Trauma Treatment Model

Monitoring Resource

This resource has been developed to assist QRTPs in implementing a trauma-informed treatment model approved by ODJFS and OhioMHAS for the population the facility serves and that addresses the youth's clinical needs. This resource is to help agency staff implement a trauma treatment model and to assist licensing and certification staff and surveyors in monitoring the implementation of the selected trauma-treatment

Trauma treatment models for Child-Serving Residential Agencies:

Intervention/Program Name	Brief description	Additional information and criteria
Acceptance & Commitment Therapy (ACT) CEBCH – Well supported by research evidence – medium child welfare relevance NCTSN – not listed	Empirically based psychological intervention that uses acceptance and mindfulness strategies, together with commitment and behavior change strategies, to increase psychological flexibility. Psychological flexibility means contacting the present moment fully as a conscious human being, and based on what the situation affords, changing or persisting in behavior in the service of chosen values. Through metaphor, paradox, and experiential exercises clients learn how to make healthy contact with thoughts, feelings, memories, and physical sensations that have been feared and avoided. Clients gain the skills to recontextualize and accept these private events, develop greater clarity about personal values, and commit to needed behavior change. Recommended Intensity: There is no recommended intensity. The number, frequency, and length of sessions can vary depending on the needs of the client or the practice of the treatment provider. Recommended Duration: There is no recommended duration. The overall duration of the intervention can vary depending on the needs of the client or the practice of the treatment provider.	There is no ACT certification process. ACBS, as a community, has decided to forego this, as it could create a hierarchical and closed process which would be antithetical to our values. Rather, we aim to foster an open, self-critical, mutually supportive community which, working together, builds a progressive psychology more adequate to the challenges of human suffering. There is no such thing as an officially certified ACT therapist. ACT does not require certification. In fact, it defines itself as a psychological intervention. As such it can be utilized by those with a license (as a treatment modality) and those without a license (as an intervention). (Ohio Guidestone developed ACT-P for their paraprofessionals). There are two basic ways to begin learning about ACT: **Reading up on it your own** or **Seeking out a community** in which to network and broaden and deepen your knowledge of ACT Because individuals can read up on their own, see the following website for recommended readings and resources: 14 Must-Read Acceptance and Commitment Therapy Books • *Get Out of Your Mind and into Your Life;* Steven Hayes, PhD; New Harbinger Publications; 1st edition (November 1, 2005) • *ACT Made Simple: An Easy-to-Read Primer on Acceptance and Commitment Therapy;* Russ Harris; New Harbinger Publications; 2nd edition (2019) • *Acceptance and Commitment Therapy, Second Edition: The Process and Practice of Mindful Change***;** Steven Hayes, Kirk Strosahl, and Kelly Wilson; Guilford Press (2012)

		There are no pre-implementation materials to measure organizational or provider readiness for *Acceptance and Commitment Therapy (ACT)*. Mandated state licensure to deliver psychotherapeutic services is required in order to become trained as an ***ACT*** therapist Peer reviewed trainers are available and available through the Association for Contextual Behavioral Science. Reviewed trainers are listed at: Find an ACT Trainer | Association for Contextual Behavioral Science (contextualscience.org) Proof of training completion; core competencies; experiential training workshops; accredited Acceptance and Commitment Therapy (ACT) training courses. ACT Certifcation | Association for Contextual Behavioral Science (contextualscience.org)
ARC: Attachment, Self-Regulation, and Competency: A Comprehensive Framework for Intervention with Complexly Traumatized Youth CEBCH – not able to be rated – high relevance child welfare NCTSN	Framework is designed to be adaptable to needs and real-life circumstances of clients (i.e., identifying culturally relevant caregiver supports; working with appropriate members of family / kinship system). Framework specifically targets the child's surrounding system (caregiver(s), treatment system, community). The approach is grounded in attachment theory and early childhood development and addresses how a child's entire system of care can become trauma informed to better support trauma focused therapy. The approach provides a framework for both trauma informed and trauma specific therapeutic intervention.	Dependent on individualized implementation and modality. Generally, the number of sessions can range from 12 to greater than52 sessions. ARC has multiple modalities including individual, group and family treatment; parent workshops; milieu/systems intervention; and a new home-based prevention program. Prerequisite/Minimum Provider Qualifications Integration of ARC into clinical intervention requires the appropriate education/licensure/certification of the provider in their profession.
		The standard foundational training is 2 days; training in the in-home caregiver coaching curriculum is 3 days. The minimum suggested follow-up consultation is 12 hours or one year (1-2 hours/month) for clinical implementation. Additional consultation to support development of infrastructure, supervisory

	Recommended Intensity: Varies dependent on client and type of setting; generally, the number of sessions can range from 12 to greater than 52 sessions. Recommended Duration: Varies dependent on client and type of setting	skills and supports, and ongoing internal training is helpful and often recommended, depending on agency size/structure. Proof of training; Designated lead ARC trainers / consultants; agency-specific supervisors and/or administrators; if/as appropriate, learning community colleagues Implementation manual arc_fact_sheet.pdf (nctsn.org)
Caley Home Program Recommended by the TIC Treatment Model Committee 05/21 ***MODEL NO LONGER AVAILABLE FOR NEW PROGRAMS TO ADOPT – Staff are no longer available to train on this model***	The Caley Home works to uphold the SAMHSA Core Principles of Trauma-Informed Care. The programs focuses on: Creating a visual timeline of the day; Clearly outlining expectations for each activity transition; Being honest, saying what you mean, and knowing it is okay to tell a resident if you don't know answer; doing what you say you are going to do and helping residents find the answers to their questions; Advocating for the each resident's best interest and teaching self-advocacy; Allowing the child to be present when communicating important information to case workers or parents when age appropriate, including during all service plan meetings and reviews and at monthly placement visits; Staff explain policies and procedures to children using easy to understand language; staff are trained to choose positive reinforcement over consequences when possible. Treatment goals: To provide for the physical and emotional needs of youth in a structured, safe, trauma-informed, client-centered, and culturally responsive environment.	There is no minimum educational level required. Staff must obtain OCCRRA/OPR certification as Trauma Aware, Trauma Informed and Trauma Competent. For more information contact: Mindy Hughes, MSSA Lake County Job and Family Services Caley Home Program Manager 408 Riverside Dr. Painesville, OH 44077 Phone: 440-350-4413 Mindy.Hughes@jfs.ohio.gov Revised handbook incorporates trauma-informed principles; youth involvement Sensory-room; residents decorate own rooms; books, entertainment devices, exercise equipment and other media resources for comfort

		Family surveys Revised school report form and inclusive service plan Visual daily timeline ACE and Columbia Suicide Severity Scale questionnaire at intake Training records; focus group documentation Staff reviews contain trauma-informed statements and questions Fiscal resources for staff training and personal belongings for residents
Child and Family Traumatic Stress Intervention (CFTSI) CEBCH - Promising research evidence – high relevance child welfare NCTSN	Brief early intervention model for children and adolescent that is implemented soon after exposure to a potentially traumatic event or in the wake of disclosure of physical and sexual abuse developed at the Yale Child Study Center. Fills the gap between acute responses/crisis intervention and evidence-based, longer-term treatments designed to address traumatic stress symptoms and disorders that have become established. Goal of this family-strengthening model is to improve the caregiver's ability to respond to and support a child who has at last one posttraumatic symptom. Aims to reduce symptoms and prevent onset of PTSD. It is delivered to children aged 7–18 years, together with their parent or caregiver, after the child has experienced a potentially traumatic event (PTE). Recommended Intensity: Session 1: Accomplished in 1-2 meetings each 1 hour in length	Children ages 7-18 recently exposed to a potentially traumatic event or having disclosed physical or sexual abuse and endorsing at least one symptom of posttraumatic stress CFTSI is provided to children and adolescents who have experienced a Potentially Traumatic Event (PTE) within the past 30 days (including disclosure about prior sexual or physical abuse, or other PTEs that have only recently been revealed). Prerequisite/Minimum Provider Qualifications: Master's level trained therapists Proof of training sessions are appropriate for supervisors and mental health providers with a master's degree or higher (who will act as the primary CFTSI provider), as well as case managers (who will play a vital role in collaboration with the primary CFTSI provider).

