Families First: Guidelines and Practices Manual

Funded by:
The Government of the District of Columbia
Department of Behavioral Health:
Children and Youth Services Division

In Partnership with:
Evidence-Based Associates (EBA)

December 12, 2017

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Acronyms List

A-CRA	Adolescent Community Reinforcement Approach
BSU	Behavioral Services Unit
CAL	Cognitive Aware Child Choice Providers
CBI	Community Based Intervention
CCP	Child Choice Providers
CDI	Child Directed Interaction
CECI	Child Ecology Check-in
CFSA	Child and Family Services Agency
CPP	Child-Parent Psychotherapy
CSAs	Core Service Agencies
CSS	Court Social Services
CSU	CFSA Clinical Services Unit
CYSD	Child and Youth Services Division
DBH	Department of Behavioral Health
DCPS	District of Columbia Public Schools
DHCF	Department of Health Care Finance
DYRS	Department of Youth Rehabilitation Services
EBA	Evidence-Based Associates
EBD	emotional/behavioral difficulties
EBPs	Evidence Based Practices
FFT	Functional Family Therapy
IEP	Individualized Education Plan
IHCBS	Intensive Home & Community Based Services
MCO	Managed Care Organization
MEM	Managing Emotions Guide
MHRS	Mental Health Rehabilitative Services
MST	Multisystemic Therapy
MST-EA	Multisystemic Therapy for Emerging Adults
MST-PSB	Multisystemic Therapy Problem Sexual Behavior
PCIT	Parent Child Interaction Therapy
PDI	Parent Directed Interaction
PIECE	Parent Infant Early Childhood Enhancement
PIR	Program Implementation Review

PPG	Physicians Psychiatric Group
PTSD	Post-Traumatic Stress Disorder
SOC	System of Care
TF-CBT	Trauma-Focused Cognitive Behavioral Therapy
TIP	Transition to Independence Process
TST	Trauma Systems Therapy

Goals and Objectives of the Guidelines and Practices Manual

This Guidelines and Practices Manual is intended to serve as the principal administrative tool regarding the implementation details of the selected EBP models funded by DC DBH. The codification of eligibility criteria, referral protocols, quality assurance guidelines, and therapist credentials, for example, are important steps in the institutionalization of practices and support the transition to doing 'what works' as standard operating procedure in the service system.

The DBH Families First program will continue to develop over the coming years. As additional EBPs are incorporated in the public mental health system, this manual will be expanded and will serve to meet the growing needs of our clients. The Manual was written for provider agencies who choose to implement one of these EBPs; for clinicians who are part of the Families First program; and for other stakeholders who want a deeper understanding of the implementation procedures required to implement each EBP successfully.

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Project Background

Over the past decade, the District of Columbia Department of Behavioral Health (DBH) has steadily improved the continuum of evidence-based, community-based mental health services for children, youth and families in the District. A seamless continuum of quality, available, and accessible services is the backbone of a children's mental health system; without the benefit of these services, children and youth will suffer from untreated health conditions, be unnecessarily hospitalized or placed in other residential facilities, and fail to achieve optimal life outcomes including education, employment, quality of life and well-being.

Although vast improvements have been made, some gaps remain, and further investment in children's mental health services are critical to building the 'world-class' network of services that all District residents deserve. Since 2010, DBH has placed particular emphasis on **strengthening the number of research-proven, evidenced-based services** available to children in the District. Evidenced-based practices are models that have been rigorously evaluated in research studies and proven to be effective when delivered with high fidelity to children, youth, and families who meet specific criteria as indicated in the treatment protocol.

Starting in fiscal year 2010, the Child and Youth Services Division (CYSD) moved forward with the development of a 3-5 year comprehensive mental health plan for children and youth. The intent of the plan was to develop a strategy to address the full range of child/youth issues and challenges coming to the attention of practitioners district-wide. The key outcomes to be achieved included:

1. Facilitating the continued development and maintenance of formal cross-agency planning and decision-making processes to support the development of the System of Care (SOC);
2. Reducing the number of youth in out-of-home residential placements;
3. Re-investing the funds saved via reductions in placement to expand the capacity of family-focused, community-based services that will support children and youth within their communities;
4. Increasing the array of services, especially, that are available to the 0-5 population;
5. Increasing family involvement in all levels of the system; and
6. Implementing an array of Evidence Based Practices (EBPs).

To achieve these outcomes, specific system changes and services were recommended, including:

a) Develop Integrated Mental Health/Substance Abuse services for youth with co-occurring disorders.
b) Provide specialized, community-based services for sex offending children and youth.
c) Expand system capacity by increasing the core competencies of Core Service Agencies (CSAs).
d) Develop services for the District's children (especially pre-school aged) who have been exposed to domestic violence or other traumatic events and who may demonstrate symptoms related to that exposure.

To facilitate an efficient and effective start-up for the models that would target these needs, DBH contracted with Evidence-Based Associates (EBA) in 2010 to identify, contract for and support the implementation of selected programs.

Support Activities:
In order to 'institutionalize' the implementation of the array of services including evidence-based programs in the District, DBH will employ the following strategies to effectively implement the EBPs that have been identified as necessary and appropriate for DC's population of children and youth:

a. Establish the number of children in need of EBPs and develop a plan to meet the capacity;
b. Create rules to integrate each EBP within the current Mental Health Rehabilitative Services System (MHRS) or the free-standing clinic option;
c. Partner with the Department of Health Care Finance (DHCF/Medicaid) to integrate codes within the State Plan in order to obtain/maximize Medicaid funding for each identified EBP;
d. Create a management system to monitor utilization and evaluate outcomes of the implementation of each EBP;
e. Manage and monitor implementation process and evaluate program outcomes on an ongoing basis, addressing and correcting program flaws as they arise; and
f. Provide ongoing support, i.e. ongoing training/technical support, as needed to CSAs based on continuous dialogue and feedback.

Program Level Information

Families First Project Overview

In January 2011, the DBH and the Children and Youth Investment Trust (the Trust), contracted with EBA to launch its Evidence-Based Practice Initiative (EBPI), also called "Families First." At the heart of the Families First project is a commitment to strengthening family units and keeping families together i.e., preventing children from being placed into out-of-home programs.

Through extensive/intensive training in identified evidence-based models, this project seeks to enhance and expand therapist skills and knowledge of treatment models that have demonstrated positive outcomes such as restoring responsible behavior for troubled children, helping family members deal with traumatic histories, and improving family interactions. Trained therapists from Core Services Agencies (CSA) and other agencies in DC would apply these model practices to empower families by promoting stronger relationships between children and their families and by increasing communication through skills such as problem solving and better decision-making.

Families First Program Components

Under Families First, EBA will provide Implementation Support (i.e. program development and program implementation support) services as Choice Providers implement chosen EBPs for various populations of children and families. For a representation of the criteria for Choice Providers within the context of DBH's delivery system, refer to Appendix A. Under the direction of DBH Children and Youth Services Division leaders, EBA will support and facilitate all aspects of the training and post-training activities for each EBP model. CSAs who elect and are chosen to deliver evidenced based treatments will be trained and provided with on-site follow-up and support. EBA, in conjunction with DBH, will develop and execute procedures and processes for client identification, referral, screening and placement associated with each EBP.

The implementation of "Families First" has created home-based, family-focused alternatives for children at risk of out-of-home placement. Also, the expert consultants contracted within Families First will train therapists to develop new and stronger skills to bring families back together where children have been placed in foster care, and to help families gain skills that prevent the need for placement or outside intervention.

The EBPs that were identified for implementation between 2011-13 by DBH include:

- Parent Child Interaction Therapy (PCIT)
- Multisystemic Therapy Problem Sexual Behavior (MST-PSB)
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Child-Parent Psychotherapy (CPP)
- Functional Family Therapy (FFT)
- Multisystemic Therapy (MST)
- Transition to Independence Process (TIP)

The EBPs that were identified for implementation between 2014-16 by DBH include:

- Trauma Systems Therapy (TST)
- Adolescent Community Reinforcement Approach (A-CRA)

I. Parent-Child Interaction Therapy (PCIT)

PCIT is an evidence-based parent-coaching, behavior-management program designed for young children ages 2 – 6 years old, to teach them skills and techniques to improve disruptive behaviors that the child may be exhibiting.

Goals of PCIT are:

a) Improve parent/caregiver-child relationships
b) Improve children's minding and listening
c) Increase children's abilities to manage frustration and anger
d) Increase children's appropriate social skills
e) Improve children's attention skills
f) Build children's self-esteem

A. Geographic Service Delivery Area

PCIT will service wards 1-8 of the District. Portions of Northern Virginia and Maryland within a 60-minute driving radius will be included for residents of the District (and District wards placed in these areas). PCIT is delivered solely in an office setting, however, and it is delivered at three (for details, see Section D below).

B. PCIT Service Criteria

1) Inclusionary Criteria

a) Children ages 2-6
b) Children who exhibit the following behavior problems at home, in school, or at daycare:
   i) refuse/defy adult requests
   ii) lose temper easily
   iii) annoy others on purpose
   iv) steal or destroy things
   v) start fights/hurt others
   vi) have difficulty staying seated
   vii) have difficulty playing quietly
   viii) have difficulty taking turns
c) Children who currently live with one or both parents reside with parents/legal guardians, or are currently in foster placement.
d) Children whose families are residents of the District of Columbia

2) **Exclusionary Criteria**

a) Child does not have a significant caregiver participating in treatment.
b) Parents who have been found to have sexually abused their children (or convicted of such a crime) or who have an active investigation pending are not eligible for PCIT.
c) Parents with active substance abuse that interferes with treatment should be referred for substance abuse treatment before being referred for PCIT.
d) Parents with significant intellectual challenges (i.e., IQ below 70) or a memory disorder.

C. PCIT Program-Specific Guidelines & Practices

1) **The key elements of Parent-Child Interaction Therapy consist of** teaching families two basic skill sets:
   a) **Child Directed Interaction (CDI):** Caregivers are taught the PRIDE skills: Praise, Reflect, Imitate, Describe and Enjoy. Caregivers follow the child's lead. They ignore annoying or obnoxious behavior and control dangerous behaviors.
   b) **Parent Directed Interaction (PDI):** Caregivers learn to use effective commands and specific behavior management techniques as they play with their child. Caregivers are taught effective discipline procedures and how to manage children's behaviors in real-world settings.

2) **Treatment & Therapy Guidelines**
   a) PCIT involves parents of children ages 2-6 who exhibit behavioral challenges at home and other settings.
   b) Each of the two phases of PCIT begins with a didactic session that parents attend alone with the PCIT therapist. During these sessions, the practitioner introduces the skill set to be learned for that phase and engages the parent in a role-play scenario during which the parent begins to practice the skills. Subsequently, the parent and child attend coaching sessions, during which parents are coached in the application of the skills as they interact with their child in a play setting.
   c) The Eyberg Child Behavior Inventory (ECBI) is completed weekly by the parent to review the child's behavior during the previous week. The outcome of the score is placed on a graph and discussed to review the child's progress.
   d) At the beginning of each coaching session, the practitioner must review homework from the previous week and observes the parent in a standardized 5-minute play situation. During this observation period, the practitioner codes the frequency of the particular skills that the parent is in the process of learning so that skills requiring further practice can be identified.
   e) The Dyadic Parent-Child Interaction Coding System (DPICS)-IV is the behavioral observation coding system that is used to measure the frequency of specific parent skills at the start of each session. Parents and practitioners review graphs of DPICS-IV data each week to evaluate progress towards skill mastery and to decide which skills need further attention.

3) **Discharge and termination of treatment criteria** - In PCIT, progress toward completion is parent driven and based mastery of skills. There is not a set number of sessions for each family. Families will graduate as they meet the treatment graduation criteria listed below. Therapists should make sure families are aware of this throughout the therapy process.

4) **Treatment Graduation Criteria -** To successfully graduate from PCIT treatment parents must:
   a) Meet CDI Mastery
   b) Meet PDI Mastery
   c) Report an Intensity Score on the Eyberg Child Behavior Inventory (ECBI) below <114 (i.e., in the sub-clinical range)
   d) Feel comfortable with their ability to manage their child's behavior

D. Referrals & Intake Process

Refer to Appendix E. Referral Guidelines, Documents 3 and 5.

PCIT is delivered in three locations in the District:

Parent Infant Early Childhood Enhancement (P.I.E.C.E.) Program
821 Howard Road, SE
Washington, DC 20020
Phone: (202) 698-1838
Fax: (202) 698-2467

Mary's Center
2333 Ontario Road, NW
Washington, DC 20009
Phone: (202) 483-8196
Fax: (202) 483-0836

Parent/Guardians may call the PIECE program or Mary's Center directly to request PCIT for their child and schedule an intake appointment. During their initial visit to the PIECE Program or Mary's Center, the child and caregiver will complete an intake and a Diagnostic Assessment including PCIT eligibility screening (ECBI checklist included).

