substance use. • Schoolwide activities and promotional materials to increase the perception of the harm of substance use, positively change social norms about substance use, and increase enforcement of and compliance with school policies and community laws.

Project SUCCESS	
	• A parent program that includes informational meetings, parent education, and the formation of a parent advisory committee. • Individual and group counseling, in which the *Project SUCCESS* counselors conduct time-limited counseling for youth following their participation in the PES and an individual assessment. Students and parents who require more intensive counseling, treatment, or other services are referred to appropriate agencies or practitioners in the community.'
Delivery setting	School
Dose	The Prevention Education Series (PES) — 8 sessions
Staffing	Counselors — local staff trained by the developers
Resources or supporting tools	Information not provided
Cost information	• 'Implementation manual (includes implementation checklists): $150 each. • Brochure for teachers: $0.50 each. • 3-day training in Tarrytown, NY (includes implementation manual, resource manual, and brochure for teachers): $350 per person. • 3-day, on-site training (includes implementation manual and resource manual): $4,200 for up to 30 participants, plus travel expenses. • Scheduled telephone conference calls: $150 per hour. • On-site consultation: $200 per hour plus travel expenses. • Process evaluation data collection log: $50 each.'
PRC rating	Supported.
Primary source	SAMHSA
Date last reviewed	November 2007

2.15. Project Towards No Drug Abuse

Project Towards No Drug Abuse	
Intervention description	'*Project TND* is a drug prevention program for high school youth who are at-risk for drug use and violence-related behavior. It originally consisted of nine sessions designed to address issues of substance abuse and violence: 1) Communication and Active Listening, 2) Stereotyping, 3) Myths and Denial, 4) Chemical Dependency, 5) Talk Show, 6) Stress, Health and Goals, 7) Self Control, 8) Perspectives, and 9) Decision Making and Commitment. Three new sessions were added from the third trial on; that is, most trials utilized a 12-session program. These three newer sessions are the 1) Marijuana Panel, 2) Positive and Negative Thought Loops and Subsequent Behavior, and 3) Smoking Cessation. Classes are taught by trained health educators, who administer the curriculum over a 3-week period. Each session lasts 40 minutes and is conducted during the class period. The current version of TND contains twelve 40-minute interactive sessions. The sessions should be taught as written. Those students who are absent on days that a lesson is implemented should be provided with single-page summaries of the material from each lesson that they can utilize as a means to "make-up" learning of missed lesson material. The Socratic method is used throughout the curriculum. Thus, the emphasis is on interactions between the students and the teacher and the students with each other. The teacher's use of questioning leads students to generate the answers based on the reasoning that information is internalized more readily when it is not imposed from someone else. Classroom management in *Project TND* involves development of positive norms of classroom behavior. Although interaction among the youth is encouraged, the course is primarily teacher-directed and highly structured. In *Project TND*, the teacher's role is to actively develop and maintain peer group support in the class by modelling support, positively reinforcing it among group members, and negatively reinforcing deviant peer bonds and activities. The teacher creates and structures interactions among youth in prosocial directions.'
Population	'High school youth who are at-risk for drug use and violence-related behaviour' 'AGE - Late Adolescence (15-18) - High School'
Target outcomes	• Child behaviour
Intervention details	'It originally consisted of nine sessions designed to address issues of substance abuse and violence: 1) Communication and Active Listening, 2) Stereotyping, 3) Myths and Denial, 4) Chemical Dependency, 5) Talk Show, 6) Stress, Health and Goals, 7) Self Control, 8) Perspectives, and 9) Decision Making and Commitment. Three new sessions were added from the third trial on; that is, most trials utilized a 12-session

Project Towards No Drug Abuse	
	program. These three newer sessions are the 1) Marijuana Panel, 2) Positive and Negative Thought Loops and Subsequent Behavior, and 3) Smoking Cessation.' The Socratic method is also used to enhance learning.
Delivery setting	Classroom.
Dose	Twelve 40-minute interactive sessions taught over a 3-week period.
Staffing	Teachers or health educators
Resources or supporting tools	Teacher's manual, Student workbooks, Drugs and Life's Dreams video, Game board
Cost information	• 'Program Benefits *(per individual)*: $174 • Program Costs *(per individual)*: $64 • Net Present Value *(Benefits minus Costs, per individual)*: $110 • Measured Risk *(odds of a positive Net Present Value)*: 51%' • 'Teacher's manual: $90 each. • Student workbook: $60 for five. • Drugs and Life's Dreams video: $25 each. • Game board: $15 each. • 1-day, on-site training: $1,200-$1,400 for up to 25 participants, plus travel expenses.' (SAMHSA)
PRC rating	Supported
Primary source	Blueprints
Date last reviewed	Not indicated but last cited publication is dated 2012

2.16. Prolonged Exposure Therapy for Adolescents (PE-A)

Prolonged Exposure Therapy for Adolescents (PE-A)	
Intervention description	'*PE-A* is a therapeutic treatment where clients are encouraged to repeatedly approach situations or activities they are avoiding because they remind them of their trauma (in vivo exposure) as well as to revisit the traumatic memory several times through retelling it (imaginal exposure). Psychoeducation about common reactions to trauma as well as breathing retraining exercises are also included in the treatment. The aim of in vivo and imaginal exposure is to help clients emotionally process their traumatic memories through imaginal and in vivo exposure. Through these procedures, they learn that they can safely remember the trauma and experience trauma reminders, that the distress that initially results from confrontations with these reminders decreases over time, and that they are capable of tolerating this distress'
Population	'Target Population: Adolescents who have experienced a trauma (e.g., sexual assault, car accident, violent crimes, etc.). The program has also been used with children 6 to 12 years of age and adults who have experienced a trauma. For children/adolescents ages: 12 – 18'
Target outcomes	• Child development • Child behavior
Intervention details	• 'Delivering rationales for the treatment program, as well as for the in vivo and imaginal exposure, to the client in order to increase understanding of the treatment', 'and how they will help diminish PTSD symptoms.' • 'Creating an in vivo exposure hierarchy together with the client and guiding the client in implementing in vivo exposures to trauma reminders and situations that feel unsafe as a result of the trauma. • Conducting repeated and prolonged imaginal exposure to the trauma memory with the client, where the client is asked to recall and retell the trauma memory. • Delivering psychoeducation regarding common reactions to trauma. • Teaching breathing retraining exercise that can help patients to feel more calm'
Delivery setting	'This program is typically conducted in a(n): • Community Agency • Outpatient Clinic'

Prolonged Exposure Therapy for Adolescents (PE-A)	
Dose	'Recommended Intensity: Once or twice a week treatment sessions that are 60-90 minutes in length Recommended Duration: Approximately 8-15 sessions, or 2 to 4 months'
Staffing	'Licensed mental health professionals or those working under the supervision of a licensed mental health professional. Psychology, social, work, and nursing staff can implement ***PE-A*** in their respective roles.' 'Training is obtained: Training can be provided onsite. Number of days/hours: 4 full days (32 hours)'
Resources or supporting tools	'The typical resources for implementing the program are: A quiet room with no interruptions or distractions is necessary to implement ***PE-A***. DVD camcorders are necessary for conducting intensive individual and group supervision. Digital voice recorders are required for audio recording the treatment sessions which the client is required to listen as part of his homework. Clients can take the recorders with them or providers can use a CD burner to burn the audio recording onto a compact disc.'
Cost information	No information available
PRC rating	Well supported
Primary source	CEBC
Date last reviewed	April 2014

2.17. SafeCare®

SafeCare®	
Intervention description	'*SafeCare*® is an in-home parenting program in which parents are taught (1) how to interact in a positive manner with their children, to plan activities, and respond appropriately to challenging child behaviors; (2) to recognize hazards in the home in order to improve the home environment; and (3) to recognize and respond to symptoms of illness and injury, in addition to keeping good health records.'

SafeCare®	
Population	**‘**Target Population: Parents at-risk for child neglect and/or abuse and parents with a history of child neglect and/or abuse For children/adolescents ages: 0 – 5 For parents/caregivers of children ages: 0 – 5**’**
Target outcomes	• Family functioning • Child behaviour • Safety and physical wellbeing • Child maltreatment prevention • Child development
Intervention details	‘Planned Activities assessment and training: • Teach parent time management • Explain rules to child • Reinforcement/rewards • Incidental teaching • Activity preparation • Outcome discussions with child • Explain expectations to child Home Safety assessment and training: • Assess accessible home hazards with the *Home Accident Prevention Inventory-Revised* to assess accessible home hazards • Provide parents with door and cabinet latches • Use graduated plan to have parents remove identified hazards and to child proof doors and cabinets • Perform healthy home assessment and training

SafeCare®	
	Infant and child health care assessment and training: • Use *HEALTH* checklists to assess parent skills • Teach any skill deficits (i.e., how to take a temperature) • Teach use of health checklists and how to determine when to self-treat illness and when to seek medical care • Include problem solving training as needed Parent and staff training: • Modeling • Role rehearsal • Performance criteria in simulation and actual interactions. • Monitoring of staff for model fidelity. • Booster training if performance falls below criteria' Components identified by PRC (Macvean *et. al.*, 2013) Delivery level: Individual Delivery: • Assessment • Praise for parents • Structured sessions • Discussion • Feedback • Modelling • Role-play

SafeCare®	
	• Didactic teaching • Coaching while parents interact with child/ active skills training • Mastery skills attainment • Verbal instructions • Homework tasks Content: • Child care skills/care-giving • Parent-child interactions • Predictable environment for child, explain rules/expectations/use of routines/ setting limits • Child health and development • Praise for desired child behaviour • Home, environment and child safety • Planned activities and training • Parent time management • Use of reinforcement/rewards for child/ behaviour charts
Delivery setting	'This program is typically conducted in a(n): • Adoptive Home • Birth Family Home • Foster/Kinship Care'
Dose	'Recommended Intensity: Weekly sessions at approximately 1.5 hours each. Recommended Duration: 18-20 weeks.'

SafeCare®	
Staffing	‘Experience suggests at least a college education, but it has not been fully explored. The most important issue is that staff be trained to performance criteria.’ Training is obtained: Provided onsite by certified trainers. Number of days/hours: 1.5 training hours per week.
Resources or supporting tools	‘The typical resources for implementing the program are: • A Home Visitor • A Coach • Space for offices Material resources needed to implement the program include: • Audio recorders (one for each home visitor so that they can audiotape each sessions for the purpose of coaching) • Basic safety latches (cabinet latches, drawer latches, and door knob latches), which are fairly inexpensive (e.g., 10 for $2) • A screwdriver for each home visitor for the installation of safety latches • Dolls (used dolls are fine) to use during role-plays with the parents • Plastic bins to carry materials • Other optional supplies include such things as digital thermometers, stickers for reinforcing children's positive behaviors • Band-Aids • An electric screwdriver for the installation of safety latches, etc.’
Cost information	Information not available
PRC rating	Supported
Primary source	CEBC

SafeCare®	
Date last reviewed	September 2013

2.18. Triple P Positive Parenting Programs – Standard and Enhanced Group Behavioural Family Interventions

Triple P Positive Parenting Programs – Standard and Enhanced Group Behavioural Family Interventions	
Intervention description	Intervention description ‘Triple P is a well-researched Australian-developed program that was originally designed for parents of children with behavioural problems and has since been adapted for other groups of parents.’
Population	‘Parenting intervention for children with behavioural problems, adapted for use with maltreatment populations and parents with mental illness.’ This program has been evaluated in ‘Mean age of 4 years. History of Maltreatment’ ‘Mean age of 3 years. Parents with a mental illness and concerns about child behavior’
Target outcomes	• Maltreatment prevention • Family functioning • Child development • Child behaviour
Intervention details	Program with Target Population: Mean age 4 years. History of Child Maltreatment ‘Standard - Child behaviour management, 10 strategies for promoting children’s competence (i.e., quality time; talking with children; physical affection; praise; attention; engaging activities; setting a good example; Ask, Say, Do; incidental teaching; and behaviour charts)

Triple P Positive Parenting Programs – Standard and Enhanced Group Behavioural Family Interventions	
	Seven strategies for managing misbehaviour (i.e., setting rules; directed discussion; planned ignoring; clear, direct instructions; logical consequences; quiet time; and time-out). Planning ahead for high risk situations in relation to difficult child behaviour. Planned activities training Enhanced - As above plus. Cognitive re-framing in relation to negative parental attributions about child behaviour. Anger management using physical, cognitive and planning strategies.' Program with Target Population: Mean age 3 years. Parents with a mental illness and concerns about child behaviour Standard- Child behaviour management – 10 strategies for promoting children's competence and seven strategies for managing misbehaviour. Planning ahead for high risk situations in relation to difficult child behaviour. Planned activities training Enhanced- As above plus. Partner support for couples (positive listening and speaking, strategies for building a caring relationship). Coping skills for couples (assist with personal adjustment difficulties such as depression, anger, anxiety, stress). Social support via a significant other for single parents' Components identified by PRC (Macvean et. al., 2013) Delivery level: Individual and group Delivery: Standard • Family goals • Structured Sessions • Written material • Discussion • Feedback

Triple P Positive Parenting Programs – Standard and Enhanced Group Behavioural Family Interventions	
	• Modelling • Role-play • Homework tasks • Rehearsal Enhanced (in addition to the above) • Cognitive re-framing Content: Standard • Child behaviour and behaviour management • Predictable environment for child, explain rules/expectations/use of routines/ setting limits • Praise for desired child behaviour • Time out • Planned activities and training • Use of reinforcement/rewards for child/behaviour charts • Planning ahead for high risk situations/crisis management • Quality time • Talking to children • Physical affection • Attention for child • Setting a good example for children • Incidental teaching

Triple P Positive Parenting Programs – Standard and Enhanced Group Behavioural Family Interventions	
	• Quiet time • Logical consequences • Directed discussions • Planned ignoring Enhanced (in addition to the above) • Partner support • Coping skills for couples • Social support • Emotional regulation
Delivery setting	Program with Target Population: Mean age 4 years. History of Child Maltreatment '… delivered in the community by a professional.' Program with Target Population: Mean age 3 years. Parents with a mental illness and concerns about child behaviour '…half delivered in a clinic and half at home.'
Dose	Program with Target Population: Mean age 4 years. History of Child Maltreatment 'Standard - 4 weekly group sessions in the community and 4 individual telephone calls. All delivered by a professional Enhanced – As above, plus 4 additional group sessions delivered in the community by a professional' Program with Target Population: Mean age 3 years. Parents with a mental illness and concerns about child behaviour 'Standard- Average of 10 weekly individual sessions delivered by a professional. Half delivered in a clinic and half at home.