	Session 2a: 1 hour Session 2b: Accomplished in 1-2 meetings each 1 hour in length Session 3: 1 hour Session 4: 1 hour Additional sessions with child, caregiver or dyad are scheduled as necessary Recommended Duration: 4-6 weeks This program involves the family or other support systems in the individual's treatment: Caregivers, including Foster Parents, participate together with the identified child in each ***CFTSI*** session (except for Session 1 when the provider meets only with the caregiver and Session 2a when the provider meets with the child alone prior to the first family session)	Training offered at a site of the agency choosing; 2 days for 12 total hours CFTSI is provided by mental health professionals who have received specialized training in this evidence-based treatment Implementation manual Additional information can be found at the Yale Childhood Violent Trauma Center The Childhood Violent Trauma Center < Child Study Center: Community Partnerships (yale.edu)
Child–parent psychotherapy (CPP) CEBCH - Supported by research evidence – high child welfare relevance NCTSN	Child Parent Psychotherapy is an intervention model for children aged 0-5 who have experienced traumatic events and/or are experiencing mental health, attachment, and/or behavioral problems. The treatment is based in attachment theory but also integrates psychodynamic, developmental, trauma, social learning, and cognitive behavioral theories. Therapeutic sessions include the child and parent or primary caregiver. 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. cultural norms 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	Dyadic intervention ages 0-5 The following organizations have conducted independent reviews of the research on CPP, have listed CPP as an evidence-based practice, and have posted summaries on their websites. • The California Evidence-Based Clearinghouse for Child Welfare: http://www.cebc4cw.org/program/child-parent-psychotherapy/ Prerequisite/Minimum Provider Qualifications: Practitioners: Master's level training Supervisors: Master's degree plus minimum of 1-year training in the model Proof of training; typically training involves an initial 3-day workshop and then quarterly (3 more times in a year) 2-day additional workshops. In

	behaviors that interfere with the child's mental health. For children exposed to trauma, caregiver and child are guided over the course of treatment to create a joint narrative of the traumatic event and to identify and address traumatic triggers that generate dysregulated behaviors and affect. Treatment is generally conducted by a master's or doctoral-level therapist and involves weekly hour-long sessions. Recommended Intensity: Weekly 1 to 1.5-hour sessions Recommended Duration: 52 weeks (one year)	addition, training involves bi-monthly telephone-based case consultation of ongoing treatment cases involving children aged 0-5 who have experienced a trauma. There are a number of different training models. Training occurs can be arranged through the Child Trauma Research Program by contacting ChildParent Psychotherapy, and may include CPP Agency Mentorship Program (CAMP), endorsed CPP 12 month internships, or through the Learning Collaborative model of the National Child Traumatic Stress Network. In general, training is tailored to the needs of the organization. ChildParent Psychotherapy HOME – Child-Parent Psychotherapy (childparentpsychotherapy.com)
Cognitive Behavioral Interventions – Core Youth (CBI-CY) University of Cincinnati Corrections Institute (UCCI)	Cognitive-Behavioral Interventions – Core Youth (CBI-CY) curriculum while originally designed for youth involved with the juvenile justice system who are at moderate to high risk for reoffending can be used for youth in residential programming. In partnership with the Bureau of Justice Assistance and Council of State Governments, the University of Cincinnati Corrections Institute (UCCI) developed this curriculum for the adult population before adapting it to meet the needs of the youth population. This curriculum can be delivered as a stand-alone curriculum or incorporated into larger programs. As the name of the curriculum suggests, this intervention relies on a cognitive-behavioral approach to teach youth strategies for identifying and managing risk factors. This program places heavy emphasis on skill-building activities to assist with cognitive, social, emotional, and coping skill	Use of core correctional practices should be employed by staff facilitating groups as well as other supporting staff who interact with group participants (see Dowden & Andrews, 2004). Core correctional practices are a set of individual staff skills that, when employed with proficiency, have demonstrated positive treatment effects. These skills address how staff should model and reinforce prosocial behavior and effectively decrease behavior that leads to risk. It will serve as strategies for addressing behavior management challenges Required training from a UC certified master trainer. Information on securing trainers can be found at: Contact | University Of Cincinnati (uc.edu) No prerequisites for training; recommended that attendees be familiar with Cognitive Behavior Therapy (CBT) and Core Correctional Practices (CCP) Certification of completion

	development. Cognitive-behavioral curricula places certain demands on participants requiring them to be able to read, write, and understand some abstract concepts. Modified worksheets were created and tips are given to facilitators throughout the curriculum to help accommodate youth at varying cognitive levels. the curriculum was designed to have the flexibility of working with youth with varying levels of cognitive functioning. Intensity/Duration: Full curriculum to be offered 2-3/week with graduated rehearsal opportunities available for those who may need more dosage.	Facilitators are required to use the manual for each session they deliver and the accompanying worksheets
Cognitive Behavioral Therapy (CBT) CEBCH NCTSN Society of Clinical and Adolescent Psychology	Cognitive behavioral therapy (CBT) for children and adolescents usually are short-term treatments (i.e., often between six and 20 sessions) that focus on teaching youth and/or their parents specific skills. CBT differs from other therapy approaches by focusing on the ways that a child or adolescent's thoughts, emotions, and behaviors are interconnected, and how they each affect one another. Because emotions, thoughts, and behaviors are all linked, CBT approaches allow for therapists to intervene at various points in the cycle. These treatments have been proven to be effective in treating many psychological disorders among children and adolescents, such as anxiety, depression, post-traumatic stress disorder (PTSD), behavior problems, and substance abuse. Individual CBT solely on the child or adolescent and includes one therapist who teaches the child or adolescent the skills needed to overcome his/her challenges. This form of CBT has been proven effective in the treatment of child and adolescent depression and	Cognitive-behavioral therapy can exist as a distinct therapeutic technique. However, is often paired with other therapeutic approaches. The term "cognitive-behavioral therapy" is a very general term for a classification of therapies with similarities. Training requirements vary depending on additional therapy focus. Types of CBT: • Individual • Group • CBT with Parents • CBT with Medication • Trauma-Focused CBT (included in this list) • CBT paired with Motivational Enhancement • CBT paired with Motivational Enhancement and Family-based Behavioral Treatment

	anxiety disorders, as well as substance abuse in adolescents. Group CBT includes not only the child or adolescent and therapist in the therapy sessions, but also others outside of the child or adolescent's social groups – usually new acquaintances who are also being treated for the same disorder. Those in the group therapy are often dealing with similar behavioral issues and, unlike individual CBT, the group format allows helpful relationships to form, in addition to learning skills needed to change behavior.	There is no licensing body for cognitive behavioral therapists, but most certifying institutes require you to hold a state license in your field of practice. Before you can apply to a training program in cognitive behavioral therapy, most institutes require you to have a certain number of years of supervised experience providing cognitive therapy. Person desiring to become cognitive behavioral therapist, must have a minimum of a Master's Degree in mental health or a Master's in a medical-related field There is no requirement that participants have an active clinical practice, just that they have had training and supervised experience in the basics of counseling or psychotherapy for Clinical Practice of CBT Training and CBT certification is available through the Beck Institute. The Beck CBT certification is valid for five years after which recertification is required. CBT certification requires a terminal education degree with a behavioral or mental health specialization. This degree should prepare individuals to see clients and practice as a clinician; work/Clinical experience; and, professional licensing documentation. Additional requirement scan found at Beck Institute | CBT Certification | Beck Institute Beck Institute also offers Beck Instittute CBT Certified Master Clinician and Beck Institute Certified Supervisor Certified Cognitive-Behavioral Therapist certification can also be obtained through the National Association of Cognitive Behavioral Therapists at Certifications in CBT (nacbt.org). Certification through NACBT is valid for five years after which recertification is required.
Collaborative Problem Solving (CPS)	CPS is an approach to understanding and helping children with behavioral challenges who may carry a variety of psychiatric diagnoses, including oppositional defiant	Prerequisite/Minimum Provider Qualifications:

CEBCH - Promising Research Evidence – medium child welfare relevance NCTSN – not listed	disorder, conduct disorder, attention-deficit/hyperactivity disorder, mood disorders, bipolar disorder, autism spectrum disorders, posttraumatic stress disorder, etc. CPS uses a structured problem-solving process to help adults pursue their expectations while reducing challenging behavior and building helping relationships and thinking skills. Specifically, the CPS approach focuses on teaching the neurocognitive skills that challenging kids lack related to problem solving, flexibility, and frustration tolerance. Unlike traditional models of discipline, this approach avoids the use of power, control, and motivational procedures and instead focuses on teaching at-risk kids the skills they need to succeed. CPS provides a common philosophy, language and process with clear guideposts that can be used across settings. In addition, CPS operationalizes principles of trauma-informed care. Services Involve Family/Support Structures: This program involves the family or other support systems in the individual's treatment: Caregivers in other settings may be involved in the problem-solving process if there are oppositional episodes in those settings	There is no minimum educational requirement to become a provider. For a clinician or educator to become certified in the **CPS** model, they must participate in a 24-week **CPS** training program. There is a manual that describes how to implement this program, and there is training available for this program. Ranges from a 1-day introductory session to more intensive (2.5 day) advanced sessions as well as hourly coaching: Introductory training: These in-person and online trainings provide a general overview exposure of the model including the overarching philosophy, the assessment, planning and intervention process. Training can accommodate an unlimited number of participants. Two-and-a-half day intensive trainings that provide participants in-depth exposure to all aspects of the model using didactic training, video demonstration, role play and breakout group practice. Tier 1 training is limited to 150 participants. Tier 2 training is limited to 75 participants. Coaching sessions for up to 12 participants that provide ongoing support and troubleshooting in the model
	Recommended Intensity: Typically, family therapy (in which the youth is the identified patient, but the parents are heavily involved in the sessions so that they can get better at using the approach with their child on their own) occurs once per week for approximately 1 hour. The approach can also be delivered in the home with greater frequency/intensity, such as twice a week for 90 minutes. Parent training	Proof of certification/training; certified trainers throughout North America who teach the model as well as well as systems that use the approach. The list is available at https://thinkkids.org/our-communities Implementation manuals: Treatment Manual: Greene, R. W., & Ablon, J. S. (2005). *Treating explosive kids: The Collaborative Problem Solving approach*. Guilford Press.

	group sessions occur once a week for 90 minutes over the course of 4 or 8 weeks. The approach can also be delivered by direct care staff in a treatment setting and/or educators in a school system, in which case delivery is not limited to scheduled sessions but occurs in the context of regular contact in a residence or classroom. Recommended Duration: Family therapy: 8-12 weeks; In-home therapy: 8-12 weeks; Parent training groups: 4-8 weeks	*Clinician Session Guide*: Guides the clinician in all aspects of the treatment, from initial assessment to ongoing work. Can be obtained by contacting the Director of Research and Evaluation, Dr. Alisha Pollastri, at apollastri@mgh.harvard.edu. *CPS Coaching Guide*: A guide specifically geared towards trainer individuals who are helping caregivers to implement the model over time. Available to certified trainers. Think:Kids provides implementation support in the form of ongoing coaching and fidelity and outcome monitoring. Additional information can be found at: Think:Kids : Home (thinkkids.org)
Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT) CEBCH - Promising research evidence – high relevance child welfare NCTSN	Empowering families who are at risk for physical abuse; short-term (16-20 Sessions), strength-based therapy program in families where parents are engage in a continuum of coercive parenting strategies. Families can include those who have been substantiated for physical abuse, those who have multiple unsubstantiated referrals, and those who fear they may lose control with the child. Children may present with PTSD symptoms, depression, externalizing behaviors. Helps child heal from the trauma of physical abuse, empowers and motivates parents to modulate their emotions and use effective non-coercive parenting strategies, strengthens parent-child relationships while helping end cycle of violence *CPC-CBT* directly provides services to children/adolescents and addresses the following:	Children ages 3- 17 and their parents/caregivers Prerequisite/Minimum Provider Qualifications: Clinicians who implement ***CPC-CBT*** should have a master's degree or higher in one of the mental health professions or be working towards one of these degrees under the supervision of a licensed mental health professional. Given that ***CPC-CBT*** is based on cognitive-behavioral principles, it is helpful but not necessary for clinicians to be well grounded in Cognitive-Behavioral Therapy. It is important for clinicians to prepare themselves to work in a supportive, nonjudgmental manner with parents who have harmed their children in some way. Proof of training; Varies depending on training program requested. ***CPC-CBT***'s developers are utilizing National Center for Child Traumatic Stress (NCCTS) Learning Collaborative (LC) methodology to enhance the adoption and implementation of ***CPC-CBT***. These are intended to help

	• Children's PTSD, depression, self-esteem, social skills, empathy skills, problem solving and behavioral problems, such as aggression and other acting out behaviors *CPC-CBT* directly provides services to parents/caregivers and addresses the following: • Parental lack of motivation and engagement, depression, anger, self-control, assertiveness, attributions about children's behavior, empathy for children, positive parenting skills, family relationships, parent-child interactions, and parental trauma history. This program involves the family or other support systems in the individual's treatment: All caregivers, including grandparents, and all siblings are encouraged to participate Recommended Intensity: Individual: 90-minute sessions weekly; Group: 120-minute session weekly Recommended Duration: 16-20 sessions	agencies gain the necessary clinical and implementation competence to incorporate and sustain ***CPC-CBT*** as a part of their current practices. There are three ***CPC-CBT*** training options available to organizations.The first two training options listed incorporate LC methodology. The first is more intensive than the second. The first training option involves a formal Learning Collaborative (LC). A LC consists of pre-work, three 2-day learning sessions spaced over the course of 8 to 12 months with consultation calls in the implementation of ***CPC-CBT*** occurring twice per month between the learning sessions. Agencies may opt for the second training option that incorporates some of the LC methodology, but is relatively less intensive. This involves two full days of in-person training on the model which includes role-plays and performance feedback. Because the program is highly structured, ongoing consultation that occurs twice per month for at least one full cycle of therapy is recommended for clinicians as well. Feedback on audiotaped client sessions is highly recommended. Two days of advanced training is also available after the initial training sessions to address advanced concepts and questions that arise after clinicians have implemented the model with multiple clients. For agencies that are unsure if they are able to commit to the above requirements or who need additional information about ***CPC-CBT*** to determine if it is feasible to implement the model, a third ***CPC-CBT*** training option is available. This option involves two days of introductory training in the model which includes role-plays and performance feedback. However, agencies should not expect staff to be able to fully implement ***CPC-CBT*** after a single training event.

		There are pre-implementation materials to measure organizational or provider readiness for ***Combined Parent-Child Cognitive-Behavioral Therapy (CPC-CBT)*** as listed below: A readiness package is provided to interested agencies. Administrators and clinicians are also asked to complete readiness survey through Survey Monkey. Implementation manual Additional information can be found at Rowan University, School of Osteopathic Medicine: CPC-CBT | School of Osteopathic Medicine | Rowan University (rowanmedicine.com)
Dialectical Behavior Therapy - DBT – Adolescents CEBCH – not listed NCTSN – not listed	Although Dialectical Behavior Therapy (DBT) was originally developed for use with adults, it has since been adapted and found to be effective with adolescents (ages 12-18). DBT for adolescents includes the same treatment strategies and primary targets as DBT for adults, while also including parents in treatment and targeting difficult behavior patterns common to adolescents and their families. In addition, DBT for adolescents is typically briefer than DBT for adults, lasting approximately 16-24 weeks. DBT for adolescents has been evaluated in randomized clinical trials with teens with repeated suicidal and self-harming behaviors, as well as teens with bipolar disorder.	Participants are expected to be mental health professionals who have attended DBT Intensive or Foundational training, have at least one year of experience delivering DBT, and currently work with pre- adolescent children. The DBT-C training involves rigorous preparation, training, and homework. The course is designed to model basic elements of the treatment in an experiential way. Just as DBT-C requires families to make a full commitment to treatment and to attend all sessions, DBT-C training requires participants to attend the entire training, do their best to learn the material, and to participate in a willing, committed manner. Staff can implement DBT strategies without being certified. Staff are encouraged to attain DBT Certification The applicant must meet the following education criteria (total minimum of 21 hours of continuing education):

