EXTENDED DAY TREATMENT: Defining a Model of Care in Connecticut

Jeffrey J. Vanderploeg, Ph.D.
Jacob Kraemer Tebes, Ph.D.
The Consultation Center, Yale University School of Medicine

Robert P. Franks, Ph.D.
Connecticut Center for Effective Practice

Connecticut Center for Effective Practice

Child Health and Development Institute of Connecticut, Inc.

EXTENDED DAY TREATMENT:
Defining a Model of Care in Connecticut

Jeffrey J. Vanderploeg, Ph.D.
Jacob Kraemer Tebes, Ph.D.
The Consultation Center
Yale University School of Medicine

Robert P. Franks, Ph.D.
Connecticut Center for Effective Practice
Child Health and Development Institute

June 19, 2007

This report was developed for the Connecticut Department of Children and Families (DCF) as a publication of the Connecticut Center for Effective Practice (CCEP). CCEP is directed by Robert P. Franks, Ph.D., under the auspices of the Child Health and Development Institute (CHDI) of Connecticut, in partnership with the Connecticut Department of Children and Families, the Judicial Branch Court Support Services Division, the University of Connecticut Health Center, and the Yale University School of Medicine. CCEP is supported through core funding from the Connecticut Health Foundation, the Connecticut Department of Children and Families, and the Children's Fund of Connecticut.

TABLE OF CONTENTS

Executive Summary

Overview, Purpose, and Organization of Report

The Extended Day Treatment (EDT) program in Connecticut is a milieu-based multimodal intervention for children and adolescents age 5-17 years old who have intermediate-level emotional and behavioral disorders, and their families. EDT is within the intermediate level of care according to standards set forth by the Connecticut Behavioral Health Partnership. The Connecticut Department of Children and Families (DCF) currently oversees the operation of all EDT programs in Connecticut. To date, much work has been done to define the practices related to EDT (see *Extended Day Treatment Practice Standards*) and seek the feedback of providers, families, and other stakeholders regarding the strengths and challenges of the EDT program in Connecticut (see *Stakeholders Report*).

In an effort to build upon this foundational work, the current report entitled, *"Extended Day Treatment: Defining a Model of Care in Connecticut,"* provides a set of recommendations for further defining a model of care that can be implemented in EDT programs across the State. The recommendations in this report are based upon a broad review of the scientific and best practices literature, a review of existing documents describing the Connecticut EDT program, observation of select EDT programs, and consultation with key stakeholders. These findings and recommendations are summarized below, and are organized into twelve sections, each representing a critical aspect for developing a model of care based on best practices in child and adolescent behavioral health care.

Findings and Recommendations

Model Description

- There is great variability among EDT programs nationwide in service emphasis and target populations, and thus, little to establish EDT as an "evidence-based practice." However, Connecticut is among national leaders with regard to available descriptive and evaluative information on their EDT program.
- A logic model is forwarded that establishes links between resources and inputs, activities and participants, and the expected short-, intermediate-, and long-term outcomes of the program. Inputs/resources specified provide support for the ongoing development and implementation of EDT programs.

Theoretical Foundations

- EDT programs are grounded in relevant theoretical models, including, but not limited to: Child Developmental Theory, Ecological Systems Theory, Attachment Theory, Social Learning Theory, and Positive Youth Development. Each of these theories influences the goals, activities, interventions, and expected outcomes of EDT services.

Treatment Focus

- Systems of care philosophy should be made an explicit part of the treatment focus of EDT. Services should target multiple domains of functioning, be individualized, seek to maintain children in the least restrictive setting appropriate to their clinical needs, include the family/caregivers in all treatment delivery, and generalize treatment progress from the center-based EDT environment to home, school, and community settings.
- EDT services should emphasize the use of evidence-based treatments and practices whenever possible. Evidence-based practices should be used across all modalities, including individual, group, family, and milieu interventions

Service Delivery Structure

- Core EDT services include: comprehensive intake assessment; treatment planning; structured therapeutic milieu; psychiatric evaluation and medication management; family therapy; group therapy; individual therapy; twenty-four crisis services; therapeutic recreation and expressive therapies; positive youth development activities; discharge planning, and; community referrals.
- Connecticut should develop three levels of EDT: Intensive, Standard, and Transitional. Intensive EDT is equivalent to Intensive Outpatient Programs and emphasizes symptom stabilization. Standard EDT maintains treatment gains and begins to form and monitor youth and family connections to community-based supports and services. Transitional EDT begins to de-emphasize center-based treatment in favor of fully establishing bridges from center-based EDT to community-based supports and services.

Screening and Assessment Instruments and Protocol

- It is recommended that EDT programs implement a comprehensive intake assessment process that includes the following elements: parent and child intake interviews; home visit; psychiatric evaluation and medication management; Ohio Scales; Yale Modified Children's Global Assessment Scale (Yale M-CGAS); UCLA-PTSD Index; Parenting Stress Index-Short Form (PSI-SF) and; Youth Satisfaction Survey.
- Screening and assessment of children and families using reliable and valid measures is central to treatment planning. Connecticut should provide training for EDT program staff in the use of recommended assessment instruments and protocols.

Menu of Evidence-Based Practices and Best Practice Interventions

- Whenever possible, the use of empirically tested and evidence-based practices (EBPs) is recommended. EBPs are recommended for individual, group, family, and milieu interventions, and are divided by developmental level (5-12 years and 13-18 years).
- Several implementation steps are recommended to facilitate integration of EBPs, and include: providing general training on evidence-based practices, system of care philosophy, and family-focused treatment; supporting the training, implementation, consultation, and technical assistance recommendations recommended by treatment developers; identifying one staff member to develop an expertise in the design and implementation of each evidence-based practice for use their EDT program, and; supporting ongoing training, technical assistance, and consultation in order to ensure long-term fidelity to all evidence-based practices that are adopted by EDT programs.

Service Standards

- The number of days of center-based participation vary, from 5 days per week at the Intensive EDT level, 3 to 5 days per week at the Standard EDT level, and 2 to 3 days per week at the Transitional EDT level. EDT services are recommended for a period of up to six months, with re-assessment of the appropriateness of EDT at 3 months post-intake.
- Linkages between the EDT program and school officials and school clinics, outside treatment agencies, and other system of care providers is strongly recommended as an important element of the EDT program. In addition, youth should not be discharged from EDT until the treatment team can demonstrate that youth and their families have at least one stable relationship with a community provider.

Staffing

- Recommendations for staffing EDT programs retain all original positions, including: Program Director, Child and Adolescent Psychiatrist, Child & Family Clinician, and Behavior Specialist.
- Additional staff positions recommended for EDT include: Family Engagement Specialist, Recreational and Expressive Therapist, Positive Youth Development Coordinator, and Quality Assurance/Performance Improvement Specialist. These positions can be filled by part-time staff (e.g., Recreational Therapist), on a contract basis (e.g., Expressive Therapist), or by designating existing staff to an additional role (e.g., Positive Youth Development Coordinator).

Staff Training

- Connecticut should adopt an approach to training that recognizes that ongoing training is critical to effective service delivery, particularly in a treatment environment that emphasizes evidence-based practices.
- A series of pre-service training and in-service training elements should be provided. Pre-service training should emphasize issues common to child and adolescent mental health programs (e.g., de-escalation, conflict resolution, and crisis management techniques, CPR). In-service training should emphasize elements of the proposed model of care (e.g., evidence-based practices, performance measurement).

Implementation

- Procedures should be put into place to guide implementation of the new model for EDT, with respect to intervention fidelity and adaptation. Recommended procedures include: bi-annual site visits, interviews with key staff, record reviews, inspect of service utilization data, and interviews with selected youth and families who utilize EDT services.

Outcomes-Based Performance Measurement

- Performance indicator data should be collected by all EDT programs and reported to DCF on at least a semi-annual basis. This data should be compared to benchmarks, tracked by programs longitudinally, and analyzed across EDT programs and according to individual programs.
- The two recommended strategies for outcomes-based performance measurement are control chart methodology and case mix adjustment methodology.

Quality Assurance

- Each EDT program should develop an individualized quality assurance plan that addresses specific performance indicators. A quality assurance plan is a central component of any system of continuous quality improvement, which refers to a system in which data is monitored and utilized on an ongoing basis to make data-driven decisions for improving service delivery.
- Connecticut should provide the necessary supports to establish CQI systems within EDT programs to monitor the quality and effectiveness of services as part their comprehensive quality assurance plan for EDT.

Section 1: Introduction

Extended Day Treatment (EDT) is a milieu-based, multimodal clinical intervention for children and adolescents 5-17 years old who have intermediate-level emotional and behavioral problems (Connecticut Behavioral Health Partnership, 2007; www.ctbhp.com). Consistent with a systems of care approach toward mental health services for children and adolescents (Stroul & Friedman, 1986), EDT seeks to:

- Maintain youth in the least restrictive and most normative environment appropriate to their clinical needs;
- Provide comprehensive clinical services to children and adolescents with serious emotional and behavioral problems; and
- Emphasize family/caregiver involvement in all aspects of treatment.

The primary goals of EDT are to reduce child and adolescent problem behaviors, promote competence, and prevent placements in more restrictive clinical environments, such as residential treatment or inpatient hospitalization.

Purpose of the Report

The purpose of this report is to describe a model of care for EDT services funded by the Connecticut Department of Children and Families (DCF). The model builds on existing strengths of EDT programs and promotes the use of evidence-based practices across sites. Model recommendations proposed also incorporate the perspectives of EDT providers and other stakeholders, such as family members, by drawing upon previous work. The recommendations are intended as guidelines for the implementation of DCF-funded EDT services.

Although a program model for EDT is described in considerable detail for adoption by all programs, there is built into the model sufficient flexibility for adaptation by individual programs so that they may be responsive to local needs and circumstances.

Finally, throughout the report, major recommendations are noted in bold and embedded in surrounding descriptions that provide the context for these bolded recommendations.

Organization of the Report

This report draws on multiple sources, including (but not limited to) the following:

- *Stakeholders Perspectives: A Report on Extended Day Treatment* (September 15, 2006). Connecticut DCF, Bureau of Behavioral Health and Medicine, and the EDT Practice Standards Committee collaborated to create this report, which was based on surveys and focus groups involving EDT providers, DCF staff, EDT consumers, school personnel, system of care coordinators, and other community stakeholders;
- The draft version of the DCF Revised Practice Standards (January 2007);
- The EDT Contextual Logic Model (October 31, 2006);
- The Connecticut Behavioral Health Partnership definitions of Intermediate Level of Care, including EDT, Intensive Outpatient (IOP), and Partial Hospitalization Programs (PHP);
- The Comprehensive Global Assessment (August 1, 2005);
- Reviews of available literature on evidence-based practices and best practices for intervention programs targeting children and adolescents with social, emotional, and behavior disorders, including information obtained online and in various databases,

such as: PsychInfo, PubMed, the Substance Abuse and Mental Health Services Administration (SAMHSA) website, the National Registry of Evidence-Based Programs and Practices (NREPP); state mental health and substance abuse services websites, Google Scholar, and Google;

- Observation of selected EDT Connecticut programs and interviews with selected EDT program leadership and staff;
- Consultation regarding Medicaid reimbursement issues with the Director of Medical Policy and Behavioral Health Medical Care Administration (Dr. Mark Schaefer; March 2, 2007);
- Participation in quarterly EDT provider meetings

The report describes a recommended model for EDT services in Connecticut and guidelines for its implementation. Sections include:

a) Introduction to EDT;

b) Model Description;

c) Theoretical Foundations;

d) Treatment Focus;

e) Service Delivery Structure;

f) Screening and Assessment Instruments and Protocol;

g) Menu of Evidence-Based Practices & Best Practices;

h) Service Standards;

i) Staffing;

j) Staff Training;

k) Implementation;

l) Outcomes-Based Performance Measurement, and;

m) Quality Assurance.

Each of these sections follows below.

Section 2: Model Description

Current State of EDT Practice

EDT is intended to provide comprehensive, multimodal treatment to children and adolescents with intermediate-level emotional and behavioral disorders and to involve families/caregivers in all aspects of treatment. Currently, however, there is no consistent model of care that describes how this should be done in Connecticut or nationally. Furthermore, since EDT is comprised of an array of component treatments configured to meet the individual needs of youth and families being served, studies have yet to be done on the combination of components of EDT to provide a scientific basis for its efficacy.

Although a few states have established EDT programs, many of these refer to after-school daycare or educational enrichment programs that are available within school districts or the community, but do not have a clinical treatment focus. Among those states that have developed *treatment-oriented* EDT, such as Minnesota, Nebraska, Ohio, Rhode Island, and Texas, only Connecticut has published draft practice standards for EDT and has specified a model of EDT services. This is indicative not only of Connecticut's commitment to EDT, but also its role as a national leader in establishing EDT as an integral form of treatment within a system of care service array.

Proposed EDT Logic Model

The proposed model for EDT described in this report draws on relevant theories (see below *Section 3: Theoretical Foundations*) and on a commitment to the use of evidence-based practices in the provision of treatments that comprise EDT services. A critical step in defining a model of care for EDT that supports evidence-based practices is to specify a logic model that describes the inputs, outputs, and outcomes of EDT.

A logic model is a visual depiction of a theory of change that describes the conditions that must be addressed, the inputs or resources that comprise the program to address those conditions, the activities and participants involved in that program, and the desired program outcomes (Tebes, Kaufman, & Connell, 2003). Logic models have been applied to many community-based child and adolescent mental health programs and service systems (Chen, Cato, & Rainford, 1999; Hernandez, 2000; Stewart, Law, Russell, & Hanna, 2004).

The figure on Page 7 depicts the logic model for EDT, with links between resources and inputs, activities and participants, and the expected short-, intermediate-, and long-term outcomes of the program. Inputs/resources specified provide support for the ongoing development and implementation of EDT programs. These include a range of resources, including: provider resources (e.g., various types of staff and the therapeutic milieu in which services are delivered; the model of care and related policies and procedures; etc.); administrative and support services (e.g., various budgets, reports, standards, committees, policies, and regulations, etc.); care coordination inputs (e.g., DCF staff; Behavioral Health Partnership; KidCare; private insurers, etc.); and, evaluation and assessment (e.g., stakeholder surveys and focus groups; CQI plans; behavioral health data system; etc.).