Triple P Positive Parenting Programs – Standard and Enhanced Group Behavioural Family Interventions	
	Enhanced- Average of 12 weekly individual sessions delivered by a professional. Half delivered in a clinic and half at home'
Staffing	Delivered by a professional
Resources or supporting tools	Information not available
Cost information	Information not available
PRC rating	Supported
Primary source	Macvean *et. al.* (2013)
Date last reviewed	2013

3. Promising

3.1. Adolescent-Focused Family Behavior Therapy (Adolescent FBT)

Adolescent-Focused Family Behavior Therapy (Adolescent FBT)	
Intervention description	'*Adolescent FBT* includes more than a dozen treatments including management of emergencies, treatment planning, behavioral goals, contingency management skills training, communication skills training, job-getting skills training, self-control, stimulus control, home safety tours, and tele-therapy to improve session attendance. Therapies are consumer-driven and culturally sensitive. *Adolescent FBT*'s goal is to result in positive outcomes in such areas as alcohol and drug use, depression, conduct problems, family dysfunction, and days absent from work/school. *Adolescent FBT* is designed to be used with youth, multiple ethnicities, differing types of substance abuse (alcohol, marijuana, and hard drugs), and across genders. Drafts of standardized client record keeping forms and quality assurance may be customized to fit agency needs.'
Population	Target Population: Youth (11-17) with drug abuse and dependence, as well as other co-existing problems. For children/adolescents ages: 11 – 17. For parents/caregivers of children ages: 11 – 17.' Other co-existing problems can include conduct problems and depression.
Target outcomes	• Child development • Child behaviour • Family functioning • Support networks • Safety and physical wellbeing
Intervention details	▪ A structured Program Orientation that includes prompts to assist in gaining feedback from clients about the obtained assessment results, and providing opportunities to review issues that are common to the target population. ▪ Assurance of Basic Necessities in which potential or impending emergencies are endorsed by clients from a list, and a self-control procedure is taught to keep the family safe.

Adolescent-Focused Family Behavior Therapy (Adolescent FBT)	
	▪ A list of commonly experienced triggers to problem behaviors that when endorsed by clients may be quickly switched into pre-established Behavioral Goals that are anchored to rewards that are provided by family members. ▪ Treatment Planning options that are anchored to specific *Adolescent FBT* components and prioritized by the client and family. ▪ Communication Skills Training exercises in which clients and their families share what they love, admire, and respect about one another, learn to make positive requests, and develop conflict resolutions skills. ▪ Job-getting Skills Training to teach clients and family how to solicit and do well in job interviews. ▪ A Self-Control intervention in which clients and their family learn to identify and manage triggers to problem behaviors, such as child neglect, HIV risk, drug abuse, and anger in imaginary trials. ▪ A Stimulus Control intervention in which clients and their family learn to restructure their environment to eliminate or manage negative emotions and things in the environment that cause them to engage in troublesome behaviors, such as substance abuse, child maltreatment, arguments, etc. ▪ Tele-therapy with clients and their significant others to assure therapy assignments and treatments are being reviewed as prescribed, and increase therapy session attendance. • Contextual Programming ▪ Structured Pre-Training Questionnaires to be completed by therapists and administrators of the treatment agency to customize the *Adolescent FBT* training experience to fit the unique needs of the agency's culture. ▪ Published and Non-Published Training Manuals include brief overviews and rationales of each of the intervention approaches, client worksheets and homework assignment forms, and methods of implementing the therapy components. ▪ Protocol Checklists depict how to implement the *Adolescent FBT* treatment components, and include step-by-step instructions for therapists to utilize during their intervention sessions. ▪ Training/Supervision Protocol Checklist depicts steps involved in maintaining on-going training and supervision protocol that are consistent with *Adolescent FBT*. ▪ Forms Relevant to Client Record Keeping include standardized progress notes, treatment plans, log of contacts, monthly client progress reports to outside parties (i.e., caseworker, judges), termination reports, etc. that correspond to *Adolescent FBT* components.

Adolescent-Focused Family Behavior Therapy (Adolescent FBT)	
	▪ Quality Assurance Monitoring forms to assure adequacy of client charting and clinic procedures. ▪ Data Management System that may be used to organize program related outcome data that is relevant to *Adolescent FBT*. • *Adolescent FBT* has a family component where siblings/children are treated at the same time as the substance abuser.'
Delivery setting	Outpatient Clinic
Dose	'Recommended Intensity: Starts with 1- to 2-hour initial outpatient or home-based sessions once or twice in the first week then it varies depending on multiple factors that are determined between the client, client's family, and treatment provider (e.g., population, setting, intensity of treatment plan, effort). Recommended Duration: Typically 6 months to 1 year. It varies depending on multiple factors that are determined between the client, client's family, and treatment provider (e.g., population, setting, intensity of treatment plan, effort).' 'Supervisors must be state-licensed mental health professionals with an interest in supervising the intervention. They should ideally have experience in conducting evidence-based therapies, particularly cognitive-behavioral therapies, and must have professional therapeutic experience serving the population that is being targeted for treatment. Providers should be state-licensed mental health professionals, or supervised by state-licensed mental health professionals (if permitted by law to do so). They should ideally have experience serving the population that is being targeted for treatment, and must have an interest in conducting therapy utilizing the intervention.'
Staffing	'Supervisors must be state-licensed mental health professionals with an interest in supervising the intervention. They should ideally have experience in conducting evidence-based therapies, particularly cognitive-behavioral therapies, and must have professional therapeutic experience serving the population that is being targeted for treatment. Providers should be state-licensed mental health professionals, or supervised by state-licensed mental health professionals (if permitted by law to do so). They should ideally have experience serving the population that is being targeted for treatment, and must have an interest in conducting therapy utilizing the intervention.'
Resources or supporting tools	• 'Protocol checklists to guide therapy implementation

Adolescent-Focused Family Behavior Therapy (Adolescent FBT)	
	• A private place in which to conduct therapy • Donohue, B., & Azrin, N. H. (2011). Family Behavior Therapy: A step-by-step approach to adolescent substance abuse. Hoboken, NJ: John Wiley & Sons, Inc.'
Cost information	• 'Family Behavior Therapy: A Step-by-Step Approach to Adolescent Substance Abuse (manual that includes CD-ROM with protocol checklists and program forms): About $48 each. • Initial 2-day, on-site training workshop: Contact the developer. • 1-day, on-site booster workshop: Contact the developer. • Annual case reviews: Contact the developer. • Annual audiotape integrity checks: Contact the developer. • Half-day, on-site consultation to review FBT clinic integration: Contact the developer.' (SAMHSA)
PRC rating	Promising
Primary source	CEBC
Date last reviewed	March 2014

3.2. Adult-Focused Family Behavior Therapy (Adult-Focused FBT)

Adult-Focused Family Behavior Therapy (Adult-Focused FBT)	
Intervention description	Intervention description '*Adult-Focused FBT* includes more than a dozen treatments including management of emergencies, treatment planning, home safety tours, behavioral goals and rewards, contingency management skills training, communication skills training, child management skills training, job-getting skills training, financial management, self-control, environmental control, home safety and aesthetics tours, and tele-therapy to improve session attendance. Therapies are consumer-driven and culturally sensitive. *Adult-Focused FBT* is designed to be used with adults, multiple ethnicities, differing types of substance abuse (alcohol, marijuana, and hard drugs), and across genders. Drafts of standardized client record keeping forms and quality assurance may be customized to fit agency needs.'

Adult-Focused Family Behavior Therapy (Adult-Focused FBT)	
Population	‘Target Population: Adults with drug abuse and dependence, as well as other co-existing problems such as depression, family dysfunction, trauma, child maltreatment, noncompliance, employment, HIV/STIs risk behavior, and poor communication skills’
Target outcomes	• Safety and physical wellbeing • Family functioning • Child behaviour • Child maltreatment prevention • Support networks
Intervention details	• ‘A structured Program Orientation that includes prompts to assist in gaining feedback from clients about the obtained assessment results, and provides opportunities to review issues that are common to the target population. • A list of commonly experienced triggers to substance abuse and other problem behaviors that, when endorsed by clients, may be quickly switched into pre-established Behavioral Goals and Rewards through the establishment of family support systems. • Treatment Planning options that are anchored to specific *Adult-Focused FBT* components and prioritized by both the client and client's family. • Communication Skills Training exercises in which clients and their families share what they love, admire, and respect about one another, learn to make positive requests, and develop conflict resolutions skills. • Child Management Skills Training in which parents learn to discipline their children by catching them being good, positive practice learning exercises, and, when necessary, provision of firm directives and undesired consequences. • Job-getting Skills Training to teach clients and family how to solicit and do well in job interviews. • A Financial Management intervention in which clients and their family learn to use a standardized worksheet with common methods of earning and saving extra income and reducing expenses. • A Self-Control intervention in which clients and their family learn to identify and manage triggers to problem behaviors, such as child neglect, HIV risk, drug abuse, and anger in imaginary trials.

Adult-Focused Family Behavior Therapy (Adult-Focused FBT)	
	• Assurance of Basic Necessities in which potential or impending emergencies are endorsed by clients from a list, and the self-control procedure is taught to keep the family safe. • Home Safety and Aesthetics Tours when intervention is implemented within the home to assist in preventing home accidents, which are the leading cause of death and serious injury in small children. • Environmental Control in which clients and their family learn to restructure their environment to eliminate or manage negative emotions and things in the environment that cause them to engage in troublesome behaviors, such as substance abuse, child maltreatment, arguments, etc. • Tele-therapy with clients and their significant others to assure therapy assignments and treatments are being reviewed as prescribed, and increase therapy session attendance.' Contextual Programming: • 'Structured Pre-Training Questionnaires to be completed by therapists and administrators of the treatment agency to customize the *Adult-Focused FBT* training experience to fit the unique needs of the agency's culture. • Published and Non-Published Training Manuals include brief overviews and rationales of each of the intervention approaches, client worksheets and homework assignment forms, and methods of implementing the therapy' • Protocol Checklists depict how to implement the *Adult-Focused FBT* and 'include step-by-step instructions for therapists to utilize during their intervention sessions.' • Training/Supervision Protocol Checklist depicts steps involved in maintaining on-going training and supervision protocol that are consistent with *Adult-Focused FBT*. • Forms Relevant to Client Record Keeping include standardized progress notes, treatment plans, log of contacts, monthly client progress reports to outside parties (e.g., caseworker, judges), termination reports, etc. that correspond to *Adult-Focused FBT* components. • Quality Assurance Monitoring forms to assure adequacy of client charting and clinic procedures. • Data Management System that may be used to organize program related outcome data that is relevant to *Adult-Focused FBT*.'
Delivery setting	'This program is typically conducted in a(n):

Adult-Focused Family Behavior Therapy (Adult-Focused FBT)	
	• Birth Family Home • Community Agency • Foster/Kinship Care • Outpatient Clinic • Residential Care Facility'
Dose	'Recommended Intensity: Starts with 1- to 2-hour initial outpatient or home-based sessions once or twice in the first week then fades in frequency depending on multiple factors that are determined between the client, client's family, and treatment provider (e.g., population, setting, intensity of treatment plan, effort). Recommended Duration: Typically 6 months to 1 year. It varies depending on multiple factors (e.g., population, setting, intensity of treatment plan, effort) that are determined by the client, client's family, and treatment provider'
Staffing	'Supervisors must be state-licensed mental health professionals with an interest in supervising the intervention. They should ideally have experience in conducting evidence-based therapies, particularly cognitive-behavioral therapies, and should have professional therapeutic experience serving the population that is being targeted for treatment. Therapists should be state-licensed mental health professionals. They should ideally have experience serving the population that is being targeted for treatment, and must have an interest in conducting therapy utilizing the intervention.' 'Training is obtained: Training may occur at the treatment agency. Other training sites are currently available in Pennsylvania, Nevada, California, Florida, Tennessee, and Kentucky. Number of days/hours: The process begins with conference calls and questionnaires to learn the unique needs of the agency wishing to be trained. Several training options are available. The full FBT training package includes 4 modules: • Substance Abuse/Problem Behavior interventions • Family Relationship Building interventions • Job-Getting and Financial Management • Child management Skills Training (when clients are parents)

Adult-Focused Family Behavior Therapy (Adult-Focused FBT)	
	The full package is conducted across a 2.5- to 3-day workshop, a 2- to 2.5-day booster workshop 4 months after the initial workshop, a 2- to 2.5-day workshop 8 months after the initial workshop, and approximately 33 on-going telephone training meetings. When less intensive training is desired, the modules can be separated. The Substance Abuse/Problem Behavior module and Child Management Skills Training Module each requires a 2-day workshop w/ 19 on-going telephone training sessions; the Family Relationship Building module, as well as the Job-Getting and Financial Management modules each require a 1-day workshop with 7 on-going telephone training sessions'
Resources or supporting tools	'The typical resources for implementing the program are: • Protocol checklists to guide therapy implementation • A private place in which to conduct therapy • Donohue, B., & Allen, D. A. (2011). Family Behavior Therapy: A step-by-step approach to adult substance abuse. Hoboken, NJ: John Wiley & Sons, Inc.'
Cost information	• 'Family Behavior Therapy: A Step-by-Step Approach to Adult Substance Abuse (manual that includes CD-ROM with protocol checklists and program forms): About $48 each. • Initial 2-day, on-site training workshop: Contact the developer. • 1-day, on-site booster workshop: Contact the developer. • Annual case reviews: Contact the developer. • Annual audiotape integrity checks: Contact the developer. • Half-day, on-site consultation to review FBT clinic integration: Contact the developer.' (SAMHSA)
PRC rating	Promising
Primary source	CEBC
Date last reviewed	April 2014

3.3. Brief Strategic Family Therapy (BSFT)

Brief Strategic Family Therapy (BSFT)	
Intervention description	‘*BSFT* is a brief intervention used to treat adolescent drug use that occurs with other problem behaviors. These co-occurring problem behaviors include conduct problems at home and at school, oppositional behavior, delinquency, associating with antisocial peers, aggressive and violent behavior, and risky sexual behavior. *BSFT* is based on three basic principles: First, *BSFT* is a family systems approach. Second, patterns of interaction in the family influence the behavior of each family member. The role of the *BSFT* counsellor is to identify the patterns of family interaction that are associated with the adolescent's behavior problems. Third, plan interventions that carefully target and provide practical ways to change those patterns of interaction that are directly linked to the adolescent's drug use and other problem behaviors. The goals of Brief Strategic Family Therapy (*BSFT*) are: For the child/youth: • Reduce behavior problems, while improving self-control • Reduce associations with antisocial peers • Reduce drug use • Develop prosocial behaviors For the family: • Improvements in maladaptive patterns of family interactions (family functioning) • Improvements in family communication, conflict-resolution, and problem-solving skills • Improvements in family cohesiveness, collaboration, and child/family bonding • Effective parenting, including successful management of children's behavior and positive affect in the parent-child interaction’
Population	‘Youth aged 12 – 18 years with substance abuse problems and co-occurring behaviour problems such as conduct problems, aggressive and violent behavior, and risky sexual behavior.’