		• Complete a minimum of 18 education hours in Dialectical Behavior Training, including 6 hours specific to Dialectical Behavior Therapy skills training. • Complete a minimum of 3 education hours in Suicide/Risk Assessment and Intervention The applicant must attest that he/she has read the following: • At least 2 practitioner books on the practice of Dialectical Behavior Therapy (i.e., not texts focused on Dialectical Behavior Therapy skills, but focused on Dialectical Behavior Therapy as a theoretical orientation). • At least two Dialectical Behavior Therapy skills training manuals Proof of certification (2 years); training manual; implementation manual; recertification is required About DBT – Behavioral Tech
Dialectical Behavior Therapy for Children – DBT-C CEBCH – not listed NCTSN – not listed	DBT-C retains the theoretical model, principles, and therapeutic strategies of standard DBT and incorporates almost all of the adult DBT skills and didactics into the curriculum. However, the presentation and packaging of the information are considerably different to accommodate for the developmental and cognitive levels of pre-adolescent children. Further, DBT-C adds an extensive parent training component to the model. DBT-C teaches parents everything their child learns (e.g., coping skills, problem-solving, didactics on emotions), plus effective contingency management techniques. DBT-C maintains that parental modeling of adaptive behaviors, reinforcement of a child's skills use, ignoring of maladaptive responses, validation, and acceptance are key to achieving lasting changes in a child's emotional and behavioral regulation.	Participants are expected to be mental health professionals who have attended DBT Intensive or Foundational training, have at least one year of experience delivering DBT, and currently work with pre- adolescent children. The DBT-C training involves rigorous preparation, training, and homework. The course is designed to model basic elements of the treatment in an experiential way. Just as DBT-C requires families to make a full commitment to treatment and to attend all sessions, DBT-C training requires participants to attend the entire training, do their best to learn the material, and to participate in a willing, committed manner. The applicant must meet the following education criteria (total minimum of 21 hours of continuing education): • Complete a minimum of 18 education hours in Dialectical Behavior Training, including 6 hours specific to Dialectical Behavior Therapy skills training.

	While there isn't a set duration for DBT, there is a rough outline that is followed. A full course of dialectical behavior therapy takes **around 6 months** to complete. There are four main modules in DBT, mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness	• Complete a minimum of 3 education hours in Suicide/Risk Assessment and Intervention The applicant must attest that he/she has read the following: • At least 2 practitioner books on the practice of Dialectical Behavior Therapy (i.e., not texts focused on Dialectical Behavior Therapy skills, but focused on Dialectical Behavior Therapy as a theoretical orientation). • At least two Dialectical Behavior Therapy skills training manuals Proof of certification (2 years); training manual; implementation manual; recertification is required Proof of certification; training manual; implementation manual Dialectical Behavior Therapy Skills Training with Adolescents: A Practical Workbook for Therapists, Teens & Parents; Jean Eich, PsyD., LP, PESI Publishing, 2014 The Dialectical Behavior Therapy Skills Workbook: Practical DBT Exercises for Learning Mindfulness, Interpersonal Effectiveness, Emotion Regulation, Matthew McKay, A New Harbinger Self-Help Workbook, September 2019 Founded by Marsha Linehan – Behavioral Tech
Eastway Behavioral Healthcare Trauma-Informed Care CEBCH – not listed NCTSN – not listed ***MODEL NO LONGER AVAILABLE FOR NEW PROGRAMS TO ADOPT – Due to the nature and intensity of the***	Eastway Behavioral Healthcare's Trauma Informed Care model aims to create a nurturing and safe residential environment for children and adolescents who have endured multiple traumatic experiences. The model assures that each child's basic needs are met while they have a variety of opportunities to engage in developmentally appropriate activities, build their social skills and peer support systems, and heal from past	This model is utilized in child/adolescent residential treatment centers. All staff in all positions are carefully screened and fully trained in trauma informed care and de-escalation techniques. Staff work from an understanding that the children in our care have learned through their life experiences that it is not always safe to trust those who are in positions of authority, and many children have been hurt by those who should have loved and protected them. Staff are taught to show the children that they are

model, personnel are not available to assist individual programs with implementation	trauma via therapeutic interventions. Children are taught that their voices are important. They are given opportunities for self-expression and decision-making, giving input into programming and activities while building on their strengths. Student Council and other age-appropriate forums also serve to give the child experience in using their voice. Family members are fully involved in assessment, treatment, and visitation, when appropriate.	worthy of being trusted by providing a safe, reliable, transparent and nurturing presence to the children within healthy and professional boundaries. Proof of training - documentation • refresher training • frequency of training Family engagement - documentation • from point of admit • participation in treatment • visitations • signed treatment plans • family participation in treatment/progress reviews Discharge planning - documentation • from admit • RTIS • monthly reviews • review discharged youth reports • follow up Schedule of activities Nursing staff schedules Safe Crisis Management - documentation • training certificates • nursing assessment • debriefing Policies/procedures • Job descriptions • job interviews – youth involved in interviewing Empowerment, voice and choice – documentation • Youth voice heard – how? • Staff voice heard – how?

Eye Movement Desensitization and Reprocessing (EMDR) [Trauma Treatment - Client-Level Interventions (Child & Adolescent)] CEBCH - Well-Supported by Research Evidence – medium child welfare relevance NCTSN – not listed	*EMDR* therapy is an 8-phase psychotherapy treatment that was originally designed to alleviate the symptoms of trauma. During the *EMDR* trauma processing phases, guided by standardized procedures, the client attends to emotionally disturbing material in brief sequential doses that include the client's beliefs, emotions, and body sensations associated with the traumatic event while simultaneously focusing on an external stimulus. Therapist directed bilateral eye movements are the most commonly used external stimulus, but a variety of other stimuli including hand-tapping and audio bilateral stimulation are often used Recommended Intensity: Usually one 50- or 90-minute session per week Recommended Duration: Length of treatment is impossible to predict and is dependent upon the severity of the trauma, etc. Often major gains are apparent within a few weeks ranging from 3-12 sessions. Length of treatment is dependent on level of dissociation	This program is typically conducted in a(n): Community Agency; Hospital; Outpatient Clinic; Residential Care Facility; School Prerequisite/Minimum Provider Qualifications Qualifying individual providers must be either fully licensed mental health professionals or be enrolled in a Master's or Doctorate level program in the mental health field (Social Work, Counseling, Marriage Family Therapy, Psychology, Psychiatry, or Psychiatric Nursing) currently involved in the practicum and/or internship portion of the program they are enrolled in (first year students not eligible) and on a licensing track working under the supervision of a fully licensed mental health professional. The basic training consists of two 3-day training modules. In addition, 10 hours of case consultation are required to learn to implement the protocol. **For In-Person Trainings:** Participants must complete the entire training (including 10 hours of case consultation) within 24 months from the initial start date. **For Virtual Online Zoom Trainings:** Participants must complete the entire training (including 10 hours of case consultation) within 12 months from the initial start date. Once trained in EMDR, a person is trained for life. There is no expectation of retraining, etc. Most people do get continuing ed and/or consultation but that is voluntary. Training should be provided by a training organization approved by EMDRIA Certification is **not required** in order for a clinician to practice EMDR therapy. If trained, can use EMDR therapy under one's professional license. EMDR Certification is an option that many therapists have wanted because of Managed Care concerns and hospital privileges.