These resources result in the completion of various activities directed to meeting the goals of EDT that involve the participation of children, adolescents, families, service providers, and others. Activities include: therapeutic services (e.g., intake; treatment and discharge planning; individual, family and group treatment; etc.) administrative and support services (e.g., staff development and training; case record-keeping; etc.); collateral and coordinating services (e.g., service coordination, etc.); and evaluation and assessment (e.g., data collection; outcome evaluation; CQI processes, etc.).

EDT program activities are related to expected short-, intermediate-, and long-term goals for children, families, and the service system. Short-term goals include: an increased number of assessment, intake, and treatment planning activities, and that more programs will use evidence-based and family-focused practices. Intermediate-term goals include: regular treatment plan reviews, lower rates of early discontinuation of services, lower rates of costly and restrictive placements, improved child-family communication, parenting, peer relationships, affect-regulation, and decreased psychiatric symptoms. Finally, long-term goals include: high rates of treatment completion and achieved treatment goals, reduced rates of restrictive placements within six months of EDT treatment completion, enhanced capacity of parents to manage youth behavior problems, increased participation in community activities, increased school attendance, and high EDT service quality ratings.

As shown in the model, these inputs, outputs, and outcomes are grounded in specific assumptions and are influenced by external factors. Many of the specific components of the model, such as the direct services provided, the staff providing them, and the involvement of other key stakeholders in various activities, are described further in this document. Specific components of the model also are described in further detail in the DCF Practice Standards for EDT. Where appropriate, readers are referred to those standards as a complement to the current model description.

Finally, meetings with providers, DCF staff, and other stakeholders, as well as a review of existing state documents describing EDT, reveal that continued work must be done to situate EDT within the broader array of services in Connecticut, particularly other services within the intermediate level of care. DCF staff, providers, and other stakeholders should continue to work the Behavioral Health Partnership to clearly define the role and practices of EDT within the existing continuum of care for children and adolescents with serious emotional and behavioral problems.

Program Title: Extended Day Treatment (EDT)

Situation Statement: EDT programs provide a set of integrated individual, group, and family treatment services in a community-based setting. Annually, these programs serve more than 800 youth, ages 5 to 17 who have serious emotional and behavioral disorders and their families. During Summer 2006, 700 stakeholders were surveyed, including parents and youth, about their perceptions of EDT. Though many strengths of EDT were highlighted, recommendations for improvement were noted, including: improving family-focused care (family treatment, outreach, engagement, and communication); providing accurate and comprehensive screening of referrals, designing effective programming for a diverse group of children and families; developing effective clinical services that produce desired child/family outcomes; and developing a standardized model of care with an emphasis on effective, empirically supported treatments. Other recommendations included improving coordination and collaboration with DCF staff, school staff, care coordinators, and other service providers in all phases of treatment and developing a standardized program evaluation, a performance measurement system for child, family and system outcomes, and a continuous quality improvement (CQI) plan.

SITUATION → PRIORITIES

Inputs

Provider Resources
- EDT Staff & Interns
- Therapeutic Milieu Settings
- EDT Model of Care
- Evidence-Based Practices

Admin. & Support Services
- Various EDT Reports
- Practice Standards Committee
- Practitioners Forum Committee
- Quarterly Providers' Meetings
- Budget
- Federal/State Laws & Regs
- Policies & Procedures
- Education & Training Plan

Care Coordination
- DCF Staff: Social Workers, Area Resource Group Specialists, BH Managers
- Referring Agents
- DCF Funding: Private Insurers; Other Funders
- Managed Services Systems; KidCare; CT BH Partnership

Evaluation and Assessment
- Stakeholders' Surveys
- Stakeholders' Focus Groups
- Quality Assurance (QA) and CQI plans
- Outcomes & Performance Plan
- Behavioral Health Data System

Outputs

Activities

Therapeutic Services
- Intake, screening/eval.
- Treatment planning
- Psychiatric eval., med. mgmt.
- Individual, family, and group therapy
- Therapeutic rec. and expressive therapies
- Positive youth development
- Crisis services
- Treatment planning & reviews
- Community referrals
- Discharge planning
- Family outreach, engagement

Admin. & Support Services
- Case record-keeping
- Staff recruitment and hiring
- Staff development and training
- Individual and group supervision
- Treatment team meetings

Collateral and Coordinating Svcs.
- Service Coordination
- Transportation Services

Evaluation and Assessment
- Data collection, analysis & reporting
- Child/family outcome evaluation; satisfaction questionnaire
- QA & CQI processes

Participation

- Children/Adolescents
- Parents/Foster Parents, Other Caregivers, Other Family Members
- EDT Treatment Team
- DCF Staff
- School Staff
- Care Coordinators
- Other Service Providers
- Health Care Providers
- Other Stakeholders
- IT Staff
- Expert Trainers
- Program Evaluators

Outcomes – Impact

Short-Term

- Increased # of family-based assessments
- Increased # of parents participating in intake interviews and treatment planning
- Increased # of service providers participating in intake assessments and treatment planning
- Increased # of youth and parents receiving evidence-based treatments
- Increased # of family based treatments, parent education & support groups and other family activities
- Increased # of parents participating in family treatment and support services

Intermediate-Term

- Increased # of youth, parents, and service providers participating in treatment plan reviews
- Decreased # of youth who discontinue treatment during months 3 through 5
- Decreased # of youth who enter more restrictive levels of care during course of treatment
- Improved child/family communications
- Improved parenting skills
- Improved peer relationships
- Improved self-management of affect and behaviors
- Decreased psychiatric symptomatology

Long-Term

- Increased # of youth who complete treatment and master treatment goals
- Decreased # of youth who enter more restrictive levels of care within 6 months of program termination
- Increased # of parents successfully managing child behaviors
- Increased # of youth participating in community activities
- Increased # of youth with improved school attendance
- Increased # of families who rate service quality as good

Assumptions

Theoretical Assumptions: Child Development Theory, Ecological Systems Theory, Attachment Theory, Social Learning Theory, and Positive Youth Development Theory

Pragmatic Assumptions: The System of Care philosophy assumes that services should be: child-centered/family-focused, community-based, culturally competent, individualized, and strengths-based. It should address multiple domains of functioning, be provided in the least restrictive environment, and involve family members caregivers in all aspects of care. Service coordination with the system of care providers and other stakeholders should occur routinely. Providers should deliver the most effective, evidence-based treatments and interventions, monitor child/family outcomes, and continuously improve services.

External Factors

- Regional variability of service types and capacity at the front and back ends of care (e.g. impacts the type of referrals, programming, and discharge planning)
- Continuous flow of appropriate referrals to EDT programs
- Recruitment and retention of qualified staff including bilingual clinicians
- Funding and availability of evidence-based training and supervision
- Adequate rates of reimbursement by state/private insurers and community
- Number of uninsured or underinsured clients and impact on fiscal stability
- Transportation barriers, e.g. adequate funding and resources

Section 3: Theoretical Foundations

The proposed model description and guidelines for EDT draw on several theories. These include: child developmental theory, ecological systems theory, attachment theory, social learning theory, and positive youth development theory. Some of these theories provide the conceptual foundation for EDT (child developmental theory, ecological systems theory, attachment theory), while others are essential to the evidence-based practices that comprise EDT (social learning theory) or the focus of after-school activities that have been found to promote positive outcomes among youth (positive youth development theory). In addition, the theoretical assumptions underlying EDT practices are linked to the activities of EDT and the ongoing training requirements for EDT staff. A summary of each theory and its relationship to EDT is provided below.

Child Developmental Theory

Child developmental theory describes normative processes of growth and maturation from birth to late adolescence that progress in sequential stages and are impacted by biological, social, psychological, and environmental factors. Growth can be depicted by developmental trajectories that reflect change over time in an individual's functioning and capacities (e.g., memory, language, emotion, behavior). Risk and protective factors are characteristics of the individual and the environment that alter these developmental trajectories. Risk factors increase the likelihood that developmental transitions will have a negative impact on normative development, whereas protective factors decrease the chances that risk factors will exert their negative influence on normative development.

Experiences such as child maltreatment, school transition, familial discord, or poor peer relations are examples of risk factors. In contrast, effective parent-child communication, social supports, enhanced self-esteem, and successful task accomplishment may serve as protective factors against specific risks. Normative development involves a constant interplay between risk and protective factors over time, with resilience defined as continued normative development despite adversity (Tebes, Kaufman, Adnopoz, & Racusin, 2001).

Interventions provided through EDT must be grounded in an appropriate developmental understanding of children and adolescents being served. They also must attempt to reduce risk factors that are amenable to change and enhance protective factors that may counteract identified risk factors so as to promote normative development and foster resilience.

Ecological Systems Theory

Ecological systems theory embeds each child's development within an ever-widening circle of contexts (Bronfenbrenner, 1989). The central context includes the child and his/her immediate surroundings, including parents, school, and peers. This context has been described as the "microsystem." The next level of context is the "mesosystem" which involves interactions among elements of the microsystem. A final context is the "exosystem" which includes community resources and polices that affect a child indirectly, and ultimately influences transactions at lower levels. According to ecological systems theory, the factors that exacerbate, cause, and maintain problem behaviors occur at multiple levels and exert influence in multiple contexts. For interventions to be maximally effective, they must target risk and protective factors at multiple contextual levels.

By emphasizing child-centered and family-focused treatments that also involve stakeholders in the school and the community, EDT programs are likely to exert positive influences in multiple contexts in the child's ecological system. Thus, treatments in EDT should emphasize evidence-

based practices at the level of the individual, the family, the therapeutic milieu, the school, and the community.

Attachment Theory

Closely related to child developmental theory, attachment theory is critical to understanding how aspects of the child and his or her immediate environment are related to each other, and influence the child's development. Attachment theory posits that there is an instinctual tendency to maintain proximity to a primary caregiver or attachment figure, and that the quality of that attachment has a significant impact on child development (Booth, Rose-Krasnor, McKinnon, & Rubin, 1994; Bowlby, 1969; Kochanska, 2001). Early interactions and experiences with a primary caregiver result in a style of interaction with other attachment figures that can have lasting effects throughout the lifespan. For example, early trauma, separation, loss, or neglect may have a negative impact on the ability of a child or adolescent to develop secure relationships with other adults or attachment figures.

Since so many of the youth that are referred to EDT have experienced early trauma or disruptions in attachments, it is critical that EDT programs ensure that treatment relationships and the therapeutic milieu are mindful of attachment issues in their interactions with youth. Therefore, a central task of EDT program staff is to develop relationships with youth that foster positive emotional attachments to adults, and even to the treatment setting itself.

Social Learning Theory

Social learning theory (Bandura, 1977; Lietz, 2004) emphasizes that behavior is learned through processes of observation, modeling, and reinforcement, and that various cognitive processes (e.g., attitudes, beliefs) mediate the relation of learning to behavior. Using aggression as an example, children who observe the aggressive behavior of others and its perceived rewards are more likely to engage in aggressive behavior themselves, and to develop aggression-supporting attitudes and beliefs. Approaches toward intervention rely upon the assumption that if behaviors are learned through observation, modeling, and reinforcement, they can be un-learned through similar processes.

Social learning theory serves as the foundation of many of the evidence-based treatments that comprise EDT, and thus, is foundational for understanding the effectiveness of the overall program. This theory also has implications for the structured therapeutic milieu in EDT programs whereby children engage in interactions with adults and other children, appropriate behavior is modeled, and children receive positive reinforcement for their behavior that makes it more likely to occur again in similar situations. In addition, negative behaviors are not reinforced in the milieu, making these behaviors less likely to occur in future situations.

Positive Youth Development Theory

Positive youth development (PYD) is an emerging area of practice and research that emphasizes a strengths-based approach to promoting positive outcomes for youth (Larson, 2000). Although more a field of practice than a theory, PYD principles emphasize a shift from conceptualizing children and adolescents as "problems" that require intervention and correction, to viewing children as "resources" that must be developed (Catalano, Berglund, Ryan, Lonczak, & Hawkins, 2004). Increased attention is given to preventing problem behaviors before they develop by providing competency-building experiences and promoting positive development.

This approach emphasizes providing youth with opportunities for empowerment, leadership, and decision-making in order to foster a sense of efficacy and to interrupt the developmental trajectories that result from risk exposure. Central to PYD theory is the belief that settings provide essential contexts to promote youth development and resilience, and that the after-

school setting is one particularly appropriate context in which this can be accomplished (Tebes et al., in press).

EDT programs are uniquely suited to provide opportunities for building competencies and strengths for many children and adolescents with emotional and behavior problems. They provide structure through the therapeutic milieu, support from caring adults, and opportunities for positive interactions with other youth. In addition, EDT settings offer occasions in which youth are given leadership responsibilities during specific activities, and chances for building competencies and strengths that may not be readily available in other settings, such as at school, at home, or in the community.

Integration of Theoretical Foundations

The preceding theoretical foundations have been utilized in the development of the model described in this report and will be integrated and reinforced through Pre-Service and In-Service Training opportunities for EDT staff. These theories have been instrumental in defining the conceptual framework, structure, and implementation of the following description of the EDT model.

Section 4: Treatment Focus

The most recent version of the EDT Practice Standards describes the underlying treatment philosophy for EDT. These are: 1) family-centered practice, 2) a focus upon resilience and recovery, 3) services that are ecological in perspective, and, 4) a treatment process that is "active, dynamic, participatory and evolutionary" (p.10). Although these statements are consistent with a systems of care approach to services (Stroul & Friedman, 1986), **it is recommended that a systems of care approach should be made an explicit part of the treatment focus of EDT. Also recommended is that EDT programs emphasize the use of evidence-based practices in treatment.** Since the EDT Practice Standards already emphasize many systems of care principles, below we describe other systems of care values and principles in some detail, emphasizing: the provision of services in the least restrictive setting, the need for developmentally appropriate services, and the importance of collaboration between service providers and various stakeholders, including the family. Also described below is a rationale for the use of evidence-based practices as a central element of EDT treatment.