Brief Strategic Family Therapy (BSFT)	
Target outcomes	• Child behaviour • Family functioning • Support networks
Intervention details	‘*BSFT* is based on three basic principles: First, *BSFT* is a family systems approach. Second, patterns of interaction in the family influence the behavior of each family member. The role of the *BSFT* counsellor is to identify the patterns of family interaction that are associated with the adolescent's behavior problems. Third, plan interventions that carefully target and provide practical ways to change those patterns of interaction that are directly linked to the adolescent's drug use and other problem behaviors.’ ‘*BSFT*'s therapeutic techniques fall into three categories: joining, diagnosing, and restructuring. The therapist initially "joins" the family by encouraging family members to behave in their normal fashion. The therapist then diagnoses repetitive patterns of family interactions. Restructuring refers to the change-producing strategies that the therapist uses to promote new, more adaptive patterns of interaction.’ (SAMHSA)
Delivery setting	‘Sessions are conducted at locations that are convenient to the family, including the family's home in some cases.’ (SAMHSA)
Dose	‘*BSFT* is typically delivered in 12-16 family sessions but may be delivered in as few as 8 or as many as 24 sessions, depending on the severity of the communication and management problems within the family.’ (SAMHSA)
Staffing	No information provided
Resources or supporting tools	Implementation, training and quality assurance materials and resources.
Cost information	‘Implementation, training, and quality assurance materials and resources are disseminated through two different entities that offer different packages. The implementation points of contact can provide detailed information about requirements and costs.’ (SAMHSA)
PRC rating	Promising
Primary source	CEBC
Date last reviewed	June 2012

3.4. Child-Parent Psychotherapy (CPP)

Child-Parent Psychotherapy (CPP)	
Intervention description	'*CPP* is a treatment for trauma-exposed children aged 0-5. Typically, the child is seen with his or her primary caregiver, and the dyad is the unit of treatment. *CPP* examines how the trauma and the caregivers' relational history affect the caregiver-child relationship and the child's developmental trajectory. A central goal is to support and strengthen the caregiver-child relationship as a vehicle for restoring and protecting the child's mental health. Treatment also focuses on contextual factors that may affect the caregiver-child relationship (e.g., culture and socioeconomic and immigration related stressors). Targets of the intervention include caregivers' and children's maladaptive representations of themselves and each other and interactions and behaviors that interfere with the child's mental health. Over the course of treatment, caregiver and child are guided to create a joint narrative of the psychological traumatic event and identify and address traumatic triggers that generate dysregulated behaviors and affect.'
Population	'Children under the age of five years who have been exposed to abuse, sexual abuse, neglect, domestic or family violence and parental substance misuse. Target Population: Children age 0-5 who have experienced a trauma, and their caregivers. For children/adolescents ages: 0 – 5 For parents/caregivers of children ages: 0 – 5'
Target outcomes	• Child development • Child behaviour • Family functioning • Safety and physical wellbeing • Support networks
Intervention details	• 'Focus on the parent-child relationship as the primary target of intervention.

Child-Parent Psychotherapy (CPP)	
	• Focus on safety: a) Focus on safety issues in the environment as needed; b) Promote safe behavior; c) Legitimize feelings while highlighting the need for safe/appropriate behavior; d) Foster appropriate limit setting; e) Help establish appropriate parent-child roles. • Affect regulation: a) Provide developmental guidance regarding how children regulate affect and emotional reactions; b) Support and label affective experiences; c) Foster parent's ability to respond in helpful, soothing ways when child is upset; d) Foster child's ability to use parent as a secure base; e) Develop/foster strategies for regulating affect. • Reciprocity in Relationships: a) Highlight parent's and child's love and understanding for each other; b) Support expression of positive and negative feelings for important people; c) Foster ability to understand the other's perspective; d) Talk about ways that parent and child are different and autonomous; e) Develop interventions to change maladaptive patterns of interactions. • Focus on the traumatic event: a) Help parent acknowledge what child has witnessed and remembered; b) Help parent and child understand each other's reality with regards to the trauma; c) Provide developmental guidance acknowledging response to trauma; d) Make linkages between past experiences and current thoughts, feelings, and behaviors; e) Help parent understand link between her own experiences and current feelings and parenting practices; f) Highlight the difference between past and present circumstances; g) Support parent and child in creating a joint narrative; h) Reinforce behaviors that help parent and child master the trauma and gain a new perspective. • Continuity of Daily Living: a) Foster prosocial, adaptive behavior; b) Foster efforts to engage in appropriate activities; c) Foster development of a daily predictable routine. • Reflective supervision’ Components identified by PRC (Macvean *et. al.*, 2013) Delivery level: Individual Delivery: • Assessment • Individual plan

Child-Parent Psychotherapy (CPP)	
	• Discussion Content: • Parent-child interactions • Predictable environment for child, explain rules/expectations/use of routines/ setting limits • Home environment and child safety • Use of reinforcement/rewards for child/ behaviour charts • Emotional regulation • Reciprocity in relationships • Trauma focused • Life skills, continuity of life course: family economics, nutrition, education, employment, relationships
Delivery setting	• Adoptive Home • Birth Family Home • Community Agency • Foster/Kinship Care • Outpatient Clinic • School
Dose	'Recommended Intensity: Weekly 1 to 1.5-hour sessions Recommended Duration: 52 weeks (one year)'
Staffing	• 'Practitioners: Master's level training. • Supervisors: Master's degree plus minimum of 1 year training in the model. Training is obtained: There are a number of different training models. Training occurs can be arranged through the Child Trauma Research Program by contacting the individual above. Training also occurs through

Child-Parent Psychotherapy (CPP)	
	the Learning Collaborative model of the National Child Traumatic Stress Network. In general, training is tailored to the needs of the organization. Number of days/hours: Typically training involves an initial 3-day workshop and then quarterly (3 more times in a year) 2-day additional workshops. In addition, training involves bi-monthly telephone-based case consultation of ongoing treatment cases involving children aged 0-5 who have experienced a trauma.'
Resources or supporting tools	'No specific room requirements are needed as the program is often implemented through a home-visiting model.'
Cost information	• 'Psychotherapy With Infants and Young Children: Repairing the Effects of Stress and Trauma on Early Attachment (manual): $35.79 for hardcover, $28 for paperback, or $21.95 for Kindle edition. Don't Hit My Mommy!: A Manual for Child-Parent Psychotherapy With Young Witnesses of Family Violence: $24.95 each. • 1-year full-time internship at specialized NCTSN sites (includes intensive didactic training, clinical practice, and weekly supervision by multiple supervisors): Free. • 1.5-year training through the NCTSN Learning Collaborative Model (includes three 2- to 3-day workshops for therapists, a half-day training for supervisors, and bimonthly phone consultation): Free, except for travel expenses. • 1.5-year training for a learning community (i.e., multiple agencies sharing the cost of training) or an individual agency (includes three 2- to 3-day workshops for therapists, a half-day training for supervisors, and bimonthly clinical consultation in person, by phone, or by video chat): $1,500-$3,000 per day of training (depending on trainer experience) for up to 30 participants, plus travel expenses. • Additional phone, email, or in-person consultation: $150-$350 per hour (depending on trainer experience), plus travel expenses if necessary. • Intervention fidelity checklist, training checklist, and supervision checklist: Free.' (SAMHSA)
PRC rating	Promising
Primary source	CEBC
Date last reviewed	June 2012

3.5. Functional Family Therapy (FFT)

Functional Family Therapy (FFT)	
Intervention description	'FFT is a family intervention program for dysfunctional youth. FFT has been applied to a wide range of problem youth and their families in various multi-ethnic, multicultural contexts. Target populations range from at-risk pre-adolescents to youth with very serious problems such as conduct disorder, violent acting-out, and substance abuse. While FFT targets youth aged 11-18, younger siblings of referred adolescents often become part of the intervention process. Intervention ranges from, on average, 8 to 12 one-hour sessions for mild cases and up to 30 sessions of direct service for more difficult situations. In most programs, sessions are spread over a three-month period. FFT has been conducted both in clinic settings as an outpatient therapy and as a home-based model. The FFT clinical model offers clear identification of specific phases which organizes the intervention in a coherent manner, thereby allowing clinicians to maintain focus in the context of considerable family and individual disruption. Each phase includes specific goals, assessment foci, specific techniques of intervention, and therapist skills necessary for success.' 'The overall phase-based goals of Functional Family Therapy (FFT) are: • Engage and motivate youth and their families by decreasing the intense negativity (blaming, hopelessness) so often characteristic of these families. Rather than ignoring or being paralyzed by the intense negative experiences these families often bring (e.g., cultural isolation and racism, loss and deprivation, abandonment, abuse, depression), FFT acknowledges and incorporates these powerful emotional forces into successful engagement and motivation through respect, sensitivity, and positive reattribution techniques. • Reduce and eliminate the problem behaviors (e.g., conduct disorder, violent acting-out, and substance abuse) and accompanying family relational patterns through individualized behavior change interventions. • Generalize changes across problem situations by increasing the family's capacity to utilize multisystemic community resources adequately, and to engage in relapse prevention.'
Population	'Target Population: 11-18 year olds with very serious problems such as conduct disorder, violent acting-out, and substance abuse

Functional Family Therapy (FFT)	
	For children/adolescents ages: 11 – 18’
Target outcomes	• Child behaviour • Family functioning • Support networks • Systems outcomes
Intervention details	‘Functional Family Therapy (FFT) consists of four distinct intervention phases: • Engagement: Introduction/Impression (Pre-Intervention) • Motivation: Induction/Therapy (Early sessions) • Behavior Change (Middle sessions) • Generalization (Later sessions) Each phase has its own unique goals, risk and protective factors addressed, assessment focus, and therapist skills and intervention focus. Engagement: • Goal: Maximize family initial expectation of positive change • Risk and Protective Factors Addressed: • Negative perception about or experiences with treatment • Reputation of treatment agency • Transportation • Therapist availability • Intake staff skills and attitudes • Assessment Focus: Superficial qualities inferred from referral source and initial screening

Functional Family Therapy (FFT)	
	• Therapist Skills/Intervention Focus: • High availability • Manage intake processes to present agency, self, and treatment in a way that matches to inferred family characteristics • Enhance perception of credibility Motivation: • Goal: Create a motivational context for long-term change • Risk and Protective Factors Addressed: ▪ Family negativity and blame ▪ Hopelessness ▪ Level of motivation • Assessment Focus: ▪ Behavioral (presenting problem) ▪ Relational risk and protective factors • Therapist Skills/Intervention Focus: ▪ Interpersonal skills (validation, positive reattribution, reframing, relational) ▪ Build balanced alliances ▪ Reduce negativity and blame ▪ Create hope ▪ Enhance motivation to change Behavior Change: • Goal: Facilitate individual and interactive/ relational change

Functional Family Therapy (FFT)	
	• Risk and Protective Factors Addressed: • Youth temperament • Parental pathology • Beliefs and values • Developmental level • Parenting skills • Conflict resolution/negotiation skills • Level of family support • Peer refusal skills • Assessment Focus: • Individual skills • Quality of relational skills • Relational problem sequence • Compliance with behavior change plans • Therapist Skills/Intervention Focus: • Directive/teaching /structuring skills • Modelling • Setting up, leading, and reviewing in-session tasks • Assigning homework Generalization: • Goal: Maintain individual and family change, and facilitate change in multiple systems • Risk and Protective Factors Addressed

Functional Family Therapy (FFT)	
	• Youth bonding to school • Parent attitudes about school, peers, drugs, etc. • Level of social support • Assessment Focus: • Access to and utilization of community resources • Maintenance of change • Therapist Skills/Intervention Focus: • Interpersonal and structuring skills • Family case manager • Accessing appropriate formal and informal community resources • Anticipate and plan for future extra-familial stresses'
Delivery setting	• Adoptive Home • Birth Family Home • Community Agency • Foster/Kinship Care • School
Dose	Dose 'Recommended Intensity: One-hour weekly sessions unless needed more frequently Recommended Duration: 8 to 12 sessions for mild cases and up to 30 sessions for difficult situations taking on average 3-4 months'
Staffing	'Qualifications can vary for therapists, but to become an onsite Program Supervisor a minimum of Master's level education is required.'