		To become certified means that you have attained the level of mastery needed to meet the requirements set out by the EMDR International Association (EMDRIA). Becoming a certified EMDR therapist ensures that one is knowledgeable in current research, and one attends advanced trainings and conferences to maintain skill level and certification. EMDR Institute Welcome to EMDR.com - EMDR Institute - EYE MOVEMENT DESENSITIZATION AND REPROCESSING THERAPY
I Feel Better Now! Trauma Intervention Program CEBCH – Not able to be rated – medium child welfare relevance NCTSN – not listed	Comprehensive trauma intervention program modified from original SITCAP program; 10-session group program designed specifically for at-risk traumatized children ages 6-12; integrates cognitive strategies with sensory/implicit strategies. Designed to alter the iconic memories of trauma to allow children the opportunity to achieve successful cognitive reordering of their traumatic experiences. Supports victim to survivor thinking and changes in negative behaviors and allows traumatized children to become more resilient	Prerequisite/Minimum Provider Qualifications Minimum 2-day training from Starr Commonwealth required Minimum 1-year group experience with elementary school aged children Supervision provided by a Master's Level Starr Certified Trauma and Loss trainer Education and Training Resources There is a manual that describes how to implement this program, and there is training available for this program.
	Recommended Intensity: One 60-minute session per week Recommended Duration: Eight to ten sessions in length	Proof of training; implementation manual I Feel Better Now! Trauma Intervention Program; William Steele, Pamela Lemerand, Deanne Ginns-Gruenber, Caelan Soma; Publisher, Starr Commonwealth, 1998 I Feel Better Now! I Feel Better Now! Trauma Intervention Program - Starr Commonwealth Starr Commonwealth Starr Commonwealth - Driven to Heal

Integrative Treatment of Complex Trauma for Adolescents - ITCT-A CEBCH – Not able to be rated – high child welfare relevance NCTSN – not listed	ITCT-A is a flexible multicomponent therapy for multiply traumatized adolescents and young adults. It involves semi-structured protocols, treatment tools and interventions that are customized to the specific issues, social context and capabilities of each client. An important component of ITCT-A is tis continuous monitoring of treatment effects over time. This involves initial and periodic psychometric and interview-based evaluation of the adolescent's symptomology, as well as assessment of their socioeconomic status, culture, ongoing level of support systems and coping skills, family and caretaker relationships, attachment issues and functional self-capacities. Especially focuses on social and cultural issues. Attention is paid to the use of culturally appropriate treatment resources, and the focus and context of treatment is adapted to the adolescent's sociocultural environment. Unlike most structured trauma treatment approaches for children and adolescents, ITCT-A does not have a pre-established number of sessions to be applied for every client. Instead, therapy may range from several months to year or more, although most clients appear to require and average of approximately six to eight months of treatment.	Prerequisite/Minimum Provider Qualifications Master's degree (or equivalent) that includes clinical training in a mental health-related field. This may be in the fields of psychiatry, psychology, social work, marriage and family therapy, counseling, etc. Trainings are conducted at the USC Adolescent Trauma Training Center in Torrance, CA, onsite at trainee organizations, and at local and national conferences. Education and Training Resources There is a manual that describes how to deliver this program, and there is training available for this program. A national ***ITCT-A*** Clinician Certification program is available. There is no cost associated with trainings offered by the USC-ATTC or the Clinician Certification program Proof of training; proof of certification; implementation manual Keck School of Medicine; University of Southern California About ITCT-A | Adolescent Trauma Training Center (USC-ATTC) Download PDF versions of treatment guides, implementation guide, specific tolls, worksheets and handouts
Motivational Interviewing – MI CEBCH – not listed NCTSN – not listed Title IV-E Preventions Services Clearinghouse	Motivational Interviewing (MI) is often recommended as an evidence-based approach to behavior change. However, definitions of MI vary widely, including out of date and inaccurate understandings. "MI is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and	Originally designed to support adults coping with substance use issues, MI has since been successfully adapted for other fields as an effective method for engaging non-voluntary or reluctant clients in making positive life changes by exploring and resolving their ambivalence toward change.

	commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion." (Miller & Rollnick, 2013, p. 29) Key qualities include: MI is a guiding style of communication, that sits between following (good listening) and directing (giving information and advice); designed to empower people to change by drawing out their own meaning, importance and capacity for change; based on a respectful and curious way of being with people that facilitates the natural process of change and honors client autonomy.	The Title IV-E Prevention Services Clearinghouse now rates MI as a "well-supported" program in the category of substance abuse programs and services There are no minimum qualifications for MI providers. MI can be used by a variety of different professionals. The Motivational Interviewing Network of Trainers (MINT) does not recommend specific trainings. However, they provide online training resources, contact information for MI trainers, and information about public trainings by MINT members. Proof of training; manual Training Expectations | Motivational Interviewing Network of Trainers (MINT) Individual study and self-training; Introduction to MI (1 hour to 1 day); Introduction to MI (Intro workshop 2-3 days) Intermediate and advanced training (2-3 days); MI Supervisor training (2-3 Days) Miller, W. R., & Rollnick, S. (2012). *Motivational Interviewing: Helping people change* (3rd ed.). Guilford Press MI Network of Trainers (MINT) Site Understanding Motivational Interviewing | Motivational Interviewing Network of Trainers (MINT)
NM - Neurosequential Model CEBCH – not listed NCTSN – not listed	The Neurosequential Model is a developmentally informed, biologically-respectful approach to working with at-risk children. The Neurosequential Model is not a specific therapeutic technique or intervention; it is a way to organize a child's history and current functioning. The goal of this approach is to structure assessment of a child, the articulation of the primary problems, identification of	Prerequisite/Minimum Provider Qualifications for individual certification: At least a master's degree in social sciences or equivalent (e.g., psychology, education, social work, nursing, OT/PT, etc.); A current license (e.g., LPC, LMFT, LMSW, etc.) or similar designation (if outside of US); Current practice working with children, youth, adults or families; Participation in at least 1 NMT Case-based Training Series (10 sessions). For those who have not completed an NMT Case-based Series but want to enroll in the Certification Program, a

	key strengths and the application of interventions (educational, enrichment and therapeutic) in a way that will help family, educators, therapists and related professionals best meet the needs of the child.	Pre-Requisite Series will be added to their training package at no additional cost. Requirements for the NMT Site Certification Process: Organizations are considered for Site Training Certification if seven or more employees or affiliated professionals are seeking Certification. The NMN will work with sites to determine whether Individual or Site Training Certification is most appropriate. While the full Site Certification process includes two phases of training, an organization may choose to enter Maintenance after Phase I. No internal training is possible in this case. Type 1: NMT Online Training Series NMT Online Courses | NMnetwork (neurosequential.com) Type 2: NMT Training Certification: Phase I, Phase II & Mentor Certification NMN_SiteCert_Overview_9_2021 (filesusr.com) Site Certification Process Organizations are considered for Site Training Certification if seven or more employees or affiliated professionals are seeking Certification. The NMN will work with sites to determine whether Individual or Site Training Certification is most appropriate. While the full Site Certification process includes two phases of training, an organization may choose to enter Maintenance after Phase I. Proof of certification Information can be found at: NMT | NMnetwork (neurosequential.com)
Parent Child Interaction Therapy CEBCH - Well supported by research evidence – medium child relevance	Parent-child interaction therapy (PCIT) is an evidence-based behavior parent training treatment for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-	Based on well-controlled randomized controlled trials, PCIT has been categorized as a probably efficacious treatment for 3- to 6-year-olds with disruptive behavior (Eyberg, Nelson, & Boggs, 2008).

