NC CHILD TREATMENT PROGRAM | CENTER FOR CHILD & FAMILY HEALTH

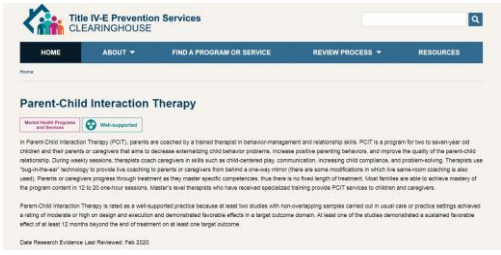
PARTNERING FOR EVIDENCE-BASED MENTAL HEALTH TREATMENT

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES | NCTSN The National Child Traumatic Stress Network

OUR SHARED GOAL

- We want families involved with child welfare in your counties to have access to the best possible services.
- We need your help
  1. Identifying mental health treatment providers in your county.
  2. Encouraging them to apply to our Learning Collaboratives to be trained in Evidence-Based Treatments (EBTs).
  3. Connecting trained providers to families in your county.

SUPPORTIVE LEGISLATION: FFPSA

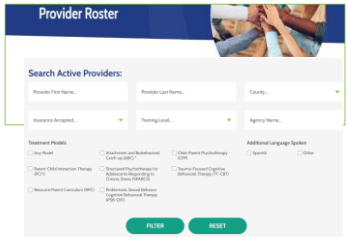


MODELS DISSEMINATED

NC CHILD TREATMENT PROGRAM

Model	Age Range
Child-Parent Psychotherapy (CPP)	Birth through 5
Parent-Child Interaction Therapy (PCIT)	2-6
Problematic Sexual Behavior – Cognitive Behavioral Therapy (PSB-CBT)	3-18
Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)	12-21
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	3-18

CONNECTING TRAINED PROVIDERS TO FAMILIES



https://www.ncchildtreatmentprogram.org/program-roster/

EARLY CHILDHOOD EBT BENEFITS

- Effective alternative for children in long term services or treatment without significant improvement
- Stability for other service needs
- Placement preservation
- Transitions to new/reintegration into family systems
- Changing intergenerational relationship patterns
  - Very low recidivism rates
  - Improvements for caregivers and siblings
  - Prevention of child maltreatment

NOT ALL EARLY CHILDHOOD TREATMENT IS THE SAME

- There is a small pool of clinicians interested in serving this population.
- Clinicians also need to be motivated to provide an Evidence-Based Treatment.
- They then need to select a model that fits their professional approach *and* the needs of the child and family: behavioral or psycho-dynamic.

PARENT-CHILD INTERACTION THERAPY (PCIT)

http://www.pcit.org/pcit-research.html

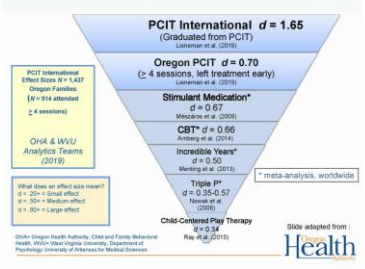
EVIDENCE FOR PCIT

- Over 300 publications
  - More than 12 Randomized Control Trial (RCTs)
  - Several with 6+ month follow-up; one with 7 year follow-up
- Outcomes show significant improvement across cultural and ethnic groups and populations in:
  - Child compliance, including in untreated siblings
  - Child internalizing and externalizing symptoms
  - Caregiver-Child relationship/attachment
  - Trauma symptoms
  - School behaviors
  - Frustration tolerance and emotion regulation
  - Attention and concentration
  - Caregiver stress and maternal depression

EVIDENCE FOR PCIT

- Routinely receives highest accolades:
  - **Families First Prevention Services Act**
  - California Clearing House for Evidence Based Practices
  - SAMHSA's National Registry of Evidence-based Programs and Practices
  - National Child Traumatic Stress Network selected PCIT
  - Ewing Marion Kauffman Foundation as "best practice" for working with children with a history of maltreatment

PCIT WORKS



PCIT IS RECOMMENDED FOR:

	Inclusion Criteria
Child (client)	○ Clinical concerns: ▪ Externalizing symptoms in the home, out-of-home placement, school, and/or community ▪ Internalizing concerns, including mood disorders ▪ Relationship and/or attachment difficulty with primary caregiver ▪ Symptomatic grief and loss ○ 2 to 7 years of age ○ Receptive language skills ≥ 24 months of age ○ Available to participate in regularly scheduled treatment sessions ○ Regular contact between client and participating primary caregiver
Primary Caregiver	○ Available to participate in regularly scheduled treatment sessions ○ Regular contact between client and participating primary caregiver

PCIT IS NOT RECOMMENDED FOR:

	Exclusion Criteria
Child (client)	○ Receptive language skills significantly < 24 months of age ○ Unable to participate in regularly scheduled treatment sessions ○ Limited contact between client and participating primary caregiver
Primary Caregiver	○ Perpetrator of sexual abuse ○ Active perpetrator of domestic violence, physical abuse, or psychological abuse ○ Actively psychotic, significantly thought-disordered, or significantly cognitively-impaired (IQ < 65) ○ Unable to participate in regularly scheduled treatment sessions ○ Limited contact between client and participating primary caregiver

PCIT HAS BEEN IMPLEMENTED WITH…

- Attention Deficit Hyperactivity Disorder (ADHD)*
- Oppositional Defiant Disorder*
- Conduct Disorders
- **Child maltreatment***
- Children with Anxiety Disorders*
- Children who witness domestic violence
- **Children in foster care***
- **Children with prenatal substance exposure or impacted by parental substance abuse***
- Mexican-American Families*
- PCIT with toddlers*
- Native American Families
- Children with developmental disabilities*
- Children born prematurely*
- **Children on the Autism Spectrum***
- Children with language disorders*
- Children in military families
- **Children with trauma history**
- Home-based PCIT*
- Group PCIT*
- Internet-based PCIT

* At least one RCT

WHAT THIS MIGHT LOOK LIKE FOR YOUR FAMILIES

- Relational problems with parent/caregiver
- Refuses adult requests/defiant
- Easily loses temper
- Purposefully annoys others
- Destroys property
- Frequently fights and/or shows aggression toward others
- Has difficulty staying seated
- Has difficulty playing quietly
- Has difficulty taking turns

PCIT: THE BASICS

- Emphasis on parent-child interaction patterns
  - Stronger focus on improvement of parent-child relationship and attachment
- Time unlimited
- Assessment driven
- Parent held to mastery criteria
- Parents and child together in treatment
- Live coaching of skills
- Short-term treatment (avg. 20-24 weekly sessions in community mental health)

CHILD PARENT PSYCHOTHERAPY (CPP)

http://www.pcit.org/pcit-research.html

EVIDENCE FOR CPP

- According to the California Evidence Based Clearinghouse, CPP has the highest scientific rating for a trauma treatment targeting children under 5 years old
- 5 Randomized Controlled Trials
- Improved children's
  - Mood
  - Problem behaviors
  - Learning
  - Trauma symptoms
  - Biological stress response
- Improved caregivers'
  - Mood
  - Parenting stress
  - Trauma symptoms
  - Partner relationship
- Improved parent-child relationship quality

CPP IS RECOMMENDED FOR:

Children birth through age 5…

- Who have experienced a traumatic event or exposure (domestic violence, parental separation, child maltreatment)
- Concerns regarding attachment relationship with primary caregiver
- Who can participate in regularly scheduled treatment sessions with their caregivers

CPP IS NOT RECOMMENDED FOR:

Children whose caregiver…

- Cannot participate in regularly scheduled treatment sessions
- Is a perpetrator of sexual abuse
- Is actively psychotic or significantly thought disordered