Functional Family Therapy (FFT)	
Resources or supporting tools	'Sites must provide each therapist with on-going computer and internet access so they can record progress notes and complete the other assessment, adherence and outcome instruments that are utilized during the course of the intervention. Meeting space and a speaker phone are needed for weekly consultation with an offsite program consultant.'
Cost information	• 'Functional Family Therapy for Adolescent Behavior Problems (book): $59.95 each. • Functional Family Therapy for Adolescent Substance Use Disorders: Training Manual (includes client handouts and quality assurance forms): Free. • Functional Family Therapy for Adolescent Substance Use Disorders (book chapter): Free. • Functional Family Therapy for Adolescent Substance Abuse and Dependence (PowerPoint slides): Free. • Stage 1 Training (includes 2 on-site trainings and guided practice): $26,000-$43,500, plus trainer travel expenses, for 3-8 therapist participants. • Stage 2 Training (includes 2 on-site trainings and guided practice): $13,000, plus trainer travel expenses, for 1 supervisor participant. • Stage 3 Training (includes 1 on-site training): $5,000, plus trainer travel expenses, per site. • Therapist certification: $500 per therapist.' (SAMHSA)
PRC rating	Promising
Primary source	CEBC
Date last reviewed	September 2013

3.6. Multisystemic Therapy With Psychiatric Supports (MST-Psychiatric)

Multisystemic Therapy With Psychiatric Supports (MST-Psychiatric)	
Intervention description	It includes specific clinical and training for staff designed to address: '(1) safety risks associated with suicidal, homicidal, or psychotic behaviors in youths, (2) the integration of evidence-based psychiatric interventions, (3) contingency management for adolescent and parent/caregiver substance abuse, and (4) evidence-based assessment and treatment of youth and parent/caregiver mental illness. *MST-Psychiatric* teams intervene primarily at the family level, empowering parents and caregivers with the skills and resources to effectively communicate with, monitor, and discipline their children. The intervention assists parents and caregivers in engaging their children in prosocial activities while disengaging them from deviant peers. In addition, it addresses individual and systemic barriers to effective parenting. The intervention is delivered in the family's natural environment (e.g., home, school, community) daily when needed and for approximately 6 months. A *MST-Psychiatric* team consists of a full-time doctoral-level supervisor, four master's-level therapists, a part-time psychiatrist, and a bachelor's-level crisis caseworker. Teams have an ongoing consultative relationship with an MST expert consultant and an MST expert psychiatrist who provide an initial 5-day training, weekly consultation, and quarterly booster trainings.'
Population	'Youth who are at risk for out-of-home placement (in some cases, psychiatric hospitalization) due to serious behavioral problems and co-occurring mental health symptoms such as thought disorder, bipolar affective disorder, depression, anxiety, and impulsivity' 'Ages: 6-12 (Childhood), 13-17 (Adolescent)'
Target outcomes	• Child behaviour • Family functioning • Support networks • Systems outcomes
Intervention details	The program includes specific clinical and training for staff designed to address: '(1) safety risks associated with suicidal, homicidal, or psychotic behaviors in youths, (2) the integration of evidence-based psychiatric interventions, (3) contingency management for adolescent and parent/caregiver substance abuse, and (4) evidence-based assessment and treatment of youth and parent/caregiver mental illness.'

Multisystemic Therapy With Psychiatric Supports (MST-Psychiatric)	
Delivery setting	• Home • School • Other community settings
Dose	'The intervention is delivered daily when needed and for approximately 6 months'
Staffing	'A *MST-Psychiatric* team consists of a full-time doctoral-level supervisor, four master's-level therapists, a part-time psychiatrist, and a bachelor's-level crisis caseworker. Teams have an ongoing consultative relationship with an MST expert consultant and an MST expert psychiatrist who provide an initial 5-day training, weekly consultation, and quarterly booster trainings'
Resources or supporting tools	Information not available
Cost information	• 'Program development start-up fees (includes site readiness visit and 7-day, on-site orientation training): $15,000 plus travel expenses. • Annual program support and service fees (includes annual agency/team license fees, start-up kit, manuals, training materials, weekly case consultation, supervisor support calls as needed, quarterly on-site booster trainings, and use of Web-based adherence monitoring and outcome tracking system): $96,500 per site plus travel expenses. • 2-day supervisor orientation training: $350 per participant plus travel expenses. • Tape coding: About $7,920. • Adherence data collection: About $3,600 per year.'
PRC rating	Promising
Primary source	SAMHSA
Date last reviewed	November 2008

3.7. Parenting with Love and Limits (PLL)

Parenting with Love and Limits (PLL)	
Intervention description	‘*PLL* combines group therapy and family therapy to treat children and adolescents aged 10-18 who have severe emotional and behavioral problems (e.g., conduct disorder, oppositional defiant disorder, attention deficit/hyperactivity disorder) and frequently co-occurring problems such as depression, alcohol or drug use, chronic truancy, destruction of property, domestic violence, or suicidal ideation. The program also has been used with teenagers with less extreme behaviors. *PLL* is also used to serve as an alternative to a residential placement for youth as well as with youth returning back from residential placement such as commitment programs, halfway houses, group homes, or foster homes. *PLL* teaches families how to re-establish adult authority through consistent limits while reclaiming a loving relationship. The goals of Parenting with Love and Limits (*PLL*) are to: • Treat children and adolescents who have severe emotional and behavioral problems • Teach families how to re-establish adult authority through consistent limits while reclaiming a loving relationship’
Population	‘Youth aged 10 – 18 years with severe emotional and behavioral problems and frequently co-occurring problems such as depression, alcohol or drug use, chronic truancy, destruction of property, domestic violence, or suicidal ideation.’
Target outcomes	• Child behaviour • Family functioning • Safety and physical wellbeing
Intervention details	• ‘Combining both group and family therapy together over a six- to eight-week period • Having a recommended 6 to 8 adolescents and their families per group • Using the Stages of Readiness Scale as an overlay to break parental resistance • Assessing fidelity using the following 4 scales plus a manualized curriculum: ▪ Video supervision using Interpersonal Process Recall (IPR)- Expert Rating Scale ▪ Group Fidelity Checklist - (Therapist Adherence Measure)

Parenting with Love and Limits (PLL)	
	▪ Family Therapy Fidelity Checklist - (Therapist Adherence Measure) ▪ Monthly *PLL* Report - (Therapist Adherence Measure)'
Delivery setting	• 'Adoptive Home • Birth Family Home • Community Agency • Foster/Kinship Care • Outpatient Clinic • Residential Care Facility'
Dose	'Recommended Intensity: 2-hour weekly group sessions with 1 hour of parents and teens meeting together and 1 hour of the parents and teens meeting separately, and 1-2 hour weekly family sessions, as needed Recommended Duration: 6 weeks for group sessions, and 4 to 20 sessions for family sessions'
Staffing	'Master's level degree in counseling related field for clinician. Bachelor's degree for co-facilitator or case manager.'
Resources or supporting tools	'There is a manual that describes how to implement this program, and there is training available for this program. Training is obtained: • Initial 5-day onsite clinical training • Semimonthly quality assurance and clinical adherence telephone consultations (2 hours each supervision session) • Motivational Interview Training (*PLL* Specific) • Outcome research and analysis that includes an independently conducted, published program evaluation on recidivism rates and clinical effectiveness, if qualify

Parenting with Love and Limits (PLL)	
	• One annual onsite visit, if needed, to observe delivery of the model for quality assurance purposes • Videotape supervision of therapist to facilitate treatment fidelity • Monthly 1-hour session for Community Based Action Team (Case Management) supervision (Reentry Teams Only) • Ongoing consultations as needed to answer questions outside the weekly telephone consultations Number of days/hours: Five days of clinical training, 48 weeks of telephone consultations'
Cost information	No information provided
PRC rating	Promising
Primary source	CEBC
Date last reviewed	July 2012

3.8. Safe Environment for Every Kid Model (SEEK)

Safe Environment for Every Kid Model (SEEK)	
Intervention description	'*SEEK* utilizes pediatric primary care as an opportunity to help prevent child maltreatment in families who may have risk factors for child maltreatment. Most children receive this care and there are frequent visits in the first 5 years. Also, the generally good relationship between health professionals and parents offers an opportunity to identify and help address prevalent psychosocial problems. *SEEK* begins with training professionals to play this role. Online videos and other materials are available on the *SEEK* website. Continuing Medical Education (CME) credit is offered as well as Maintenance of Certification (MOC) Categories 2 and 4 credit (through the American Board of Pediatrics and the American Board of Family Medicine). The *SEEK* Parent Questionnaire (PQ) is a tool to screen for the targeted

Safe Environment for Every Kid Model (SEEK)	
	problems: parental depression, substance abuse, major stress, intimate partner violence, food insecurity, and harsh punishment. It is completed in advance and given to the professional at the start of a regular check-up. The trained professional then briefly assesses and initially addresses identified risk factors and makes necessary referrals to community resources, ideally with the help of a mental health professional. Principles of Motivational Interviewing have been incorporated into *SEEK* and parent handouts are available as adjuncts to advice offered in the visit.'
Population	'Target Population: Families with children aged 0-5 years who have risk factors for child maltreatment such as parental depression or substance abuse For children/adolescents ages: 0 – 5 For parents/caregivers of children ages: 0 – 5'
Target outcomes	• Child maltreatment • Support networks • Safety and physical wellbeing • Child development
Intervention details	• 'Health Professional Training: *SEEK* recognizes the importance of preparing child health professionals to assess and address problems such as parental depression. In addition to the initial training via online videos and other materials, ongoing training and support is offered. Continuing Medical Education (CME) credit is available, and Maintenance of Certification Categories 2 and 4 credit is available through the American Board of Pediatrics and the American Board of Family Medicine. • Motivational Interviewing (MI): *SEEK* incorporates principles of Motivational Interviewing to improve upon the traditional prescriptive approach to more effectively work with parents in planning and engaging in services. • The *SEEK* Parent Screening Questionnaire (PQ): The PQ is a brief screening tool parents complete in the pediatrician's office before seeing the pediatrician. It has 15 questions, takes 2-3 minutes to complete, and is currently available in English, Spanish, Chinese, and Vietnamese. It can be completed on paper or computer. • *SEEK* Parent Handouts: User-friendly, one-page handouts are available for all of the targeted problems, with space to list local resources and customized information about the practice. It is critical that

Safe Environment for Every Kid Model (SEEK)	
	professionals know what is available in the community to help address identified problems, such as substance abuse. • Mental Health Professional: It is recommended that medical professionals work with a mental health colleague, such as a social worker. The *SEEK* Model, however, has been designed to be deliberately flexible regarding who does what in addressing problems. Some health professionals are interested in playing a substantial role, others less so. Some parents may prefer discussing sensitive matters with the professional they know and trust. Thus, many health professionals do address psychosocial problems, with office or clinic staff helping to facilitate referrals. Nevertheless, a mental health colleague is a valuable asset.'
Delivery setting	Paediatric Primary Care Setting
Dose	'Recommended Intensity: It is recommended that the Parent Questionnaire be administered at many of the regular check-ups in the first 5 years, such as at 2, 9, 15, 24, 36, 48, and 60 months. There is no set intensity for the response or treatment; this hinges on the specific situation. Recommended Duration: Until the child reaches 5 years of age'
Staffing	'Medical professionals should be licensed to practice as pediatricians, family medicine physicians, nurse practitioners, or physician assistants. Mental health professionals need at least a Master's degree in a relevant field and to be licensed to provide clinical services' 'Training is obtained: Online, electronically, webinars, phone Number of days/hours: Initial training: 2-3 hours; Ongoing training: Variable, depending on needs and interest; Maintenance of Certification (MOC) Category 4: 12 hours'
Resources or supporting tools	Resources or supporting tools. 'The typical resources for implementing the program are: • A "champion" to lead implementation of the *SEEK* Model • Buy-in from the health professionals in the practice • 1 hour to train office staff • Access to a mental health professional is ideal, but not essential'
Cost information	Information not available

Safe Environment for Every Kid Model (SEEK)	
PRC rating	Promising
Primary source	CEBC
Date last reviewed	April 2014

3.9. Teaching Kids to Cope (TKC)

Teaching Kids to Cope (TKC)	
Intervention description	'*Teaching Kids to Cope (TKC)* is a cognitive-behavioral health education program, based on stress and coping theory, for adolescents ages 12-18 with depressive symptomatology and/or suicidal ideation. This group treatment program teaches adolescents a range of skills designed to improve their coping with stressful life events and decrease their depressive symptoms. Participants are guided through a process to discover their distorted thinking patterns and to test their thinking against reality using suggested approaches. They also explore and practice problem identification, alternate ways of viewing a situation, and alternate ways of reacting. During each group session, adolescents are first provided with information on topics such as common teen stressors, self-image, coping, family relationships, and communication. In the second portion of each session, they participate in experiential learning, identifying their problems and engaging in concrete problem-solving tasks. Activities also include group discussion, role-play, group projects, and the use of worksheets, handouts, films, and audiotapes. Homework assignments provide an opportunity for the adolescents to practice using new skills.'
Population	'Adolescents ages 12-18 with depressive symptomatology and/or suicidal ideation'
Target outcomes	• Child behaviour • Safety and physical wellbeing
Intervention details	'Participants are guided through a process to discover their distorted thinking patterns and to test their thinking against reality using suggested approaches. They also explore and practice problem identification, alternate ways of viewing a situation, and alternate ways of reacting. During each group session, adolescents are first provided with information on topics such as common teen stressors, self-image, coping, family

Teaching Kids to Cope (TKC)	
	relationships, and communication. In the second portion of each session, they participate in experiential learning, identifying their problems and engaging in concrete problem-solving tasks.' 'Homework assignments provide an opportunity for the adolescents to practice using new skills.'
Delivery setting	Schools, hospitals, outpatient clinics, churches, summer camps, or other community-based settings.
Dose	Ten weekly 1-hour group sessions
Staffing	'Professional with a bachelor's degree in education, social work, child development, nursing, psychology, or other health-related field, and 1 year of experience working with children or adolescents.'
Resources or supporting tools	Includes 1-day on-site training and an implementation manual. Activities include the use of '….worksheets, handouts, films, and audiotapes'.
Cost information	• '1-day, on-site training (includes five implementation manuals, rights for use and duplication, and ongoing technical assistance): $1,000 plus travel expenses. • Additional implementation manuals: $15 each.'
PRC rating	Promising
Primary source	SAMHSA
Date last reviewed	February 2010