NCTSN	child relationship and changing parent-child interaction patterns. Children and their caregivers are seen together in PCIT. Specifically, parents are initially taught relationship enhancement or discipline skills that they are actually going to be practicing in session and at home with their child. In subsequent sessions, most of the session time is spent coaching caregivers in the application of specific therapy skills. PCIT outcome research has demonstrated statistically and clinically significant improvements in the conduct-disordered behavior of preschool age children: after treatment, children's behavior is within the normal range. Studies have documented the superiority of PCIT to wait list controls and to parent group didactic training. In addition to significant changes on parent ratings and observational measures of children's behavior problems, outcome studies have demonstrated important changes in the interactional style of the fathers and mothers in play situations with their children.	PCIT has been rated as Promising by Blueprints for Healthy Youth Development as a treatment for young children with emotional and behavioral problems. In terms of the use of PCIT for a child welfare population, there is a nice review of the literature from Child Welfare Information Gateway. Prerequisite/Minimum Provider Qualifications: 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.
	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.	Training Type/Location: 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 Proof of training; implementation manual

		The Blueprints website for PCIT lists additional information about PCIT including a Fact Sheet, Program Costs, Funding Strategies, and a Detailed Evaluation Abstract. PCIT International www.pcit.org/find-a-trainer.html
Psychological First Aid CEBCH – not able to be rated – medium relevance child welfare NCTSN	PFA is an evidenced-informed intervention designed to be put into place immediately following disasters, terrorism, and other emergencies, and has received wide usage worldwide. PFA is comprised of eight core helping actions: contact and engagement, safety and comfort, stabilization, information gathering, practical assistance, connection with social supports, information on coping support, and linkage with collaborative services	Disasters, terrorism, and acute trauma, Post-disaster adversity, displacement PFA online includes a 6-hour interactive course Proof of training; implementation manual National Childhood Traumatic Stress Network (NCTSN) – at this time, all NCTSN Learning Center courses for CEs are FREE. Users must register with NCTSN Learning Center Psychological First Aid Online (nctsn.org) Mental Health Preparedness - Training - Johns Hopkins Public Health Preparedness Programs - Johns Hopkins Bloomberg School of Public Health (jhsph.edu)
Sanctuary Model CEBCH – promising research evidence – medium child welfare relevance NCTSN	The aims of the Sanctuary Model are to guide an organization in the development of a trauma-informed culture with seven dominant characteristics all of which serve goals related to recovery from trauma spectrum disorders while creating a safe environment for clients, families, staff, and administrators with measurable goals: Culture of Nonviolence; Culture of Emotional Intelligence; Culture of Inquiry & Social Learning; Culture of Shared Governance; Culture of Open Communication; Culture of Social Responsibility; and, Culture of Growth and Change	Sanctuary implementation is typically a three-year process Prerequisite/Minimum Provider Qualifications: The minimum qualifications for an organization to participate are a fundamental readiness to engage in trauma-informed practices at the organizational level as a way to include a trauma component in their work or to complement and enhance other trauma specific treatment interventions. The resources for implementation vary by organization, but should include release time for employee training and core team meetings as well as funding for the three-year training and consultation

	Recommended Intensity: This is an organizational model that shapes the treatment milieu, offers some clinical tools and is used continually once it is implemented. See Training and Implementation sections below for more information. Recommended Duration: Once implemented, clients receive Sanctuary model throughout their residence in the program See Training and Implementation sections below for more information.	Manual for implementation Sanctuary implementation is typically a three-year process: • Year 1 Engaging • Year 2 Embedding • Year 3 Evaluating Number of days/hours: The initial training for a select group of employees lasts 5 days and is followed by a three-year agency consultation period. All staff members participate in a minimum of 15 hours of in-house training per year to maintain knowledge and skills for practice of the Model. Sanctuary Institute Standards for Certification Microsoft Word - Completed 2019 Standards in Word.docx (thesanctuaryinstitute.org) Sanctuary Institute Sanctuary Model – Sanctuary Institute (thesanctuaryinstitute.org)
SPARCS: Structured Psychotherapy for Adolescents Responding to Chronic Stress CEBCH – not able to be rated – medium relevance child welfare NCTSN	SPARCS is a manually guided and empirically supported group treatment designed to improve the emotional, social, academic, and behavioral functioning of adolescents exposed to chronic interpersonal trauma (such as ongoing physical abuse) and/or separate types of trauma (e.g,, community violence, sexual assault). The curriculum was designed to address the needs of adolescents who may still be living with ongoing stress and may be experiencing problems in several The curriculum has been successfully implemented with at-risk youth in various service systems (e.g., schools, juvenile justice, child-welfare, residential) in over a dozen states.	16 sessions one-hour in length Prerequisite/Minimum Provider Qualifications: Group leaders are generally mental health clinicians with a Masters Degree. Proof of training; implementation manual Trainings can be conducted on-site for agencies who are interested in hosting their own Collaborative. Participants can also join an existing Collaborative that may be taking place in another part of the country.

	Recommended Intensity: It is recommended that treatment sessions occur for at least one hour each week. Many agencies, especially those with shorter lengths of stay, have successfully implemented the model by providing 2 (and on select occasions 3) sessions per week. In agencies, such as school settings, where there is often less than 1 hour available, sessions have been divided into two segments and conducted twice a week for 35-40 minutes each, in order to accommodate class periods. Recommended Duration: Each group cycle consists of 16 sessions with a minimum length of an hour per session. It is recommended that the program be implemented in settings where adolescents can remain in treatment long enough to complete the intervention.	SPARCS trainings are conducted using a Learning Collaborative/Community model of training, which consists of a planning/readiness phase, 4 days of training (conducted across two 2-day training sessions), consultation calls, and ongoing email/phone support throughout the duration of the collaborative (approximately 8-12 months). • Learning Collaborative participants consist of teams of at least 2 (preferably 3 individuals): 1 administrator/ supervisor and 2 clinicians. Each group is co-led. • Attendance at both full days of two separate Training Sessions. • Active participation in 80% of consultation calls. • Audio or Videotape of one session in which a core skill is implemented (requirement for certification only). • Completion of two 16-session cycles of SPARCS groups under supervision of trainers (requirement for certification only). National Child Traumatic Stress Network (NCTSN) sparcs_fact_sheet.pdf (nctsn.org) **Stars Training Academy** collaborates with community-based and government organizations to provide enriched training and customized consultation to achieve high fidelity and sustainable implementation of evidence-supported and evidence-based practices Structured Psychotherapy for Adolescents Responding to Chronic Stress - Stars Training Academy
Structured Sensory Interventions for Traumatized Children, Adolescents and Parents – SITCAP ® CEBCH – Not listed NCTSN – Not listed	Process directs itself at actively involving children in new experiences in order for them to build new connections related to what they are learning about themselves and trauma as a result of the sensory-based activities they engage in when participating in SITCAP®. Developed and used over the past 24 years, field tested in schools and community agencies, SITCAP® is supported by the latest scientific advances in neuroscience and has been featured	***NOTE: Starr Commonwealth's Trauma and Loss Center has several SITCAP© interventions for children and adolescents, including "SITCAP-ART" and "I Feel Better Now!"***

	in leading scholarly journals and numerous books on childhood trauma	
Structured Sensory Interventions for Traumatized Children, Adolescents and Parents - SITCAP-ART ® CEBCH – Promising Research Evidence - medium child welfare relevance NCTSN – not listed	Model group program is for at-risk and adjudicated youth. This program provides Juvenile Court Systems with trauma intervention that supports the needs of adolescents exposed to traumatic incidents. The goal of the program is to reduce traumatic reactions, restore a sense of safety and power, improve the adolescent's behavior, and ability to learn and be productive within his family and community environments. This program was included in SAMHSA's National Registry of Evidence-based Programs and Practices Recommended Intensity: One hour-long session per week Recommended Duration: Eight to Ten weeks in length	Prerequisite/Minimum Provider Qualifications: Intervener: Minimum training requirements Children of Trauma and Resilience: 6-hour virtual online training Structured Sensory Intervention II: 6-hour virtual online training Minimum 1-year group experience with adjudicated adolescents, preferred Masters Level Education Supervisor: Supervision provided by Master's Level TLC Institute trained professional. Proof of training/certificate of completion; implementation manual *Children of Trauma and Resilience Guidebook and Structured Sensory Interventions II Guidebook* Structured Sensory Interventions for Children, Adults and Parents - Starr Commonwealth SITCAP® - Starr Commonwealth
Teaching-Family Model (TFM) CEBCH - Promising research evidence – high relevance child welfare NCTSN – not listed	*TFM* is an approach to human services characterized by clearly defined goals, integrated support systems, and a set of essential elements. *TFM* has been applied in residential group homes, home-based services, foster care and treatment foster care, schools, and psychiatric institutions. The model uses a married couple or other "teaching parents" to offer a family-like environment in	Prerequisite/Minimum Provider Qualifications The qualifications vary from agency to agency as their selection criteria are often based on state requirements in addition to the program's selection components. Minimum is a Bachelors degree for practitioners, usually in social work or psychology. Education and Training Resources

