Trauma treatment models for Child-Serving Residential Agencies:

Intervention/Program Name	Brief description	Additional information and criteria
Acceptance & Commitment Therapy (ACT) CEBS – not listed NCTSN – not listed	Empirically based psychological intervention that uses acceptance and mindfulness strategies, together with commitment and behavior change strategies, to increase psychological flexibility. Psychological flexibility means contacting the present moment fully as a conscious human being, and based on what the situation affords, changing or persisting in behavior in the service of chosen values. Through metaphor, paradox, and experiential exercises clients learn how to make healthy contact with thoughts, feelings, memories, and physical sensations that have been feared and avoided. Clients gain the skills to recontextualize and accept these private events, develop greater clarity about personal values, and commit to needed behavior change.	There is no ACT certification process. ACBS, as a community, has decided to forego this, as it could create a hierarchical and closed process which would be antithetical to our values. Rather, we aim to foster an open, self-critical, mutually supportive community which, working together, builds a progressive psychology more adequate to the challenges of human suffering. There is no such thing as an officially certified ACT therapist. ACT does not require certification. In fact, it defines itself as a psychological intervention. As such it can be utilized by those with a license (as a treatment modality) and those without a license (as an intervention). (Ohio Guidestone developed ACT-P for their paraprofessionals). There are two basic ways to begin learning about ACT: **Reading up on it your own** or **Seeking out a community** in which to network and broaden and deepen your knowledge of ACT
ARC: Attachment, Self-Regulation, and Competency: A Comprehensive Framework for Intervention with Complexly Traumatized Youth CEBS – not able to be rated – high relevance child welfare NCTSN	Framework is designed to be adaptable to needs and real-life circumstances of clients (i.e., identifying culturally relevant caregiver supports; working with appropriate members of family / kinship system). Framework specifically targets the child's surrounding system (caregiver(s), treatment system, community). The approach is grounded in attachment theory and early childhood development and addresses how a child's entire system of care can become trauma informed to better support trauma focused therapy. The approach provides a framework for both trauma informed and trauma specific therapeutic intervention.	Dependent on individualized implementation and modality. Generally, the number of sessions can range from 12 to greater than52 sessions. ARC has multiple modalities including individual, group and family treatment; parent workshops; milieu/systems intervention; and a new home-based prevention program. Prerequisite/Minimum Provider Qualifications Integration of ARC into clinical intervention requires the appropriate education/licensure/certification of the provider in their profession.

Child and Family Traumatic Stress Intervention (CFTSI) CEBC - Promising research evidence – high relevance child welfare NCTSN	Brief early intervention model for children and adolescent that is implemented soon after exposure to a potentially traumatic event or in the wake of disclosure of physical and sexual abuse developed at the Yale Child Study Center. Fills the gap between acute responses/crisis intervention and evidence-based, longer-term treatments designed to address traumatic stress symptoms and disorders that have become established. Goal of this family-strengthening model is to improve the caregiver's ability to respond to and support a child who has at last one posttraumatic symptom. Aims to reduce symptoms and prevent onset of PTSD. Provided by Master's level clinicians.	Children ages 7-18 recently exposed to a potentially traumatic event or having disclosed physical or sexual abuse and endorsing at least one symptom of posttraumatic stress CFTSI is provided to children and adolescents who have experienced a Potentially Traumatic Event (PTE) within the past 30 days (including disclosure about prior sexual or physical abuse, or other PTEs that have only recently been revealed). Prerequisite/Minimum Provider Qualifications: Master's level trained therapists
Child–parent psychotherapy (CPP) CEBC - Supported by research evidence – high child welfare relevance NCTSN	Child Parent Psychotherapy is an intervention model for children aged 0-5 who have experienced traumatic events and/or are experiencing mental health, attachment, and/or behavioral problems. The treatment is based in attachment theory but also integrates psychodynamic, developmental, trauma, social learning, and cognitive behavioral theories. Therapeutic sessions include the child and parent or primary caregiver. A central goal is to support and strengthen the caregiver-child relationship as a vehicle for restoring and protecting the child's mental health. Treatment also focuses on contextual factors that may affect the caregiver-child relationship (e.g. cultural norms and socioeconomic and immigration-related stressors). Targets of the intervention include caregivers' and children's maladaptive representations of themselves and each other and interactions and behaviors that interfere with the child's mental health. For children exposed to trauma, caregiver and child are guided over the course of treatment to create a joint narrative of the traumatic event and to identify and address traumatic triggers that generate dysregulated	Dyadic intervention ages 0-5 The following organizations have conducted independent reviews of the research on CPP, have listed CPP as an evidence-based practice, and have posted summaries on their websites. • The California Evidence-Based Clearinghouse for Child Welfare: http://www.cebc4cw.org/program/child-parent-psychotherapy/ • Oregon.gov Additions and Mental Health Approved Practices and Process: http://www.oregon.gov/OHA/mentalhealth/ebp/practices.shtml Prerequisite/Minimum Provider Qualifications: Practitioners: Master's level training Supervisors: Master's degree plus minimum of 1-year training in the model