4. Emerging

4.1. AVANCE Parent-Child Education Program (PCEP)

AVANCE Parent-Child Education Program (PCEP)	
Intervention description	‘*AVANCE*’s philosophy is based on the premise that education must begin in the home and that the parent is the child’s first and most important teacher. The *PCEP* fosters parenting knowledge and skills through a nine-month, intensive bilingual parenting curriculum that aims to have a direct impact on a young child’s physical, emotional, social, and cognitive development. Parents/primary caregivers are taught how to make toys out of common household materials and how to use them as tools to teach their children school readiness skills and concepts. Monthly home visits are also conducted to observe parent-child interactions and provide guidance in the home on learning through play.’ Along with parenting education, ‘parents/primary caregivers are supported in meeting their personal growth, developmental and educational goals to foster economic stability. While parents/primary caregivers attend classes, their children under the age of three are provided with early childhood enrichment in a developmentally appropriate classroom setting which aims to build the academic, social, and physical foundation necessary for school readiness.’ ‘Program Goals: Using a two-generation approach, the goals of the *AVANCE Parent-Child Education Program (PCEP)* are to: • Increase parents’ understanding of child development so they are better able to foster optimal development of their children • Empower parents to view themselves as their child’s first and most important teacher and the home as the first classroom *PCEP* achieves these goals by targeting the following outcomes: • Increased school readiness in children from birth to age three • Increased family engagement in the development and education of young children • Increased civic engagement, including knowledge of how to advocate for themselves and their families • Increased knowledge of community resources’

AVANCE Parent-Child Education Program (PCEP)	
Population	'Parents with children from 0 – 3 years or pregnant women. Vulnerable due to issues such as teenage parenting or low education levels.'
Target outcomes	• Child development
Intervention details	'Participants: • Voluntary • Parents/primary caregivers and their children from birth to age three • Pregnant mothers and their partners Intervention context: • Theoretical framework: • Human ecology • Attachment • Weekly three-hour small group sessions: • Toy-making • Parenting Education • Community Resource Speakers/Group Activities • Recommended adult class size: 15 to 25 participants; if more than 25 families wish to enrol in the program, recommend scheduling an additional class day to maintain the optimal group size that is conducive for learning • Early childhood education • Provided while adult participants attend weekly three-hour class • Size of child class depends on the age of the child and the recommended caregiver-to-child ratio for that age group • Monthly home visits

AVANCE Parent-Child Education Program (PCEP)	
	• Ongoing advocacy and support • Additional services (optional): • Transportation—provided as needed to help eliminate barriers to participation in the program • Food services—nutritious meals for children and nutritious snacks for parents/primary caregivers during the parenting class Program delivery staff: • Complete initial *AVANCE* orientation and biannual recertification training Program monitoring and use of data: • Data collected by Parent Educators and Home Educators as directed by the *AVANCE* National Office and sent data to the National Office for entry and analysis • Reports issued to *PCEP* providers by *AVANCE* National Office issues reports and used to evaluate and guide program implementation • Reports used by providers to monitor, identify and improve variances, and assure fidelity to the *AVANCE* model Partnerships: • Partnerships highly encouraged both to provide additional support services to families and to off-set program costs through in-kind support • Examples of partnerships include local school districts; children's museums; food banks, grocery stores and restaurants; medical and dental clinics; women's shelters (needs assessment and mental health counseling); colleges and universities (the adult continuing education of *PCEP*, program research and interns); places of worship (classroom space); discount stores (home and hygiene products, books and toys, etc. to use as incentives for program participation for parents/caregivers)'
Delivery setting	• Birth Family Home • Community Agency

AVANCE Parent-Child Education Program (PCEP)	
	• School
Dose	‘Recommended Intensity: Parent/primary caregiver contacts: Once per week for three hours - Child contacts: Once per week for three hours (early childhood education provided while parents are in class) - Parent-Child contacts: Once per month for 30-45 minutes (minimum) in the home Recommended Duration: Families participate in the voluntary program for nine months. Upon completion of a minimum of 75% of classes, parents/primary caregivers graduate and participate in the commencement ceremony with their children, Parents/primary caregivers are encouraged to return for a second year in which they are assisted with adult education and job training’
Staffing	‘All positions are required to complete initial *AVANCE* training and obtain biannual refresher training. All staff must be able to read and speak the language of the families they serve. *AVANCE* parent graduates are to be considered for staff positions. Generally, staff are from the community or very familiar with the area being canvassed. They are trained to be culturally sensitive, alert, enthused, self-confident, and self-assured and to present themselves in a caring and genuine manner. Because many staff members tend to be program graduates, they can relate firsthand experiences on the benefits of participation and can calm newcomers who may be nervous about enrolling in the program. Educational requirements for primary *PCEP* positions: • Parent Educator – BA degree in education, psychology or related human services field • Toy-making Instructor – high school diploma or equivalent • Home Educator – high school diploma or equivalent • Early Childhood Educator – high school diploma or equivalent with a Child Development Associate credential • Early Childhood Educator Aide – high school diploma or equivalent

AVANCE Parent-Child Education Program (PCEP)	
	Preferred skills/training: • Bilingual (in English and in the preferred language of participants; traditionally Spanish) • Experience working with adults and children or in a family support services environment *PCEP* graduate • Experience in management and supervision'
Resources or supporting tools	'The typical resources for implementing the program are: • Personnel (based on number of families served): Parent Educator, Home Educator, Toy-making Instructor, Early Childhood Educator • Adequate space for parents/primary caregivers and children (child classrooms should follow general ratio requirements) • Computer and telecommunication capabilities • A/V equipment (projector and speakers) • Toy-making materials/supplies • Early childhood development furniture/toys/books/supplies • Community resource materials and books • Transportation compliant with child safety standards (for families unable to travel to classes) • Nutritious meals/snacks • Strong, stable, and sustainable funding for agency operations In addition, a community advisory board is recommended to help develop partnerships that are integral to the *AVANCE* Parent-Child Education Program.'
Cost information	No information provided
PRC rating	Emerging

AVANCE Parent-Child Education Program (PCEP)	
Primary source	CEBC
Date last reviewed	September 2013

4.2. Coping And Support Training (CAST)

Coping And Support Training (CAST)	
Intervention description	‘*CAST (Coping And Support Training)* is a high school-based suicide prevention program targeting youth 14 to 19 years old. *CAST* delivers life-skills training and social support in a small-group format (6-8 students per group *CAST* serves as a follow-up program for youth who have been identified through screening as being at significant risk for suicide. In the original trials, identification of youth was done through a program known as *CARE (Care, Assess, Respond, Empower)*, but other evidence-based suicide risk screening instruments can be used. *CAST*'s skills training sessions target three overall goals: increased mood management (depression and anger), improved school performance, and decreased drug involvement. Group sessions incorporate key concepts, objectives, and skills that inform a group-generated implementation plan for the *CAST* leader. Sessions focus on group support, goal setting and monitoring, self-esteem, decision-making skills, better management of anger and depression, "school smarts," control of drug use with relapse prevention, and self-recognition of progress through the program. Each session helps youth apply newly acquired skills and increase support from family and other trusted adults. Detailed lesson plans specify the type of motivational preparation, teaching, skills practice, and coaching activities appropriate for at-risk youth. Every session ends with "Lifework" assignments that call for the youth to practice the session's skills with a specific person in their school, home, or peer-group environment.’
Population	‘ Youth who have been identified through screening as being at significant risk for suicide’ Youth aged 12-18 years.
Target outcomes	• Child behaviour • Safety and physical wellbeing

Coping And Support Training (CAST)	
Intervention details	‘Sessions focus on group support, goal setting and monitoring, self-esteem, decision-making skills, better management of anger and depression, "school smarts," control of drug use with relapse prevention, and self-recognition of progress through the program. Each session helps youth apply newly acquired skills and increase support from family and other trusted adults.’
Delivery setting	School
Dose	Twelve 55-minute group sessions administered over 6 weeks in a small-group format (6 – 8 students per group).
Staffing	‘Trained high school teachers, counselors, or nurses with considerable school-based experience.’
Resources or supporting tools	‘*CAST* curriculum, student notebooks, 4-day training, an online *CAST* tutorial, 2-day advanced training, 1-day on-site follow up consultation, evaluation materials and services.’
Cost information	• ‘*CAST* curriculum: $425 each. • Student notebooks: $16 each or $115.20 for eight. • 4-day, on- or off-site training workshop for *CAST* leaders and coordinators: $8,800 per group of five to eight participants, or $9,900 per group of nine participants, or $1,100 per participant to attend an open training. • Self-paced online *CAST* tutorial for administrators: $49 per person for unlimited access. • 2-day, on- or off-site advanced training for *CAST* coordinators: $800 per person. • Unlimited phone consultation: Free. • 1-day, on-site follow-up consultation: Varies depending on site needs and location. • Evaluation materials and services: Varies depending on site needs.’
PRC rating	Emerging
Primary source	SAMHSA
Date last reviewed	February 2007

4.3. Child FIRST

Child FIRST	
Intervention description	'*Child FIRST* is a system of care that targets children aged between 6 months and 3 years with emotional and behaviour problems where the parents are at psychosocial risk.' 'The intervention commences with a child and family assessment conducted in partnership between a clinician, a care coordinator and the parents, with other service providers involved as needed. A family plan is developed outlining supports and services for all family members and this is focused on family priorities, strengths, culture and needs. The home visiting component of the service is guided by parental need rather than a set curriculum. Families are also linked in with appropriate services, such as mental health, health and early care, early intervention, education, child protection and social and concrete services'
Population	'Children aged between 6 months and 3 years with emotional and behaviour problems where the parents are at psychosocial risk'. Psychosocial risk can be due to maltreatment or parent mental illness.
Target outcomes	• Child Development • Child Behaviour • Safety and Physical Wellbeing • Child Maltreatment Prevention • Family functioning • Systems Outcomes
Intervention details	• 'Assessment of child and family. • Individualised plan. • Linkage to other services, such as mental health, health and early care, early interventions, education, child protection and social and concrete services. • Based on family priorities, strengths, culture and needs. • Collaboration with families. • Home visiting components are guided by parental need rather than a fixed curriculum.

Child FIRST	
	• Observations of child's emotional, cognitive and physical development. • Observation of parent-child interactions. • Psychoeducation including developmental stages, expectations and means of typical behaviours. • Reflective functioning to understand the child's feelings and the meaning of the child's unique and challenging behaviours. • Psychodynamic understanding of the mother's history, feelings and experience of the child. • Alternative perspectives of child behaviour and new parental responses. • Positive reinforcement of both parents' and child's strengths to promote parents self-esteem.' (appendix 6, p.10) Components identified by PRC (Macvean *et. al.*, 2013) Delivery level: Individual Delivery: • Service linkage • Assessment • Individual plan • Collaboration with family • Based on strengths, needs, resources Content: • Individualised home visiting component rather than fixed curriculum • Child behaviour and behaviour management • Parent-child interactions

Child FIRST	
	• Child health and development • Reinforcement of parents strengths
Delivery setting	Home
Dose	'Delivered by a professional in 24 weekly home-based sessions to individual parents'
Staffing	A professional
Resources or supporting tools	Information not available
Cost information	Information not available
PRC rating	Emerging
Primary source	Macvean *et. al.* (2013)
Date last reviewed	2013

4.4. Children with Problematic Sexual Behavior Cognitive-Behavioral Treatment Program: School-age Group

Children with Problematic Sexual Behavior Cognitive-Behavioral Treatment Program: School-age Group	
Intervention description	'*Children with Sexual Behavior Problems Cognitive-Behavioral Treatment Program*: School-Age Group is a family-oriented, cognitive-behavioral, psychoeducational, and supportive treatment group designed to reduce or eliminate incidents of sexual behavior problems: • The program is an outpatient group treatment program for children ages 6 to 12 years and their parents or other caregivers. • Program can be provided to individual families when group is not an option. • The treatment is provided as an open-ended group, with children able to graduate in 4-5 months.

Children with Problematic Sexual Behavior Cognitive-Behavioral Treatment Program: School-age Group	
	• Collaboration with child protective services, juvenile court personnel, school personnel, and others involved is highly recommended. The children acknowledge the previous breaking of sexual behavior rules, learn coping and self-control strategies, and develop a plan of how they were going to keep these rules in the future. Caregivers were taught how to supervise the children, teach and implement rules in the home, communicate about sex education, and reduce behavior problems utilizing behavior parent training strategies. The goals of *Children with Sexual Behavior Problems Cognitive-Behavioral Treatment Program*: School-Age Group are to: • Eliminate or reduce problematic sexual behavior • Improve child behavior via better parental monitoring, supervision, and behavior management skills • Improve parent-child interaction and communication • Improve coping, self-control, and social skills'
Population	Children aged 6 – 12 years with problem sexual behaviours and their parents
Target outcomes	• Child behaviour • Family functioning
Intervention details	• 'Modelling, observing, and providing constructive and corrective feedback on skills • Structured program and providers who use a directive approach' Addressing components with Children and Caregivers • 'Rules about sexual behavior • Boundaries • Abuse prevention skills • Emotional regulation and coping skills • Impulse control and problem solving skills • Sex education

Children with Problematic Sexual Behavior Cognitive-Behavioral Treatment Program: School-age Group	
	• Social skills and peer relationships • Acknowledge, apology, and amends' Addressing additional components for caregivers • 'Behavior parent training to prevent and respond to sexual behavior problems as well as other behavior problems • Sexual development and child development including moral development • Dispelling misconceptions regarding the behavior and implications to the child • Support' 'Separating out the groups by age: • 6-9 year olds with 5 to 8 children per group • 10-12 year olds with 5 to 8 children in each group. • One caregiver group for children of the combined age ranges can be used – or separate caregiver group depending on program decisions.'
Delivery setting	Outpatient Clinic
Dose	'Recommended Intensity: 60-90 minute weekly session Recommended Duration: 4 to 5 months depending on meeting graduation criteria'
Staffing	'Supervisor and lead therapists are recommended to be licensed mental health practitioners with previous experience in treatment for children and their caregivers for children with behavior problems and children who have been maltreated'
Resources or supporting tools	'The typical resources for implementing the programs are: Group rooms including one room large enough to hold all the families for the parent-child group component. Chalk or dry erase board.