	the residence. The teaching parents help with learning living skills and positive interpersonal interaction skills. They are also involved with children's parents, teachers, and other support network to help maintain progress. Recommended Intensity: For all residential settings, it is a 24/7 arrangement. For home-based interventions, it is a 10-15 sessions per week arrangement. Recommended Duration: Ideally, 9 months, however, program has been applied in emergency care settings, as well. Duration for home-based is typically 6-10 weeks.	There is a manual that describes how to deliver this program, and there is training available for this program. Pre-Service is roughly 1 week — 40 hours; ongoing consultation after placement with individual certification typically occurring after one year of practice Proof of Accreditation; training records Training, coaching/supervision, evaluation, and facilitative administrative support systems Only Accredited agencies can claim genuine implementation of the Teaching-Family Model Teaching-Family Association ®
Think Trauma CEBCH – not able to be rated – high relevance child welfare NCTSN Learning Center	*Think Trauma: A Training for Working with Juvenile Justice Involved Youth, 2nd Edition* is an in-person training curriculum focused on the complex process of creating a trauma-informed juvenile justice system. This course includes all the documents and other resources necessary for juvenile justice administrators and leaders to facilitate four comprehensive, skills-based, and interactive modules aimed at audiences of direct care staff who provide services to residential youth. Recommended Intensity:	*Think Trauma* is structured into four modules that are approximately 16 hours and can be implemented continuously during all-day trainings or module-by-module over the curse of several weeks. The NCTSN developed two resources to support agencies examination of their progress toward becoming a trauma-informed agency: *Essential Elements of a Trauma-Informed Juvenile Justice System* and the *Trauma-Informed Juvenile Court Self-Assessment (TI-JCSA)*. It is recommended that agencies view these resources along with a few others in deciding whether the Think Trauma training is right for your facility. Treat is driven by Trauma-Informed Individualized Safety Plans. Focus includes: trauma and justice involvement; trauma's impact on development; trauma in context and coping; and, trauma and staff wellness. Information available through the NCTSN Learning Center. The NCTSN developed two resources to support agencies examination of their progress toward becoming a trauma-informed agency: *Essential Elements of*

	This program is not a client-specific intervention, but a whole system approach that targets the entire organization. Recommended Duration: This program is meant to be implemented at an organization and kept as a framework that helps the staff understand trauma better.	*a Trauma-Informed Juvenile Justice System* and the *Trauma-Informed Juvenile Court Self-Assessment (TI-JCSA)*. It is recommended that agencies view these resources along with a few others in deciding whether the Think Trauma training is right for your facility. Additionally, Isaiah Pickens, PhD, one of the lead developers, has recorded a series of short videos about the development of this comprehensive toolkit and what's new in this second edition. *Think Trauma* is structured into four modules that are approximately 16 hours and can be implemented continuously during all-day trainings or module-by-module over the course of several weeks. The *Think Trauma* curriculum may be downloaded from the website and taught to organization staff without any additional training from the curriculum developer. There are additional resources available online as well including videos and significant content to assist the trainer in the manual. With assistance from the curriculum developer, staff training is also available via a train-the-trainer model which enables multiple staff members to train future staff member on **Think Trauma**. National Child Traumatic Stress Network (NCTSN) Think Trauma: A Training for Working with Justice Involved Youth, 2nd Edition (nctsn.org)
Trauma Affect Regulation: Guide for Education and Therapy for Adolescents (TARGET-A) CEBCH - Promising research evidence – medium relevance child welfare NCTSN	Educational and therapeutic intervention designed to prevent and treat traumatic stress disorders (including PTSD, sever anxiety disorders, depression and dissociative disorders), co-occurring addictive, personality or psychotic disorders and adjustment disorders related to other types of stressors.	Manualized protocol for brief (4-session) time limited (10-14 sessions) and extended (26+ sessions) individual, groups or family education and therapy; delivered in community, outpatient, inpatient, residential Tx or healthcare setting. Prerequisite/Minimum Provider Qualifications: Bachelor's level mentors, case managers, or advocates with supervision by Master of Arts, Master of Social Work, or PhD level profession

	Services Involve Family/Support Structures: This program involves the family or other support systems in the individual's treatment: *TARGET-A* individual or group therapy with children provides education for family and support system members, and conjoint family therapy sessions with family/support persons when clinically indicated. Recommended Intensity: Weekly or twice-weekly contacts for 50 minutes (for individual therapy) or 60-90 minutes (for family or group therapy) Recommended Duration: One month for brief therapy; 3-4 months for time-limited therapy; 6+ months for extended therapy	Proof of training; implementation manual; number of days/hours: Introductory: 3 days Advanced: 3 days Train-the-Trainer: 5 days On-going consultation: 75 hours Formal Support for Implementation There is formal support available for implementation of *Trauma Affect Regulation: Guide for Education and Therapy for Adolescents (TARGET-A)* as listed below: Advanced Trauma Solutions, Inc., provides a comprehensive approach to implementing the *TARGET-A* curriculum. A two-hour web-based video introductory course describing *TARGET-A* is available for agencies and clinicians/facilitators who are preparing for the in-person *TARGET-A* training curriculum. Advanced Trauma Solutions Professionals http://Atspro.org/
Trauma-focused cognitive-behavioral therapy (TF-CBT) CEBCH - Well supported by research evidence – high relevance child welfare NCTSN	F-CBT addresses the multiple domains of trauma impact including but not limited to Posttraumatic Stress Disorder (PTSD), depression, anxiety, externalizing behavior problems, relationship and attachment problems, school problems and cognitive problems. TF-CBT includes skills for regulating affect, behavior, thoughts and relationships, trauma processing, and enhancing safety, trust, parenting skills and family communication. Recommended Intensity:	Has been modified for residential treatment facilities (e.g., additional training materials are available for training direct care staff to support the use of TF-CBT skills in the residential setting) Prerequisite/Minimum Provider Qualifications: Master's degree and training in the treatment model; Experience working with children and families National therapist certification is not required to practice TF-CBT, but TF-CBT developers suggest that the minimal recommended training requirements are similar to those required for certification. Specifically, master's level clinicians* should **at a minimum** complete:

	Weekly 30- to 45-minute sessions for the child and parent separately until the end of treatment nears; then conjoint sessions of 30-45 minutes are included Recommended Duration: 12-18 weeks	1) TF-CBT*Web* (available at https://tfcbt2.musc.edu) 2) 2 day TF-CBT face-to-face (or virtual) training by an approved national TF-CBT trainer; and 3) 12 TF-CBT consultation calls by an approved national TF-CBT trainer (including presenting their own cases) Steps 2 and 3 can be replaced by participation in an approved TF-CBT learning collaborative led by at least one approved national TF-CBT trainer. TF-CBT cannot be provided by bachelor level clinicians in the US. Ancillary training and materials is available for RTF direct care staff and other RTF providers (e.g., educators, nurses, etc.) about how to support the provision of TF-CBT. TF-CBT Certification Criteria All eight steps must be met to achieve certification**.** 1. Master's degree or above in a mental health discipline. 2. Permanent professional license in home state, including having passed the state licensing exam in your mental health discipline. 3. Completion of **TF-CBTWeb;** 4. Participation in a live TF-CBT training (two days) conducted by a treatment developer or an approved national trainer (graduate of our TF-CBT Train-the-Trainer Program); or Live training in the context of an approved national, regional, or state TF-CBT Learning Collaborative of at least six months duration in which one of the treatment developers or a graduate of our TF-CBT Train-the-Trainer (TTT) Program has been a lead faculty member. 5. Participation in follow-up consultation or supervision on a twice a month basis for at least six months or a once-a-month basis for at least twelve months. The candidate must participate in at least nine out of the twelve consultation or supervisory sessions. This consultation must be provided by one of the treatment developers or a graduate from our TTT program.