If the results of the Diagnostic Assessment determine that the child meets medical necessity and eligibility criteria for PCIT, then the child and family will be assigned to a PCIT therapist at that location.

E. Clinical Documentation & Record Keeping

Families will be provided with the following:

1) Families First Brochure;
2) PCIT Brochures (and the name and contact information of their therapist); and
3) Any other agency specific information.
4) The consent form for authorization to film/record sessions (see Appendix C).

The goal is to have the first PCIT session within 7-10 business days of assignment. All PCIT sites shall maintain clinical documentation of all sessions in client records.

F. On-Going Training & Consultation

1) The PIECE program and Mary's Center's therapists shall commit to monthly consultation calls with the PCIT trainers/expert.
2) The PIECE program and Mary's Center's leadership will participate in DBH monthly calls with CSFA, EBA, the PIECE Program, and Mary's Center to:
   a. Assess PCIT utilization and implementation (i.e., monitor the referral process and resolve any identified issues);
   b. Conduct utilization reviews and evaluate continued capacity; and
   c. Ensure goals related to therapist retention and certification, family enrollment, and short- and long-term outcomes are being met.

G. PCIT Reporting Guidelines & Practices

Referral Census – Each PCIT therapist shall complete and submit summaries of client activities to the DBH FF program director. This monthly census will contain demographic information on each referral received, referral source and details on whether the referral was accepted or not. The monthly report enables the project director to keep track of referrals and PCIT vacancies. This data will be compiled and aggregated quarterly.

II. Multisystemic Therapy for Problem Sexual Behavior (MST-PSB)

MST-PSB is an intensive family- and community-based treatment program that addresses the many factors that influence problem sexual behavior. MST-PSB provides caregivers with the tools to help the identified youth view challenging situations more clearly and respond to them in a more effective way. MST-PSB teaches caregivers how to identify the possible factors that influence the youth's problem sexual behavior. Within the family's home, MST-PSB works to positively change the thought patterns and behavioral choices of the youth by providing caregivers the tools and teaching skills that will help them better manage the behaviors and choices of their youth.

MST-PSB goals are to:

a. Identify specific risks that may be contributing to the child's problematic sexual behavior.
b. Ensure that the child, family, community and victims are safe.
c. Help the family develop a well-defined risk reduction and safety plan.
d. Reduce the parents and young person's denial about the sexual offense.
e. Increase parents' understanding of appropriate and inappropriate sexual behaviors (within the child and family).
f. Increase parents' use of effective parenting strategies.
g. Increase affection and effective communication within the family.
h. Promote a normative trajectory for the child's sexual functioning and behavior.

A. Geographic Service Delivery Area

MST-PSB will service wards 1-8 of the District. Portions of Northern Virginia and Maryland within a 60-minute driving radius will be included for residents of the District wards placed in these areas. MST-PSB will be delivered in the community and at a scheduled time convenient to the family.

B. MST-PSB Service Criteria

1) **Inclusionary Criteria:**
   - **a.** Immediate placement risks. Parent or caregiver willing to participate in treatment.
   - **b.** Children returning home from an out-of-home placement.
   - **c.** District resident or ward of the District.
   - **d.** Axis I (NOTE: Mental Health Diagnosis/other level 2-5)
   - **e.** DC Medicaid/Managed Care Organization (MCO) eligible.

2) **Exclusionary Criteria**
   - **a.** Youth living independently, or youth for whom a primary caregiver cannot be identified despite extensive efforts to locate all extended family, adult friends and other potential surrogate caregivers.
   - **b.** Youth referred primarily due to concerns related to suicidal, homicidal, or psychotic behaviors.
   - **c.** Youths whose psychiatric problems are the primary reason leading to referral, or who have severe and serious psychiatric problems
   - **d.** Youth with pervasive developmental delays (e.g Intellectual Disability and Autism Spectrum).
   - **e.** Youth for whom there is not a primary caregiver that believes the sexual abuse/offense did indeed occur *(Clarification: there must be at least <u>one</u> caregiver who believes a sexual event occurred and is willing to therefore engage in safety planning, implementation and behavioral and environmental management. The caregiver can evidence some minimization, blame the*

victim, etc., as this can be handled in treatment, but total denial renders community treatment unsafe).

C. Program-Specific Guidelines & Practices

1) MST-PSB targets those factors shown to be linked to acting out behavior and recidivism. Research studies on youth who break the law repeatedly, commit sexual offenses, and/or abuse illegal substances are clear that the causes of juvenile offending are difficulties in the following areas:

a. Family relations
b. School performance
c. Peer relations
d. Neighborhood and community relations

Counselors seek to understand the link between youths' problems and factors which contribute to them. They conduct a comprehensive functional assessment of youth in the context of their families, peer group, school and neighborhood. Within the MST-PSB model counselors provide 24-hour support and place developmentally appropriate demands on the adolescent and families. Adolescent and families are encouraged to make positive changes that target factors that contribute to acting out behavior such as:

a. Improve caregiver discipline policies
b. Enhance family relationships
c. Decrease a youth's association with deviant peers
d. Increase a youth's association with pro-socials
e. Improve a youth's vocation or academic performance
f. Focus on helping parents build supportive social networks in the community

All interventions are designed in collaboration with family members and key figures in the child's life - parents or legal guardians, school teachers and probation officers, etc. Interventions are designed to empower parents to address the needs of youth more effectively in these areas. All interventions are designed to emphasize long term change thus a lot of focus is placed on the development of a support network of extended families and friends to help caregivers and families maintain changes after their involvement with MST-PSB.

2) The primary goals of MST-PSB treatment

a. Eliminate or significantly reduce the frequency and severity of the youth's referral behavior(s);
b. Empower parents with the skills and resources needed to independently address the inevitable difficulties that arise in raising children and adolescents; and
c. Empower youth to cope with family, peer, school, and neighborhood problems.

3) Overarching case-specific goals for treatment

MST-PSB defines the primary case-specific treatment goals as "Overarching Goals."

An overarching goal:

a. Refers directly to the referral/target behavior;
b. Incorporates the desired outcomes of caregivers and other key participants; and
c. Is written objectively, so an outside observer can easily determine whether or not the goal has been met.

Assuring that case-specific overarching goals are always consistent with program goals is the responsibility of each MST-PSB therapist and supervisor. To accomplish this objective, each therapist must be aware of both the goals and the referral criteria for the MST-PSB program. Therapists should fully engage the referral staff to ensure that the goals of their agency or department are reflected in the overarching goals of each case.

4) Length of Treatment

Typical duration of treatment is **three to five months for the standard MST population and five to seven months for MST-PSB population**. From the first meeting the therapist is planning for discharge by establishing overarching goals with clear criteria for success and by facilitating interventions that are carried out, as much as possible, by family members and other key participants.

The therapist needs to gauge decisions about discharge based upon achievement of overarching goals. The therapist needs to end treatment when:

a. There is evidence ***at any point in the treatment*** that overarching goals have been sustained over a period of 3-4 weeks; or
b. Overarching goals have not been met and treatment has reached a point of diminishing returns.

5) Extending MST-PSB treatment

Factors affecting the decision to extend treatment beyond designated length of treatment:

a. What are the identified needs of this specific youth and family, and how do these needs weigh against the needs of youth yet to be served? (input from the referral agency will be required)
b. To what extent has the family been engaged and what other specific strategies can be used to improve engagement?
c. What additional investment of time/energy will be needed by therapist to move the case forward?
d. What are the projected outcomes of extended treatment time?
e. What are the funding-related requirements?

6) Discharge Criteria

The determination to discharge a youth from MST-PSB is based upon evidence of intervention effectiveness as evaluated from multiple perspectives (e.g. youth, parent, school, probation officer) indicating that:

a. A majority of the overarching goals for the case have been met and sustained;
b. The youth has few significant behavioral problems;
c. The family is able to effectively manage any recurring problems and functions reasonably well for at least 3 to 4 weeks;
d. The youth is making reasonable educational/vocational efforts;
e. The youth is involved with pro-social peers and is not involved with, or is minimally involved with problem peers; and
f. The therapist and supervisor feel the caregivers have the knowledge, skills, resources, and support needed to handle subsequent problems.

Discharge from MST-PSB may also occur when few of the overarching goals have been met, but despite consistent and repeated efforts by the therapist and supervisor to overcome the barriers to further success, the treatment has reached a point of diminishing returns for the additional time invested. For a more complete description of MST-PSB discharge criteria, please refer to Appendix D.

D. Referrals & Intake Process

Refer to Appendix E. Referral Guidelines, Document 3 and 5.

DBH is currently in the process of identifying a new agency(ies) to provide MST-PSB services in the District.

E. Clinical Documentation & Record Keeping

During the intake process, the intake coordinator will provide the family with the following:
1) MST-PSB Brochures; name and contact information of their assigned therapist; and
2) Any other agency specific information.

The goal is to have the first MST-PSB session within 48 hours of assignment. All MST- PSB sites shall maintain clinical documentation of all sessions in client records.

F. On-Going Training & Consultation

1) MST-PSB therapists shall commit to monthly consultation calls with the MST-PSB consultant.
2) MST-PSB therapists will participate in monthly calls with invited child serving agencies, DBH and EBA, to:
   a) Assess access to MST-PSB (i.e., monitor the referral process and resolve any identified issues);
   b) Conduct utilization reviews and evaluate continued capacity; and
   c) Ensure goals related to therapist retention and certification, family enrollment, and short- and long-term outcomes are being met.

G. Communicating Outcomes to Stakeholders

Sharing key case-level and program level outcomes with the appropriate stakeholders promotes active stakeholder engagement for program support and ongoing problem-solving. When reporting to referral agencies, it is the burden of the MST-PSB providers to translate outcomes from the clinical terminology used in case-specific evaluation to the terms being used for program goal setting and program evaluation. All case outcomes should be reported in ways that refer to the program goals listed earlier. Additionally, at the on-set of the case the identified MST-PSB therapist must make contact with the referring POC and determine how often (weekly, monthly or PRN) and type (phone or e-mail; details or summary) of case update that is expected.

H. Outcome Reporting Requirements

1) **Reporting case outcomes to the referral source:** All referring agents are provided copies of the discharge summary which outlines the goals met and those not met throughout treatment as well as aftercare recommendations. This documentation will be provided within 14 days of the youth's discharge from the program.
2) **Sharing Program-level Reviews with Key Stakeholders:** Every six months the MST-PSB program will be reviewed for purposes of identifying status of adherence, program-level goals, strengths, identified barriers to program success, and interventions for ongoing program improvement.

3) **Program Implementation Review (PIR):** Is completed in collaboration between the MST-PSB supervisor, potentially other provider agency staff, and the assigned MST-PSB Expert. The format of this document may be difficult for non-program stakeholders to interpret, so a summary report is often developed for the purpose of stakeholder information and engagement.

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

The goal of TF-CBT is to reduce symptoms of Post-Traumatic Stress Disorder (PTSD) and behavioral difficulties in children who have experienced sexual abuse or other traumas. At least 80 percent of children treated in the program show marked improvement in symptoms within 12 to 16 sessions, demonstrated by the following:

- Reduced children's negative emotional and behavioral responses to the trauma experienced
- Corrected maladaptive or unhelpful beliefs and attributions related to the abusive experience (e.g., a belief that the child is responsible for the abuse)

TF-CBT also aims to provide the following:

- Support non-offending parent(s)/caregiver, helping them cope effectively with their own emotional distress; and
- Skills that enable parent(s)/caregiver to respond optimally to and offer support for their children.

A. Geographic Service Delivery Area

TF-CBT will service wards 1-8 of the District. Portions of Northern Virginia and Maryland within a 60-minute driving radius will be included for residents of the District wards placed in these areas.

TF-CBT will be offered in the community (to include in-home) or in an office setting. District TF-CBT provider agencies can accommodate consumers in either setting or a combination of both settings.

B. TF-CBT Service Criteria

1) Inclusionary Criteria

a) TF-CBT is for children and youth who:

i. Age 3-18, and young adults up to age 21 still living with their parents/caregivers
ii. Meet criteria for PTSD or experience some PTSD symptoms
iii. Show clinically significant levels of depression, anxiety, shame, or other dysfunctional abuse-related feelings, thoughts, or developing beliefs or behavior problems related to a traumatic event
iv. Have a history of at least one significant potentially traumatic event, such as sexual assault, physical assault, witnessing serious violence in the home or community, unexpected, traumatic death of a loved one, motor vehicle accident, dog attack, or other similar incident.