Systems of Care Values and Principles

Systems of care values and principles guide the treatment focus of EDT. According to Stroul and Friedman (1986), a system of care should be child-centered and family-focused, community-based, and culturally competent. In addition, **services should target multiple domains of functioning, be individualized, seek to maintain children in the least restrictive setting appropriate to their clinical needs, and include the family/caregivers in all aspects of treatment delivery.** Consistent with this approach, EDT seeks to restore youth to optimal functioning in the home, school, and community environments, and prevent placement in more restrictive treatment environments, such as residential treatment or inpatient hospitalization.

Because EDT seeks to maintain children in their homes and schools rather than in more restrictive treatment and placement settings, children are expected to return home following treatment whenever possible. There is considerable evidence that parenting, the family, and the home environment each are strongly related to externalizing and internalizing behavior problems (Tebes et al., 2001). Consequently, many evidence-based practices incorporate strong family involvement into their treatment models. As a result, **EDT must seek to involve parents/caregivers and other family members in treatment services in order to maximize the effectiveness of treatment and to foster generalization of skill acquisition and treatment gains to the home environment.**

EDT services must be developmentally appropriate. One should not assume that an EDT service that is effective for children ages 5 to 9 will be effective for adolescents ages 15 to 17. Whenever appropriate, EDT services should be structured in a manner that clearly delineates program activities for children (aged 5 to 12 years) and adolescents (aged 13 to 17 years). Each of these developmental "tracks" within EDT will have activities that adhere to the model of care, but are developmentally appropriate to the age group being served. In addition, specific evidence-based practices are recommended for each age group. This is discussed in more detail in *Section 7: Menu of Evidence-Based Practices & Best Practice Interventions*.

EDT aims to be an ecologically-based treatment that is consistent with systems of care philosophy. Thus, **treatment should focus on generalizing skills from EDT to other environmental contexts, such as the home, the school, and the community. This will require ongoing communication and collaboration among stakeholders linked to the various environments that impact the child or adolescent.** Key stakeholders, such as parents, school personnel, and community service providers should be invited to participate in treatment planning, aid in the assessment of treatment progress, and help determine whether

the gains observed in EDT also are successfully generalizing to other environmental contexts. **Strategies that can increase communication and collaboration with relevant stakeholders include frequent phone calls, letters, cross-context progress reports, and face-to-face meetings with family members and relevant providers**.

Discharge planning should occur throughout treatment in order to further facilitate the transition from the EDT treatment environment back to the community. This process culminates at the time of discharge from EDT, at which time a discharge plan should be in place that identifies the ongoing sources of support for maintaining treatment gains, and identifies the clinical and non-clinical community-based linkages that have been put in place. This process should be grounded in a strengths-based approach that begins early in EDT treatment, and referrals at discharge should be aimed at fostering and promoting identified strengths. It is recommended that all EDT providers in Connecticut adopt this practice.

Evidence-Based Practices

There are several interventions that have been developed and evaluated for the treatment of serious emotional and behavioral disorders among children and adolescents. Those interventions that have received empirical support for their effectiveness in reducing symptoms and promoting competency and resilience, usually through randomized clinical trials (RCTs), are known as evidence-based practices or treatments. The use of such evidence-based practices throughout EDT programs is the best way to assist youth to meet their treatment goals. Thus, in order to maximize the impact of EDT services on the reduction of symptoms, the promotion of competence, and the prevention of placement in more restrictive settings, **EDT services should emphasize the use of evidence-based treatments and practices whenever possible. Evidence-based practices should be used across all modalities, including individual, group, family, and milieu interventions.** The use of such practices also will lead to better outcomes for youth and their families that are more likely to be maintained following discharge.

Section 5: Service Delivery Structure

Types of EDT Services

This section provides a menu of the core services to be provided by EDT programs. Many of these services and their related procedures are described in greater detail in the DCF Practice Standards for EDT. For all youth, and across all treatment modalities (e.g., individual, group, family, milieu), evidence-based practices should be used to increase the likelihood of positive outcomes. The specific types of evidence-based practices recommended are described later in *Section 7: Menu of Evidence-Based Practices and Best Practices Interventions*.

Comprehensive intake assessment. Upon referral, the child/family clinician will coordinate the intake assessment. The intake assessment should take place before any treatment begins to ensure that the presenting problems are understood well enough to guide individualized treatment planning and service delivery. **The intake assessment should consist of: 1) structured intake interviews with the youth and their parent(s) or caregiver(s), 2) measures of child and family functioning, and 3) a home visit.** The family engagement specialist should conduct the home visit during the intake assessment, and again prior to discharge. The treatment team will refer for a psychiatric evaluation by the child/adolescent psychiatrist, as appropriate. Each of the elements of the Comprehensive Intake Assessment is described in greater detail in *Section 6: Screening and Assessment Instruments and Protocols*.

Elements of the Comprehensive Intake Assessment

- Structured intake interview with parent and child
- Psychiatric evaluation and medication management (as needed)
- Home visit
- *Administration of assessment scales*: Ohio Scales, Modified Children's Global Assessment Scale, UCLA PTSD Index, and Parenting Stress Index – Short Form

Treatment planning. The current Practice Standards call for "the formulation of multi-axial diagnoses and a concomitant treatment plan" (p. 11) and specify that the treatment plan should be "individualized, holistic, and family-driven" (p. 12). The Practice Standards also specify that the treatment plan should: identify child and family strengths; identify clinical issues that will be the focus of treatment; include measurable individual, family, and peer goals with target dates; specify units and frequency of services; identify criteria for termination and expected outcomes; define an anticipated discharge date; identify the person(s) responsible for coordinating the treatment plan; and include all applicable signatures and dates (Connecticut Department of Children and Families, 2007).

Treatment planning requires establishing a treatment team composed of multiple stakeholders, including, but not limited to: the child or adolescent (as deemed appropriate based on age and developmental capacity); at least one parent, guardian, or primary caregiver; the supervising psychiatrist; the child/family clinician; the DCF social worker or care coordinator; and other stakeholders (Connecticut Department of Children and Families, 2007).

An individualized treatment plan should be developed within 15 business days of the admission. The information gathered during the intake assessment should provide the necessary data to complete the treatment plan, as specified in the Practice Standards. The treatment team must identify family strengths and clinical issues that will be targeted across all

interventions and services. **The treatment team will be responsible for monitoring progress toward goals and modifying the treatment plan as needed by engaging in a review of the treatment plan every 30 days.** These recommendations are consistent with current practice standards, and providers should refer to these standards for guidance concerning the completion of specific components and requirements of the treatment plan.

Structured therapeutic milieu. The structured therapeutic milieu refers to the organization of the treatment environment and the activities that take place there, and encompasses any broad environmental interventions designed to enhance adaptive functioning and reduce problem behaviors. The milieu also includes the relational aspects of care that occur primarily as a result of youth-staff interaction. **The structured therapeutic milieu should encourage the acquisition of core skills and competencies for youth. These core competencies include: feeling identification; anger management; social skills; coping and problem solving; affect regulation; and trauma recovery and coping.**

In many programs in Connecticut and across the country, the acquisition of core competencies often is accomplished through the use of behavior management systems such as point, level, or phase systems, or token economies. However, the structure of the therapeutic milieu should not excessively rely upon high levels of monitoring, punishment, and behavioral charting. Rather, **the structured therapeutic milieu should be oriented toward forming positive attachments between youth and adult staff, and between youth and their peers, and should have activity-based programming available to all youth so as to foster the development of core personal competencies** (see VanderVen, 1995).

Specific milieu-based interventions currently are being used in some EDT programs and have shown promise for creating a safe and structured therapeutic environment, promoting a culture that addresses the clinical needs of youth and families, training staff members to be responsive to the trauma histories of youth, and helping youth to form positive relationships. Two effective milieu-based interventions are The Sanctuary Model (Bloom, 2005) and Risking Connections (Saakvitne, Gamble, Pearlman, & Lev, 2000). **Connecticut should provide support to agencies in receiving the necessary training to implement one of these milieu-based interventions with fidelity, in accordance with the recommendations of the model developers. Furthermore, Connecticut should arrange for agencies to receive ongoing consultation and technical assistance to ensure long-term fidelity to the model.**

Psychiatric evaluation and medication management. **Psychiatric assessment is recommended only when this is deemed necessary, based on the findings of the comprehensive intake assessment and the recommendations of the treatment team.** The purpose of the psychiatric evaluation is to determine whether medications can be beneficial to managing psychiatric symptoms experienced by youth who participate in EDT. When it is an appropriate referral, the child/family psychiatrist will conduct the psychiatric evaluation, and will be responsible for medication management. During each treatment plan review (every 30 days), the treatment team will receive recommendations from the psychiatrist regarding the effectiveness of the medications and the need for ongoing medication management. Psychiatric evaluations and medication management should include medication protocols with proven efficacy to treat the presenting symptoms, in accordance with the best available science and practice.

Family therapy. Family therapy refers to treatment involving the child or adolescent, at least one parent or current caregiver, and a clinician. Family therapy is one of the primary clinical services used to implement the family-focused aspect of EDT. The results of the Stakeholder Survey reveal that family participation currently is a weakness in the treatment delivery model. Thus, **it is recommended that EDT programs involve families in treatment planning and service**

delivery to the greatest extent possible, and for the duration of treatment. If additional parenting intervention is needed, supplemental intervention in the form of an evidence-based parent training intervention, particularly for younger children, should be provided.

In addition, for younger children, increased family participation is expected. The treatment team should coordinate family engagement and treatment participation, monitor this throughout treatment, and implement additional outreach or engagement interventions to achieve a high level of family participation. The family engagement specialist's primary role will be to engage in outreach to families who face barriers to full treatment participation, as directed by the treatment team. **At a minimum, the family engagement specialist should report a family's progress every 30 days to the treatment team during the treatment plan review meeting.**

Although parents of youth participating in EDT programs may be difficult to engage and retain in treatment, at least one hour of family therapy or family-focused services is expected per week, with more frequent family-focused services for youth at higher levels of acuity, and for families of younger children. This is described more fully below in this section under "Levels of Care within Extended Day Treatment." Center-based family therapy is preferred to in-home services due to the logistical difficulties of delivering family therapy in the homes of all youth and their families. However, for cases in which center-based family therapy cannot be implemented reliably (e.g., there are problems in family engagement, the family lacks access to transportation, a parent is disabled), in-home family therapy should be used. Regardless of the setting in which family therapy is delivered, evidence-based family treatments should be used. These are described in *Section 7: Menu of Evidence-Based Practices and Best Practices Interventions*.

Group therapy. In addition to family therapy, group therapy is a core clinical service provided to youth referred to EDT. Group therapy can be a beneficial modality in programs that serve many youth and children, or that have limited hours in which to provide intensive clinical services. The number of expected hours of group therapy will vary depending on the level of treatment need and the level of care (see below). Groups should be created so that youth of similar developmental levels are served together, based on age and developmental capacity. The use of evidence-based group treatments also is recommended, in particular, Trauma Adaptive Recovery Group Education and Therapy (TARGET). Although TARGET primarily is a group therapy intervention for victims of trauma, this intervention focuses on developing core skills that have been identified by providers as the most important, such as, emotional awareness and regulation, coping, and interpersonal problem solving. TARGET is listed in *Section 7: Menu of Evidence-Based Practices and Best Practices Interventions*, and is described in further detail in the Appendix.

Individual therapy. Individual therapy refers to treatment involving a clinician-youth dyad. Individual therapy can be useful for treating children or adolescents with higher levels of clinical acuity. The recommended mix of individual, family, and group therapy is described in detail later in this section. The initial intake assessment and recommendations, the treatment plan, and the treatment plan review will help to determine a level of care recommendation (described later in this section) which will influence the decision of the extent of individual therapy recommended for youth. However, **at least one hour per week of individual therapy is recommended for all children and youth, with more intensive individual treatment recommended for youth with more acute clinical difficulties.** The child/family clinician will provide individual therapy so as to address the goals identified in the treatment plan. **Once again, evidence-based treatments for individual therapy are recommended.** Treatment plan reviews, conducted every 30 days, will provide the forum in which progress in individual therapy is monitored.

Recommended individual evidence-based treatments are described in *Section 7: Menu of Evidence-Based Practices and Best Practices Interventions*.

Twenty-four hour crisis services. EDT primarily is a site-based treatment service, yet it serves youth with serious emotional and behavioral problems and maintains their connection to the home, school, and community. EDT program staff often must address behavioral crises that occur after the end of the treatment day, when a child leaves the clinic setting and returns home. Because off-site crises may result in hospitalization, EDT programs should have a crisis plan in place to address off-site emergencies.

In some programs, this has involved EDT staff carrying a pager during non-program hours in order to manage crises as they occur, and to consult and make recommendations with school personnel or caregivers. **All EDT programs should make 24-hour crisis services available to participating youth and their families. Furthermore, EDT programs should develop close ties with respite programs, within their own agencies if possible, or through other community agencies that offer this service.** When crises occur in the home or community, EDT providers can make referrals to respite services. Respite care can be useful for preventing more costly and restrictive treatments, such as hospitalization.

Therapeutic recreation and expressive therapies. Therapeutic recreation and expressive therapies refer to treatment activities that supplement traditional clinical treatment (i.e., psychiatric, individual, family, and group therapies) and are directed toward meeting specific goals on the master treatment plan. These activities include, but are not limited to: supervised physical activities, arts and crafts, music, and supervised community outings. The focus of such activities is on providing opportunities for enrichment, skill acquisition, creative expression, competency promotion, self-esteem, and a sense of mastery. Therapeutic recreation and expressive therapies are to be specifically designed to address treatment goals and recovery. **A trained, licensed recreation therapist or equivalent professional should provide these services. Such therapists may be employed by providers on a full- or part-time basis or contracted for a few hours per week from an outside agency.**

Positive youth development activities. As noted earlier, positive youth development refers to an orientation toward practice that emphasizes youth participation in activities that are designed to promote their competencies, empower them to become active decision-makers in their life, take on opportunities for leadership and individuation, and form positive collaborative relationships with supportive and caring adults. Characteristics of programs that use a positive youth development approach include: emphasizing talents, strengths, interests, and potential rather than deficits; recognizing adversities that threaten positive development; building on strengths; and promoting resiliency. Consistent with an ecological systems approach, positive youth development programs aim to enhance protective factors at the level of the individual, the family, the school, and the community. This approach has been used with success primarily with adolescents, but also is appropriate in limited ways in developing structured activities with children. Positive youth development activities serve as a way to ensure that activities designed for enjoyment and recreation serve an additional purpose – to help youth develop their strengths and assets, mostly through the implementation of peer-directed and peer-led activities.