	behaviors and affect. Treatment is generally conducted by a master's or doctoral-level therapist and involves weekly hour-long sessions.	
Collaborative Problem Solving CEBS - Promising Research Evidence – medium child welfare relevance NCTSN – not listed	CPS is an approach to understanding and helping children with behavioral challenges who may carry a variety of psychiatric diagnoses, including oppositional defiant disorder, conduct disorder, attention-deficit/hyperactivity disorder, mood disorders, bipolar disorder, autism spectrum disorders, posttraumatic stress disorder, etc. CPS uses a structured problem-solving process to help adults pursue their expectations while reducing challenging behavior and building helping relationships and thinking skills. Specifically, the CPS approach focuses on teaching the neurocognitive skills that challenging kids lack related to problem solving, flexibility, and frustration tolerance. Unlike traditional models of discipline, this approach avoids the use of power, control, and motivational procedures and instead focuses on teaching at-risk kids the skills they need to succeed. CPS provides a common philosophy, language and process with clear guideposts that can be used across settings. In addition, CPS operationalizes principles of trauma-informed care.	Prerequisite/Minimum Provider Qualifications: Service providers and supervisors must be certified in ***CPS***. There is no minimum educational level required before certification process can begin. There is a manual that describes how to implement this program, and there is training available for this program. Training can be obtained onsite, at Massachusetts General Hospital in Boston, at trainings hosted in other locations, online (introductory training only), or via video/phone training and coaching. Ranges from a 1-day introductory session to more intensive (2.5 day) advanced sessions as well as hourly coaching: Introductory training: These in-person and online trainings provide a general overview exposure of the model including the overarching philosophy, the assessment, planning and intervention process. Training can accommodate an unlimited number of participants. Two-and-a-half day intensive trainings that provide participants in-depth exposure to all aspects of the model using didactic training, video demonstration, role play and breakout group practice. Tier 1 training is limited to 150 participants. Tier 2 training is limited to 75 participants. Coaching sessions for up to 12 participants that provide ongoing support and troubleshooting in the model
Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT)	Empowering families who are at risk for physical abuse; short-term (16-20 Sessions), strength-based therapy program in families where parents are engage in a	Children ages 3- 17 and their parents/caregivers

CEBC - Promising research evidence – high relevance child welfare NCTSN	continuum of coercive parenting strategies. Families can include those who have been substantiated for physical abuse, those who have multiple unsubstantiated referrals, and those who fear they may lose control with the child. Children may present with PTSD symptoms, depression, externalizing behaviors. Helps child heal from the trauma of physical abuse, empowers and motivates parents to modulate their emotions and use effective non-coercive parenting strategies, strengthens parent-child relationships while helping end cycle of violence	Prerequisite/Minimum Provider Qualifications: Clinicians who implement ***CPC-CBT*** should have a master's degree or higher in one of the mental health professions or be working towards one of these degrees under the supervision of a licensed mental health professional. Given that ***CPC-CBT*** is based on cognitive-behavioral principles, it is helpful but not necessary for clinicians to be well grounded in Cognitive-Behavioral Therapy. It is important for clinicians to prepare themselves to work in a supportive, nonjudgmental manner with parents who have harmed their children in some way.
Dialectical Behavior Therapy - DBT – Adolescents CEBS – not listed NCTSN – not listed	Although Dialectical Behavior Therapy (DBT) was originally developed for use with adults, it has since been adapted and found to be effective with adolescents (ages 12-18). DBT for adolescents includes the same treatment strategies and primary targets as DBT for adults, while also including parents in treatment and targeting difficult behavior patterns common to adolescents and their families. In addition, DBT for adolescents is typically briefer than DBT for adults, lasting approximately 16-24 weeks. DBT for adolescents has been evaluated in randomized clinical trials with teens with repeated suicidal and self-harming behaviors, as well as teens with bipolar disorder.	
Dialectical Behavior Therapy for Children – DBT-C CEBS – not listed NCTSN – not listed	DBT-C retains the theoretical model, principles, and therapeutic strategies of standard DBT and incorporates almost all of the adult DBT skills and didactics into the curriculum. However, the presentation and packaging of the information are considerably different to accommodate for the developmental and cognitive levels of pre-adolescent children. Further, DBT-C adds an extensive parent training component to the model. DBT-	Participants are expected to be mental health professionals who have attended DBT Intensive or Foundational training, have at least one year of experience delivering DBT, and currently work with pre- adolescent children. The DBT-C training involves rigorous preparation, training, and homework. The course is designed to model basic elements of the treatment in an experiential way. Just as DBT-C requires families to make