2) Exclusionary Criteria

a) TF-CBT is NOT for:

i. **Children and youth** who do not have a trauma history.
ii. **Children and youth** whose primary problems include conduct problems or other significant behavioral problems that existed prior to the trauma, and whose symptoms do not appear to be related to trauma.
iii. **Children and youth** who are acutely suicidal or who actively abuse substances. The gradual exposure component of TF-CBT may temporarily worsen symptoms. However, other components of TF-CBT have been used successfully to address these problems.

iv. **Children and youth** who are primarily engaging in tension reducing behavior such as running away, cutting themselves, or other para-suicidal behavior. For these teens, a stabilizing therapy approach such as dialectical behavior therapy would be more suitable.
v. **Children and youth** who do not have significant mental health symptoms related to a traumatic event.
vi. **Children and youth** who have severe cognitive disabilities, autism spectrum disorder, or other problems that make it impossible for them to engage in cognitive therapy
vii. **Children and youth** who have problems to be managed prior to trauma-focused therapy:
    a. Imminent threats to safety; and
    b. Severe disruptive behavior problems.

Parent/caregiver involvement is highly desirable and is likely to improve treatment outcome, but it is not mandatory.

C. Program Specific Guidelines & Practices

TF-CBT is a short-term treatment typically provided in 12 to 18 sessions of 60 to 90 minutes, depending on treatment needs. The treatment involves individual sessions with the child and parent (or caregiver) separately and joint sessions with the child and parent together. Each individual session is designed to build the therapeutic relationship while providing education, skills, and a safe environment in which to address and process traumatic memories. Joint parent-child sessions are designed to help parents and children practice and use the skills they learned, while also fostering more effective parent-child communication about the trauma and related issues.

Protocol Components

The components of the TF-CBT protocol can be summarized by the word "PRACTICE":

P – Psycho education and Parenting skills; Discussion and education about trauma in general, the specific trauma that is the target for treatment and typical emotional and behavioral reactions to trauma. Training for parents in child behavior management strategies and effective communication.

R – Relaxation; Teaching relaxation methods, such as focused breathing and progressive muscle relaxation to help cope with anxiety and trauma-related symptoms (e.g. reduce physiologic manifestations of fear, anxiety, stress and PTSD).

A – Affective expression and regulation; Helping the child and parent manage their emotional reactions to reminders of the abuse, improve their ability to express emotions, and participate in self-soothing activities.

C – Cognitive coping; Helping children and parents understand the cognitive triad: connections between thoughts, feelings and behaviors, as they relate to everyday events. Help children and parents view events in more accurate and helpful ways.

T – Trauma narrative; Gradual exposure exercises, including verbal, written, or symbolic recounting of traumatic or abusive events. Increasing the child's understanding of the trauma within the context of their life by making meaning and addressing cognitive distortions.

I – In vivo exposure; Gradual exposure to nonthreatening trauma reminders in the child's environment (e.g., basement, darkness, school), so the child learns to control his or her own emotional reactions.

C – Conjoint parent/child sessions; Family work to enhance communications and create opportunities for therapeutic discussion regarding the trauma or abuse.

E – Enhancing personal safety and future growth; Education and training on personal safety skills, interpersonal relationships, and healthy sexuality; encouragement in the use of new skills in managing future stressors and trauma reminders.

D. Referrals & Intake Process

Refer to Appendix E. Referral Guidelines, Documents 1 and 2.

TF- CBT is offered by the following District agencies:

Community Connections 650 Pennsylvania Ave., SE Wash., DC 20003 (202) 548-4885	**MD/DC Family Resource** 903 Brightseat Rd. Landover, MD 20785 (301) 333-2980	**Hillcrest Children & Family Center** 915 Rhode Island Ave., NW Washington, DC 20001 (202) 232-6100	**Foundations for Home and Community** 1012 14th Street, NW Washington, DC 0005 (202) 737-2554

E. Clinical Documentation & Record Keeping

The CSA will provide the family with the following, if it is determined that TF-CBT is the recommended service:

1) TF-CBT Brochure; and the name and contact information of their therapist
2) Agency specific information

The goal is to have the first TF-CBT session within 7-10 business days of assignment. All TF-CBT sites shall maintain clinical documentation of all sessions in client records.

F. On-Going Training & Consultation

1) The TF-CBT therapists shall commit to initial consultation calls once a month with the TF-CBT consultant and quarterly once initial calls are completed.
2) All TF-CBT agency leadership will participate in monthly calls with invited child serving agencies, DBH and EBA, to:
    a. Assess access to TF-CBT (i.e., monitor the referral process and resolve any identified issues);
    b. Conduct utilization reviews and evaluate continued capacity; and
    c. Ensure goals related to therapist retention and certification, family enrollment, and short- and long-term outcomes are being met.

G. Communicating Outcomes to Stakeholders

Sharing key case-level and program level outcomes with the appropriate stakeholders promotes active stakeholder engagement for program support and ongoing problem-solving. When reporting to referral agencies, it is the responsibility of the TF-CBT providers to translate outcomes from the clinical terminology used in case-specific evaluation to the terms being used for program goal setting and program evaluation. All case outcomes should be reported in ways that refer to the program goals listed earlier. Additionally, at the on-set of the case the identified the TF-CBT therapist must make contact

with the referring POC and determine how often (weekly; monthly or PRN) and type phone, e-mail; detail or summary) of case update that is expected.

H. Outcome Reporting Requirements

Reporting case outcomes to the referral source: All referring agents are provided copies of the discharge summary which outlines the goals met and those not met throughout treatment as well as aftercare recommendations. This documentation will be provided within 14 days of the youth's discharge from the program.

IV. Child Parent Psychotherapy (CPP)

CPP is a therapeutic intervention for young children and their caregivers who have a history of trauma exposure or maltreatment. This treatment approach supports child development, aims to restore the child-parent relationship and overall feelings of safety, while reducing symptoms associated with the experience of trauma.

CPP is a therapy for families with infants, toddlers, and preschoolers who have experienced trauma(s). Parents and their children meet with a trained CPP therapist to talk, play, learn about and decide on the best ways to help their family heal after the trauma. The goal of CPP is to help parents and their children feel safe and strengthen their attachment so that the children can meet their full potential.

1) The goals of CPP are to:

- Encourage normal development
- Strengthen and support the parent-child relationship Maintain regular levels of affective arousal
- Establish trust in bodily sensations
- Achieve reciprocity in intimate relationships
- Increase capacity to respond realistically to threat
- Differentiate between reliving and remembering
- Normalize the traumatic response
- Place the traumatic experience into perspective
- Co-construct a mutually meaningful trauma narrative
- Safety

2) Parents will learn:

- To help their children stay and feel safe
- To understand and address their child's behaviors and feelings
- To manage their own difficult feelings and memories
- To help their child manage trauma related memories and triggers.

A. Geographic Service Delivery Area

CPP will service wards 1-8 of the District. Portions of Northern Virginia and Maryland within a 60-minute driving radius will be included for residence of District wards placed in these areas.

CPP will be offered in the community (to include in-home) or in an office setting. District CPP provider agencies will be able to accommodate consumers in either setting or a combination of both settings.

B. CPP Service Criteria

1) Inclusionary Criteria

a) Children ages 0-7
b) Child victims or witnesses (of)
   - Family/domestic violence
   - Child physical abuse
   - Child sexual abuse

- Traumatic loss and separations
- Community violence and disasters

c) Child victims or witnesses who display trauma –related symptoms including**:**
- Traumatic Stress Disorder
- Aggression
- Defiance
- Noncompliance
- Excessive tantrums
- Multiple fears
- Inconsolability
- Anxiety (including separation anxiety)
- Difficulties sleeping
- Social and emotional withdrawal

2) Exclusionary Criteria
- Child or caregiver does not have a trauma or maltreatment history.
- Child does not have a significant caregiver participating in treatment.
- Caregiver denies the child's experience of trauma.
- There are safety risks for the child to engage in trauma-involved treatment.
- Caregiver has active mental illness which inhibits the dyadic work or safety of child.
  *It may be indicated to start CPP work with the parent/caregiver first before bringing the child into session (see fidelity tools for guidance).

C. Program Specific Guidelines & Practices

CPP IS:

1) CPP – theoretical basis
   - Psychodramatic Theory
   - Attachment theory
   - Stress and trauma theory
   - Developmental theory
   - Psychopathology theory
   - Social Learning Theory
   - Cognitive Behavioral Theory
2) CPP is conducted during weekly one hour sessions for a period of 6-12 months which may occur in the home or clinic.
3) CPP starts with the Foundational Phase: Assessment & Engagement. In the Foundation phase, the family and clinician are structured assessments or interview to obtain information regarding the child's trauma history, trauma symptoms, developmental functioning, and behavioral symptoms. In addition, the parent is asked about their trauma history, trauma symptoms and behavioral symptoms.
4) Once completed, the family moves into the Core Intervention Phase where the clinician and the family explore ports of entry, intervention modalities and domains of intervention.
   - CPP therapist offer unstructured/reflective developmental guidance. Therapist are conduits that help parents explore and understand appropriate expectations of young children and help children name and cope with strong feelings while attending to the family's cultural norms and values.

- CPP therapists provide concrete assistance with problems of daily living.
- CPP therapists help parents provide physical and emotional safety for their children and model protection when needed.
- CPP therapists interpret feelings and actions and help parents and caregivers link past experiences to present behaviors all while remembering the past includes ghosts as well as angels.
- CPP therapists help families to construct a joint trauma narrative which allows the child and parent to make sense of the trauma events. Parents work with the therapist to understand the developmental perspectives of trauma, and those emotional responses, experiences and expectations differ based on developmental capacities and parent's experiences/expectations.
- CPP therapist must participate in reflective supervision - Reflective Supervision is non-judgmental supervision that gives the therapist a setting to reflect on the process of the treatment and on the process of individual sessions.
- CPP Fidelity Mnemonic:
  REA**D**Y **T**O **P**RO**C**ESS
  R = Reflective Practice Facility
  E = Emotional Process Facility
  D = Dyadic-Relational Fidelity
  T = Trauma Framework Fidelity
  P = Procedural Fidelity
  C = Content Fidelity

5) Lastly, the family enters the Recapitulation Phase to review the work they have completed over the course of treatment, post measures and saying goodbye.

CPP is NOT:

1) Bug in the ear to guide parent or therapist's actions;
2) Flooding interventions that immerse people in traumatic experience;
3) Desensitization techniques that exposed people to traumatic reminders;
4) Curriculum driven didactic instruction;
5) Using adverse stimuli to change behavior; and
6) Didactic instruction that is either not developmentally appropriate or responsive to in the moment responses.

D. Referrals & Intake Process

Refer to Appendix E. Referral Guidelines, Documents 1 and 2.

CPP is offered through the following District Agency:

Parent Infant Early Childhood Enhancement (P.I.E.C.E.) Program
821 Howard Rd. SE
Washington, DC 20020
Phone: (202) 698-1838
Fax: (202) 698-2467

Community Connections
650 Pennsylvania Ave., SE
Washington, DC 20003
Phone: (202) 548-4885

Foundations for Home and Community
1012 14th Street, NW
Washington, DC 20005
Phone: (202) 737-2554

Mary's Center
2333 Ontario Road, NW
Washington, DC 20009
Phone: (202) 483-8196
Fax: (202) 483-0836

Mary's Center
100 Gallatin Street, NE
Washington, DC 20011
Phone: (202) 483-8196
Fax: (202) 420-7164

E. Clinical Documentation & Record Keeping

At the intake, the intake coordinator will provide the family with the following:

a. CPP Brochure; and the name and contact information of their therapist
b. Agency specific information

The goal is to have the first CPP session within 7- 10 business days of assignment. All CPP sites shall maintain clinical documentation of all sessions in client records.

F. On-Going Training & Consultation

1) The CPP therapists shall commit to monthly telephonic consultation with the CPP consultant.

2) All CPP agency leadership will participate in monthly calls with invited child serving agencies, DBH and EBA, to:
   a) Assess access to CPP (i.e., monitor the referral process and resolve any identified issues);
   b) Conduct utilization reviews and evaluate continued capacity;
   c) Ensure goals related to therapist retention and certification, family enrollment, and short- and long-term outcomes are being met.

G. Communicating Outcomes to Stakeholders

Sharing key case-level and program level outcomes with the appropriate stakeholders promotes active stakeholder engagement for program support and ongoing problem-solving. When reporting to referral agencies, it is the burden of the CPP providers to translate outcomes from the clinical terminology used in case-specific evaluation to the terms being used for program goal setting and program evaluation. All case outcomes should be reported in ways that refer to the program goals listed earlier. Additionally, at the on-set of the case the identified CPP therapist must make contact with the referring POC and determine how often (weekly; monthly or PRN) and type (phone, e-mail; detail or summary) of case update that is expected.

H. Outcome Reporting Requirements

Reporting case outcomes to the referral source: All referring agents are provided copies of the discharge summary which outlines the goals met and those not met throughout treatment as well as aftercare recommendations. This documentation will be provided within 14 days of the youth's discharge from the program.

V. Functional Family Therapy (FFT)

FFT is a short-term (up to 30 hours), family-based therapeutic intervention for delinquent youth at risk for institutionalization and their families. FFT is designed to improve within-family attributions, family communication and supportiveness while decreasing intense negativity and dysfunctional patterns of behavior. Parenting skills, youth compliance, and the complete range of behaviors (cognitive, emotional, and behavioral) domains are targeted for change based on the specific risk and protective factor profile of each family.