EDT programs should incorporate positive youth development activities within various recreational opportunities and the therapeutic milieu. Programs can utilize a positive youth development approach by offering creative, participatory learning experiences that cut across individual, parent/family, and community levels. A first step in establishing a positive youth development approach is to train and encourage programs to adopt a strengths-based framework for understanding youth. This already takes place in many programs. An additional step is to identify the strengths of the youth and family during the intake assessment, and use

these to guide the selection of activities for youth and family participation. A third step is to train and encourage each EDT program to develop a range of positive youth development activities that promote individual, family, and community-level strengths. At the level of the family, parent and family connectedness and shared participation between youth and their parents in enjoyable activities is recommended. At the level of school, EDT programs are encouraged to facilitate the establishment of stronger connections between youth and their schools, and to help school personnel identify youth's strengths and link them to prosocial activities in the school. Finally, at the level of the individual, EDT programs should develop activities that promote self-esteem and academic achievement, coping resources, civic and community participation, and a positive orientation toward the future.

Discharge planning. As described in the Practice Standards, **discharge planning should be a central consideration by EDT providers throughout treatment, starting at admission. All youth receiving EDT services should have a discharge plan in place prior to completion of the program, and elements of the discharge plan should be implemented shortly after the initiation of EDT participation.** The rationale for this approach is grounded in systems of care treatment philosophy that emphasizes community-based treatment and maintaining children in the least restrictive settings possible. Thus, linkages between EDT programs and other community providers (e.g., mental health providers, schools, community and neighborhood organizations) should be established in order to maintain the links between the youth, their family, and their homes, schools, and communities.

A primary emphasis within discharge planning should be the identification of community and clinical support structures that will sustain treatment gains made in EDT. By identifying these resources throughout the course of treatment and encouraging youth and parents to get involved with them, strengths are promoted and linkages to aftercare activities are established. All discharge planning activities are to be linked to youth needs identified during the intake assessment and throughout treatment, and should be appropriate to the family's capacities and resources. Furthermore, EDT programs are encouraged to be familiar with available community resources for the purposes of discharge planning.

As community resources are identified throughout discharge planning, care coordinators are expected to serve as a link between the EDT programs and these community providers. Linkages to clinical (e.g., outpatient therapy, home-based treatment, therapeutic support services) and non-clinical (e.g., sports, art, music, and dance programs) community resources and supports are encouraged, as deemed appropriate by the treatment team. The family's engagement in these activities should be encouraged by the treatment team, and care coordinators and family engagement specialists are expected to report to the treatment team throughout discharge planning to ensure that existing barriers to engagement are addressed.

Elements of Discharge Planning

- Discharge summary with family and child
- Enrollment in community, clinical, and recreational services
- Home visit
- Contact with school personnel, as appropriate
- Referral to psychiatric evaluation, as appropriate

Community referrals. **If services that are identified in the intake assessment are not available within the EDT program, youth and families should receive appropriate referrals to other service providers, either within the host agency or in the community.** These referrals should be updated continuously to ensure that once a child or youth enters EDT, treatment provision is seamless either through the same agency or in combination with other service providers in the community.

Levels of Care within Extended Day Treatment

EDT services fit within the Intermediate Level of Care as defined by the Behavioral Health Partnership (see www.ctbhp.com). Intermediate care is defined as "a continuum of ambulatory psychiatric treatment programs that offer intensive, coordinated and structured therapeutic and assessment services within a stable therapeutic milieu" (Connecticut Behavioral Health Partnership, 2007). The intermediate level of care programs are EDT, Partial Hospitalization Programs (PHP) and Intensive Outpatient Programs (IOP).

Although there are several similarities among these programs, there are some important differences that distinguish EDT from other intermediate level of care programs. Children who are appropriate for EDT demonstrate moderate symptomatology that is persistent in nature (present for more than 6 months), whereas IOP referrals have symptomatology that moderately impairs their functioning, and PHP referrals have symptomatology that severely impairs their functioning. A major focus of EDT is community reintegration, whereas this is less central to IOP and PHP. Finally, the duration of EDT is up to six months whereas the duration of IOP is 2-6 weeks and the duration of PHP is 2-4 weeks. **The State of Connecticut, DCF, providers, and other EDT stakeholders should continue to work with the Behavioral Health Partnership to further clarify where EDT fits in the service array, particularly in communities that do not have a full complement of intermediate psychiatric services for children.**

Children who participate in EDT services often differ greatly in their level of acuity, and consequently, their degree of treatment need. In addition, regional variations exist in the continuum of services available to children and adolescents. In some Connecticut communities, EDT generally serves youth with low levels of acuity because there is a wider range of available community-based services. In other communities, EDT often serves youth with higher levels of acuity because there are fewer available treatment options, such as IOP or PHP. The quantity of services provided by EDT programs varies based on a child's presenting problems, their individual treatment plan, and their progress in treatment. **There is a need to adopt a consistent model of care for all youth in EDT, but one that also is adaptable to the level of individual clinical need for each child and family and flexible to differences in the service array of various communities.**

One solution is to offer youth different levels of service within EDT based on their clinical presentation and treatment needs. Levels of care within EDT must be supportive of the stated treatment focus of establishing and retaining the involvement of children and families in their communities. More than one level of treatment within EDT will allow youth to gradually transition from mostly center-based treatment to a greater emphasis on community-based interventions, services, and supports as youth near termination of EDT services.

It is recommended that Connecticut develop three levels of EDT programming:

1) **Intensive EDT**
2) **Standard EDT**
3) **Transitional EDT**

These levels of care are described in detail, below. **Across all three levels of care, the full range of EDT services should be offered,** as described in *Section 5: Service Delivery Structure*. However, the levels of care differ in the clinical presentation of children who are appropriate for the level of care, the treatment focus, and the emphasis and intensity of the clinical services that are provided.

Intensive EDT

Clinical presentation. Intensive EDT is appropriate for youth with highly acute clinical presentations, and is one of the levels at which youth can be enrolled following the intake assessment. **This level of EDT services is equivalent to an Intensive Outpatient Program (IOP).** In many communities, hospitals that offer IOP and PHP programs have limited available treatment slots. Integrating IOP into the EDT program will increase the number of available IOP slots in a given community. This level of care will be particularly useful for children and adolescents who have highly acute treatment needs and are likely to require a longer-term treatment program following completion of an IOP program.

Treatment focus. Children and adolescents enrolled in Intensive EDT are experiencing highly acute clinical problems. The goal of this level of care is to stabilize the symptoms that led to the referral.

Service emphasis and intensity. Youth in Intensive EDT are expected to participate in EDT five days per week. Youth at this level of care receive all EDT services, including at least three hours of group therapy each week. Intense individual and family therapy will be provided for at least four total hours each week. The combination of individual and family therapy will vary depending on the ability to engage the family in treatment and the perceived benefit of individual vs. family therapy. Youth can receive two or three hours of individual therapy and one or two hours of family therapy. For example, if a family lacks consistent transportation to the EDT program, they might only be able to engage in therapy one hour per week, and youth then should receive three hours of individual therapy per week for a total of four hours of individual and family therapy. If a child's family were to receive two hours of family therapy per week, that child also should receive at least two hours of individual therapy.

Standard EDT

Clinical presentation. Standard EDT is appropriate for youth with moderately acute clinical presentations that are less severe than children who are appropriate for the Intensive EDT level of care. Standard EDT is one of the levels at which youth can be enrolled following the intake assessment.

Treatment focus. Youth enrolled in Standard EDT are experiencing a moderate level of clinical acuity, and thus, the goals of this level of care are to continue to reduce the acuity of symptoms, maintain treatment gains, and **begin to establish connections between the youth, their family, and various community supports, interventions, and resources**. The nature of these community supports and services may be clinical (e.g., outpatient therapy, therapeutic after-school programs, therapeutic support services) or non-clinical (e.g., art, music, drama, sports). The EDT treatment team will monitor all community involvements and maintain active communication and collaboration with the community providers.

Service emphasis and intensity. At this level of EDT service, youth will participate in three to five days of EDT services each week in order to allow more time for establishing community involvements and services. As described in the discharge planning discussion of *Section 5: Service Delivery Structure*, care coordinators and family engagement specialists are expected to facilitate the transition toward increased utilization of community supports, resources, and services. The treatment team should closely monitor new community referrals and obtain

progress notes. Standard EDT should include one or more hours of family therapy per week, and one or more hours of individual therapy, along with at least two hours of group therapy per week.

Transitional EDT

Clinical presentation. Transitional EDT is appropriate for children and adolescents who are experiencing low to moderate acuity of symptoms. Youth should not be enrolled in Transitional EDT initially following the intake assessment. Rather, they should enter this phase as they near termination from the program.

Treatment focus. Transitional EDT is consistent with system of care values that emphasize maintaining children's community connections, capitalizing on child and family strengths, and engaging in discharge planning throughout treatment. **The goal of Transitional EDT is to create a bridge between center-based EDT clinical services and community-based interventions, supports, and resources.** The EDT treatment team will monitor all community services and maintain active communication and collaboration with the community providers.

Service emphasis and intensity. As children approach discharge, community-based interventions and supports are expected to maintain treatment gains and their level of functioning. As a result, youth will be expected to participate in EDT services for two or three days per week. During this phase, family involvement, support, and engagement remains an important emphasis of services. At this level of care, youth will receive at least one hour of family therapy, one hour of group therapy, and one hour of individual therapy per week. This will free up time for increased participation in appropriate community activities and services. At this level of care, EDT providers should closely monitor any community activities that are implemented. Care coordinators and family engagement specialists will closely monitor youth and their families to facilitate engagement in new programs, address barriers that impede engagement, and report progress to the treatment team.

Section 6: Screening & Assessment Instruments and Protocols

Child and Family Assessment

As described in *Section 5: Service Delivery Structure*, the initial comprehensive assessment is an essential first step in developing an individualized treatment plan that is focused on the strengths and clinical needs of youth and their families. This assessment also identifies clinical problems that determine the youth's level of care and strengths that are relevant to positive youth development activities and discharge planning. The use of established assessment instruments and protocols increases the likelihood that reliable and valid information will be collected for the purpose of treatment planning. **Completion of child assessments should be accompanied by ongoing training of staff responsible for assessing the clinical functioning of youth and their families, primarily child and family clinicians and the child and adolescent psychiatrists.** Most of the assessment procedures described below will be collected at intake, at three months post-intake, and at discharge. Programs will use the information collected to make initial decisions about level of care and needed services, to determine progress during treatment, and to assess outcomes at discharge. **To support this process, Connecticut should provide training for EDT program staff in the use of the assessment instruments and protocols described below.**

We recognize that completion of the recommended assessments may be perceived as a burden to EDT programs because of the scarcity of time and resources available. However, the collection of reliable and valid data in a systematic manner will provide programs and stakeholders with valuable information about program outcomes and effectiveness that otherwise would not be available. **Many children who participate in EDT services will have recent assessment materials from other treatment agencies, and these records should be obtained and incorporated into the EDT intake assessment whenever possible.** This will allow for further identification of the most relevant strengths and treatment needs in light of previous assessment findings.

The following are recommendations for interviews, screening instruments, and measures for use in EDT programs. Some recommendations for measures and instruments are drawn from elements of The Comprehensive Global Assessment created by Connecticut DCF.

Child and parent intake interview. Consistent with a family-based approach to assessment and treatment, **interviews with the child and the parent/caregiver should be conducted upon admission.** Interviews with both the child and parent/caregiver also will improve the reliability and validity of the information gathered. Required elements of the intake interview include, but are not limited to: educational history; medical history; developmental history; family, social, and interpersonal history; child psychiatric history; child/adolescent substance abuse history; and mental status exam. Finally, the strengths and competencies of the child and the family should be identified. **The child and parent interviews should take place once, only at intake**.

Home visit. The structure and organization of the home environment can yield valuable information that relates to the current clinical functioning of children and adolescents, and can guide treatment planning as well as discharge planning. **It is recommended that, whenever possible, home visits take place during the intake process and prior to discharge.** The family engagement specialist is responsible for both of these visits, and should report her or his findings to the treatment team to guide treatment and discharge planning.