Children with Problematic Sexual Behavior Cognitive-Behavioral Treatment Program: School-age Group	
	Co-therapists for each child group (recommended). One therapist for the caretaker/parents group. Personnel to conduct the intake assessments. Supervisor/director of the program. Therapeutic materials, such as books.'
Cost information	No information provided
PRC rating	Emerging
Primary source	CEBC
Date last reviewed	June 2013

4.5. Clinician-Based Cognitive Psychoeducational Intervention for Families (Family Talk)

Clinician-Based Cognitive Psychoeducational Intervention for Families (Family Talk)	
Intervention description	'The *Clinician-Based Cognitive Psychoeducational Intervention for Families (Family Talk)* is intended for families with parents with significant mood disorder. Based on public health models, the intervention is designed to provide information about mood disorders to parents, equip parents with skills they need to communicate this information to their children, and open dialogue in families about the effects of parental depression.'
Population	'Families with parents with significant mood disorder' 'Ages: 6-12 (Childhood), 13-17 (Adolescent), 26-55 (Adult)'
Target outcomes	• Support networks • Family functioning • Child behaviour

Clinician-Based Cognitive Psychoeducational Intervention for Families (Family Talk)	
Intervention details	'The core elements of the intervention are (1) an assessment of all family members, (2) teaching information about affective disorders and risks and resilience in children, (3) linking information to the family's life experience, (4) decreasing feelings of guilt and blame in children, and (5) helping children to develop relationships within and outside the family to facilitate their independent functioning in school and in activities outside the home. In family meetings, parents talk about their own sessions, their treatment, and how they are working to build resilience and protect their children'
Delivery setting	• Outpatient • Home • Other community settings
Dose	' The intervention consists of 6-11 modules that include separate meetings with parents and children, family meetings, and telephone contacts or refresher meetings at 6- to 9-month intervals'
Staffing	' Sessions are conducted by trained psychologists, social workers, and nurses'
Resources or supporting tools	Includes 2-day initial training, online training, a training CD, an implementation manual and ongoing supervision and consultation.
Cost information	• 'Implementation manual: Free. • Online training: Free. • Training CD: $10 each. • 2-day initial training: $500 per day. • Ongoing biweekly supervision and consultation: $100 per hour.'
PRC rating	Emerging
Primary source	SAMHSA
Date last reviewed	October 2006

4.6. Cognitive Behavioural Therapy for Sexually Abused Preschoolers (CBT-SAP)

Cognitive Behavioural Therapy for Sexually Abused Preschoolers (CBT-SAP)	
Intervention description	'*CBT-SAP* is a program for 3 to 6 year old children with a history of maltreatment…The intervention targets child development, child behaviour, parent-child relationships and family relationships and is delivered in a clinical setting. Twelve sessions are delivered to individual parent-child dyads on a weekly basis by professionals. As the name suggests, this intervention involves the provision of cognitive behavioural therapy to parents and children. Delivery takes the form of cognitive reframing, thought stopping, positive imagery and contingency reinforcement. Parenting management training is also provided, as well as problem solving, psychoeducation and supportive interventions. Intervention content for the parents covers ambivalence about belief in the sexual abuse, ambivalence towards the perpetrator, attributions regarding the abuse, feelings that the child is damaged, the provision of appropriate emotional support to the child, management of child fear and anxiety, management of appropriate behaviours, and dealing with the parents' issues in relation to their own abuse. Intervention content for the children covers similar concerns such as attributions regarding the abuse and ambivalent feelings towards the perpetrators, but also child safety and assertiveness training, appropriate versus inappropriate touching, inappropriate behaviour and issues of fear and anxiety.' (p.33-34)
Population	Parents and their children aged 3 – 6 years with a history of maltreatment.
Target outcomes	• Child development • Child behaviour • Safety and physical wellbeing • Child maltreatment prevention • Family functioning
Intervention details	'Delivery takes the form of cognitive reframing, thought stopping, positive imagery and contingency reinforcement. Parenting management training is also provided, as well as problem solving, psychoeducation and supportive interventions.' (p.33-34)

Cognitive Behavioural Therapy for Sexually Abused Preschoolers (CBT-SAP)	
	Components identified by PRC (Macvean *et. al.*, 2013) Delivery level: Individual Delivery: • Structured sessions • Cognitive re-framing • Thought stopping • Positive imagery • Parent management training • Psycho-education • Supportive interventions Content: • Problem solving skills • Child behaviour and behaviour management • Home, environment and child safety • Emotional regulation • Ambivalence in belief of abuse, ambivalence toward perpetrators, feeling the child is damaged, emotional support for child, parental issues regarding their own abuse • Child assertiveness training, appropriate vs inappropriate touching
Delivery setting	Clinic
Dose	12 weekly sessions with parent and child. '90 minutes (50 mins with parent and 30-40 mins with child)' appendix 6, p.20.

Cognitive Behavioural Therapy for Sexually Abused Preschoolers (CBT-SAP)	
Staffing	Delivered by a professional
Resources or supporting tools	Information not provided.
Cost information	Information not provided.
PRC rating	Emerging
Primary source	Macvean et. al. (2013)
Date last reviewed	2013

4.7. Community Advocacy Project (CAP)

Community Advocacy Project (CAP)	
Intervention description	'The *Community Advocacy Project* involves providing home-based and community-based advocacy services for survivors of intimate partner abuse. Highly trained paraprofessionals, receiving intensive supervision, work with survivors of domestic abuse (and their children), helping them obtain the community resources and social support they desire. This is an empowerment-based, strengths-focused intervention designed to increase women's quality of life and decrease their risk of re-abuse.' • 'Increase children's self-competence • Decrease women's depression • Increase women's quality of life • Increase women's access to resources • Increase women's social support • Increase women's and children's safety' 'Services offered are community-based and home-based. • Activities are driven by the women, not the advocates.

Community Advocacy Project (CAP)	
	• Advocates are proactive and engaged in linking women with community resources. • Advocates are knowledgeable about available community resources and effective strategies for obtaining them. • Advocates focus on enhancing women's social support. • Advocates should be highly trained in empathy and active listening.’
Population	‘Target Population: Designed for and tested with survivors of domestic abuse who have utilized shelters. Can be expanded to non-shelter users.’ Includes their children.
Target outcomes	• Family functioning • Support networks • Systems outcomes
Intervention details	‘ The intervention is composed of five phases: • Assessment. The advocate gathers important information regarding the needs and goals of each participant and her child. The participant, not the advocate, guides the direction and activities of the intervention by identifying issues that are important to her. • Implementation. The advocate and the participant actively work together to generate, mobilize, and access community resources. For women, resources often involve legal assistance, housing, employment, education, transportation, child care, social support, and/or material goods. For children, advocacy often focuses on participation in recreational activities (e.g., joining a Boys and Girls Club, getting on a sports team, going to camp), help with school, and/or material goods. • Monitoring. The advocate checks in with the participant regularly to determine whether her unmet needs have been fulfilled. • Secondary implementation. If the community resources were ineffective in satisfying the participant's original needs, the advocate suggests alternative strategies to generate, mobilize, or access other resources. • Termination. This phase occurs during the last few weeks of the intervention, when the advocate focuses even more intensively on the transfer of skills and knowledge to the participant, ensuring that she no longer needs the advocate at the end of the intervention.’ (SAMHSA)

Community Advocacy Project (CAP)	
	• ‘Services offered are community-based and home-based. • Activities are driven by the women, not the advocates. • Advocates are proactive and engaged in linking women with community resources. • Advocates are knowledgeable about available community resources and effective strategies for obtaining them. • Advocates focus on enhancing women's social support. • Advocates should be highly trained in empathy and active listening. ‘(CEBC)
Delivery setting	Adoptive Home Birth Family Home
Dose	‘Recommended Intensity: 4-6 hours per week Recommended Duration: 10 weeks’
Staffing	‘Advocates must be highly trained in strengths-based philosophy, domestic abuse dynamics, safety planning, and obtaining community resources. Advocates need ongoing, intensive supervision to ensure they are maintaining fidelity of the model.’ ‘Supervisors should have at least two years’ experience providing domestic abuse services, ideally in community settings. They should be highly trained in empathy, active listening, strengths-based services, and safety planning.’
Resources or supporting tools	No specific resources are needed to implement the intervention. It occurs in women's homes and communities
Cost information	‘Advocate logbook for weekly activities: $5 each. The Community Advocacy Project: Advocate Manual (includes weekly progress report forms): Free. The Community Advocacy Project: Instructor Manual: Free.

Community Advocacy Project (CAP)	
	Training handouts: Free. Training PowerPoint slides: Free. Why Does He Do That? Inside the Minds of Angry and Controlling Men (book by Lundy Bancroft): $8.80 each. Safety Planning With Battered Women: Complex Lives/Difficult Choices (book by Jill Davies, Eleanor Lyon, and Diane Monti-Catania): $59.99 each. In Her Shoes: Economic Justice Edition (kit from the Washington State Coalition Against Domestic Violence): $125 each. StarPower (kit from Simulation Training Systems): $249 each. Bafa'Bafa' (kit from Simulation Training Systems): $289 each. The Story of Rachel (DVD from Praxis International): $49 each. 40-hour, on-site training: $9,000 for an unlimited number of participants, plus trainer travel expenses, if training is provided by the developer. Free, if training is provided by a local qualified trainer. 40-hour, on-site train-the-trainer workshop: $9,000 for an unlimited number of participants, plus trainer travel expenses. Online technical assistance and consultation: Cost varies depending on site needs (free for simple inquiries). CAP Fidelity Measure (includes process and outcome measures, CAP Fidelity Coding Sheet, and Fidelity Coding Framework): Free.' (SAMHSA)
PRC rating	Emerging
Primary source	CEBC
Date last reviewed	April 2014

4.8. Early Start

Early Start	
Intervention description	'*Early Start* is a program for children aged up to 3 months who are at risk of maltreatment'
Population	'Children aged up to 3 months who are at risk of maltreatment' Risk of maltreatment can be due to family circumstances including domestic, family or intimate partner violence and parental substance abuse.
Target outcomes	• Child development • Child behaviour • Safety and physical wellbeing • Child maltreatment prevention • Family functioning • Support networks • Systems outcomes
Intervention details	'The program commences with an assessment of family needs, issues, challenges, strengths and resources. Individualised service plans are developed. There is a focus on relationship development between the worker and the family, in which there is collaborative problem solving focused on family challenges. Families receive support, teaching, mentoring and advice to assist them to use their strengths and resources. Content of the intervention includes information about child health and safety, such as timely medical visits, compliance with immunisation and wellbeing checklists and home safety. Parenting skills information is also provided including parental sensitivity, positive parenting and non-punitive parenting. There is support for parental physical and mental health such as reductions of unplanned pregnancies and early detection and treatment of depression/anxiety/substance abuse. Other content includes information about family economic and material wellbeing (budgeting, employment), positive adult relationships and crisis management.' Components identified by PRC (Macvean *et. al.*, 2013)

Early Start	
	Delivery level: Individual Delivery: • Assessment • Individual plan • Based on family strengths, needs, resources • Collaborative relationship with family Content: • Parent mental and physical health • Child health and development • Planning ahead for high risk situations/crisis management • Positive parenting • Non-punitive parenting • Life skills, continuity of life course: family economics, nutrition, education, employment, relationships • Positive adult relationships
Delivery setting	Home
Dose	'intervention. Individual families participant for up to 3 years, with the number of visits varying from a maximum of one per week to a minimum of one per month'
Staffing	'Professional-delivered'
Resources or supporting tools	Information not available
Cost information	Information not available

Early Start	
PRC rating	Emerging
Primary source	Macvean et. al. (2013)
Date last reviewed	2013

4.9. Family Connections

Family Connections	
Intervention description	'*Family Connections* is a service model evaluated in the USA with an intervention focus. It draws on Ecological/Systems Theory. The service is delivered in the home to child-caregiver dyads by trained social workers in up to 40 sessions that last one-and-a-half hours each. The approach has shown good fidelity.'
Population	'Children targeted in this service model are aged 5–11 years and have been exposed to neglect, domestic or family violence, parental substance misuse or parental mental illness.'
Target outcomes	• Child behaviour • Child maltreatment prevention • Family functioning • Support networks • Systems outcomes
Intervention details	'Individual family support, Community outreach, tailored interventions, helping alliance, empowerment, strengths-based, cultural competence, developmental appropriateness, & outcome-driven service plans.' (appendix 2, p.20)
Delivery setting	Home
Dose	'up to 40 sessions that last one-and-a-half hours each'

Family Connections	
Staffing	Trained social workers
Resources or supporting tools	Information not available
Cost information	Information not available
PRC rating	Emerging
Primary source	Australian Centre for Posttraumatic Mental Health and Parenting Research Centre (2013)
Date last reviewed	2013

4.10. Families Facing the Future

Families Facing the Future	
Intervention description	'The *Families Facing the Future* parent training curriculum consists of one five-hour family retreat and 32 hour-and-a-half parent training sessions. Sessions are conducted twice a week over a 16-week period. Children attend 12 of these sessions to practice the skills with their parents. Parent sessions are conducted with groups of six to eight families.' It is necessary to provide practice opportunities as well as skill areas that address recurring problem behaviors specific to the needs of the parents. 'The parent training format combines a peer support and skill training model. The training curriculum teaches skills using the 'guided participant modelling.' Skills are modelled by trainers and other group members, then discussed by participants. Skills steps are reviewed and then parents practice the steps. Video-tape is frequently used in modelling the skills or during practice of the skills. The training focuses on affective and cognitive as well as behavioral aspects of performance.'
Population	'Target Population: Parents receiving methadone treatment and their children ages 5 – 14. For children/adolescents ages: 5 – 14 For parents/caregivers of children ages: 5 – 14'
Target outcomes	• Child development