The phase-based goals of FFT are to:

1) **Engage and motivate** youth and their families by decreasing family hostility, conflict and blame, increasing hope and building balanced alliances with family members.
2) **Change Behavior:** Reduce and eliminate the problem behaviors and accompanying family relational patterns through individualized behavior change interventions.
3) **Generalize** changes across problem situations by increasing the family's capacity to **utilize various community resources** adequately, and to engage in relapse prevention.

A. Geographic Service Delivery Area

FFT will service wards 1-8 of the District. Portions of Northern Virginia and Maryland within a 60-minute driving radius will be included for District wards placed in these areas.

FFT is being offered in the home and community settings.

B. FFT Service Criteria

1) Inclusion Criteria

a) 10 to 18 years old
b) In community or ready to ready to re-enter into the community
c) Family is willing and make themselves available for treatment
d) Youth is returning to family

Inclusionary referral behaviors include externalizing behaviors, internalizing symptoms, and/or substance abuse.

Referral issues can be from one domain (externalizing alone) or in combination (co-morbidity of substance abuse and externalizing behaviors).

2) Exclusion Criteria

a) Youth 9 years of age or below (as primary referral)
b) Youth who have no psycho-social system that constitutes family (shared history, sense of future, some level of co-habitation)
c) Youth is scheduled to be sent away from family (remand, placement, foster care, etc.)
d) Youth with current acute psychosis.
e) Youth that present with severe psychiatric illness:
    i) actively suicidal
    ii) actively homicidal
    iii) actively psychotic

C. Program Specific Guidelines & Practices

The intervention program itself consists of five major components in addition to pretreatment activities: Engagement in change; Motivation to change; Relational/Interpersonal Assessment and planning for Behavior change; Behavior Change; and Generalization across behavioral domains and multiple systems.

1) **Pretreatment:** The goals of this phase involve responsive and timely referrals, a positive "mindset" of referring sources, and immediacy. Activities include establishing collaborative relationships with referring sources, ensuring availability, appraising multidimensional (e.g., medical, educational, justice) systems already in place, and reviewing referral and other formal assessment data.

2) **Engagement Phase:** The goals of this phase involve enhancing perception of responsiveness and credibility; demonstrating a desire to listen, help, respect, and "match;" and addressing cultural competence. The main skills required are demonstrating qualities consistent with positive perceptions of clients, persistence, cultural /population sensitivity and matching. Therapist focus is on immediate responsiveness and maintaining a strength-based relational focus. Activities include high availability, telephone outreach, appropriate language and dress, proximal services or adequate transportation, contact with as many family members as possible, "matching" and respectful attitude.

3) **Motivation Phase:** The goals of this phase include creating a positive motivational context, minimizing hopelessness and low self-efficacy, and changing the meaning of family relationships to emphasize possible hopeful experience. Required phase skills consist of relationship and interpersonal skills, a nonjudgmental approach, plus acceptance and sensitivity to diversity. Therapist focus is on the relationship process; separating blaming from responsibility while remaining strength-based. Activities include the interruption of highly negative interaction patterns and blaming (e.g. divert and interrupt), changing meaning through a strength-based relational focus, pointing process, sequencing, and reframing of the themes by validating negative impact of behavior, while introducing possible benign / noble (but misguided) motives for behavior. Finally, the introduction of themes and sequences that imply a positive future are important activities of this phase.

4) **Relational Assessment:** The goals of relational assessment include eliciting and analyzing information pertaining to relational processes, as well as developing plans for Behavior Change & Generalization. The skills of perceptiveness and understanding relational processes and interpersonal functions are required. The focus is directed to intrafamily and extra family context and capacities (e.g., values, attributions, functions, interaction patterns, sources of resistance, resources, and limitations). Therapist activities involve observation, questioning; inferences regarding the functions of negative behaviors, and switching from an individual problem focus to a relational perspective.

5) **Behavior Change Phase:** Behavior Change goals consist of skill building, changing habitual problematic interactions and other coping patterns. Skills such as structuring, teaching, organizing, and understanding behavioral assessment are required. Therapists use of a variety of cognitive and behavioral interventions, which may include communication training, using technical aids, assigning tasks, and training in conflict resolution. Phase activities are focused on modeling and prompting positive behavior, providing directives and information, developing creative programs to change behavior, all while remaining sensitive to family member abilities and interpersonal needs.

6) **Generalization Phase:** The primary goals in the Generalization phase are extending positive family functioning; planning for relapse prevention and incorporating community systems. Skills include a multisystemic/systems understanding and the ability to establish links, maintain energy, and provide outreach. The primary focus is on relationships between family members and multiple community systems. Generalization activities involve knowing the community, developing and maintain contacts, initiating clinical linkages, creating relapse prevention plans, and helping the family develop independence.

D. Referrals & Intake Process

Refer to Appendix E. Referral Guidelines, Documents 4 and 5.

FFT is offered at the following District agencies:

Parent & Adolescent Support Services (PASS)
DC Department of Human Services-Family Services Administration
645 H Street, NE,
3rd Floor
Washington, DC 20002
(202) 698-4334

Hillcrest Children & Family Center
915 Rhode Island Ave.,
NW Washington, DC 20001
(202) 232-6100

E. Clinical Documentation & Record Keeping

At the intake, the intake coordinator will provide the family with the following:

a. FFT Brochure; and the name and contact information of their therapist; and
b. Agency specific information.

The goal is to have the first FFT session within 48 hours of assignment. All FFT sites shall maintain clinical documentation of all sessions in client records.

F. On-Going Training & Consultation

1) The FFT therapists shall commit to weekly consultation with either a FFT National Consultant or a local FFT Site Supervisor.
2) All FFT agency leadership will participate in monthly calls with invited child serving agencies, DBH and EBA, to:
   a) Assess access to FFT (i.e., monitor the referral process and resolve any identified issues)
   b) Conduct utilization reviews and evaluate continued capacity s
   c) Ensure goals related to therapist retention and certification, family enrollment, and short- and long-term outcomes are being met

G. Communicating Outcomes to Stakeholders

Sharing key case-level and program level outcomes with the appropriate stakeholders promotes active stakeholder engagement for program support and ongoing problem-solving. When reporting to referral agencies, it is the responsibility of the FFT providers to translate outcomes from the clinical terminology used in case-specific evaluation to the terms being used for program goal setting and program

evaluation. All case outcomes should be reported in ways that refer to the program goals listed earlier. Additionally, at the onset of treatment, the FFT therapist must make contact with the referring POC and determine how often (weekly, monthly or PRN) and type (phone, e-mail, summary?) of case update that is expected.

H. Outcome Reporting Requirements

Reporting case outcomes to the referral source: All referring agents are provided copies of the discharge summary which outlines the goals met and those not met throughout treatment as well as aftercare recommendations. This documentation will be provided within 14 days of the youth's discharge from the program.

VI. Multisystemic Therapy (MST)

MST is an intensive family- and community-based treatment program that focuses on addressing all environmental systems that impact chronic and violent juvenile offenders. MST is a family-based mental health treatment model. It is built on the principle that a seriously troubled child's behavioral problems are multidimensional and must be confronted using multiple strategies. The serious behavior problems of a child typically stem from a combination of influences, including family factors, deviant peer groups, problems in school or the community, and individual characteristics. The MST model calls for simultaneously addressing all of those inter-related areas.

MST aims to:

1. Increase the caregivers' parenting skills
2. Improve family relations
3. Involve the youth with friends who do not participate in criminal behaviour
4. Help him or her get better grades or start to develop a vocation
5. Help the adolescent participate in positive activities, such as sports or school clubs
6. Create a support network of extended family, neighbors, and friends to help the caregivers maintain the changes

A. Geographic Service Delivery Area

MST will service wards 1-8 of the District. Portions of Northern Virginia and Maryland within a 60-minute driving radius will be included for residence of District wards placed these areas. MST will be delivered in the community and at a scheduled time convenient to the family.

B. MST Service Criteria

1) Inclusionary Criteria:

a) Children/Youth living with or returning to family with whom child has a long-term relationship and who are willing to play a long-term parenting role
b) Parents/caregiver willing to participate in treatment (4 hours per week)
c) Children/Youth at risk for out of home placement including residential treatment, juvenile detention, group home, foster care, etc.
d) Children/Youth returning home from an out of home placement within 30 days of referral.
e) Children/Youth who has been in residential treatment 12 months or less.
f) Children/Youth with behavior disorders, but may have co-morbid psychiatric illness – behavioral issues must be the primary reason for referral (runaway, truancy, aggression, illegal activity, substance use, oppositional behavior, etc.)
g) Child/Youth must have an Axis I diagnosis and be DC Medicaid/ Medicaid MCO eligible
h) Families living in the District, and wards of DC.

2) Exclusionary Criteria, children/youth who are:

a) Actively suicidal
b) Actively Homicidal
c) Psychotic without medication stabilization
d) Children without a viable and committed family placement and/or children placed in a non-family foster home
e) Children who will not be returning home within 30 days of the referral.

f) Diagnosed with moderate to severe social communication, social interaction, and repetitive behaviors, which may be captured by a diagnosis of autism (may be reviewed on a case-by-case basis for eligibility)

C. Program-Specific Guidelines & Practices

MST targets those factors shown to be linked to acting out behavior and recidivism. Research studies on youth who break the law repeatedly, commit sexual offenses, and/or abuse illegal substances are clear that the causes of juvenile offending are difficulties in the following areas:

- Family Relations
- School Performance
- Peer Relations
- Neighborhood and community relations

Counselors seek to understand the link between youth's problems and factors which contribute to them. They conduct a comprehensive functional assessment of youth in the context of their families, peer group, school and neighborhood. Within the MST model counselors provide 24-hour support and place developmentally appropriate demands on the adolescent and families. Adolescent and families are encouraged to make positive changes that target factors that contribute to acting out behavior such as:

- Improve caregiver discipline policies
- Enhance family relationships
- Decrease a youth's association with deviant peers
- Increase a youth's association with pro-socials
- Improve a youth's vocation or academic performance
- Focus on helping parents build supportive social networks in the community

All interventions are designed in collaboration with family members and key figures in the child's life - parents or legal guardians, school teachers and probation officers, etc. Interventions are designed to empower parents to address the needs of youth more effectively in these areas. All interventions are designed to emphasize long term change thus a lot of focus is placed on the development of a support network of extended families and friends to help caregivers and families maintain changes after their involvement with MST.

1) The primary goals of MST treatment:

a) Eliminate or significantly reduce the frequency and severity of the youth's referral behavior(s);
b) Empower parents with the skills and resources needed to independently address the inevitable difficulties that arise in raising children and adolescents; and
c) Empower youth to cope with family, peers, school, and neighborhood problems.

2) Overarching case-specific goals for treatment:

MST defines the primary case-specific treatment goals as "Overarching Goals."

3) An overarching goal:

a) Refers directly to the referral/target behavior;
b) Incorporates the desired outcomes of caregivers and other key participants; and
c) Is written objectively, so an outside observer can easily determine whether or not the goal has been met.

Assuring that case-specific overarching goals are always consistent with program goals is the responsibility of each MST therapist and supervisor. To accomplish this objective, each therapist must be aware of both the goals and the referral criteria for the MST program. Therapists should fully engage the referral staff to ensure that the goals of their agency or department are reflected in the overarching goals of each case.

4) Length of Treatment

Typical duration of treatment is **three to five months for the standard MST population. Caregivers are expected to meet 4+ hours/week for sessions.** From the first meeting the therapist is planning for discharge by establishing overarching goals with clear criteria for success and by facilitating interventions that are carried out, as much as possible, by family members and other key participants.

The therapist needs to gauge decisions about discharge based upon achievement of overarching goals. The therapist needs to end treatment when:

a) There is evidence ***at any point in the treatment*** that overarching goals have been sustained over a period of 3-4 weeks, or
b) Overarching goals have not been met and treatment has reached a point of diminishing returns.

5) Extending MST treatment

Factors affecting the decision to extend treatment beyond designated length of treatment:

a) What are the identified needs of this specific youth and family, and how do these needs weigh against the needs of youth yet to be served? (Input from the referral agency will be required).
b) To what extent has the family been engaged and what other specific strategies can be used to improve engagement?
c) What additional investment of time/energy will be needed by therapist to move the case forward?
d) What are the projected outcomes of extended treatment time?
e) What are the funding-related requirements?

6) Discharge Criteria

The determination to discharge a youth from MST is based upon evidence of intervention effectiveness as evaluated from multiple perspectives (e.g. youth, parent, school, probation officer) indicating that:

a) A majority of the overarching goals for the case have been met and sustained;
b) The youth has few significant behavioral problems:
c) The family is able to effectively manage any recurring problems and functions reasonably well for at least 3 to 4 weeks;
d) The youth is making reasonable educational/vocational efforts;
e) The youth is involved with pro-social peers and is not involved with, or is minimally involved with problem peers; and
f) The therapist and supervisor feel the caregivers have the knowledge, skills, resources, and support needed to handle subsequent problems.