Psychiatric evaluation and medication management. **A psychiatric evaluation is recommended only when the treatment team deems that it is appropriate during the comprehensive intake assessment.** When it is appropriate, a board-certified child and

adolescent psychiatrist, or an APRN, must conduct the psychiatric evaluation and oversee any required medication management. **If a child or adolescent is found to require medication, the child and adolescent psychiatrist or APRN should meet at least once a month with the child/adolescent to monitor the effectiveness of the prescribed medication and make any necessary adjustments. The child and adolescent psychiatrist or APRN also should report treatment progress to the treatment team at least monthly.**

Administration of established child and family measures. Four reliable and valid child and family measures should be administered as part of EDT services: the Ohio Scales (OS; Ogles, Melendez, Davis, & Lunnen, 2000), the Yale Modified Children's Global Assessment Scale (Yale M-CGAS; Tebes, Shah, Brabham, Schroeder, & Kaufman, 2007), the UCLA Post-Traumatic Stress Index (UCLA PTSD Index; Pynoos et al., 1998), and the Parenting Stress Index-Short Form (PSI-SF; Abidin, 1995). The Ohio Scales (Ogles, Melendez, Davis, & Lunnen, 2001) were developed to measure outcomes in mental health programs for youth ages 5-18 years. Youth, Parent, and Worker versions of the measure are available. The Problems and Functioning subscales of the measure are recommended for use in EDT programs. The Problems subscale includes 44-items of problem behavior, measured on a 6-point scale, and the Functioning subscale is a strengths-oriented 20-item measure of competent behaviors measured on a 5-point scale. Studies indicate good reliability and validity (Ogles et al., 2000). The youth and parent versions of the Ohio Scales should be completed at intake, three months, and again at discharge from the EDT program. **The child's primary clinician should complete the Worker version of the Ohio Scales at intake, three months, and at discharge from EDT.**

The *Yale M-CGAS* (Tebes et al., 2007) is a modified version of the Children's Global Assessment Scale (C-GAS; Shaffer et al., 1983). This measure, currently in development by Yale School of Medicine researchers at The Consultation Center, includes behavioral anchors that bolster reliability and validity of the measurement of current functioning. The Yale M-CGAS is completed by the clinician, and yields a single score that captures the overall functioning of the child. **The child's primary clinician should complete the Yale M-CGAS at intake, three months, and discharge.**

Providers have reported that many of the children referred to EDT have experienced a history of maltreatment or other significant traumatic events (see the *EDT Stakeholders Report*). Thus, a measure for use with children and adolescents with identified histories of trauma may be helpful in identifying PTSD symptoms. The *UCLA PTSD Index* (Pynoos et al., 1998) is a 48-item semi-structured interview appropriate for use as a brief screener for PTSD symptoms for children ages 7 years and older. The measure has three factor scores: 1) Positive Reminiscing, 2) Intrusion of PTSD on Grieving Process, and 3) Existential Loss. Items also map onto DSM-IV criteria to aid in the diagnosis of PTSD in children and adolescents. **When this measure is deemed appropriate, the child's primary clinician should complete the UCLA PTSD Index at intake, three months, and discharge.**

The *Parenting Stress Index-Short Form* (Abidin, 1995) is recommended to assess perceived parenting stress. Parenting stress is associated with parenting behavior and with child behavior problems and competencies. The PSI-SF is a 36-item measure and includes three subscales: Parental Distress, Parent-Child Interaction, and Difficult Child. Parents respond to items using a 5-point scale. A total score is computed and higher scores indicate increased parental role stress. **The child's primary clinician should complete the PSI-SF at intake, three months, and discharge.**

Satisfaction with EDT Services

The *Youth Satisfaction Survey* is recommended to assess youth satisfaction with EDT services. Satisfaction questionnaires yield valuable information about the degree to which EDT services are meeting the needs of youth and their families. This information can be used mid-way through services as an element of a Continuous Quality Improvement plan that is aimed at ensuring the intervention is meeting the family's needs. In addition, completion of the Youth Satisfaction Survey can be completed at discharge to assess the family's perceptions of the services they received. Thus, **the family engagement specialist or another appropriate staff member should administer this measure at 3-months following the intake date and again at discharge.**

Section 7:

Menu of Evidence-Based Practices & Best Practice Interventions

Whenever possible, the use of empirically tested and evidence-based treatments are recommended for use in EDT. These interventions are preferable to other treatment approaches because they have demonstrated effectiveness with youth and families with the presenting problems that are common among EDT referrals. Although treatments vary with regard to the degree of evidence that has been accumulated to support their effectiveness, all those identified below have been found to be at least minimally effective with youth. The best treatments across all modalities tend to include manuals that describe treatment sessions in enough detail to ensure some level of treatment fidelity.

Without support and training to the staff who will deliver an evidence-based treatment, implementation efforts would likely result in delivery of an intervention that does not adhere to the original guidelines, intention, and design of the treatment. Under such circumstances, an intervention should not be expected to yield the positive results that were found in rigorous empirical testing. **Therefore, several implementation steps are recommended to facilitate the integration of evidence-based practices within Connecticut EDT programs:**

1) Connecticut should provide general training on evidence-based practices, system of care philosophy, and family-focused treatment in order to foster understanding and buy-in for evidence based practice.

2) Connecticut should support the training, implementation, consultation, and technical assistance recommendations offered by treatment developers.

3) Agencies should identify one staff member to develop an expertise in the design and implementation of each evidence-based practice for use their EDT program.

4) Connecticut should support ongoing training, technical assistance, and consultation in order to ensure long-term fidelity to all evidence-based practices that are adopted by EDT programs.

EDT programs should demonstrate proficiency in at least one evidence-based practice in each of the following four domains:

1) Individual therapy,

2) Group therapy,

3) Family therapy or parent training, and

4) Milieu-based intervention.

The information in this section about specific evidence-based treatments was drawn from recent reviews of child and adolescent evidence-based treatments (Center for Mental Health Quality and Accountability, 2006; Washington State Department of Social and Health Services, 2005; Hawaii Department of Health, Child and Adolescent Mental Health Division, 2007) and on a matrix of evidence-based treatments summarized in a recent report of the National Association of State Mental Health Program Directors (NASMHPD). Several of the evidence-based treatments listed also are included in the National Registry of Evidenced-based Practices and Programs (NREPP) maintained by SAMHSA. Only those psychosocial interventions considered applicable to the EDT population in Connecticut are described; psychopharmacological interventions were considered beyond the scope of this report.

One or two interventions are recommended for individual therapy, group therapy, center-based family therapy, in-home family therapy, supplemental parent training, and milieu-based interventions. In addition, interventions are divided according to the developmental level of the target population (5-12 years and 13-18 years).

Several considerations guided the selection of recommended evidence-based treatments. First, there are few evidence-based individual treatments for young children. However, since young children in particular benefit from interventions that target parenting behaviors and family functioning, the families of these children should have high levels of involvement in treatment. Second, since externalizing behavior disorders and trauma were the most common presenting problems for EDT youth identified in the Stakeholders Report, treatments to address these clinical issues were a particular focus of the recommendations. Third, recommendations are made separately for center-based and in-home family therapy. Fourth, supplemental parent-training treatments for cases in which youth and their parents require additional parent support are recommended, even though one potential limitation in such approaches is that they generally do not focus explicitly on older adolescents. Fifth, some interventions are effective for a wide age range, and therefore are listed for both age groups. And sixth, since milieu-based interventions generally focus on targeting staff and organizational development, all age groups were combined in this category.

In the sections that follow, a brief description is provided for the type of intervention, the age of targeted child/adolescent, the presenting problem, the treatment focus, the evidence base, and any important limitations. A more complete description of the recommended treatments for EDT is available in the Appendix, along with several other applicable treatments.

Individual Child and Adolescent Interventions

5-12 Age Group

- *Problem-Solving Skills Training*. This treatment is appropriate for 7-13 year olds youth with conduct or behavioral problems. The intervention is primarily cognitive-behavioral in nature and has demonstrated positive effects on behavior problems, parenting stress, and family functioning.
- *Trauma-Focused Cognitive-Behavioral Therapy*. This treatment is appropriate for 3-18 year old youth with exposure to traumatic events and symptoms of trauma-related depression, PTSD, and/or oppositional/defiant behavior.

13-18 Age Group

- *Trauma-Focused Cognitive-Behavioral Therapy*. This treatment is appropriate for 3-18 year old youth with exposure to traumatic events and symptoms of trauma-related depression, PTSD, and/or oppositional/defiant behavior.
- *Interpersonal Psychotherapy for Depressed Adolescents*: This intervention is appropriate for 12-18 year old adolescents who are depressed. The focus is on identifying and changing problematic relationships as the underlying cause of depression and a primary source of its maintenance over time.

Group Child or Adolescent Interventions

5-12 Age Group

- *Anger Control for Aggressive Youth*: This CBT group intervention focuses on treating youth (average age 10 years) with aggression problems by targeting social-cognitive factors that are related to aggressive behavior. The program has been shown to have positive effects on self-esteem and aggression, and evidence supports that these treatment gains are maintained at long-term follow-up.
- *Peer Coping Skills*: This group-based treatment has been tested for treating aggressive behavior in younger children (ages 6-8 years). The focus is on teaching communication and listening skills through the use of practice social situations, role-playing, and games and crafts. Although group-based, the intervention is limited by having only been tested in school settings. However, there appears to be potential for application to milieu-based clinic settings.

13-18 Age Group

- *Trauma Adaptive Recovery Group Education and Therapy (TARGET)*: TARGET is a group-based intervention for trauma stress related to child physical or sexual abuse, exposure to domestic or community violence, or traumatic loss. Child and adolescent versions of the intervention are available. Core competencies include bodily self-regulation, emotional awareness and regulation, information processing, coping skills, interpersonal problem solving, stress management, and experiential exercises. Interventions are organized around the acronym F.R.E.E.D.O.M. (Focus; Recognize triggers; Emotion self-check; Evaluate thoughts; Define personal needs/goals; Open new options for achieving goals; Make a contribution). The program is designed for approximately 3-12 sessions, and versions are available that can be adapted to individual or family sessions.

Center-Based Family Therapy Interventions

5-12 Age Group

- *CASASTART*: The Center on Addiction and Substance Abuse (CASA) at Columbia University developed the community-based program, Striving Together to Achieve Rewarding Tomorrows (START). CASASTART has been tested for use with youth (ages 8-13 years) who are at risk for behavior problems, substance use, and criminal involvement. There are individual, family, and school-based components to the program, as well as intensive case management. The program also utilizes a positive youth development framework. The outcomes indicate reduced substance use, violence, delinquent peer associations, and increased family cohesion and positive peer influence.
- *Strengthening Families Program*: This family-based program draws upon cognitive-behavioral and family systems theory to address early individual and family risk factors that affect children (ages 6-12 years). Multi-family group sessions focus on parent-child interactions and parent training. Child group sessions focus on life and social skill development. The program is designed as a 5-24 week intervention with groups of 4-14 families. The results suggest wide-ranging effects on risk factors and outcomes that affect parents, families, and youth. There are separate versions of the program, including the program for 6-12 year old youth and their families, and a separate program for 10-14 year old youth and their families (*SFP 10-14*).

- *Brief Strategic Family Therapy*: This family-based treatment draws heavily upon family systems theory, and treats conduct problems among boys (ages 6-12 years). Studies support its effectiveness in reducing behavior problems. It has been used in clinic, home, and community settings.

13-18 Age Group

- *Multidimensional Family Therapy*: This family-based intervention has been used with the families of youth (ages 12-17 years) at-risk for substance use and behavior problems. Interventions address youth and parent problems individually, problems in the whole family system, issues that involve interactions between family members and relevant social systems, and the impacts of the home and school settings on family functioning. Substance use and social/emotional competence are main targets, and the intervention is designed for 4-6 month delivery. Multiple studies have supported the effects of this intervention on a broad range of problems from substance use to delinquency, family conflict, and academic functioning.
- *Functional Family Therapy*: This family-focused program has been used to treat adolescents (ages 11-18 years) with violence and conduct problems. Treatment progresses in five phases, including engagement, motivation, assessment, behavior change, and generalization. The intervention has been conducted in multiple settings, and empirical evidence demonstrates that this intervention prevents the escalation of problem behaviors.

Home-Based Family Therapy Interventions

5-12 Age Group

- *Brief Strategic Family Therapy*: This family-based treatment draws heavily upon family systems theory, and treats conduct problems among boys (ages 6-12 years). Studies support its effectiveness in reducing behavior problems. It has been used in clinic, home, and community settings.

13-18 Age Group

- *Functional Family Therapy*: This family-focused program has been used to treat adolescents (ages 11-18 years) with violence and conduct problems. Treatment progresses in five phases, including engagement, motivation, assessment, behavior change, and generalization. The intervention has been conducted in multiple settings, and empirical evidence demonstrates that this intervention prevents the escalation of problem behaviors.

Supplemental Parent Training Interventions

5-12 Age Group

- *The Incredible Years*: This primarily parent-training approach also uses individual and teacher components to treat children (ages 2-8 years) with early onset oppositional and conduct related problem behaviors. Multiple components are used in the intervention, including videotaped modeling, psychoeducation on parenting and child development, and parent coping strategies. Numerous studies support the effectiveness of this approach in reducing children's aggression, and improving their self-esteem and classroom behavior.

- *Parent Management Training*: This parent-training program is used with parents of children and early adolescents (ages 3-13 years) with conduct problems. The treatment focuses on basic behavior management strategies.

Milieu-Based Interventions

All Age Groups

- *The Sanctuary Model*: This milieu-based approach developed by Bloom (2005) teaches child mental health workers to create an environment that is sensitive to the trauma experiences of youth ages 6 to 18 years by training staff and organizations to develop trauma-informed structures, processes, and behaviors. A primary core competency taught to children is affect regulation, and activities and exercises focus around the acronym S.E.L.F. (Safety, Emotions, Loss, Future). The model promotes an organizational culture characterized by: nonviolence; emotional intelligence; inquiry and social learning; shared governance; open communication; social responsibility; and growth and change.
- *Risking Connections*: This milieu-based approach developed by Saakvitne et al. (2000) is a trauma-informed model that focuses on teaching child mental health professionals to develop empowerment, connection, and collaboration among youth with serious trauma histories (e.g., abuse and family violence). Staff and providers are trained in understanding the nature of trauma and trauma symptoms, helping youth develop safe and healthy relationships, preventing and managing crises in a way that avoids re-victimization, and managing dissociations and flashbacks.

Section 8: Service Standards

Frequency and Duration of EDT Services

Currently, EDT Practice Standards indicate that services are to be delivered two to five days per week. **With the new level of care recommendations, the number of days of center-based participation will vary, starting with an expectation for five day per week involvement at the Intensive EDT level, three to five days per week at the Standard EDT level, and 2-3 days per week at the Transitional EDT level.** As the number of days per week of center-based treatment decrease, the amount of time spent in clinical and non-clinical community supports, resources, and interventions should increase. The balance between center-based and community-based interventions should be monitored and documented, directed by the treatment team, and aimed toward meeting the goals of the master treatment plan.

Consistent with the Practice Standards, EDT services are recommended for a period of up to six months. Children should proceed through the levels of care as the treatment team deems appropriate. **However, the appropriateness of EDT for youth and their families should be fully re-assessed after three months.** The monthly treatment plan reviews provide an ongoing basis for such a re-evaluation and should be combined with the more formal assessments scheduled for completion after three months. Youth and families for whom EDT does not appear to be the most appropriate placement should be discharged to a more suitable service within the system of care.