	C teaches parents everything their child learns (e.g., coping skills, problem-solving, didactics on emotions), plus effective contingency management techniques. DBT-C maintains that parental modeling of adaptive behaviors, reinforcement of a child's skills use, ignoring of maladaptive responses, validation, and acceptance are key to achieving lasting changes in a child's emotional and behavioral regulation.	a full commitment to treatment and to attend all sessions, DBT-C training requires participants to attend the entire training, do their best to learn the material, and to participate in a willing, committed manner.
Eye Movement Desensitization and Reprocessing (EMDR) [Trauma Treatment - Client-Level Interventions (Child & Adolescent)] CEBS - Well-Supported by Research Evidence – medium child welfare relevance Not listed with NCTSN	*EMDR* therapy is an 8-phase psychotherapy treatment that was originally designed to alleviate the symptoms of trauma. During the *EMDR* trauma processing phases, guided by standardized procedures, the client attends to emotionally disturbing material in brief sequential doses that include the client's beliefs, emotions, and body sensations associated with the traumatic event while simultaneously focusing on an external stimulus. Therapist directed bilateral eye movements are the most commonly used external stimulus, but a variety of other stimuli including hand-tapping and audio bilateral stimulation are often used	This program is typically conducted in a(n): Community Agency; Hospital; Outpatient Clinic; Residential Care Facility; School Prerequisite/Minimum Provider Qualifications Qualifying individual providers must be either fully licensed mental health professionals or be enrolled in a Master's or Doctorate level program in the mental health field (Social Work, Counseling, Marriage Family Therapy, Psychology, Psychiatry, or Psychiatric Nursing) currently involved in the practicum and/or internship portion of the program they are enrolled in (first year students not eligible) and on a licensing track working under the supervision of a fully licensed mental health professional.
I Feel Better Now! Trauma Intervention Program CEBS – Not able to be rated – medium child welfare relevance NCTSN – not listed	Comprehensive trauma intervention program modified from original SITCAP program; 10-session group program designed specifically for at-risk traumatized children ages 6-12; integrates cognitive strategies with sensory/implicit strategies. Designed to alter the iconic memories of trauma to allow children the opportunity to achieve successful cognitive reordering of their traumatic experiences. Supports victim to survivor thinking and changes in negative behaviors and allows traumatized children to become more resilient	Prerequisite/Minimum Provider Qualifications Minimum 2-day training from TLC Institute required Minimum 1-year group experience with elementary school aged children Supervision provided by a master's Level TLC Institute trained professional Education and Training Resources There is a manual that describes how to implement this program, and there is training available for this program.

NM - Neurosequential Model CEBS – not listed NCTSN – not listed	The Neurosequential Model is a developmentally informed, biologically-respectful approach to working with at-risk children. The Neurosequential Model is not a specific therapeutic technique or intervention; it is a way to organize a child's history and current functioning. The goal of this approach is to structure assessment of a child, the articulation of the primary problems, identification of key strengths and the application of interventions (educational, enrichment and therapeutic) in a way that will help family, educators, therapists and related professionals best meet the needs of the child.	Prerequisite/Minimum Provider Qualifications for individual certification: At least a master's degree in social sciences or equivalent (e.g., psychology, education, social work, nursing, OT/PT, etc.);A current license (e.g., LPC, LMFT, LMSW, etc.) or similar designation (if outside of US); Current practice working with children, youth, adults or families; Participation in at least 1 NMT Case-based Training Series (10 sessions). For those who have not completed an NMT Case-based Series but want to enroll in the Certification Program, a Pre-Requisite Series will be added to their training package at no additional cost. Requirements for the NMT Site Certification Process: Organizations are considered for Site Training Certification if seven or more employees or affiliated professionals are seeking Certification. The NMN will work with sites to determine whether Individual or Site Training Certification is most appropriate. While the full Site Certification process includes two phases of training, an organization may choose to enter Maintenance after Phase I. No internal training is possible in this case.
Parent Child Interaction Therapy CEBC Well supported by research evidence – medium child relevance NCTSN	Parent-child interaction therapy (PCIT) is an evidence-based behavior parent training treatment for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. Children and their caregivers are seen together in PCIT. Specifically, parents are initially taught relationship enhancement or discipline skills that they are actually going to be practicing in session and at home with their child. In subsequent sessions, most of the session time is spent coaching caregivers in the application of specific therapy skills.	Based on well-controlled randomized controlled trials, PCIT has been categorized as a probably efficacious treatment for 3- to 6-year-olds with disruptive behavior (Eyberg, Nelson, & Boggs, 2008). PCIT has been rated as Promising by Blueprints for Healthy Youth Development as a treatment for young children with emotional and behavioral problems. The Blueprints website for PCIT lists additional information about PCIT including a Fact Sheet, Program Costs, Funding Strategies, and a Detailed Evaluation Abstract. In terms of the use of PCIT for a child welfare population, there is a nice review of the literature from Child Welfare Information Gateway.