Discharge from MST may also occur when a few of the overarching goals have been met, but despite consistent and repeated efforts by the therapist and supervisor to overcome the barriers to further success, the treatment has reached a point of diminishing returns for the additional time invested.

7) Evaluating case status review at discharge

When it has been determined that a case will be discharged, the MST team will review the status of the case in three areas:

a) Current status of case progress,
b) Status of key instrumental outcomes, and
c) Status of the case relative to four areas of "ultimate," or real-word, outcomes.

The information is collected in these three areas, reviewed with the MST expert, then entered into the MSTI database for program quality assurance and improvement as follows:

A) Case Progress Review Item

1) Reason for case closure:

a) Completion: The youth was discharged based upon the mutual agreement of the primary caregiver(s) and the MST team.

(i) The reason for case closure does not meet any of the other categories AND

(ii) Team and family agree that there is evidence that overarching goals have been sustained over a period of 3-4 weeks, OR

(iii) Team and family agree that overarching goals have not been met and treatment has reached a point of diminishing returns for the additional time invested.

Selection of this category does not assume that the case closed with all goals met, only that primary caregiver(s) and team agreed that no further progress on overarching goals is likely.

b) Lack of engagement: The decision to discharge the youth was made because the MST team was not able to engage the family in treatment, despite persistence on the therapist's part to engage and align with the family.

i) Despite persistent efforts by the therapist, the family has not EVER been seen face-to-face for two consecutive weeks;

OR

ii) Family has formally declined MST-PSB services;

OR

iii) Family states they do not want to continue (a statement to this effect should be included in note section);

AND

iv) The consultant and team have identified and addressed barriers to inadequate engagement and agree that all engagement strategies have been exhausted.

Selection of this category indicates that the family has chosen to not participate in MST Services, (this category documents that the team never had engagement). As long as the family was actively involved in working on at least one goal for some part of treatment, this category is NOT checked. This latter case would be counted as" completed" with lack of progress reflected in instrumental goals.

c) Placement: The youth was placed in a restrictive setting (detention center, residential placement or foster) care for a duration of time that precluded further MST involvement.

d) Placement, prior event: The youth was placed in a restrictive setting (detention center or residential placement or foster care) due to an event or offense that occurred prior to the beginning of MST treatment.

e) MST Program administrative removal/withdrawal: Youth was removed from the program by the MST program administration due to administrative issues or decisions unrelated to the progress of the case.

f) Funding/referral source administrative removal/withdrawal: Youth was removed from the program by the funding or referral source due to administrative issues or decisions unrelated to the progress of the case.

g) Moved: The family moved out of the program's service area.

B) Instrumental Outcomes

The Instrumental Outcomes are documented in the MST Goals and Guidelines as the criteria for determining whether a case was closed successfully or not. While some guidance in defining these items is provided, it is critical for each program to define these in terms of objectives for the case. For example, if the case had an overarching goal of increasing involvement in pro-social activities as evidenced by attending one approved recreational activity a week, then the related instrumental outcome would be rated as met if the Overarching Goal is met. Therefore, responses to these items are not completely standardized across programs.

1) **The following six categories are instrumental for the long-term success of MST youth and are rated as yes or no by the MST team at the time of discharge to indicate areas of success:**

   a) The therapist and supervisor have evidence that the primary caregiver(s) has improved the parenting skills necessary for handling subsequent problems.

   b) There is evidence of improved family relations specific to the instrumental and affective domains in that family's subsystems that were drivers of the youth referral behavior.

   c) The family has improved their network of informal social supports in the community and has demonstrated skill at successfully accessing a range of supports (informal to formal) as needed.

   d) The youth is showing evidence of success in an educational or vocational setting.

e) The youth is involved with pro-social peers and activities and is minimally involved with problem peers.

f) Changes in behavior of the youth and in the systems contributing to the referral problems have been sustained for 3-4 weeks.

C) Ultimate Outcomes

These items provide some basic information about how the youth is functioning at the time of discharge.

a) Youth is living at home. Home is defined as a private residence that is approved by the youth's guardian. This could include a parent's home, the home of an approved relative or friend of the family. Foster homes or other types of placement would not be included in the definition of "home". Youth who are on runaway status would not be considered living at home.

b) Youth is attending school (is not truant,) or vocational training or, if of the legally appropriate age to not attend school, has a paying job (20 hours/week).

i) Youth is attending school, a high school equivalency program (GED program,) or a vocational program in the youth's natural ecology, or working. The primary objective of the program is educational or vocational. A youth in a correctional facility or treatment setting in which educational or vocational activities are provided, where the primary objective is treatment or correction, will NOT count as a "yes" for this item.

ii) If the youth is in school, youth is attending frequently enough to meet expectations placed on youth by school system or court. If the discharge occurs during the summer when school is not in session, it is recommended that the response "yes" be selected if the youth was attending school at the end of the last school year, or is working.

c) Youth has not been arrested since the beginning of MST treatment, for an offense committed during MST treatment. "Arrest" is defined as a new legal charge obtained during treatment, not a violation of probation or interaction with the police that does not lead to legal charges.

D. Referrals & Intake Process

Refer to Appendix E. Referral Guidelines, Documents 4 and 5.

DBH is currently in the process of identifying a new agency(ies) to provide MST services in the District.

E. Clinical Documentation & Record Keeping

During the intake process, the intake coordinator will provide the family with the following:
1) MST Brochures; and the name and contact info of their therapist.
2) Any other agency specific information.

The goal is to have the first MST session within 48 hours of assignment. All MST sites shall maintain clinical documentation of all sessions in client records.

F. On-Going Training & Consultation

1) MST therapists shall commit to weekly telephonic consultation with the MST expert.
2) MST will participate in monthly calls with invited child serving agencies, DBH and EBA, to:
   a) Assess access to MST (i.e., monitor the referral process and resolve any identified issues);
   b) Conduct utilization reviews and evaluate continued capacity; and
   c) Ensure goals related to therapist retention and certification, family enrollment, and short- and long-term outcomes are being met.

G. Communicating Outcomes to Stakeholders

Sharing key case-level and program level outcomes with the appropriate stakeholders promotes active stakeholder engagement for program support and ongoing problem-solving. When reporting to referral agencies, it is the responsibility of the MST providers to translate outcomes from the clinical terminology used in case-specific evaluations to the terms being used for program goal setting and program evaluation. All case outcomes should be reported in ways that refer to the program goals listed earlier. Additionally, at the on-set of the case the identified MST therapist must make contact with the referring POC and determine how often (weekly, monthly or PRN) and type (phone, e-mail, summary) of case update that is expected.

H. Outcome Reporting Requirements

1) **Reporting case outcomes to the referral source:** All referring agents are provided copies of the discharge summary which outlines the goals met and those not met throughout treatment as well as aftercare recommendations. This documentation will be provided within 14 days of the youth's discharge from the program.
2) **Sharing Program-level Reviews with Key Stakeholders:** Every six months the MST program will be reviewed for purposes of identifying status of adherence, program-level goals, strengths, identified barriers to program success, and interventions for ongoing program improvement.
3) **PIR:** Is completed in collaboration between the MST supervisor, potentially other provider agency staff, and the assigned MST Expert. The format of this document may be difficult for non-program stakeholders to interpret, so a summary report is often developed for the purpose of stakeholder information and engagement.

VII. Transition to Independence Process (TIP) Model™

The TIP Model™ provides an evidence-supported practice for facilitating the transition of youth and young adults to improve their outcomes across the transition domains of Employment and Career, Educational Opportunities, Living Situation, Personal Effectiveness and Wellbeing, and Community-Life Functioning. The TIP system prepares youth and young adults with emotionally and behavioral difficulties (EBD) for their movement into adult roles through an individualized process, engaging them in their own futures planning process, as well as providing developmentally-appropriate services and supports.

A. Geographic Service Delivery Area

TIP will be made available to youth and young adults residing in Wards 1-8 of the District (i.e., District-wide). Portions of Northern Virginia and Maryland within a 60-minute driving radius will also be included for residents or wards of the District who have been temporarily placed in these areas.

TIP services will be delivered in the least stigmatized, youth friendly environment possible, not in a clinical or medical setting. TIP is preferably delivered in the community, on a one-on-one basis guided by the youth's needs and/or preferences and at a scheduled time convenient to the youth, young adult, and family/caregivers if applicable.

B. TIP Service Criteria

The TIP Model ™ was developed for working with youth and young adults during a transitional period with unique barriers that put them at significantly higher risk for school failure, involvement with correctional authorities and/or dependency on social services:

1) Inclusionary Criteria

a) Youth and young adults (14-26 years old) for DBH TAY
b) Youth and young adults with emotional/behavioral difficulties (EBD)
c) Youth who are:
   i) currently involved in the child welfare/social service system
   ii) currently involved in juvenile justice system
   iii) identified with Special education needs
   iv) considered 'At-risk'
   v) In foster care
   vi) Homeless

2) Exclusionary Criteria

Youth/young person with no emotional and behavioral difficulty.

a) A diagnosis of Autism or PDD, or moderate to severe Intellectual Disability
b) Actively Suicidal, Homicidal or actively Psychotic without medication stabilization

C. Program-Specific Guidelines & Practices

TIP Model™ Defined

The *TIP Model™* was developed for working with youth and young adults (14-29 years old) with EBD to: a) engage them in their own futures planning process; b) provide them with developmentally-appropriate, non-stigmatizing, culturally-competent, and appealing services and supports; and c) involve them and their families and other informal key players in a process that prepares and facilitates them in their movement toward greater self-sufficiency and successful achievement of their goals related to relevant transition domains (i.e., employment/career, educational opportunities, living situation, personal effectiveness/wellbeing, and community-life functioning). The TIP system is operationalized through seven guidelines and their associated practices that drive the work with young people and provide the framework for the program and community system to support these functions.

TIP Model™ Guidelines

1. Engage young people through relationship development, person-centered planning, and a focus on their futures.
2. Tailor services and supports to be accessible, coordinated, appealing, non-stigmatizing, and developmentally-appropriate -- and building on strengths to enable the young people to pursue their goals across relevant transition domains
3. Acknowledge and develop personal choice and social responsibility with young people.
4. Ensure a safety net of support by involving a young person's parents, family members, and other informal and formal key players.
5. Enhance young persons' competencies to assist them in achieving greater self-sufficiency and confidence.
6. Maintain an outcome focus in the TIP system at the young person, program, and community levels.
7. Involve young people, parents, and other community partners in the TIP system at the practice, program, and community levels.

TIP Transition Facilitators

To ensure the continuity of planning, services, and supports, the TIP system is implemented directly by ***transition facilitators*** who work with the young people, their parents, and other informal and formal support people.

- The term *transition facilitator* is used to emphasize the function of ***facilitating*** the young person's future, not directing it.
- Different sites and service systems use similar terms such as transition specialist, resource coordinator, mentor, transition coach, TIP facilitator, service coordinator, or life coach.
- The role of transition facilitators with young people, their parents, and other informal and formal key players will be described in detail throughout this manual.

Length of treatment typically ranges from 6-18 months, depending on the specific needs of the youth. Taking the flexibility of this approach into consideration, there is no formal discharge criteria set for TIP - discharge occurs when results for identified goals are obtained for each individual.

D. Referrals & Intake Process

Refer to Appendix E. Referral Guidelines, Documents 3 and 5.

TIP is offered at the following District agencies:

Contemporary Family Services
3300 Pennsylvania Ave. SE
Washington, DC 20020
(202) 735-0761

Community Connections
801 Pennsylvania Ave SE
Washington, DC 20005
(202) 546-1512

Parent & Adolescent Support Services (PASS)
DC Department of Human Services-Family Services Administration
64 New York Ave. NE
Washington, DC 20002
(202) 698-4334

Family Preservation Services
3341 Benning Road, NE
Washington, DC 20019
(202) 543-0387

MBI Health Services
4017 Minnesota Ave., NE
Washington, DC 20019
(202) 388-9202

Total Family Care Coalition
1214 I St SE, Suite 11
Washington, DC 20003
(202) 232-6100

Life Enhancement Services
1321 Southern Ave., SE
Suite 301
Washington, DC 20001
(202) 562-6262

E. Clinical Documentation & Record Keeping

At the intake, the intake coordinator will provide the family, youth or young adult with the following:

Agency specific information: All TIP sites shall maintain clinical documentation of all sessions in client records.