Service Coordination and Collaboration

Linkages between the EDT program and school officials and school clinics, outside treatment agencies, and other system of care providers is strongly recommended as an important element of the EDT program. If a child or adolescent is involved in individual or family therapy at the time of referral to EDT, these linkages should be maintained throughout participation in EDT, to the extent possible. Information sharing and collaboration between EDT and all other providers is strongly encouraged. EDT should obtain and share (with consent) progress reports and treatment summaries to monitor the degree to which progress generalizes across various ecological settings.

Discharge and Termination

As youth near EDT program termination, they should not be discharged until the treatment team can demonstrate that youth and their families have at least one stable relationship with a community provider, either clinical or non-clinical, as appropriate to the needs of the child or family.

Section 9: Staffing

The professional and paraprofessional staff members of EDT programs are critical to providing high quality services to children, adolescents, and their families. This section provides a brief description of the staff that comprise the core positions within EDT programs, although there are many others who work in EDT agencies, such as support and administrative staff, who make the EDT program function effectively on a day-to-day basis.

Program Director

The Program Director is responsible for overseeing all day-to-day administrative operations of the EDT program. **All EDT Program Directors should have experience in direct clinical care and in carrying out the administrative duties associated with treatment programs for children and adolescents. The Program Director should be independently licensed in the State of Connecticut as a psychologist, social worker, marriage and family therapist, or licensed professional counselor, and have experience in administering the delivery of clinical services and/or evidence-based treatments.** The Director is responsible for supervision of clinicians and behavior specialists. In addition, to ensure shared information across providers about the clinical functioning of youth served in the program, the Director should hold regular meetings with the Child and Adolescent Psychiatrist to discuss clinical issues of youth receiving EDT services. Meetings can occur in a dyadic or team format.

Child and Adolescent Psychiatrist

The Child and Adolescent Psychiatrist is responsible for providing psychiatric oversight for all children and adolescents participating in EDT services, including psychiatric assessment, medication management, and psychiatric consultation. This position can be filled by a staff member of an agency or by a consultant. **Persons in this position must be a board-certified child and adolescent psychiatrist with an M.D. or equivalent from an accredited medical school, and possess experience in providing direct clinical psychiatric care for children and adolescents with serious emotional or behavioral disorders.** Psychiatrists also are responsible for ensuring that the services provided to participating youth are medically necessary, in accordance with Medicaid requirements.

Child and Family Clinician

The Clinician is responsible for the direct clinical care of participating youth, including conducting the initial assessment, treatment planning, and providing individual, family, and group therapy. **Persons in this position should be licensed in the State of Connecticut as a psychologist, social worker, marriage and family therapist, or licensed professional counselor, or work under the supervision of a licensed mental health professional. The requirement for a Master's Degree can be waived for bilingual/bicultural individuals given appropriate professional experience.** It is preferred that clinicians have experience implementing evidence-based practices. Clinicians also may provide supervision to Behavior Specialists to support effective practices in the day-to-day management of the milieu.

Behavior Specialist

The Behavior Specialist is responsible for the day-to-day implementation of program activities, managing the milieu and associated behavior management programs, and for the direct monitoring and supervision of participating youth. **Persons in this position should have at least a Bachelor's Degree in psychology, social work, or a related field, and have some experience working in milieu-based treatment settings for children and adolescents.** Ideally, Behavior Specialists will possess a familiarity with the implementation of evidence-based practices, and the use of behavior management strategies in group treatment settings.

Family Engagement Specialist

Persons in this position are responsible for conducting home visits and maintaining consistent contact with the families of participating youth. They also will establish connections with difficult to engage families or families that face significant barriers to EDT treatment utilization, make active attempts to retain parents or caregivers and other family members in treatment, and report their findings to the treatment team. **Persons in this position should have at least a High School Diploma.** The Family Engagement Specialist often lives in the community served by the EDT program, or has experience as a former parent or youth consumer of EDT program services.

Recreational and Expressive Therapists

The Recreational and Expressive Therapists are responsible for providing interventions that utilize physical education, art, music, drama, or other non-traditional clinical services to meet master treatment plan goals. An agency employee or a consultant can fill this position. **Persons in this position should possess at least a Master's Degree in psychology, social work, recreational therapy, art therapy, or a related field.**

Positive Youth Development Coordinator

The Positive Youth Development Coordinator is responsible for overseeing the implementation of positive youth development activities in the EDT milieu. **The person in this position should have experience working in recreational and/or after-school programs with youth and have at least a Bachelor's Degree.** This position can be filled by designating an existing staff member or by hiring a staff member dedicated to this activity.

Quality Assurance/Performance Improvement Specialist

The QA/Performance Improvement Specialist is responsible for collecting and reporting quality assurance and performance improvement data to monitor program outcomes. Although this position may involve hiring a new staff member, it is more likely to be filled by another EDT staff position described above or by an administrative position at the program. **The person in this position should have at least a Bachelor's Degree or its equivalent in experience and be comfortable working with computer databases.**

Other Staffing Considerations

An existing outpatient provider may continue to be used while a child is involved with EDT, in order to maintain continuity of treatment and facilitate a potential transition back to a previous treatment provider following EDT service termination.

Section 10: Staff Training

Description of Training Components

Current versions of the EDT Practice Standards specify, "staff must be clinically trained and highly skilled in dealing with complex emotional-psychiatric-behavioral disorders." **Connecticut should adopt an approach to training that recognizes that ongoing training is critical to effective service delivery, particularly in a treatment environment that emphasizes evidence-based practices.** Currently, the Practice Standards call for three training elements:

1) Preventing incidents of assault and containing them if they occur;

2) Diversity and cultural competence and;

3) Interpersonal communication for effective listening and limit-setting skills.

Each of the above three training elements of the current practice standards should be retained, but incorporated into a more comprehensive plan for pre-service and in-service training as listed below.

Pre-service training elements should include:

- Blood born pathogen
- CPR
- Effective communication and limit-setting
- De-escalation, conflict resolution, and crisis management techniques
- Mandated reporting
- Medication administration

In-service training elements should include:

- The EDT model of care
- Core theoretical foundations of EDT
- Child, adolescent, and family psychosocial functioning
- Child and adolescent trauma and risk
- Understanding the intake process: Assessment procedures and clinical measures
- Evidence-based practices
- Group therapy techniques
- Milieu-based intervention
- Supervision
- Cultural competence
- Performance measurement
- Data collection and reporting procedures.

Table 1. Recommended Training Elements to be Completed by EDT Staff												
	1	2	3	4	5	6	7	8	9	10	11	12
Program Director	X	X	X	X	X	X	X	X	X	X	X	X
Child and Adolescent Psychiatrist	X	X	X	X	X	X	X	X	X	X	X	X
Child and Family Clinician	X	X	X	X	X	X	X	X	X	X	X	X
Behavior Specialist	X	X	X	X	X	X		X		X		
Family Engagement Specialist	X	X	X	X		X				X		
Recreational-Expressive Therapist	X	X	X	X	X	X	X	X	X	X	X	X
PYD Coordinator	X	X	X	X	X	X	X	X	X	X	X	X
QA/Performance Improvement Spec.										X	X	X
Note. Numbers correspond to training elements listed in *Section 10: Staff Training*.												

All staff should receive the pre-service trainings listed above, but only those staff identified in the description of in-service trainings below and depicted in Table 1 should complete the in-service trainings recommended. The numbers below correspond to the numbers shown in Table 1 above.

1. The EDT model of care. All staff should receive training to introduce them to the elements of the new model of care, as described in this document. Particular emphasis should be given to intake procedures and service delivery structures, including: core services and levels of care within EDT; data collection, evaluation, and quality assurance; and discharge planning.
2. Core theoretical foundations of EDT. All staff should receive training on the core theoretical foundations that guide EDT treatment delivery, including: Child Developmental Theory, Ecological Systems Theory, Attachment Theory, Social Learning Theory, and Positive Youth Development (see *Section 3: Theoretical Foundations* for a more complete description of each).
3. Child, adolescent, and family psychosocial functioning. All staff that work with youth should be trained in basic developmental and clinical knowledge about children, adolescents, and their families. Training should include information about normative child and adolescent development, positive youth development approaches, clinical assessment and diagnosis, child and adolescent psychopathology, characteristics of the treatment relationship, and family functioning.
4. Child and adolescent trauma and risk. All staff that work with youth also should be trained in trauma, child maltreatment, and risk assessment. These are central concerns to many of the youth and families served in EDT.
5. Understanding the intake process: Assessment procedures and clinical measures. Staff members who are responsible for administering, scoring, interpreting, and reporting on the assessment measures should receive training to ensure that the measures are used appropriately. In particular, staff should receive training on the administration, scoring, and interpretation of intake and other measures used in EDT.
6. Evidence-based practices. Due to the centrality of evidence-based practices to the EDT model and the need to ensure that these practices are delivered with a high degree of fidelity (Fixsen et al., 2005), staff that work with youth should receive training on the use of evidence-based practices in EDT settings. Training should include: 1) initial training to explain the rationale for evidence-based practices in child and adolescent mental health service settings; 2)

training on specific evidence-based practices, and; 3) ongoing training, implementation and fidelity assessment, consultation, technical assistance, and quality assurance, as recommended by the model developers of selected evidence-based practices.

7. Group therapy techniques. Staff involved in direct clinical service provision and group therapy should receive training on techniques related to effective group therapy with children and adolescents.

8. Milieu-based interventions. Staff members who supervise the milieu should receive training on creating a safe and structured therapeutic milieu, in accordance with the milieu-based intervention that will be utilized on their units (*The Sanctuary Model* or *Risking Connections*).

9. Supervision. Directors, psychiatrists, and child and family clinicians are likely to provide supervision to other staff members. They should receive training on providing supervision in the context of EDT programs and other youth services.

10. Cultural competence. Cultural competence is a core element of the systems of care philosophy and central to a recovery-oriented system of care. Children and families involved in EDT come from diverse racial, ethnic, religious, and cultural backgrounds, and staff should ensure that their services are culturally appropriate. Each program should have in place a cultural competence plan that details what the program has done to ensure that services are delivered in a culturally competent manner. Training should be provided to all EDT staff, including administrative staff, to ensure that each program is able to carry out activities consistent with their cultural competence plan so as to provide culturally appropriate services to youth and their families.

11. Performance measurement. Clinical measures for children and families, and measures of the program and service system, will be used to assess EDT program and service system performance. One staff member within each EDT program should be responsible for submission of these indicators, and should receive training on the purposes and use of performance indicator data for program development and improvement. Trainings should be developed for collecting, interpreting, and utilizing performance indicators data for these purposes. Further details about the performance indicator monitoring plan is provided below in *Section 12: Outcomes-Based Performance Measurement*.

12. Data collection and reporting procedures. Designated staff will be responsible for entering and reporting data in a standardized format in order to facilitate analyses, evaluation, and feedback to EDT programs. Training should be developed for staff with these responsibilities to ensure timely and accurate submission of data.

Section 11: Implementation

Two broad questions capture the quality of implementation of a treatment intervention. First, *"To what extent is the model being implemented as designed?"* Second, *"To what extent has the model been adapted to the needs of the local setting?"* These questions address implementation fidelity and implementation adaptation, respectively. **Site visits should be conducted bi-annually to assess the extent to which implementation fidelity and adaptation have been adequately achieved.** Site visits should emphasize adherence to the recommended program model through interviews with program leadership and staff, record reviews, inspection of utilization review data, and interviews with select youth and families served.

Individual elements of the model of care require additional attention to implementation issues, in particular, evidence-based practices. As described in *Section 7: Menu of Evidence-Based Practices & Best Practice Interventions*, **Connecticut should begin by providing training to providers that focuses on establishing a culture that supports the integration of evidence-based practices into child and adolescent mental health programs. Connecticut also should support the various training, implementation, consultation, technical assistance, and quality assurance protocols provided by model developers for evidence-based practices adopted by EDT providers.**

And finally, **Connecticut should consider offering incentives to programs that can demonstrate consistent implementation of evidence-based practices in their EDT programs, perhaps by offering them a higher reimbursement rate for those programs employing evidence-based practices.** The incentive for using evidence-based practices would be similar to the approach currently being used in Connecticut Enhanced Care Clinics.

Section 12: Outcomes-Based Performance Measurement

Data collection, data reporting, continuous quality improvement, quality assurance, and other related evaluation procedures are important elements of mental health services, and are essential to EDT programs. This section recommends procedures for outcomes-based performance measurement based on the collection of program-specific performance indicator data.

Performance indicators measure whether the objectives and outcomes set forth by a program are being met, and allow for tracking of these objectives and outcomes over time. Performance indicators are expressed primarily through quantitative measures in the form of mean scores and/or percentages.

Performance indicator data should be collected by all EDT programs and reported to DCF on at least a semi-annual basis. This data should be analyzed in comparison to pre-established standards that apply to all programs (i.e., benchmarks), and be tracked by programs longitudinally in order to assess changes over time. Data should be analyzed across EDT programs and by individual program, and then discussed confidentially with Directors and designated staff from each program. These discussions should focus on implementing strategies to effect changes that would improve program performance. The regular collection of a common set of performance indicators will enhance program development and data-driven decision-making at the program and service system level. To the extent possible, data collection should be integrated with the existing requirements of the Behavioral Health Data System and the Behavioral Health Partnership data collection initiatives.

One strategy to consider is the use of control chart methodology to track changes in performance indicators over time. Control chart methodology identifies four or five performance indicators that are benchmarked according to pre-determined performance criteria. Each program reports on the same set of performance indicators at regular intervals. Reports then are generated for each program that plot each performance indicator, allowing for within-program and across-program comparisons.

For example, let us assume that an EDT program's overall satisfaction score is selected as a common performance indicator for all programs. Program A submits the mean and standard deviation for their program on overall satisfaction during the most recent quarter. Evaluators calculate the overall mean and standard deviation across programs by collecting the reported scores for all programs and computing an overall EDT mean score and an associated standard deviation. Evaluators then plot the overall satisfaction score for Program A along with the overall satisfaction score across all programs, thus allowing for comparisons across programs. Program A then can determine the relative location of their program's satisfaction score in the overall distribution, as compared to EDT programs as a whole. Scores that are significantly lower (i.e., outside the standard deviation for all EDT programs) suggest that overall program satisfaction might be a target area for further investigation by the Quality Improvement team. The team then could engage in a process of determining the reasons for dissatisfaction with the program and engaging in programmatic changes to improve client satisfaction over time (see *Section 13: Quality Assurance*).