CPP HAS BEEN IMPLEMENTED WITH…

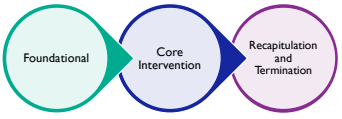
- Preschoolers exposed to domestic violence
- Maltreated preschoolers
- Infants from families with histories of domestic violence
- Anxiously attached infants of Latina immigrant mothers
- Toddlers with depressed mothers
- Culturally diverse children in foster care
- Children whose families are involved in Child Welfare Court/Safe Babies Court Teams (parental poverty, substance abuse, unemployment, housing insecurity, etc)
- High-risk pregnant women with depression and PTSD
- Families in Israel and Sweden

WHAT THIS MIGHT LOOK LIKE FOR YOUR FAMILIES

Some examples…

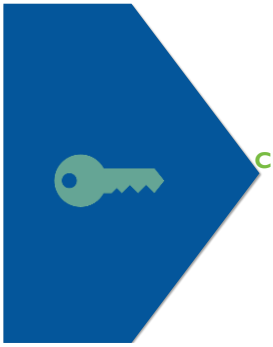
- Caregivers with depression, PTSD, and/or substance abuse, etc.
- Children with anxious attachment
- Families living in chaotic and/or violent environments
- Families with exposure to the child welfare system

CPP: THE BASICS THREE PHASES TO TREATMENT



Ghosh Ippen, Van Horn, & Lieberman, 2012

Focus on Reflective Practice, Emotional Process, Dyadic-Relational, Trauma Framework, Procedural, and Case Conceptualization and Content Fidelity throughout



CHILD-ADULT RELATIONSHIP ENHANCEMENT (CARE)

EVIDENCE FOR CARE

- CARE is not a therapy
  - It is not intended to treat significant behavior problems in children and teens
  - Children with significant problems may require a referral for therapy.
- Utilizes evidenced-based relationship skills to help adults interact with children and teens
- CARE has no known negative outcomes and is based on over 40 years of research from parenting programs. (See www.pcit.org for references.)
- Derived from evidence-based parenting programs:
  - Helping the Non-compliant child
  - Incredible Years
  - Parent-Child Interaction Therapy
  - Parent Management Training Program—Oregon model
- CARE is in its infancy, but several clinical trials are underway!

CARE IS RECOMMENDED:

Anywhere, anyone interacting with Children!!

- Day care settings
- School settings
- Treatment centers/Residential living facilities
- Medical facilities
- Law enforcement agencies
- Child welfare agencies
- Drug and Family Court personnel
- Parents/Foster/Adoptive parents
- Medical, Mental Health, and Allied Health professionals
- Child Life Specialists
- Child victim advocates
- Clergy
- Scout Leaders/Sports coaches
- Military family support personnel

CARE HAS BEEN IMPLEMENTED…

- Across the country and has recently gone global (Australia, Sweden, and a couple of others)!
- It has been successfully implemented in all areas listed on previous slide… and more!

WHAT THIS MIGHT LOOK LIKE

- Child or teen adjusting to new environment and engaging in limit testing through minor behavior problems
- Student/camper unengaged and/or defying rules
- Caregiver requesting low-level assistance with parenting
- Unfamiliar professionals needing to engage children/teens (e.g.: DSS, police, etc.)

OTHER CONSIDERATIONS

- CARE is for a non-clinical population and is generalizable.
- A trauma-informed way for *any* adult to interact with *any* child or teen.
- For any adult working with children or teens who wants to improve relationships and reduce mild-to-moderate behavior challenges.
  - Positive relationships enhance a child's social-emotional development and learning potential.

THE BASICS

- Play-based and child-led relationship-building methods.
- Relationship-enhancement techniques through active skills-building.
- Effective methods for giving directions to children and adolescents to increase the likelihood of compliance.
- Strategies for decreasing children's negative behavior.

NEXT STEPS

1. To bring CPP and PCIT to your community, share our info with your local mental health providers or connect us with them! Kelly.knapp@duke.edu
2. To bring CARE to your agency, contact us! Kelly.knapp@duke.edu
3. Use our roster to find clinicians: https://www.ncchildtreatmentprogram.org/program-roster/

For more info: https://www.ncchildtreatmentprogram.org/