F. On-Going Training & Consultation

TIP training is delivered in 3 sessions per year. The first session is 3 days and sessions 2 and 3 are both 2 days each. Following the first 3-Day Training visit up to 6 monthly Teleconference Technical Assistance Sessions will be provided. The TIP Teleconferences will be designed by the Health Services for Children with Special Needs (HSCSN) leadership at the transition site in concert with the primary NNYT Consultant for this site—and will include the following topics and approaches:

- Guidance, Coaching and Support of Site-Based Trainers utilizing telephonic and videoconference individual and group consultation, videotape review, TIP Training materials discussion and training feedback.
- TIP Solutions Review sessions for continuing competency enhancement of site personnel;
- General technical assistance and planning around a particular set of issues that the site is interested in or having difficulty with at the practice, program, system, or policy levels; and/or
- Theme Teleconference Sessions on topics such as: youth and young leadership, supported employment, supported education, career development, prevention planning for high risk behaviors and situations, family involvement, community resource mapping, documentation of TIP interventions in mental health notes, preparation for a fidelity assessment, or site-relevant evaluation strategies.

- Training Materials will be provided to HSCSN electronically prior to the start of each training. HSCSN is allowed to duplicate these materials for use within the organization as a means to incorporate the TIP model.
- Planning for the training will take place prior to the site visit via teleconference.

G. Reporting Outcomes and Practices

At the heart of the TIP™ practice model are proactive Transition Facilitators with small caseloads (i.e. life coaches, transition specialists, or coaches, serving 15 or fewer youth/young adults).

The TIP™ Transition Facilitators use core practices in their work with young people (e.g. rationales, social problem solving, in-vivo teaching, prevention planning on high-risk behaviors), to facilitate youth making better decisions, as well as improving their progress and outcomes.

Expectations for the young person should be focused on desired outcomes and achievements should be acknowledged – how do you celebrate success?

Review Goal Achievement Relative to Exit Criteria:

- When does *young person* graduate transition program?
  - Identify criteria which will signal that the *young person* is ready to graduate transition program
- Y*oung person* sets criteria early on
  - Have *young person* set the exit criteria early in his/her relationship with the facilitator
- Is *young person* making progress?
  - Discuss progress toward exit criteria when a goal is achieved
  - If discussions appear to upset the young person, use SODAS to identify and resolve the Y*oung person*'s feelings about separation
- Keep exit criteria brief
  - (e.g. complete HS; find and keep a job as a nurse's assistant for at least 6 months; get an apartment and be able to budget and pay bills; no involvement with justice for at least one year)
- Is responsibility being transferred?
  - Progressively transfer responsibility to the *young person* or informal support

H. Outcome Reporting Requirements

There are no specific outcome reporting requirements required by the TIP model. Each provider is required to establish and adhere to policies and procedures for clinical record documentation, security, and confidentiality of consumer and family information, clinical records retention, maintenance, purging and destruction, and for disclosure of consumer and family information, and informed consent that comply with applicable federal and District laws and regulations (Clinical Records Policy). TIP providers are required to submit monthly trackers to EBA to capture the activity that has transpired with consumer cases.

VIII. Trauma Systems Therapy (TST)

TST as a clinical model

TST is a comprehensive model for treating traumatic stress in children and adolescents that adds to individually-based approaches by specifically addressing the child's social environment and/or system of care. TST was designed to provide an integrated and highly coordinated system of services guided by the specific understanding of the nature of child traumatic stress. Specifically, this model conceptualizes the development of a 'Trauma System', which is comprised of two main elements:

Given the presence of a 'Trauma System', ***the essence of TST is to help the child gain control over emotions and behavior via enhancing the child's capacity to regulate emotion and diminishing the ongoing stresses and threats in the social environment***. TST was also designed to build the capacity of significant others in the child's environment to help the child control her or his emotional and behavioral responses.

TST as an organizational model

Besides being a unique and innovative clinical model, TST also provides a framework for organizing trauma-informed services. TST takes a phase-based approach to treatment and consists of four primary intervention modules:

1) Home- and community-based care;
2) Services advocacy;
3) Emotion regulation skills training; and
4) Psychopharmacology

These various modules are clinically indicated depending on the child's degree of emotional dysregulation and stability of her/his social environment.

To effectively implement TST, several organizational elements must be in place. First, TST must fit with a given agency's mission such that genuine commitment is effected at all levels of the organization. Second, the agency must possess the capacity to form cross-disciplinary TST teams that deliver the disparate treatment modules. Third, individual team members must be trained in, and have enthusiasm for, TST. Lastly, an ongoing evaluation system must exist to ensure that TST is delivered with fidelity. A full description of TST is offered in our book: *Trauma Systems Therapy for Children and Teens:* Second Edition (Saxe, Ellis, & Brown, 2016).

TST research support

Results of an open trial of 110 families comprising a cohort of children from inner city Boston and another from rural New York state have been published (Saxe, Ellis, Fogler, Hansen, & Sorkin, 2005). These children

were largely multiply traumatized and managing significant environmental stressors such as poverty, risk of homelessness, and parental mental illness and substance abuse. While almost 60% of families needed more intensive home- and community-based care at the beginning of treatment, only 39% of families needed this level of treatment after three months. A follow-up study shows that these gains persist and even improve at 15 months after enrollment in treatment (Ellis, Fogler, Hansen, Forbes, Navalta, & Saxe, 2011). Unpublished data from a pilot randomized controlled trial of TST vs. treatment as usual for an inner city sample of traumatized children demonstrate that three months following enrollment in treatment 90% of families receiving TST were still in treatment whereas only 10% of the treatment as usual families were receiving services. This finding suggests that TST is quite effective at treatment engagement and highlights the importance of 1) family engagement; and 2) integration of care within the existing services system.

A. Geographic Service Delivery Area

TST will service wards 1-8 of the District. Portions of Northern Virginia and Maryland within a 60-minute driving radius will be included for residents of the District (and District wards placed in these areas). TST will be delivered within Mental Health contract agencies overseen by the DC DBH within the DC region. Currently, TST is provided by the following agencies:

- Contemporary Family Services
- Maryland Family Resource, Inc.
- Adoptions Together
- Hillcrest

An expansion plan is being developed to include additional DBH providers in the future.

B. TST Service Criteria

1) Inclusionary Criteria:

Inclusion criteria include youth with plausible trauma histories, evidencing difficulty regulating emotional and behavioral states, with this dysregulation being plausibly related to the trauma history.

Agencies implementing TST must provide, or form partnerships to provide, four (4) Core TST Services:

a. Home- and community-based care
b. Services advocacy
c. Emotion regulation skills training
d. Psychopharmacology

2) Exclusionary Criteria

TST is applicable to a wide range of populations and service settings.

Exclusion criteria will be determined at the clinical discretion of the team at each provider site.

C. Program-Specific Guidelines & Practices

TST is a team-based approach. There are four key service elements required to implement TST:

- Skill-based psychotherapy;
- Psychopharmacology;

- Home/community based stabilization and
- Advocacy.

The Moment by Moment Assessment. Within TST gathering a clear, specific understanding of the environmental factors that trigger dysregulation is vitally important. The Moment by Moment Assessment (MMA) is the tool used to identify these triggers in the environment that lead to changes in the 3 As and the 4 Rs. To identify and accurately define areas for intervention, the TST clinical team is expected to document episodes of emotional or behavioral dysregulation and the stimuli that provoke them via the MMA. The following steps are used to conduct this assessment:

1) Inquire about episodes of dysregulation;
2) Understand how the 3 A*s* shift during these episodes;
3) Ascertain the precipitants to these episodes;
4) Understand how family members (or other members of the social environment) helped or made things worse; and
5) Determine the cost to the child and family of these episodes.

Via this process, the team gathers exquisitely detailed information about what the youth was thinking, feeling, and doing immediately prior to, during, and after a specified instance of dysregulation. In addition, the team also gathers specific information about precise environmental conditions immediately prior to the episode. This information is gathered by: interviewing the youth (only when they are back to a regulated state); interviewing other youth who may have witnessed the event, and interviewing other adults who were present as well.

TST Priority Problems. In usual care/treatment, the clinical targets for interventions parallel the diagnostic formulation. For a child diagnosed with major depressive disorder, for example, depressive symptoms such as sad/unhappy mood, social withdrawal/isolation, and neuro-vegetative symptoms are the foci? whereby significant symptom reduction is the primary goal of treatment. Within TST, however, the trauma system is the focal point of all interventions – in particular, the TST Priority Problems that precisely define the trauma system for a given child. The TST Priority Problems are based on the interface between the child's emotional regulation problems and stressful stimuli in the environment.

Once the information from the MMA is gathered, the TST team then establishes:

1) Links or patterns of links between emotional/behavioral dysregulation and the stimuli that elicit them;
2) Role of members of the child's social environment in helping or hindering regulation during these patterns of links; and
3) Functional implications for these patterns of links.

Then, these patterns are assigned priorities via clinical judgment of the amount of dysfunction that they cause. Such dysfunction includes, but is not limited to, problems that jeopardize physical safety; engagement in treatment, home placement, school placement, or healthy development; problems that cause significant distress to the child or family members; and problems that can be solved relatively easily and are highly meaningful to the child or family members. The TST Priority Problems are thus those patterns that are assigned the highest priorities (typically one to four problems in total). Finally, the TST Priority Solutions to address the corresponding Priority Problems are formulated via the clinically indicated treatment modules and the individuals who are responsible for carrying out these solutions are identified as well (e.g., child, parent, outpatient clinician, home-based therapist, advocate, etc.).

A youth is assessed by the team as being in one of three categories of regulation:

- No Survival States
- Survival States, or
- Dangerous Survival States

Similarly, the social environment is evaluated across a three-category designation:

- Helpful and Protective
- Insufficiently Helpful & Protective, or
- Harmful

By determining the relationship between these two ratings (i.e., trauma system), the youth is ascertained as being in one of three phases of treatment labeled as:

- Safety Focused,
- Regulation Focused, and
- Beyond Trauma

The TST Planning Grid is used to determine the phase of treatment, each of which is associated with a defined set of recommended treatment interventions.

		Social Environmental Stability		
		Helpful and Protective	Insufficiently Helpful & Protective	Harmful
Emotional/ Behavioral	No Survival States	Beyond Trauma	Beyond Trauma	Safety- focused
	Survival States	Regulation-focused	Regulation-focused	Safety-focused
	Dangerous Survival States	Regulation-focused	Safety-focused	Safety-focused

Four (4) key factors are considered when assessing whether a child is experiencing survival states or dangerous survival states, or neither.

1) An episode of dysregulation is defined as changes in awareness (or consciousness), affect (or emotion), and action (or behavior) when the child is exposed to a stressor or triggering stimulus (i.e., *'3 As'*). If these three changes do not occur, the child is not considered to be dysregulated.
2) The rate or frequency of dysregulation episodes is taken into consideration. Typically, the number of weekly or monthly episodes is documented to help ascertain the degree to which dysregulation is present.
3) Some evidence must exist that the dysregulation episode causes a problem with the child's school, family, peer relationships, or self. This problem can either be related to the dysregulation episode itself or to feelings or behaviors related to the anticipation of a dysregulation episode (i.e., an impairment or distress criterion).
4) When a child engages in risky or potentially dangerous behaviors during an episode (e.g., aggressive, suicidal, self-mutilatory, or otherwise impulsive behaviors), s/he is considered to be **behaviorally dysregulated**. This distinction is the most severe emotion regulation tier in the TST Assessment Grid (Figure 2). In contrast, a child is categorized as **experiencing survival states**

when changes in the 3 A*s* occur but with no risky or potentially dangerous behaviors (i.e., middle tier).

Within the framework of TST, a traumatized child who experiences a dysregulation episode transitions time-wise across four emotional states: regulating, revving, re-experiencing, and reconstituting (the *'4 Rs')*. The development of the TST Treatment Plan is dependent on the designation of the child as experiencing no survival states, survival states or dangerous survival states.

As previously stated, TST conceptualizes the social environment/system of care along a three-tier continuum of stability (i.e., Helpful and Protective, Insufficiently Helpful and Protective and Harmful). The constructs of *'help'* and *'protect'* are critical in distinguishing among these three levels of stability. *'Help'* refers to the capacity of the social environment or system of care to help the child manage emotion and emotionally-motivated behavior. In contrast, *'protect'* pertains to the capacity of the social environment or system of care to protect the child from stressors that may lead to dysregulated emotional states as described above. Collectively, the degree to which these capacities are present helps to precisely ascertain the stability of the social environment/system of care.

A child's social environment/system of care is considered **Helpful and Protective** when the following three conditions are met:

1) The child's immediate caregivers are able to help him/her to regulate emotion and to protect him/her from stressors;
2) The child's extended family, peer group, or neighbors are able to support the child such that any limitations of the immediate caregivers to help or protect are mitigated; and
3) The child's system of care has been accessed successfully to provide needed functions that the immediate caregivers and extended family are not able to provide.

In contrast, a child's social environment/system of care is considered **Insufficiently Helpful and Protective** when neither the child's primary caregivers, extended family, nor system of care are able to help the child regulate emotional states and/or protect him/her from environmental stressors.