	PCIT outcome research has demonstrated statistically and clinically significant improvements in the conduct-disordered behavior of preschool age children: after treatment, children's behavior is within the normal range. Studies have documented the superiority of PCIT to wait list controls and to parent group didactic training. In addition to significant changes on parent ratings and observational measures of children's behavior problems, outcome studies have demonstrated important changes in the interactional style of the fathers and mothers in play situations with their children.	Prerequisite/Minimum Provider Qualifications: A firm understanding of behavioral principles and adequate prior training in cognitive-behavior therapy, child behavior therapy, and therapy process skills (e.g., facilitative listening) is required. For training in this treatment protocol outside an established graduate clinical training program, the equivalent of a master's degree and licensure as a mental health provider is required. It is recommended that the 40 hours of intensive skills training be followed by completion of two supervised cases prior to independent practice. For within program supervisors, it is recommended that they complete a minimum of 4 prior cases and complete a within program trainer training
Psychological First Aid CEBS – not able to be rated – medium relevance child welfare NCTSN	PFA is an evidenced-informed intervention designed to be put into place immediately following disasters, terrorism, and other emergencies, and has received wide usage worldwide. PFA is comprised of eight core helping actions: contact and engagement, safety and comfort, stabilization, information gathering, practical assistance, connection with social supports, information on coping support, and linkage with collaborative services	Disasters, terrorism, and acute trauma, Post-disaster adversity, displacement
Sanctuary Model CEBS – promising research evidence – medium child welfare relevance NCTSN	The aims of the Sanctuary Model are to guide an organization in the development of a trauma-informed culture with seven dominant characteristics all of which serve goals related to recovery from trauma spectrum disorders while creating a safe environment for clients, families, staff, and administrators with measurable goals: Culture of Nonviolence; Culture of Emotional Intelligence; Culture of Inquiry & Social Learning; Culture of Shared Governance; Culture of Open Communication; Culture of Social Responsibility; and, Culture of Growth and Change	Sanctuary implementation is typically a three-year process Prerequisite/Minimum Provider Qualifications: The minimum qualifications for an organization to participate are a fundamental readiness to engage in trauma-informed practices at the organizational level as a way to include a trauma component in their work or to complement and enhance other trauma specific treatment interventions.

SPARCS: Structured Psychotherapy for Adolescents Responding to Chronic Stress CEBS – not able to be rated – medium relevance child welfare NCTSN	SPARCS is a manually-guided and empirically-supported group treatment designed to improve the emotional, social, academic, and behavioral functioning of adolescents exposed to chronic interpersonal trauma (such as ongoing physical abuse) and/or separate types of trauma (e.g. community violence, sexual assault). The curriculum was designed to address the needs of adolescents who may still be living with ongoing stress and may be experiencing problems in several The curriculum has been successfully implemented with at-risk youth in various service systems (e.g. schools, juvenile justice, child-welfare, residential) in over a dozen states.	16 sessions one-hour in length Prerequisite/Minimum Provider Qualifications: Group leaders are generally mental health clinicians with a Master's Degree.
Structured Sensory Interventions for Traumatized Children, Adolescents and Parents – SITCAP ® CEBS – Not listed NCTSN – Not listed	Process directs itself at actively involving children in new experiences in order for them to build new connections related to what they are learning about themselves and trauma as a result of the sensory-based activities they engage in when participating in SITCAP®. Developed and used over the past 24 years, field tested in schools and community agencies, SITCAP® is supported by the latest scientific advances in neuroscience and has been featured in leading scholarly journals and numerous books on childhood trauma	
Structured Sensory Interventions for Traumatized Children, Adolescents and Parents - SITCAP-ART ® CEBS – Promising Research Evidence - medium child welfare relevance NCTSN – not listed	Model group program is for at-risk and adjudicated youth. This program provides Juvenile Court Systems with trauma intervention that supports the needs of adolescents exposed to traumatic incidents. The goal of the program is to reduce traumatic reactions, restore a sense of safety and power, improve the adolescent's behavior, and ability to learn and be productive within his family and community environments. This program was included in SAMHSA's National Registry of Evidence-based Programs and Practices	Prerequisite/Minimum Provider Qualifications: Intervener: Minimum two (2) day TLC Institute training required, Minimum 1-year group experience with adjudicated adolescents, Preferred Master's Level Education Supervisor: Supervision provided by master's Level TLC Institute trained professional