One limitation of the control chart methodology is that it does not control for differences in the characteristics of participating youth and families between programs, but rather, assumes equivalency of populations across all programs. This can lead to inaccurate and potentially unfair estimates of program success (or of a need for program improvement). For example, if Program A tends to have a more difficult caseload than Program B, and significantly more families with multiple risk factors, their performance is likely to be poorer as a result of a more challenging population. However, case control methodology would not take this into

consideration. **An alternative approach to case control methodology that takes into consideration differences in characteristics across various agencies is case mix adjustment methodology.** This approach calculates means and standard deviations (or percentages) for each program then adjusts these scores based on the case mix of populations served. Regardless of the type of methodology used to track performance indicator data, it should be collected by all EDT programs and reported to DCF on a regular basis.

Section 13: Quality Assurance

In an effort to inform data-driven decision-making and program improvement at the agency level, **each program should develop an individualized quality assurance plan that addresses specific performance indicators.** A quality assurance plan refers to a program-specific plan that targets a subset of two to five performance indicators for program improvement. The Youth Satisfaction Survey administered to youth and families also is an integral element of a quality assurance plan.

A quality assurance plan is a central component of any system of continuous quality improvement (CQI). CQI refers to a system in which data is monitored and utilized on an ongoing basis to make data-driven decisions related to improving service delivery. There are several steps to effective CQI.

The first step is to designate a team of key staff members and a quality assurance officer that meet regularly to review all performance indicator data and monitor whether their services are meeting the stated objectives and outcomes of the EDT program. Next, each program should identify performance indicators that are below identified standards to be monitored. Third, programs should develop an Action Plan that describes the strategies to be used to improve performance on each identified performance indicator being examined. Fourth, the program should begin monitoring the indicator for a designated period, perhaps a year, or for one or two quarters. Fifth, date related to the selected performance indicators should be tabulated and reviewed by the quality assurance team and then discussed with program leadership. And finally, the success of the action plan should be evaluated based on the data collected, resulting in a new action plan that repeats this process in a cycle of continuous quality improvement.

Since the above process often requires changes in administrative, ITS, staff, and program infrastructure as well as new staff skills and knowledge related to implementation, Connecticut should provide the necessary supports to establish CQI systems within EDT programs to monitor the quality and effectiveness of services as part their comprehensive quality assurance plan for EDT.

Conclusions and Implications

The proposed model of care for Extended Day Treatment offers a comprehensive, best-practices approach to model development. Findings and recommendations are reported that address the critical elements to designing a child and adolescent mental health program that is theoretically-driven, grounded in systems of care philosophy, child-centered and family-focused, and supportive of the integration of evidence-based practices.

Given the scope of the findings and recommendations, Connecticut will need to explore the resources that are available to put this model into practice, in collaboration with the Connecticut Behavioral Health Partnership, Connecticut Department of Children and Families, EDT providers, and other stakeholders. Connecticut will need to develop an implementation plan and timeline that details the steps required to phase in aspects of the new model. Finally, Connecticut will need to develop a funding strategy that supports model implementation and takes into account existing resources and state priorities.

References

Abidin, R. R. (1995). Parenting Stress Index Manual-Third Edition. Odessa, FL: Psychological Assessment Resources.

Bandura, A. (1977). *Social Learning Theory*. New York: General Learning Press.

Bloom, S.L. (2005). Creating sanctuary for kids: Helping children to heal from violence. *Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations, 26*(1), 57-63.

Booth, C.L., Rose-Krasnor, L., McKinnon, J.A., & Rubin, K.H. (1994). Predicting social adjustment in middle childhood: The role of preschool attachment security and maternal style. *Social Development, 3*, 189-204.

Bowlby, J. (1969) *Attachment* , Vol. 1 of Attachment and loss. London: Hogarth Press. New York: Basic Books.

Bronfenbrenner, U. (1989). Ecological systems theory. *Annals of Child Development, 6*, 187-249.

Catalano, R.F., Berglund, M.L., Ryan, J.A.M., Lonczak, H.S., & Hawkins, J.D. (2004). Positive youth development in the United States: Research findings on evaluations of positive youth development programs. *The Annals of the American Academy of Political and Social Science, 591*, 98-124.

Center for Mental Health Quality and Accountability (2006). Matrix of children's evidence-based interventions. Retrieved April 1, 2007, from http://systems of care.samhsa.gov/headermenus/docsHM/MatrixFINAL1.pdf.

Chen, W.W., Cato, B.M., & Rainford, N. (1999). Using a logic model to plan and evaluate a community intervention program: A case study. *International Quarterly of Community Health Education, 18*(4), 449-458.

Connecticut Behavioral Health Partnership (2007). Connecticut Behavioral Health Partnership – Child Psychiatric Level of Care Guidelines. Document Retrieved May 14, 2007 from http://www.ctbhp.com/provider/handbook/ProviderHandbook_Appendix E_040907.pdf.

Connecticut Department of Children and Families (2007). Practice standards for extended day treatment programs. Retrieved April 1, 2007 from http://www.ct.gov/dcf/lib/dcf/behavioral_health/pdf/standedt.pdf.

Fixsen, D., S. Naoom, et al. (2005). *Implementation Research: A Synthesis of the Literature*. Tampa, FL, National Implementation Research Network.

Hawaii Department of Health, Child and Adolescent Mental Health Division (2007). *Summary of Effective Interventions for Youth with Behavioral and Emotional Needs*. Retrieved April 1, 2007, from http://www.hawaii.gov/health/mental-health/camhd/library/pdf/ebs/ebs011.pdf.

Hernandez, M. (2000). Using logic models and program theory to build outcome accountability. *Education and Treatment of Children, 23*(1), 24-40.

Kochanska, G. (2001). Emotional development in children with different attachment histories: The first three years. *Child Development, 72*, 474-490.

Larson, R.W. (2000). Toward a psychology of positive youth development. *American Psychologist, 55*(1), 170-183.

Lietz, C.A. (2004). Resiliency based social learning: A strengths based approach to residential treatment. *Residential Treatment for Children & Youth, 22*(2), 21-36.

Ogles, B.M., Melendez, G., Davis, D.C., & Lunnen, K.M. (2000). *The Ohio Youth Problem, Functioning, and Satisfaction Scales: Technical Manual*. Document Retrieved on the World Wide Web on March 30, 2007: http://www.mh.state.oh.us/oper/outcomes/instruments/os.technical.manual.pdf

Pynoos, R., Rodriguez, N., Steinberg, A., Stuber, M., & Frederick, C. (1998). *UCLA PTSD Index for DSM-IV*. Los Angeles, UCLA Trauma Psychiatry Program.

Saakvitne, K.W., Gamble, S., Pearlman, L.A., & Lev, B.T. (2000). *Risking Connection: A training curriculum for working with survivors of childhood abuse*. Baltimore: Sidran Press.

Shaffer, D., Gould, M., Brasic, J., Ambrosini, P., Fisher, P., Bird, H., & Aluwahlia, S. (1983). A children's global assessment scale (CGAS). *Archives of General Psychiatry, 40*, 1228-1231.

Stewart, D., Law, M., Russell, D., & Hanna, S. (2004). Evaluating children's rehabilitation services: An application of a programme logic model. *Child: Care, Health, and Development, 30*(5), 453-462.

Stroul, B.A. & Friedman, R.M. (1986). *A system of care for severely emotionally disturbed children and youth*. Washington, DC: Georgetown University Child Development Center.

Tebes, J.K., Feinn, R., Vanderploeg, J.J., Chinman, M.J., Shepard, J., Brabham, T., Genovese, M., & Connell, C.M (in press). Impact of a positive youth development intervention in urban after-school settings on the prevention of adolescent substance use. *Journal of Adolescent Health*.

Tebes, J. K., Kaufman, J. S., Adnopoz, J. & Racusin, G. R. (2001). Resilience and family psychosocial processes among children of parents with serious mental disorders. *Journal of Child and Family Studies, 10*, 115-136.

Tebes, J.K., Kaufman, J.S., & Connell, C.M. (2003).

Tebes, J.K., Shah, S., Brabham, T., Schroeder, J., & Kaufman, J.S. (2007). *The Yale*

modified children's global assessment of functioning scale. New Haven, CT: Yale University School of Medicine, Division of Prevention and Community Research, and The Consultation Center.

VanderVen, K. (1995). "Point and level systems": Another way to fail children and youth. *Child & Youth Care Forum, 24*(6), 345-367.

Washington State Department of Social and Health Services (2005). Report of the Children's Evidence Based Practices Expert Panel. Retrieved April 1, 2007, from http://www.1.dshs.wa.gov/word/ea/EBPExpertPanel.doc

Appendix of Evidence-Based Treatments

Individual Child and Adolescent Treatments

Anxiety Disorders

Modeling. This treatment for anxious, avoidant, and phobic behaviors has been tested for use with children and early adolescents (ages 3-13 years). Modeling often is used in the forms of live, filmed, participant, and symbolic modeling techniques. Several RCTs demonstrate effectiveness for reducing anxiety and avoidant behaviors, often related to specific phobias.

Reinforced Practice: This intervention is used for the treatment of anxiety, phobia, and associated avoidance and conduct problems among children and early adolescents (ages 4-12 years). The focus is on graduated exposure to feared stimuli, reinforcement, and verbal coping. Evidence suggests promising effects, but no randomized controlled trials (RCTs) have been conducted.

Desensitization: Used for the treatment of children (ages 3-10 years) with anxiety, desensitization includes systematic, imaginal, and in vivo desensitization techniques, all of which involve graduated exposure (imagined or real) to anxiety-provoking stimuli paired with a relaxation technique. Several controlled studies support the effectiveness of this set of treatments.

Exposure: This treatment is used for children and adolescents (ages 3-17 years) with anxiety problems. It can also be adapted for use with groups. The treatment entails repeated exposure to feared stimuli to reduce the avoidant responding.

Coping Cat: Used for the treatment of anxious and avoidant behavior among children (ages 9-13 years), this treatment program teaches children skills to recognize cues for anxiety, and to use coping and relaxation strategies to manage arousal. There is some parent involvement, though the treatment is primarily individual. Three RCTs support its effectiveness in reducing anxiety to below clinical thresholds, with evidence of sustained treatment gains at long-term follow-up.

Depression

Interpersonal Psychotherapy for Depressed Adolescents: This intervention for depressed adolescents (ages 12-18 years) focuses on identifying and changing problematic relationships as the underlying cause of depression. It has been tested primarily in clinic settings, with a racially and ethnically diverse group of youth, and RCTs have reported positive impacts on reducing symptoms of depression.

Primary and Secondary Control Enhancement Training for Youth Depression (PASCET). Using cognitive-behavioral techniques, this intervention is used to treat depression in children and young adolescents (third to sixth grade). This individual intervention also includes some parent involvement, as well as a home and school component. The intervention focuses on teaching children to use active control for modifiable situations and cognitive coping skills for situations that are not modifiable. One RCT found significant reductions in symptoms of depression relative to a control group.

Behavioral and Conduct Problems

Problem-Solving Skills Training: This treatment uses primarily individually focused treatment of children and adolescents (ages 7-13) with disruptive behaviors and conduct problems. Problem Solving Skills Training applies cognitive-behavioral strategies to interpersonal problem situations. There is some evidence that when combined with Parent Management Training, this treatment is more effective than either intervention alone, with positive effects reported for behavior problems, parenting stress, and family functioning.

Trauma and Abuse

Trauma-Focused Cognitive-Behavioral Therapy: This program utilizes multiple modalities, including family and individual therapy, as well as group sessions for youth (ages 3-18 years) who have experienced traumatic events such as abuse, loss, school and community violence, domestic violence, or disasters/terrorism/war. The intervention utilizes cognitive and behavioral strategies such as therapeutic intervention, social skill development, artistic activities, parent education, family therapy, and parenting skills to support trauma recovery. The program has completed several pre-post and RCT design studies, and has demonstrated positive impacts on a wide range of outcomes and reduces symptoms of depression, PTSD, and oppositional/defiant behavior. It is delivered over the course of 5 to 54 weeks.

Group Child or Adolescent Treatments

Anxiety Disorders

Relaxation: This intervention is used for the treatment of depression, anxiety and phobia, and ADHD among adolescents (ages 11-15 years). Relaxation exercises are taught in a group format, and specific skills include deep breathing, progressive muscle relaxation, and guided imagery. The intervention is limited by having been tested only in school group sessions, but the group format has potential for use in clinic settings.

Client-Centered and Play Therapy: This group-based intervention has been tested for youth with anxiety and/or conduct problems. The treatment focus includes feeling identification and expression, social skill development, developing trust, and developing listening skills. Studies suggest treatment effects above those of comparison or alternative treatment groups.

Friends Program: This multi-modal treatment addresses anxiety problems among children and adolescents (ages 7-14 years). Although this program is multi-modal, it has a strong child/adolescent youth group component, along with parent and family components. The treatment is cognitive-behavioral in nature, targets family problem solving, and enhances effective behavioral parenting strategies as well as harmful parent cognitions. It is based on the Coping Cat treatment, which has strong empirical support.

Depression

Relaxation: This intervention is used for the treatment of depression, anxiety and phobia, and ADHD among adolescents (ages 11-15 years). Relaxation exercises are taught in a group format, and specific skills include deep breathing, progressive muscle relaxation, and guided imagery. The intervention is limited by having been tested only in school group sessions, but the group format has potential for use in clinic settings.

CBT Group for Depression: This cognitive-behavioral treatment (CBT) has been tested among populations of depressed adolescents (ages 13-18 years), with and without delinquency, and with and without depressed parents. The treatment is group-based and participatory, and focuses on problem-solving and communication skills, in addition to targeting negative beliefs

that cause and/or maintain depression. Several RCTs have been conducted, with significant symptom reduction in the treatment group compared to a wait-list group.