Lastly, a child's social environment/system of care is considered **Harmful** when one or both of the following scenarios exists:

1) The child's caregivers pose a true threat of harm to the child; the child's extended family, peer group, or neighbors cannot adequately protect the child from this threat; and the child's system of care has either not been accessed or has not adequately protected the child from this threat, and/or
2) A threat of harm to the child from outside the immediate caregivers exists and the child is not adequately protected from this outside threat.

In sum, the use of these three constructs (Helpful and Protective, Insufficiently Helpful and Protective and Harmful) will determine the extent of stability/instability of a child's social environment and /or system of care and will help in the completion of the TST Assessment Grid.

Each of the three (3) phases of TST intervention is accompanied by specific worksheets to guide the intervention provided by the team:

Safety Focused	Regulation Focused	Beyond Trauma
• S.A.F.E. • Safety Establishment • Avert Survival States • Facilitate Services Organization • Enable the Caregiver	• B.A.S.E. • Building Awareness • Applying Awareness • Spreading Awareness • Enable the Caregiver	• S.T.R.O.N.G. • Strengthening Cognitive Skills • Telling Your Story • Re-evaluating needs • Orienting to the Future • Nurturing Parent Child Relations • Going Forward

D. Referrals & Intake Process

Refer to Appendix E. Referral Guidelines, Documents 1 and 2.

TST is offered at the following District agencies:

Contemporary Family Services
3300 Pennsylvania Ave. SE
Washington, DC 20020
(202) 735-0761

MD/DC Family Resource
903 Brightseat Rd.
Landover, MD 20785
(301) 333-2980

Foundations for Home and Community
1012 14th Street, NW
Washington, DC 0005
(202) 737-2554

Hillcrest Children & Family Center
915 Rhode Island Ave. NW
Washington, DC 20001
(202) 232-6100

Adoptions Together FamilyWorks Together
508 Kennedy Street, NW
Washington, DC 20011
(202) 526-4802

E. Clinical Documentation & Record Keeping

TST Clinical Assessment Documentation includes the use of three (3) core assessment worksheets:

1) TST Assessment Form
    a. Child Ecology Check-in (CECI)
    b. Moment-by-Moment Assessment Form
2) TST Treatment Plan Form
3) TST Treatment Plan

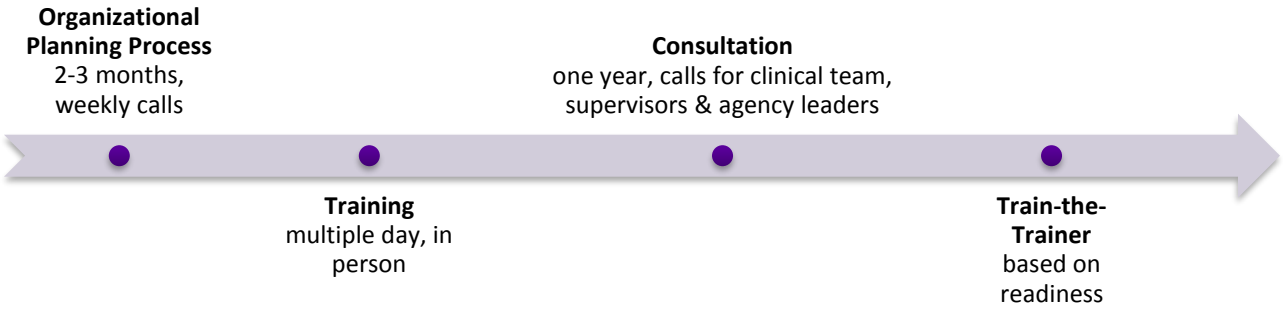
TST Treatment Intervention includes two (2) specific guides for each of the three phases of treatment:

1) Safety Focused
    a. The Safety-Focused Guide
    b. The Helpers Guide
2) Regulation Focused
    a. The Regulation-Focused Guide
    b. Managing Emotions Guide (MEM)
3) Beyond Trauma
    a. The Beyond Trauma Guide
    b. Cognitive Awareness Log (CAL)

F. On-Going Training & Consultation

Ongoing training and consultation includes:

- 1-2 year Consultation Agreement
- 2-3 months, weekly organizational planning process calls
- Multiple-Day, On-Site Training
- Weekly Team Consultation Call
- Ongoing Consultation Calls to Supervisors
- Ongoing Consultation Calls to Agency Leadership
- Train-the-Trainer Process
- Weekly team meetings
- Case specific supervision in-house
- 1 annual provider-based/in-house training



G. Reporting Guidelines/Practices & Outcome Reporting Requirements

Organizations implementing TST will be expected to monitor fidelity on a quarterly basis for each case using the TST Fidelity Monitoring Tool. Data on fidelity will be shared with the NYU team to help organizations assess clinical outcomes as well as aggregate agency outcomes.

Appendices

A. DC Mental Health Agency Designation Criteria

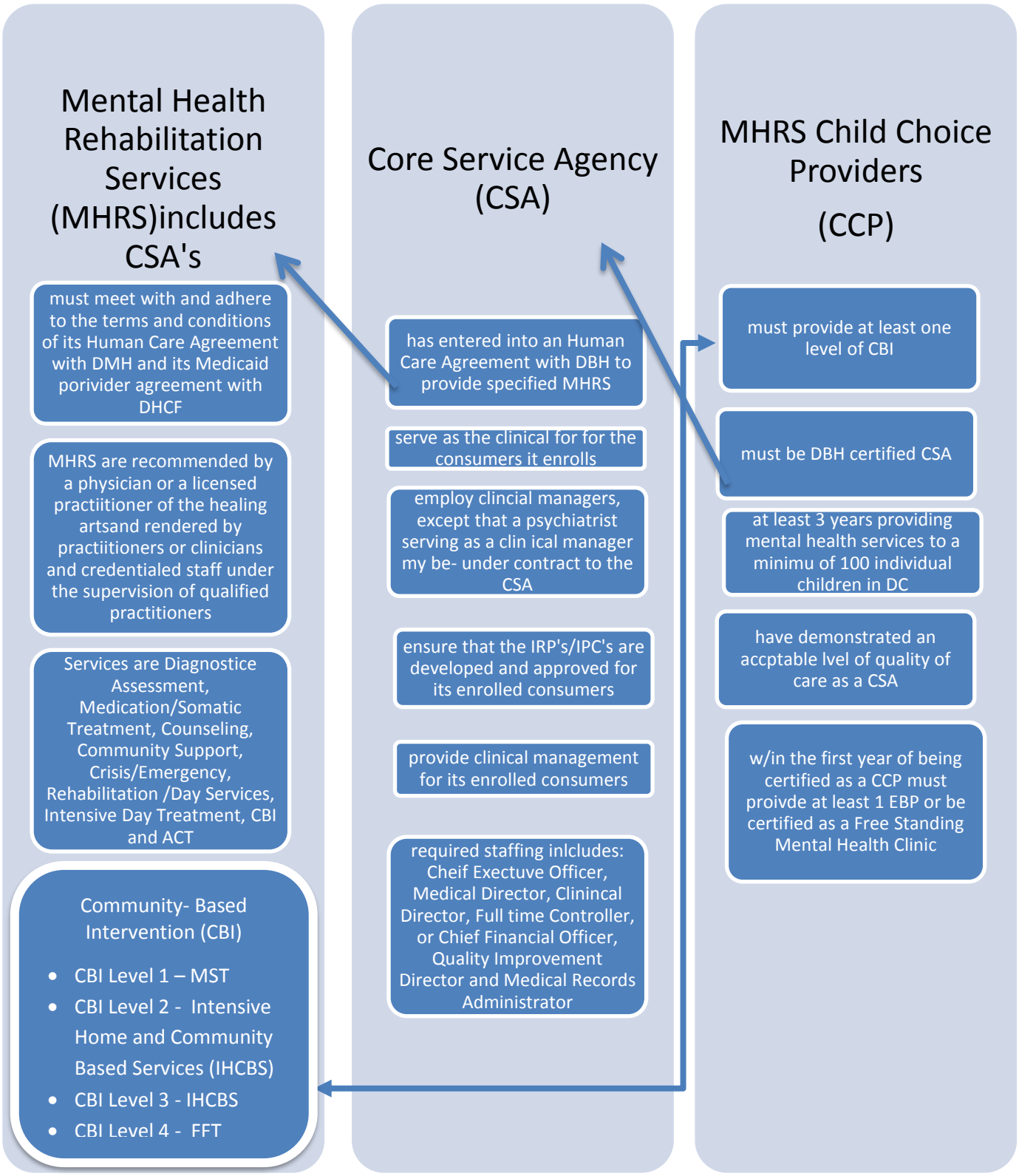
B. Clinical Services Unit Mental Health Referral Form

C. PCIT P.I.E.C.E Consent Forms

D. Evaluating MST PSB Case Status at Discharge

E. Referral Guidelines

Appendix A. DC Mental Health Agency Designation Criteria



Appendix B. CSU Referral Form

Referral Form

Child Identification Information			
Child's Name (Last, First, Middle)	Date of Birth	Age	Gender Male ☐ Female ☐
Parent/Legal Guardian	Relationship to Child		
Address:			Ward
Home Telephone:	Cell or Work Telephone:		
Child's Social Security Number	Insurance Name		Medicaid Number:
Child's School or Daycare:			Telephone Number:
Child's Involvement in CFSA: Yes ☐ No ☐ Check CFSA Status: ☐ Shelter Care ☐ Commitment ☐ Protective Supervision ☐ Other (explain)			
Referral Information			
Organization Making Referral:			
Name of Referrer			Referrer's Telephone:
Reason for Referral: (Please include the health, educational, family, social, behavioral and other concerns regarding the child).			
Child has a completed developmental screening. ☐ Yes ☐ No. Previous Screenings/Evaluations: (Please check all that apply) ☐ Child was screened by the *Office of the State Superintendent of Education*: Tools Used: ☐ Child was screened by *Early Stages*: Tools Used: ☐ Child was diagnosed with a mental condition by *Children's National Medical Center*/Private Pediatrician. Describe: ☐ Other Evaluations: Please provide copies of screenings/evaluations to assist with the referral process (Complete Release of Information Document)			

Signed: Date of Referral:

Referring Person

Appendix C. PCIT PIECE Consent Forms

THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

PARENT INFANT EARLY CHILDHOOD ENHANCEMENT (PIECE) PROGRAM

Informed Consent to Release Visual and/or Auditory Records

Parent-Child Interaction Therapy (PCIT) is an evidence-based treatment for young children with disruptive behaviors and their caregiver, that emphasize improving the characteristics of the parent-child relationship while changing parent-child interaction patterns. In PCIT, parents are taught specific skills to improve the nurturing and secure relationship with their child while increasing their child's social skills and decreasing non-compliant behavior. This treatment utilizes two basic interactions: Child Directed Interaction (CDI), which is similar to play therapy in that parents engage their child in a play situation with the goal of strengthening the parent-child relationship; and Parent Directed Interaction (PDI), which resembles behavior modification in that parents learn to use specific behavior management techniques as they play with their child.

In PCIT, therapists often use videos to review progress and plan treatment in consultation with other PCIT therapists. By signing this informed consent, you are allowing your PCIT therapist to share a video of your therapy session only with a Certified PCIT Master Trainer, for consultation regarding PCIT treatment. (Consultation focuses on implementation of PCIT and does not include supervision on other aspects of treatment that your therapist is licensed to provide). Your video will be protected and maintained in compliance with the Health Insurance Portability and Accountability Act (HIPPA). After your tape has been reviewed the original and copies will be destroyed by the PCIT Master trainer and your therapist so that no copies of your session remain at the end of treatment. All videos will be destroyed within 4 weeks of the session date.

PARENT INFANT EARLY CHILDHOOD ENHANCEMENT (PIECE) PROGRAM

Client Consent to Release Visual and/or Auditory Records

I, hereby authorize the

Guardian's name (print)

Parent Infant Early Childhood Enhancement (PIECE) program acting under the authority of the DC Government Department of Behavioral Health to:

(Check yes or no in each box)

☐ Yes ☐ No The PCIT interventions and videotaping requirements were explained to me by my therapist, and all of my concerns and questions were answered.

Usage of Visual and/or Auditory Recording

I understand that the visual and/or auditory recordings may be used as stated below, and I consent to the following:

☐ Yes ☐ No Make a video recording of me, and my child including the audio of any related interview or general conversation.

☐ Yes ☐ No To use, in whole or edited form, by PCIT clinical professionals for consultation with the PCIT Master trainer to monitor progress and plan treatment.

☐ Yes ☐ No I understand that my child and I may be identified as DBH consumers, or as individuals who are receiving mental health services as a result of our participation in the PCIT program.

☐ Yes ☐ No I understand that I may stop the videotaping involving me and my child, for any reason, and revoke my consent.