Trauma Affect Regulation: Guide for Education and Therapy for Adolescents (TARGET-A) CEBC - Promising research evidence – medium relevance child welfare NCTSN	Educational and therapeutic intervention designed to prevent and treat traumatic stress disorders (including PTSD, sever anxiety disorders, depression and dissociative disorders), co-occurring addictive, personality or psychotic disorders and adjustment disorders related to other types of stressors	Manualized protocol for brief (4-session) time limited (10-14 sessions) and extended (26+ sessions) individual, groups or family education and therapy; delivered in community, outpatient, inpatient, residential Tx or healthcare setting. Prerequisite/Minimum Provider Qualifications: Bachelor's level mentors, case managers, or advocates with supervision by Master of Arts, Master of Social Work, or PhD level professionals
Trauma-focused cognitive-behavioral therapy (TF-CBT) CEBC - Well supported by research evidence – high child welfare relevance NCTSN	TF-CBT addresses the multiple domains of trauma impact including but not limited to Posttraumatic Stress Disorder (PTSD), depression, anxiety, externalizing behavior problems, relationship and attachment problems, school problems and cognitive problems. TF-CBT includes skills for regulating affect, behavior, thoughts and relationships, trauma processing, and enhancing safety, trust, parenting skills and family communication.	12-25 sessions (60-90-minute sessions, divided approximately equally between youth and parent/caregiver) Has been modified for residential treatment facilities (e.g., additional training materials are available for training direct care staff to support the use of TF-CBT skills in the residential setting) Prerequisite/Minimum Provider Qualifications: Master's degree and training in the treatment model; Experience working with children and families
Trauma-Responsive Care Training and Consultation (Seeking clarification from Matt Price) CEBS – not listed NCTSN – not listed	Trauma Responsive Care goes beyond traditional Trauma Informed Care by not only helping to understand trauma and its effects but additionally providing interventions to assist in alleviating trauma symptoms and lead to a higher level of functioning. The interventions utilized in Trauma-Responsive Care are derived from a synthesis of emerging research in the neurobiology complex trauma and attachment trauma. Training and consultation is delivered one and one to therapists, in small group with leadership and supervisors as well as whole staff trainings. Leadership and supervisors are being trained to follow-up and coach front line staff in the Trauma Responsive Model and practical interventions.	Trauma Responsive Care Training and Consultation are provided by Carol Hudgins-Mitchell LSW, Certified Trauma Specialist Fonder of Mindful Possibilities LLC, who holds a Certificate in Traumatic Studies from Bessel van der Kolk's Trauma Center at the Justice Resource Institute in Boston.

Trauma-System Therapy (TST) CEBC – Not able to be rated; high child welfare relevance NCTSN	TST is applicable across all trauma types. It has most often been used with children and teens who have experienced complex, chronic traumatic events, in settings such as foster care, inpatient units, residential treatment, and with specialized populations such as refugees, and substance abusing adolescents.	Length varies by level of severity and phases of treatment administered. There are 3 phases of treatment in TST: Safety Focused Treatment, Regulation Focused Treatment, and Beyond Trauma Treatment. Length of treatment varies depending on which phase a child starts in (determined by the TST assessment process). Typical length of treatment is between 7 and 9 months. Prerequisite/Minimum Provider Qualifications: A multidisciplinary team is required including clinical, educational, and case management staff members that are able to collaborate on assessment, treatment planning and implementation. The minimum educational requirement varies by discipline. Clinicians should have at least a master's degree and case workers often have a bachelor's degree.

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

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