Coping with Stress: This group treatment for depressed adolescents (ninth and tenth grade) uses cognitive-behavioral training focused on changing the negative and irrational thoughts and beliefs that cause and/or maintain depression. One RCT revealed significant treatment effects on reducing the presence of a diagnosis of Major Depression or Dysthymia. This treatment is limited by having only been provided in a school setting.

Behavior and Conduct Problems

Peer Coping Skills: This group-based treatment has been tested for treating aggressive behavior in younger children (ages 6-8 years). The focus is on teaching communication and listening skills through the use of practice social situations, role-playing, and games and crafts. Although group-based, the intervention is limited by having only been tested in school settings. However, there appears to be potential for application to clinic settings. To avoid iatrogenic effects, the intervention is recommended for use with groups of children who do and do not demonstrate aggressive behavior problems. The program has one randomized controlled trial to support its effectiveness.

Client-Centered and Play Therapy: This group-based intervention has been tested for youth with anxiety and/or conduct problems. The treatment focus includes feeling identification and expression, social skill development, developing trust, and developing listening skills. Studies suggest treatment effects above those of comparison or alternative treatment groups.

Rational-Emotive Therapy: This group treatment for children and adolescents (ages 6-17 years) is used to treat disruptive behavior and conduct disorders. The treatment uses direct therapist confrontation to challenge youth to take responsibility for their actions and emotions. A RCT reported an effect size of 3.07, and the intervention has been tested with diverse groups of youth.

Anger Coping Therapy: This group treatment has been tested for effectiveness with pre-adolescent and adolescent males (ages 9-15 years) with disruptive behavior and conduct problems. The focus is on developing coping skills, self-management and monitoring, perspective taking, and problem solving. The intervention is limited by having only been implemented in school settings. A separate treatment called Anger Control Therapy (Feindler, 1995) is very similar to Anger Coping Therapy and has been found to be effective with elementary and junior high school students and adolescents in residential treatment.

Coping Power: This intervention is designed for delivery to older children and early adolescents (ages 9-13 years) with disruptive behavior problems. In addition to the groups for youth, a manual for multi-parent groups also is available. The treatment utilizes cognitive-behavioral skills such as goal setting, anger management, gaining positive attention, and promoting academic and study skills. Some evidence suggests that the intervention effects on indicators of covert and overt delinquency are strongest when the youth and parent groups are used simultaneously.

Anger Control for Aggressive Youth: This CBT group intervention focuses on treating youth (average age 10 years) with aggression problems by targeting social-cognitive factors that are related to aggressive behavior. The program has been shown to have effects on self-esteem and aggression, and evidence supports that these treatment gains are maintained at long-term follow-up.

Leadership and Resiliency Program: This group-based intervention is focused on the use of strengths-based activities for adolescents (ages 14-19 years) who have exhibited disciplinary problems, low academic functioning, substance use, and/or violence. Activities include adolescent group sessions, community service opportunities, artistic expression (e.g., developing a puppet show for young children), and outdoor adventure programming. The program has been shown to reduce school behavior problems, suspensions, and arrests, and to increase grades, attendance, and school bonding.

Trauma and Maltreatment

Trauma Adaptive Recovery Group Education and Therapy (TARGET): TARGET is a group-based intervention for trauma stress related to child physical or sexual abuse, exposure to domestic or community violence, or traumatic loss. Child and adolescent versions of the intervention are available. Group sessions focus on bodily self-regulation, emotional awareness and regulation, information processing, coping skills, interpersonal problem solving, stress management, and experiential exercises. Interventions are primarily group-based and organized around the acronym F.R.E.E.D.O.M. (Focus; Recognize triggers; Emotion self-check; Evaluate thoughts; Define personal needs/goals; Open new options for achieving goals; Make a contribution). The program is designed for approximately 3-12 sessions, and versions are available that can be adapted to individual or family sessions.

Milieu-Based Interventions for Children and Adolescents

The Sanctuary Model (Bloom, 2005) is one milieu-based approach that has been used to organize a therapeutic community in a way that is sensitive to the trauma experiences of youth ages 6 to 18 years. In addition, this approach fosters the development of core competencies, does not rely excessively on behavior charting or token economies, and promotes safe and healing peer and adult relationships. This is accomplished primarily through training staff and organizations to develop trauma-informed structures, processes, and behaviors that create a culture of nonviolence; emotional intelligence; inquiry and social learning; shared governance; open communication; social responsibility; and growth and change. The curriculum also utilizes the S.E.L.F. (Safety, Emotions, Loss, Future) acronym for promoting core competencies with trauma-exposed youth, with a particular focus on promoting affect regulation skills. Although training is available from developers, there is no manual. We recommend that the Sanctuary Model be replicated across EDT sites, and that DCF support agencies to receive training on the implementation of the Sanctuary Model from the model developers. In addition, we recommend that ongoing consultation and technical assistance be provided to ensure long-term fidelity to the Sanctuary Model.

Risking Connections (Saakvitne, Gamble, Pearlman, & Lev, 2000) is another trauma-informed group milieu intervention that focuses on developing empowerment, connection, and collaboration among youth with serious trauma histories (e.g., abuse and family violence). Staff and providers are taught to understand the nature of trauma and trauma symptoms, help youth develop safe and healthy relationships, prevent and manage crises in a way that avoids re-victimization, and manage dissociations and flashbacks.

In-Home Evidence-Based Family Treatments

Multisystemic Therapy: This intervention for high-risk adolescents (ages 10-17 years) has demonstrated effects for youth with conduct problems, sexual offense, and substance use

problems. Although this treatment is strongly multi-modal and targets multiple ecologies, it has strong parent and individual treatment components, in addition to school and family based treatment components. Effects have been demonstrated at the level of the youth and the family, and in the areas of criminal behavior, out of home placements, and substance use.

Brief Strategic Family Therapy: This family-based treatment draws heavily upon family systems theory, and treats conduct problems among boys (ages 6-12 years). A few controlled studies support its effectiveness in reducing behavior problems. It has been used in clinic, home, and community settings.

Multidimensional Family Therapy: This family-based intervention has been used with the families of youth (ages 12-17 years) at-risk for substance use and behavior problems. Interventions address individual youth and parent problems individually, problems in the whole family system, and issues that involve interactions between family members and relevant social systems, as well as the impacts of home and school on family functioning. Substance use and social/emotional competence are main targets, and the intervention is designed for 4-6 month delivery. Multiple RCTs have supported the effects of this intervention on a broad range of problems from substance use to delinquency, family conflict, and academic functioning.

Functional Family Therapy: This family-focused program has been used to treat primarily adolescents (ages 11-18 years) with violence and conduct problems. Treatment progresses in five phases, including engagement, motivation, assessment, behavior change, and generalization. It generally is conducted in multiple settings, and the evidence demonstrates that the treatment prevents escalation of problem behaviors.

In-Office Evidence-Based Family Treatments

Anxiety Disorders

CBT Plus CBT for Parents: This combined treatment is used for treatment of anxious/avoidant and disruptive behavior by youth (ages 7-14 years), and focuses on unspecified cognitive-behavioral skills. At least one RCT has been conducted to support its effectiveness in reducing disruptive behavior.

Self-Control ("Taking Action" Program for Depressed Youth): This treatment is primarily individually based for children and young adolescents (ages 3-12 years) with problems of depression and anxiety. A parent component and family meetings are available. The treatment focuses on self-observation, understanding triggers for depression and anxiety, social skills, assertiveness, relaxation, and cognitive restructuring. Controlled studies suggest significant treatment effects at post-test and 7-month follow-up.

CBT with Parents: This intervention is used for the treatment of parents whose adolescents (ages 14-18 years) have problems with anxiety or depression. RCTs have been conducted that support positive effects on symptoms of anxiety and avoidant behavior, as well as depression.

Depression

Self-Control ("Taking Action" Program for Depressed Youth): This treatment is primarily individually based for children and young adolescents (ages 3-12 years) with problems of depression and anxiety. A parent component and family meetings are available. The treatment focuses on self-observation, understanding triggers for depression and anxiety, social skills, assertiveness, relaxation, and cognitive restructuring. Controlled studies suggest significant treatment effects at post-test and 7-month follow-up.

CBT with Parents: This intervention is used for the treatment of parents whose adolescents (ages 14-18 years) have problems with anxiety or depression. RCTs have been conducted that support positive effects on children's symptoms of anxiety and avoidant behavior, as well as depression.

Behavioral and Conduct Problems

Montreal Longitudinal Experiment Study: This intervention is meant for use with aggressive boys (ages 6-12 years) and their parents, though youth and parents receive separate interventions. The program has been tested for children in school settings, and with parents in the home. The evidence base includes one RCT, with positive impacts on conduct problems, substance use, and achievement. The model calls for individual and parent components to treatment.

FAST Track: This multidimensional intervention is meant to treat children and early adolescents (ages 6-12 years) at high-risk for conduct problems, school dropout, substance use, and other social, emotional, and behavioral problems. Although the intervention is primarily school-based, it intervenes at multiple ecological system levels (child, family, school), and has universal, selected, and indicated prevention components. Among the focus of treatment are parenting skills and child social and academic skills. Several studies support its effectiveness.

Linking the Interests of Family and Teacher (LIFT): The program works with both youth (first and fifth graders) and their parents to prevent conduct problems. Though it is primarily school-based, the intervention focuses on teaching social and communication skills, and teaches behavior management skills to parents. There is one RCT to support intervention effects on substance use and conduct problems.

CBT Plus CBT for Parents: This combined treatment is used for treatment of anxious/avoidant and disruptive behavior by youth (ages 7-14 years), and focuses on a number of cognitive-behavioral skills. At least one RCT has been conducted to support its effectiveness in reducing disruptive behavior.

Positive Parenting Program (Triple P): This parent-training intervention also includes multi-parent group components. The focus is on treating children and early adolescents (ages birth to 12 years), who have conduct problems, by teaching parents behavior management techniques.

Living With Children: This parent-training program has primarily been tested for use with children and early adolescents (ages 3-12 years) with disruptive behavior problems, although some family involvement sessions are available if the identified patient is older. The focus of treatment is on teaching parents behavior management skills. The evidence base for the program includes one RCT with some effects on reducing problem behavior.

Helping the Noncompliant Child: This program targets noncompliance by children (ages 3-8 years). The treatment is focused on enhancing parent's skills in child management, including self-control, problem-solving, and social learning principles. It is supported by several RCTs, and demonstrates effects on children's noncompliant behaviors.

Videotaped Modeling-Parent Training: This multi-group parent intervention uses videos and discussions to assist parents whose children have oppositional, defiant, and conduct problems.

Parent Management Training: This parent-training program is used with parents of children and early adolescents (ages 3-13 years) with conduct problems. The treatment focuses on basic behavior management strategies.

Cognitive-Behavioral Training for Parents of Children with ADHD: This parent-training program can be used for individual parents or multi-parent groups who are dealing with a child with ADHD. It focuses on supporting parents in accepting their difficult child and teaching behavior management techniques. Control studies report positive effects, while other studies have demonstrated mixed results when compared with other interventions.

Parent Training: This treatment has been tested in multiple RCTs for use with youth (ages 3-15 years) for the treatment of disruptive and conduct problems, particularly with males. Basic behavior management skills are taught using videotaped discussions, parent groups, and opportunities for practicing skills with children. Multiple controlled studies have been conducted to test parent training for its effects on behavior problems.

The Incredible Years: This primarily parent-training approach also uses some individual and teacher components to treat children (ages 2-8 years) with early onset oppositional and conduct related problem behaviors. Multiple components are used in the intervention, including videotaped modeling, psychoeducation on parenting and child development, and parent coping strategies. Numerous RCTs support the effectiveness of this approach in reducing aggression, improving self-esteem, and improving classroom behavior.

Behavior Therapy: Techniques are taught to parents to help them replace negative behaviors with positive ones through principles of reinforcement and conditioning. This treatment has been used with a wide age range of youth (ages 3-18) and has demonstrated effectiveness in reducing symptoms associated with AD/HD, as well as depression, substance use, and conduct problems.

CASASTART: This community-based program has been tested for use with high-risk youth (ages 8-13 years) who are at risk for behavior problems, substance use, and criminal involvement. There are individual, family, and school-based components to the program, as well as intensive case management. The program also utilizes a positive youth development framework. The outcomes indicate reduced substance use, violence, delinquent peer associations, and increased family cohesion and positive peer influence.
Creating Lasting Family Connections: This family-based program has been used with high-risk youth (ages 9-17 years) who are exhibiting risk behaviors for later substance use and antisocial/aggressive behavior. The program components include substance use prevention activities and life skills development for youth, parent education and training, and peer resistance skills. The program is designed for delivery over the course of six months to one year.

Families and Schools Together: This intervention is based primarily on the use of multi-family group sessions to enhance family functioning, prevent school failure, prevent parent and youth substance use, and reduce parenting stress. It includes an 8-week multi-family group curriculum followed by monthly multi-family meetings for up to 21 months.

Family Effectiveness Training: This family-based therapy program is designed specifically for use with Hispanic/Latino(a) families with high levels of family conflict, and their children (ages 6-12 years) with behavior problems. The program is designed for delivery over 5 to 24 weeks, and uses Brief Strategic Family Therapy as the primary family intervention strategy, tailored to use

with Hispanic families. Family sessions focus on developing bicultural skills, addressing substance use risk factors, educating parents on adolescent development, and developing effective parenting skills. The program impacts negative attitudes and behaviors, enhances culturally-appropriate assimilation, and increases family cohesiveness and bonding.

Strengthening Families Program: This family-based program draws upon cognitive-behavioral and family systems theory to address early individual and family risk factors that affect children (ages 6-12 years). Multi-family group sessions focus on parent-child interactions and parent training. Child group sessions focus on life and social skill development. The program is designed as a 5-24 week intervention with groups of 4-14 families. The results suggest wide-ranging effects on risk factors and outcomes that affect parents, families, and youth. There are separate versions of the program, including the program for 6-12 year old youth and their families, and a separate program for 10-14 year old youth and their families (*SFP 10-14*).