		Supervision may be provided by one of the treatment developers, a graduate of our TTT program, or a graduate of our TF-CBT Train-the-Supervisor (TTS) Program (In the latter instance, the supervisor must be employed at the same organization as the certification candidate); or Active participation in at least nine of the required cluster/consultation calls in the context of an approved TF-CBT Learning Collaborative. 6. Completion of three separate TF-CBT treatment cases with three children or adolescents with at least two of the cases including the active participation of caretakers or another designated third party (e.g., direct care staff member in a residential treatment facility) 7. Use of at least one standardized instrument to assess TF-CBT treatment progress with each of the above cases. 8. Taking and passing TF-CBT Therapist Certification Program Knowledge-Based Test. The TF-CBT therapist certification is good for 5 years, during which time there are no trainings or CEUs required to maintain certification After completion of recertification modules, the date of expiration of the new certificate will be five years from when an individual has completed the required education. TF-CBT Certification Program - Official Website (tfcbt.org) FAQs - Trauma Focus Cognitive Behavioral Therapy Certification Program (tfcbt.org)
Trauma-Responsive Care Training and Consultation CEBCH – not listed NCTSN – not listed	Trauma Responsive Care goes beyond traditional Trauma Informed Care by not only helping to understand trauma and its effects but additionally providing interventions to assist in alleviating trauma symptoms and lead to a higher level of functioning. The interventions utilized in Trauma-Responsive Care are derived from a synthesis of emerging research in the neurobiology complex trauma and	Trauma Responsive Care Training and Consultation are provided by Finding Hope Consulting • Two-day Foundational Training Sessions • Six Theory to Practice Sessions • 200-page Strategy and Intervention manual provided to each TRCC participant

	attachment trauma. Training includes understanding Felt Safety vs. Actual Safety: Felt Safety is the Cornerstone of our ability to Connect & Regulate. Training and consultation is delivered one and one to therapists, in small group with leadership and supervisors as well as whole staff trainings. Leadership and supervisors are being trained to follow-up and coach front line staff in the Trauma Responsive Model and practical interventions.	• Trauma Responsive Care Certification for those who complete the series Proof of training and consultation records/documentation Certification Program | Finding Hope Consulting, LLC
Trauma-System Therapy (TST) CEBCH – Not able to be rated; high relevance child welfare NCTSN	TST is applicable across all trauma types. It has most often been used with children and teens who have experienced complex, chronic traumatic events, in settings such as foster care, inpatient units, residential treatment, and with specialized populations such as refugees, and substance abusing adolescents. Recommended Intensity: For a given case, there is a weekly team meeting, with multiple members of the team engaged in assessment and treatment planning. Interventions will vary depending on the phase of treatment the trauma system is assessed as being in at a given time. For youth assessed as being in the most intense phase, safety-focused treatment (a dysregulated youth in a threatening environment), interventions will take place in the home/community, and will likely be frequent (at least twice a week for at least 60 minutes) and intensive. In the highest phase, beyond trauma (an emotionally regulated youth in a stable environment), the intervention will likely be individual psychotherapy to focus on trauma processing, correcting cognitive distortions and meaning making, for 45-60 minutes per week.	Length varies by level of severity and phases of treatment administered. There are 3 phases of treatment in TST: Safety Focused Treatment, Regulation Focused Treatment, and Beyond Trauma Treatment. Length of treatment varies depending on which phase a child starts in (determined by the TST assessment process). Typical length of treatment is between 7 and 9 months. Prerequisite/Minimum Provider Qualifications: A multidisciplinary team is required including clinical, educational, and case management staff members that are able to collaborate on assessment, treatment planning and implementation. The minimum educational requirement varies by discipline. Clinicians should have at least a master's degree and case workers often have a bachelor's degree. Proof of training Implementation manual Training is provided via contract to an agency onsite. Training is typically done in the context of a one-year consulting relationship which involves organizational planning, 3 days of onsite training, weekly consultation/technical assistance for one year, and a train-the-trainer and certification process.

	Recommended Duration: As an organizational model, the intervention is carried out on a universal basis continuously. For a given youth/trauma system, it will depend on the phase of treatment. Ideally, a youth will continue to receive services until they reach phase 3. As services within the child welfare system are often time-limited, phase-based needs may be recommended as follow-up care. Full implementation of the model for a given youth typically and ideally lasts approximately 7-9 months.	Trauma Systems Therapy | The National Child Traumatic Stress Network (nctsn.org) CEBC » Trauma Systems Therapy Tst › Program › Detailed (cebc4cw.org)
Trust Based Relational Intervention (TBRI) CEBCH – Promising Research Evidence – high relevance child welfare	TBRI is a holistic approach that is multidisciplinary, flexible, and attachment centered. It is a trauma-informed intervention that is specifically designed for parents and caregivers of children who come from 'hard places,' such as maltreatment, abuse, neglect, multiple home placements, and violence, but is an approach that can be used by parents and caregivers with all children. TBRI consists of three sets of harmonious principles: Connecting, Empowering, and Correcting. These principles can be used in homes (e.g., birth homes, foster homes, kinship homes, adoptive homes, etc.), schools, orphanages, residential treatment centers, and other environments. They are designed to be used by parents and caregivers with children and youth of all ages and risk levels. TBRI is based upon how optimal development *should* have occurred. By helping caregivers understand what should have happened in early development (including prenatal development), TBRI principles can be used by parents and caregivers to help guide children and youth back to their natural developmental trajectory.	*TBRI Caregiver Training* is a group in-person parent training program. Prerequisite/Minimum Provider Qualifications: Trainers must be TBRI Educators in order to train others in the intervention. There is no minimum educational requirement to attend the trainings to be a TBRI Educator. TBRI Practitioner Training is intended for professionals working with caregivers and children (note: these practitioners do not train parents on TBRI, they learn the TBRI principles to help them work with the children and families they see in their practice). It includes 2 phases and is approximately 80 hours in length Karyn Purvis Institute of Child Development, TCU child.tcu.edu/professionals/tbri-training Proof - Successful completion of all components of Phase 1 and Phase 2 are required to be recognized as a TBRI® Practitioner. After successful completion

	Recommended Intensity: 6-hour training session Recommended Duration: Four days	of the TBRI® Practitioner Training, all TBRI® Practitioners may train within their organization using the TBRI® Caregiver Training Package. Caregivers not attending the training sessions and other people who provide care for the child are strongly encouraged to attend a *TBRI Caregiver Training* session (or watch a DVD from The Healing Families series or read The Connected Child book) in order to use the same voice with the child.
UKERU CEBCH – not listed NCTSN – not listed	Ukeru helps providers explore and understand the effects of trauma on behavior and functioning. Participants will learn how to assess the impact of trauma, understand trauma symptoms, and take those symptoms into consideration when developing a support plan for each client who has experienced trauma. • Introduces the importance of creating a trauma-Informed treatment environment. • Explores the effects of trauma on the brain and subsequent behavioral, emotional, and adaptive functioning; • Provides a better understanding of why individuals may exhibit behaviors that are considered "maladaptive" but may actually be quite "adaptive" in protecting the individual from real or perceived threat. • Presents cultural and environmental factors associated with "trauma-informed" and "trauma-uninformed" settings, • Reviews specific information to consider when assessing the impact of trauma and developing a support plan to minimize traumatic stress in the future	Customized to fit the unique needs of your organization, Ukeru® offers direct participant trainings as well as a train-the-trainer series. Training is straightforward, easy to implement, and focuses on what caregivers want to do most – communicate effectively with clients and avoid stressful, escalating behaviors. Through trauma informed training, Ukeru helps providers explore and understand the effects of trauma on behavior and functioning. Participants will learn how to assess the impact of trauma, understand trauma symptoms, and take those symptoms into consideration when developing a support plan for each client who has experienced trauma. Prerequisite/Minimum Provider Qualifications: None Anyone who uses the Ukeru approach must have a user certification; the User Certification consists of a 1-day training https://www.ukerusystems.com/contact/ Ukeru parent organization: Grafton Integrated Health Network Home - Grafton Proof of training; implementation manual

CEBCH – California Evidence-Based Clearinghouse for Child Welfare https://www.cebc4cw.org/search/

NCTSN – National Childhood Traumatic Stress Network https://www.nctsn.org/treatments-and-practices/trauma-treatments/interventions