Families Facing the Future	
	• Family functioning • Child behavior • Safety and physical wellbeing • Support networks
Intervention details	• ‘Groups consist of 6 to 8 families per group • Session topics are targeted at specific risk and protective factors and include: ▪ Family Goal Setting: This five-hour session focuses on bringing a variety of families together to share a common, trust-building experience. Families work together to develop goals for their participation. ▪ Relapse Prevention: These four sessions include identification of relapse signals or triggers, anger and stress control, and creating and practicing a relapse plan in the event of relapse. The primary focus during these sessions is the impact of relapse on the client's children and skills to prevent and cope with relapse situations. ▪ Family Communication Skills: The skills of Paraphrasing, Open Questions, ‘I’ Messages are taught during these sessions. Families practice using the skills during two practice sessions. Families also practice and use Family Involvement Skills to develop family expectations and plans for regular family meetings or family play and fun time. All subsequent groups reinforce the use of the communication skills taught in these early sessions. Families are asked to conduct weekly family meetings to practice the skills learned in the training. ▪ Family Management Skills: Parents learn and practice setting clear and specific expectations, monitoring expectations, rewarding for positive behaviors, and instilling consequences for negative behaviors. Parents practice implementing ‘the law of least intervention,’ using the smallest intervention to get the desired behavior from their child. A variety of discipline practices are learned and practiced by parents. These include, praise, ignoring, expressing feelings, if-then messages, time-outs, and privilege restrictions. ▪ Creating Family Expectations about Drugs and Alcohol: Families work together to define and clarify expectations about drugs and alcohol in their families. ▪ Teaching Children Skills: Parents learn how to teach their children two important skills, Refusal Skills and Problem Solving Skills, using a five-step process. ▪ Helping Children Succeed In School: Parents build on the previously learned skills to create, monitor, and consequence a home learning routine for their children.

Families Facing the Future	
	• The curriculum allows for participant practice in situations they currently face with their own children. Parents complete home extension exercises after each session to generalize the skills from the training setting to the home setting. After parents learn and practice skills, family sessions are conducted where parents and children practice using their new skills together. ▪ The *Families Facing the Future* case management intervention comprehensively addresses important aspects of family life. The case management intervention is designed to test the effectiveness of: ▪ Helping families to identify their goals and empowering them to work toward those goals ▪ Building on families' strengths to stabilize their household through providing tangible services and skills ▪ Working directly with clients and their families to reduce post-treatment relapse factors and risk factors for later drug abuse by children ▪ Motivating and encouraging continuation with the parenting skills training ▪ Further reinforcing, practicing, and generalizing parenting skills to the home environment • Case managers approach these tasks by providing families with a pro-social model, offering them opportunities for involvement in pro-social activities, networking them into needed services, and changing their reward structure through coaching and reinforcement of their new skills. Case managers also work with families to accomplish the family goals established in the initial parent training session.'
Delivery setting	• Outpatient clinic
Dose	'Recommended Intensity: Parents: 1.5 hour sessions, twice a week; Children: 1.5 hour session, approximately once a week Recommended Duration: Parents: One 5-hour session, then 32 sessions (16 weeks); Children: 12 sessions (12 weeks)'
Staffing	'Training in chemical dependency and parenting, Master's level education. Training is obtained: Onsite; travel expenses must be reimbursed Number of days/hours: 3 days at 8 hours per day'
Resources or supporting tools	'The typical resources for implementing the program are: • 1 meeting room

Families Facing the Future	
	• Cost of two full to half-time staff are needed for group work and home visits • Childcare • DVD or VHS player • TV’
Cost information	Information not available
PRC rating	Emerging
Primary source	CEBC
Date last reviewed	June 2013

4.11. Home Instruction for Parents of Preschool Youngsters (HIPPY)

Home Instruction for Parents of Preschool Youngsters (HIPPY)	
Intervention description	‘*HIPPY* is a home-based and parent-involved school readiness program that helps parents prepare their children ages three to five years old for success in school and beyond. The parent is provided with a set of carefully developed curriculum, books, and materials designed to strengthen their child’s cognitive and early literacy skills, as well as their social, emotional, and physical development. *HIPPY* believes that parents play a critical role in their children’s education. The *HIPPY* program seeks to support parents who may not feel sufficiently confident to prepare their children for school, and is designed to remove barriers to participation in education.’
Population	‘Parents with children aged up to 5 years, who have little resources or education or who are adolescent parents’
Target outcomes	• Child development • Child behaviour

Home Instruction for Parents of Preschool Youngsters (HIPPY)	
Intervention details	• ‘The developmentally appropriate curriculum • Role play as the method of instruction • Staff consisting of coordinators and home visitors • parent engagement through home visits and group meetings • Parent and child educational interactions encouraged through the use of the HIPPY curriculum • Designed to support parents with limited formal education • Scripted curriculum that serves as a lesson plan for parents • Curriculum based on exposure to skills, rather than mastery’
Delivery setting	• Adoptive Home • Birth Family Home • Foster/Kinship Care
Dose	‘Recommended Intensity: Home visitors engage their assigned parents on a weekly basis. Service delivery is primarily through home visits. A home visit consists of a one-hour, one-on-one interaction between the home visitor and their assigned parents. Parents then engage their children in educational activities for five days per week for 30 weeks. At least six times per year, one or more cohorts of parents meet in a group setting with the coordinator and their assigned home visitor(s). Group meetings feature enrichment activities for parents and their children and last approximately two hours. Recommended Duration: A minimum of 30 weeks of interaction with the home visitor; curriculum available for up to three years of home visiting services’
Staffing	‘The home visitors live in the community they serve and work with the same group of parents for three years. They receive weekly comprehensive training to well equip them to serve their assigned families effectively. The training also encourages them to seek further education. Many home visitors earn degrees in early childhood education. Educational requirements are established by the implementing agency and are usually a

Home Instruction for Parents of Preschool Youngsters (HIPPY)	
	high school diploma or GED. Home visitors must be able to read in and speak the language of the families they serve. The coordinator, who trains the home visitors and oversees the local program, is required to have the minimum of a Bachelor's degree.'
Resources or supporting tools	'The typical resources for implementing the program are: • Office space, furniture and basic furnishing, and a computer for administrative functions of program • Supplies for home visitation part that are not always commonly found in a home setting are provided by the program, such as coffee stirrers, sand paper, screws, etc. • Group meetings are held in the program office or community settings, such as a church, school, community center, etc.'
Cost information	No information provided
PRC rating	Emerging
Primary source	CEBC
Date last reviewed	April 2014

4.12. Homebuilders®

Homebuilders®	
Intervention description	'*Homebuilders*® is a home and community-based intensive family preservation services treatment program designed to avoid unnecessary placement of children and youth into foster care, group care, psychiatric hospitals, or juvenile justice facilities. The program model engages families by delivering services in their natural environment, at times when they are most receptive to learning, and by enlisting them as partners in assessment, goal setting, and treatment planning. Reunification cases often require case activities related to reintegrating the child into the home and community. Examples include helping the parent find childcare, enrolling the child in school, refurbishing the child's bedroom, and helping the child connect with clubs, sports or other community groups. Child neglect referrals often require case activities related to improving the

Homebuilders®	
	physical condition of the home, improving supervision of children, decreasing parental depression and/or alcohol and substance abuse, and helping families access needed community supports.'
Population	'Target Population: Families with children (birth to 18) at imminent risk of placement into, or needing intensive services to return from, foster care, group or residential treatment, psychiatric hospitals, or juvenile justice facilities. For children/adolescents ages: 0 – 17 For parents/caregivers of children ages: 0 – 17'
Target outcomes	• Child behavior • Support Networks • Child maltreatment prevention • Child development • Family Functioning • Systems outcomes
Intervention details	• 'Engagement: Use a collaborative and collegial approach to engage and motivate families. • Assessment and Goal Setting: Use client-directed assessment across life domains, ongoing safety assessment and planning, domestic violence assessment, suicide assessment, and crisis planning. • Behavior Change: Use cognitive and behavioral research-based practices and behavioral interventions. • Skills Development: Teach parents and children a wide variety of "life skills." Use "teaching interaction" process including practice, feedback, and homework. • Concrete Services: Provide and/or help the family access concrete goods and services that are directly related to achieving the family's goals, while teaching them to meet these needs on their own. • Community Coordination and Interactions: Coordinate, collaborate, and advocate with state, local, public, and community services and systems affecting the family, while teaching clients to advocate and access support for themselves. • Immediate Response To Referral: Accept referrals 24 hours a day, 7 days a week. Therapist and back-up are available 24-hours a day, 7 days a week.

Homebuilders®	
	• Service Provided in the Natural Environment: Provide services in the families' homes and community. • Caseload Size: Carry caseloads of two families at a time on average, but it can be as high as five. • Flexibility and Responsiveness: Tailor services to each family's needs, strengths, lifestyle, and culture.’
Delivery setting	• Adoptive home • Birth family home
Dose	‘Recommended Intensity: Three to five 2-hour sessions contacts per week; an average of 8 to 10 hours per week of face to face contact, with telephone contact between sessions. Recommended Duration: An average of four to six weeks. Two aftercare 'booster sessions' totalling up to five hours are available in the six months following referral’
Staffing	‘A team of 2-5 therapists, 1 supervisor (carries a partial caseload) and 1 secretary/support staff • Therapist: Master's degree in psychology, social work, counseling, or a related field, or Bachelor's degree in same fields plus two years of experience working with families. • Supervisor: Master's degree in psychology, social work, counseling or a related field, or Bachelor's degree in same fields plus two years of experience providing the program, plus one year supervisory/management experience.’
Resources or supporting tools	• ‘A small amount of staff work/office space, supplies, telephone, copier, etc. • Pagers and /or cell phones • Clinical staff use their own vehicles for home visits, mileage is paid for all client and program related travel • Access to a computer and Internet for client records and data collection’
Cost information	‘*HOMEBUILDERS* site development and implementation readiness consultation (in person or by phone): Varies depending on site needs and travel expenses. • 4-day, on-site *HOMEBUILDERS* Core Curriculum Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $120 per participant for materials.

Homebuilders®	
	• 1-day, on-site Goal Setting and Paperwork Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $20 per participant for materials. • 2-day, on-site Motivational Interviewing Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $40 per participant for materials. • 1-day, on-site Relapse Prevention Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $20 per participant for materials. • 1-day, on-site Utilizing Cognitive Strategies With Families Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $20 per participant for materials. • 1-day, on-site Utilizing Behavioral Principles and Strategies With Families Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $20 per participant for materials. • 1-day, on-site Teaching Skills to Families Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $15 per participant for materials. • 2-day, on-site Improving Decision Making Through Critical Thinking Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $25 per participant for materials. • 2- to 5-day, on-site Fundamentals of Supervising HOMEBUILDERS: Intensive Family Preservation Services Training (2-part training): $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $275 per participant for materials. • 2- to 3-day, on-site Program Consultation and Quality Assurance Skills for HOMEBUILDERS Supervisors Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $75 per participant for materials. • 1.5- to 2-day, on-site Online Data Manager Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $15 per participant for materials.

Homebuilders®	
	• 2-day, on-site Addressing Domestic Violence: Strategies for In-Home Practitioners Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $45 per participant for materials. • 1-day, on-site Ethical Issues in In-Home Services Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $15 per participant for materials. • 1-day, on-site Self-Advocacy Skills for Families: A Territorial Model of Assertiveness Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $10 per participant for materials. • 1-day, on-site Working With Parents With Cognitive Limitations Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $15 per participant for materials. • 1-day, on-site Substance Exposed Newborns Training: $1,250 per day for 1 trainer (up to 15 participants) or $2,500 per day for 2 trainers (up to 30 participants), plus travel expenses. $15 per participant for materials. • Phone consultations (held weekly in the first 2 years of implementation, monthly in year 3, and quarterly thereafter): $100 per hour. • 3- to 4-day, on-site visits (2 times per year): $1,250 per day, plus travel expenses. Technical assistance as needed via phone or email: $100 per hour. File and fidelity reviews (2 times per year): $100 per hour. • Access to the Online Data Manager, a Web-based client information and data system that includes assessments, service plans, service summaries, contact logs, referral information, and other quantitative data tools for program fidelity: $4,900 activation fee (year 1 only). $350 monthly fee. $980 annual upgrade fee.' (SAMHSA)
PRC rating	Emerging
Primary source	CEBC
Date last reviewed	June 2013

4.13. Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)

Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)	
Intervention description	'*MST-CAN* is for families with serious clinical needs who have come to the attention of child protective services (CPS) due to physical abuse and/or neglect. *MST-CAN* clinicians work on a team of 3 therapists, a crisis caseworker, a part-time psychiatrist who can treat children and adults, and a full-time supervisor. Each therapist carries a maximum caseload of 4 families. Treatment is provided to all adults and children in the family. Services are provided in the family's home or other convenient places. Extensive safety protocols are geared towards preventing re-abuse and placement of children and the team works to foster a close working relationship between CPS and the family. Empirically-based treatments are used when needed and include functional analysis of the use of force, family communication and problem solving, Cognitive Behavioral Therapy for anger management and posttraumatic stress disorder (PTSD), clarification of the abuse or neglect, and Reinforcement Based Therapy for adult substance abuse.'
Population	'Target Population: Families who have come to the attention of Child Protective Services within the past 180 days due to the physical abuse and/or neglect of a child in the family between the ages of 6 and 17; where the child is still living with them or is in foster care with the intent of reunifying with the parent(s). Other criteria may apply. For children/adolescents ages: 6 – 17 For parents/caregivers of children ages: 6 – 17'
Target outcomes	• Systems outcomes • Family functioning • Child maltreatment prevention • Child behaviour • Safety and physical wellbeing • Child development
Intervention details	'Clients

Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)	
	• Youth between the ages of 6 and 17. • Youth who have come to the attention of child protective services due to physical abuse and/or neglect and for whom the abuse report was filed within the last 180 days. • Youth who are currently in foster care or another out-of-home placement and will be reuniting with their family. Intervention Context • Services are provided in the family's home or other places convenient to them and at times convenient to the family. • Services are intensive, with intervention sessions being conducted from three times per week to daily. • A 24/7 on-call roster is utilized to provide round-the-clock services for families. • Treatment is provided to multiple children in the family and one or both parents, with a greater emphasis on parent treatment than standard *MST*. Therapists and Supervisors • *MST-CAN* staff work on a clinical team of 3 therapists, a crisis caseworker, a part-time psychiatrist, and a full-time supervisor. • The *MST-CAN* supervisor must have an understanding of the child protective services system, experience with family therapy and cognitive behavioral therapy for posttraumatic stress disorder (PTSD)/trauma. The supervisor must have experience in managing severe family crises that involve safety risk to the children or entire family. The supervisor must also have a thorough understanding of state mandated abuse reporting laws. The supervisor must have a PhD or Master's degree in counseling, social work, or a related field. • Supervisors must be full-time and may supervise a single team only. • The *MST-CAN* therapist must have a Master's degree in counseling, social work, or a related field. • The *MST-CAN* Team must have access to an appropriate percentage of a psychiatrist's time that has been trained in the *MST* and *MST-CAN* treatment models. This psychiatrist must be integrated into the clinical team and should be able to serve adults and children.

Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)	
	• The *MST-CAN* team must include one full-time crisis caseworker. This staff member should be at least a Bachelors-prepared professional. Application of the Intervention • Interventions are developed along an analytical model that guides the therapist to assess factors that are driving clinical problems and then interventions are applied to the driving factors or "fit factors." • All interventions are those that are evidence-based or evidence-informed. • Each therapist carries a maximum caseload of 4 families and case length is 6-9 months. Program Fidelity and Quality Assurance • Each team member completes a 5-day *MST* orientation training, a 4-day *MST-CAN* training, and 4 days of training in adult and child trauma treatment. • Weekly on-site group supervision. • Weekly telephone consultation with an *MST-CAN* expert. • Quarterly on-site booster trainings conducted by the *MST-CAN* expert. • Measurement of model adherence through monthly phone interviews with the parent or caregiver. Program Monitoring and Use of Data • Agencies collect data as specified by MST Services and all data are sent to the MST Institute (MSTI) which is charged with keeping the national database system. • MSTI data reports are used to assess and guide program implementation. • Agencies use these reports to monitor and assure fidelity to the MST model. • There must be a formal Memorandum of Agreement (MOA) in place regarding access to abuse and placement data prior to implementation'
Delivery setting	'This program is typically conducted in a(n):

Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)	
	• Adoptive Home • Birth Family Home • Foster/Kinship Care • School’
Dose	‘Recommended Intensity: Services are intensive, with intervention sessions being conducted from three times per week to daily. However, there is no expectation of a specific number of contact hours, as staff contact waxes and wanes according to the needs of the families. Session length depends on the needs of the family and may range from 50 minutes to 2 hours. Multiple types of sessions may be conducted in one day (e.g., parental drug screening and session; family communication and problem solving). Recommended Duration: Treatment length ranges from 6-9 months.’
Staffing	‘*MST-CAN* Supervisor: • Must be assigned to *MST-CAN* 100%. • Must have a Master's degree in counseling, social work, or a related field. • Must be independently licensed. • May only supervise a single team. • May not carry their own caseload. • Must have an understanding of the child welfare system. • Must have experience in managing severe family crises that involve safety risk to the children and/or entire family. • Must have a thorough understanding of state and national mandated abuse reporting laws. • Should have experience implementing Standard MST or *MST-CAN*. • Should have knowledge and experience in the *MST-CAN* Supervision Model. • Should have experience with family therapy and Cognitive-Behavioral Therapy (CBT) for Post-traumatic Stress Disorder (PTSD).

Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)	
	MST-CAN Therapist: • Must be assigned to a single *MST-CAN* team 100%. • Must have a Master's degree in counseling, social work, or a related field. • Should have a background in child development. • Should have an understanding of family violence. • Should have skills in engaging families reluctant to participate. • Should have experience in crisis intervention where homicidal or suicidal risk is present. • Should have knowledge of the child welfare system. *MST-CAN* Crisis Caseworker: • Must be assigned to a single *MST-CAN* team 100%. • Must have a minimum of a Bachelor's degree. • Should have knowledge, of interventions related to practical life skills such as employment seeking, budgeting, and housing. • Should have experience in the child welfare system. • Should have knowledge of child development. *MST-CAN* Psychiatrist: • Must be available to team at least 8 hours per week. • MD or DO, board certification eligibility in Child and Adolescent Psychiatry. • Must be trained in the *MST* treatment model and the *MST-CAN* adaptations by MST, Inc. • Must have a thorough understanding of state and national mandated abuse reporting laws. • Should have a thorough understanding of existing ethical guidelines and laws concerning clinical situations that may occur in crisis treatment (i.e., restraints, commitments, reporting abuse or neglect).

Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)	
	• Should have experience with both child and adult populations. • Should have experience in trauma treatment for youth and adults. • Should have experience working in local organizations and systems.' 'Training is obtained: Training is only available to staff who will be implementing *MST-CAN* in a licensed program. With regard to the initial 5-day *MST* orientation, organizations can access the training in one of two ways. New staff can come to Charleston, SC and participate in one of the quarterly open-enrolment trainings provided by MST Services Inc. Alternatively, providers can elect to have MST Services Inc. conduct an additional 5-day initial training at their site. *MST-CAN* training and the 4-day trauma training are provided on site by *MST-CAN* experts at this time. After start-up, training continues through weekly telephone *MST-CAN* consultation and on-site quarterly booster trainings for each team of *MST-CAN* clinicians. Number of days/hours: All trainees complete the Standard MST 5-day orientation. Then each team member completes a 4-day *MST-CAN* specific training and 4 days of training in adult and child trauma treatment. All training is open to CPS caseworkers who will be working with the *MST-CAN* team. After start-up, training continues through weekly telephone *MST-CAN* consultation for each team of *MST-CAN* clinicians aimed at monitoring treatment fidelity and adherence to the *MST-CAN* treatment model, and through quarterly on-site booster trainings (1 1/2 days each). Trained *MST-CAN* experts will teach the *MST-CAN* supervisor to implement a manualized *MST* supervisory protocol and collaborate with the supervisor to promote the ongoing clinical development of all team members. The *MST-CAN* expert will also assist at the organizational level as well as needed.'
Resources or supporting tools	'The typical resources for implementing the program are: Office space to house the team and conduct consultation and supervision is required as well as laptops and mobile phones for all staff.'
Cost information	Information not available
PRC rating	Emerging
Primary source	CEBC

Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)	
Date last reviewed	September 2013

4.14. Parent Training Prevention Model (not the name of an intervention; description only)

Parent Training Prevention Model (not the name of an intervention; description only)	
Intervention description	'This parent training program is for children aged 18 months to 4 years of age who are at risk of maltreatment and have parents who have a low SES status or who are disadvantaged. The main focus of the program content is on child behaviour management, such as positive parenting techniques including child-let play, distraction, "catching child being good" and effective compliance strategies, as well as the use of time out for managing difficult child behaviour. Problem solving, time management and anger management skills are also included, as well as child health and safety content.'
Population	'Children aged 18 months to 4 years of age who are at risk of maltreatment and have parents who have a low SES status or who are disadvantaged'
Target outcomes	• Child development • Child behaviour • Safety and physical wellbeing • Child maltreatment prevention • Family functioning
Intervention details	'The program is delivered in a non-didactic format in which there is continuous interaction between group members and group facilitator. Written materials are provided that outline the group curriculum. Group sessions start with one or more women sharing a positive experience with their child that happened over the week. There is also a review of previous week's curriculum. During sessions, Socratic dialogue is used, as well as role-play, modelling and homework tasks. Barriers to the use of the curriculum are discussed.' 'The main focus of the program content is on child behaviour management, such as positive parenting techniques including child-let play, distraction, "catching child being good" and effective compliance strategies, as well as the use of time out for managing difficult child behaviour. Problem solving, time management and anger management skills are also included, as well as child health and safety content.'

Parent Training Prevention Model (not the name of an intervention; description only)	
	Components identified by PRC (Macvean *et. al.*, 2013) Delivery level : individual Delivery: • Structured sessions • Written material • Discussion • Modelling • Role-play • Sharing stories of positive interactions with child • Review the course curriculum • Socratic dialogue Content: • Problem solving skills • Child behaviour and behaviour management • Child health and development • Time out • Home, environment and child safety • Parent time management • Emotional regulation • Positive parenting

Parent Training Prevention Model (not the name of an intervention; description only)	
Delivery setting	15 weekly home based sessions for individuals. Groups.
Dose	'Professionals deliver the program in 15 weekly sessions to individual parents, plus there are sessions for groups of parents.'
Staffing	Delivered by a professional
Resources or supporting tools	Information not available
Cost information	Information not available
PRC rating	Emerging
Primary source	Macvean et. al. (2013)
Date last reviewed	2013

4.15. Parents Under Pressure (PUP)

Parents Under Pressure (PUP)	
Intervention description	'The overarching aim of the *PuP* program is to help parents facing adversity develop positive and secure relationships with their children. Within this strength-based approach, the family environment becomes more nurturing and less conflictual and child behavior problems can be managed in a calm non punitive manner. Program aims: Strengthen the parent's view that they are competent in the parenting role Help parents develop skills in coping with negative emotional states through use of mindfulness skills Positive parenting skills including praise, rewards for good behaviour, and child-centred play skills Non-punitive child management techniques such as time-out Coping with lapse and relapse (to use of alcohol and drugs)

Parents Under Pressure (PUP)	
	Extending social networks Life skills: practical advice on diet and nutrition, budgeting, health care and exercise Relationships (effective communication between partners)'
Population	Families of children aged 2 – 8 years who are at risk of child abuse and neglect due to problems such as parental mental illness, substance misuse, family conflict and severe financial stress. 'Parents of children aged 2-8 years with substance abuse issues'
Target outcomes	• Child behaviour • Safety and physical wellbeing • Family functioning • Support networks • Child maltreatment Prevention
Intervention details	• 'Begins with assessment and individualised case planning in collaboration with parents • Additional case management can occur outside treatment session (e.g., housing, legal advice, school intervention) • 10 modules • Strengthen the parent's view that they are competent in parenting role • Help parents develop skills in coping with negative emotional states through use of mindfulness skills • Positive parenting skills including praise, rewards for good behaviour, and child-centred play skills • Non-punitive child management techniques such as time out • Coping with lapse and relapse (to use of alcohol and drugs) • Extending social networks • Life skills: practical advice re -diet and nutrition, budgeting, health care and exercise • Relationships (effective communication between partners)' (appendix 6, p.53).

Parents Under Pressure (PUP)	
	Components identified by PRC (Macvean et. al. 2013) Delivery level: Individual Delivery: • Assessment • Individual plan • Structured sessions Content: • Descriptive for child behaviour/descriptive/labelled praise for child • Praise for desired child behaviour • Use of reinforcement/rewards for child/behaviour charts • Planning ahead for high risk situations/crisis management • Emotional regulation • Positive parenting • Non-punitive parenting • Life skills, continuity of life course: family economics, nutrition, education, employment, relationships • Positive adult relationships • Mindfulness
Delivery setting	Home
Dose	10 sessions over 10 – 12 weeks

Parents Under Pressure (PUP)	
Staffing	'In order to use the *PuP* program in clinical settings, a clinician is required to have training and clinical supervision in the *PuP* model. This will lead to accreditation as a *PUP* therapist. Formal qualifications are not required in order to become a *PuP* therapist.'
Resources or supporting tools	No information provided
Cost information	'The cost of the training and clinical supervision is $3,000 per clinician (excluding travel) where clinical supervision is conducted in pairs and includes a combination of telephone and face-to-face clinical supervision.'
PRC rating	Emerging
Primary source	Macvean et. al. (2013)
Date last reviewed	2013

4.16. Project Support

Project Support	
Intervention description	'Project support targets children aged 3–8 years who are at risk of or exposed to child abuse, neglect or domestic/family violence. It aims to reduce child conduct problems among families departing from domestic violence shelters.' P. 35.
Population	'Children aged 3–8 years who are at risk of or exposed to child abuse, neglect or domestic/family violence.'
Target outcomes	• Child behaviour • Child maltreatment prevention • Family functioning • Systems Outcomes

Project Support	
Intervention details	'Designed to decrease coercive patterns of aggressive discipline & increase positive parenting, by: 1. teaching mother's child management skills; 2. Providing instrumental & emotional support to mothers. A very intensive, hands-on approach.' (appendix 2, p. 22) Draws on CBT and attachment/relational theory as a theoretical paradigm.
Delivery setting	Delivered in the home
Dose	'Sessions are between one and one-and-a-half hours in duration and last for up to eight months.' P. 35.
Staffing	Unclear
Resources or supporting tools	Information not available
Cost information	Information not available
PRC rating	Emerging
Primary source	Australian Centre for Posttraumatic Mental Health and Parenting Research Centre (2013)
Date last reviewed	2013

5. References

Australian Centre for Posttraumatic Mental Health and Parenting Research Centre. (2013). *Approaches targeting outcomes for children exposed to trauma arising from abuse and neglect – Evidence, practice and implications. Report prepared for the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs*. Australian Centre for Posttraumatic Mental Health and Parenting Research Centre: Authors.

Macvean, M., Mildon, R., Shlonsky, A., Devine, B., Falkiner, J., Trajanovska, M., & D'Esposito, F. (2013). *Evidence Review: An analysis of the evidence for parenting interventions for parents of vulnerable children aged up to six years. Report prepared for the Families Commission of New Zealand.* Parenting Research Centre.