Parent/Guardian Signature

Date:

Clinician/Witness:

Date:

Appendix D. Evaluating MST PSB Case Status at Discharge

When it has been determined that an MST-PSB case will be discharged, the clinical team will review the status of the case in three areas:

a. Current status of case progress;
b. Status of key instrumental outcomes; and
c. Status of the case relative to four areas of "ultimate" or real-word outcomes.

The information is collected in these three areas, reviewed with the MST-PSB expert, then entered into the MSTI database for program quality assurance and improvement as follows:

A. Case Progress Review Item

(1) Reason for case closure:

(a) Completion: The youth was discharged based upon the mutual agreement of the primary caregiver(s) and the MST-PSB team.

i) The reason for case closure does not meet any of the other categories; AND

ii) Team and family agree that there is evidence that overarching goals have been sustained over a period of 3-4 weeks; OR

iii) Team and family agree that overarching goals have not been met and treatment has reached a point of diminishing returns for the additional time invested.

Selection of this category does not assume that the case closed with all goals met, only that primary caregiver(s) and team agreed that no further progress on overarching goals is likely.

(b) Lack of engagement: The decision to discharge the youth was made because the MST-PSB team was not able to engage the family in treatment, despite persistence on the therapist's part to engage and align with the family.

i) Despite persistent efforts by the therapist, the family has not EVER been seen face-to-face for two consecutive weeks; OR

ii) Family has formally declined MST-PSB services; OR

iii) Family states they do not want to continue (a statement to this effect should be included in note section); AND

iiii) The consultant and team have identified and addressed barriers to inadequate engagement and agree that all engagement strategies have been exhausted.

Selection of this category indicates that the family has chosen not to participate in MST-PSB services (this category documents that the team never had engagement). As long as the family was actively involved in working on at least one goal for some part of treatment, this category is

NOT checked. This latter case would be counted as "completed" with lack of progress reflected in instrumental goals.

(c) Placement: The youth was placed in a restrictive setting (detention center, residential placement or foster care) for a duration of time that precluded further MST-PSB involvement.

(d) Placement; prior event: The youth was placed in a restrictive setting (detention center, residential placement or foster care) due to an event or offense that occurred prior to the beginning of MST-PSB treatment.

(e) MST-PSB program administrative removal/withdrawal: Youth was removed from the program by the MST-PSB program administration due to administrative issues or decisions unrelated to the progress of the case.

(f) Funding/referral source administrative removal/withdrawal: Youth was removed from the program by the funding or referral source due to administrative issues or decisions unrelated to the progress of the case.

(g) Moved: The family moved out of the program's service area.

B. Instrumental Outcomes

The Instrumental Outcomes are documented in the MST-PSB Goals and Guidelines as the criteria for determining whether a case was closed successfully or not. While some guidance in defining these items is provided, it is critical for each program to define these in terms of objectives for the specific case. For example, if the case had an overarching goal of increasing involvement in pro-social activities as evidenced by attending one approved recreational activity a week, then the related instrumental outcome would be rated as met if the Overarching Goal is met. Therefore, responses to these items are not completely standardized across programs.

1) **A lead-in would be helpful here to explain these items:**
   - **a)** The therapist and supervisor have evidence that the primary caregiver(s) has improved the parenting skills necessary for handling subsequent problems.
   - **b)** There is evidence of improved family relations specific to the instrumental and affective domains in that family's subsystems that were drivers of the youth referral behavior.
   - **c)** The family has improved their network of informal social supports in the community and has demonstrated skill at successfully accessing a range of supports (informal to formal) as needed.
   - **d)** The youth is showing evidence of success in an educational or vocational setting.
   - **e)** The youth is involved with pro-social peers and activities and is minimally involved with problem peers.
   - **f)** Changes in behavior of the youth and in the systems contributing to the referral problems have been sustained for 3-4 weeks.

C. Ultimate Outcomes

These items provide some basic information about how the youth is functioning at the time of discharge. The meaning of the terms (e.g., 'arrests') may vary from county to county, state to state, and country to country; therefore, it is difficult for the MST Institute to establish a "one-size-fits-all" definition. The operational definition of each of the following should be made clear for each MST-PSB program and documented in the Goals and Guidelines document.

The following definitions are offered as guidance based on common performance measures used in the United States:

a) Youth is living at home. Home is defined as a private residence that is approved by the youth's guardian. This could include a parent's home, the home of an approved relative or friend of the family. Foster homes or other types of placement would not be included in the definition of "home". Youth who are on runaway status would not be considered living at home.

b) Youth is attending school (is not truant,) or vocational training or, if of the legally appropriate age to not attend school, has a paying job (20 hours/week).

i) Youth is attending school, a high school equivalency program (GED program,) or a vocational program in the youth's natural ecology, or working. The primary objective of the program is educational or vocational. A youth in a correctional facility or treatment setting in which educational or vocational activities are provided, where the primary objective is treatment or correction, will NOT count as a "yes" for this item.

ii) If the youth is in school, youth is attending frequently enough to meet expectations placed on youth by school system or court. If the discharge occurs during the summer when school is not in session, it is recommended that the response "yes" be selected if the youth was attending school at the end of the last school year, or is working.

(c) Youth has not been arrested since the beginning of MST-PSB treatment, for an offense committed during MST-PSB treatment. Many MST-PSB programs have defined arrests as involvement with police that results in a charge for a new criminal behavior (i.e., not a violation of probation).

Each MST-PSB program should view the lack of a clear definition of the above as an 'opportunity' to revise, clarify, and improve their existing Goals & Guidelines document. This will likely entail drafting a working definition and then seeking input from key stakeholders in order to establish a clear, specific, objective, and measurable definition to guide future entries on the website.

Appendix E. Referral Guidelines

Document 1: How to Make a Referral for Trauma Models

Document 2: Decision Tree for Trauma Models

Document 3: How to Make a Referral for Non-Trauma Models (excluding MST & FFT)

Document 4: CBI Referral Form (includes MST and FFT)

Document 5: Decision Tree for non-Trauma Models (includes MST & FFT)

Document 1: How to Make a Referral for Trauma Models

What are the Evidence Based Practice (EBP) Trauma Models within DBH?

Trauma Model Descriptions

CPP: Child Parent Psychotherapy is a therapeutic intervention for young children with a history of trauma exposure or maltreatment and their caregivers. CPP-FV supports child development, restores the child-parent relationship and the overall feelings of safety, while reducing symptoms associated with the experience of trauma. Age criteria: 0-6

TF-CBT: Trauma Focus Cognitive Behavioral Therapy is an intervention designed to help children, youth, and their parents overcome the negative effects of traumatic life events and address feelings. Age criteria: 3-18

TST: Trauma Systems Therapy is a systems based therapy that is a comprehensive model for treating traumatic stress in children and adolescents. It is an individually-based approach that specifically addresses the child's social environment and/or system of care. Age criteria: 2-21

TREM: The Trauma Recovery and Empowerment Model is a fully manualized group intervention for women, men, and adolescents who are trauma survivors. TREM address a broad range of trauma among people with severe mental disorders and/or substance use. Models use cognitive restructuring, psychoeducation, and coping skills training. Age criteria:12-18 or 18-22. TREM is not an EBP within the Family First Program. For additional information regarding TREM contact Lori L. Beyer, LICSW, Director of trauma Training and Education at Community Connections at 202-608-4788 or lbeyer@ccdc1.org. (Please note TREM is not a part of the Families First Program)

Please note that there are other agencies such as District of Columbia Public Schools (DCPS) and individual therapist that use other models to address trauma.

How Do You Know a Youth Needs an EBP Trauma Model?

A youth can be identified for Trauma Services by the following ways:

- **Diagnostic Assessment** – Core Service Agencies (CSA) conduct Diagnostic Assessments that can determine a youth's trauma symptoms and exposures.
- **Trauma Assessment Tools** – Some CSA's use trauma assessment tools other than those listed in the following bullet.
- **Tools to Identify Trauma Symptoms and Exposure** – The following tools are used by CFSA Social Workers and Child Choice Providers to screen for trauma symptoms and exposures:
    - **Child Stress Disorder Checklist of the District of Columbia (CSDC-DC)**
    - **UCLA PTSD Reaction Index**
    - **Trauma Symptom Checklist for Young Children (TSCYC)**
    - **Trauma Symptom Checklist for Children (TSCC)**
    - **Maryland Family Resource (MFR) Trauma Screener** (only used by MFR)
- **Clinical Assessment and Judgment** – Clinicians may determine a need for further assessment for trauma services based on their interactions with a youth, family, or treatment team.

What Criteria Is Required for Each EBP Trauma Model?

Below is a chart that provides basic information on the Trauma Models. This chart is a quick reference guide to help a professional scan the trauma model criteria.

EBP	CPP	TF-CBT	TST	TREM*
AGE	0-6	4-18**	6-18 **	12-18 or 18 and older
CAREGIVER PARTICPATION	Required	Required	Not Required	Not Required
INDIVIDUAL VS GROUP	Individual	Individual	Individual	Group
TYPES OF TRAUMA YOUTH EXPOSED TO AND BEHAVIORS	**Child Victims or witnesses of:** • family violence • intimate partner violence • child physical abuse • child sexual abuse	**Child/Youth who have a history of at least one significant potentially traumatic event** to include but not limited to: • sexual assault • physical assault • witnessing serious violence in the home or community • unexpected traumatic death of a loved one • motor vehicle accident • dog attack, • exposure to disasters • exposure to terrorist attacks • exposure to war trauma	**Child/Youth/Young Person has:** • been exposed to trauma • plausible trauma histories, • evidencing difficulty regulating emotional and behavioral states • dysregulation being plausibly related to the trauma history • has stable housing or a plan to achieve stable housing in the community	**Youth/Adults who has:** • trauma exposure • severe mental disorders and/or substance use problems
DIAGNOSIS	Yes	Yes	Yes	Yes
ENDORSED TRAUMA ON AN ASSESEMNT	Yes	Yes	Yes	Yes

TRAUMA SYMPTOMS PRESENT	Yes	Yes	Yes	Yes

* TREM is a group model offered to youth 12-18 years however some programs have found that trauma survivors are developmentally younger than their chronological age and use Girl's TREM and Boy's TREM until the age of 22.

**Youth in CFSA care ages 18-20 are qualified to receive the above Trauma Models

For a complete overview of the Trauma Models please refer to Document 2, Families First: Evidence Based Trauma Models Decision Tree for Children & Youth (Age 0-Adult).

TF-CBT VS TST - What to Consider?

Many times, professionals can struggle with how to select between TF-CBT and TST because the models appear similar and making a determination for the right service can be confusing. Below are some pertinent questions that can help determine which model may be the best fit. These questions are not exhaustive, but are things to consider. Ultimately, trauma model providers and DBH staff can support examining the right fit of services. The models have similar focus but parent interaction, safety issues, and client environment can be determining factors in matching a service fit for client need.

Ask these questions when considering whether to choose TF-CBT or TST:

- Does the child/youth have a healthy and supportive environment?
- Are the caregivers present able to engage in services to help the traumatized child who is not able to regulate their emotional stress?
- Are the caregivers and the environment able to support the child/youth cope with their ability to self- regulate (control themselves) when responding to a traumatic reminder that leads to a stressor (survival-in-the moment states)?

Choose TF-CBT when:

- A child/youth has been assessed and it is identified that there are plausible trauma histories.
- A child/youth is struggling to cope but has a relatively supportive, healthy and engaged environment with caregivers who are able to engage in services.

Choose TST when:

- A child/youth is struggling to cope with overwhelming emotions and their environment.
- A child/youth is not able to regulate survival-in-the moment states (controlled themselves when they are triggered).
- A child/youth does not have a healthy engaged environment and/or do not have caregivers who are able to engage in services.

What Phase of TST is appropriate?

TST has 3 Phases of treatment

Teams assess regulation (ability to self-control) and social environment states (home, community, and family life) to determine the appropriate phase of TST a child/youth should enter. By determining the relationship between these two states, the child/youth will be placed in one of three below phases of treatment.

Phases of TST	Description
Safety	• The child/youth is in acute crisis with trauma as an underlining issue. • The child/youth lives in a harmful environment that is triggering them. • The caregivers are insufficiently helpful and protective for the child/youth that shifts into dangerous survival states.
Regulation Focused	• Developing children's emotional regulation capacity, so they can best navigate their world without switching to survival states. • Developing caregivers' capacities to help and protect their children, so their children can best navigate their world without switching into survival states.
Beyond Trauma	• To help child/youth build their cognitive skills and tell their trauma story. • To help child/youth leave their trauma and therapy in the past, orienting to the future, and nurturing parent-child relationships.

What to expect if a child gets the Safety Phase of TST?

- There are 8 TST providers, 5 of which also provide CBI Level II &III
- While all TST providers can provide the Safety Phase of the Model, providers that additionally offer CBI II & III can provide intense services that includes 24/7 support, home visits 3-5 times weekly, and staff that are skilled in dealing with children/youth that are acute, complex, and have significant safety issue

While the Safety Phase focuses on children/youth that are emotionally and behaviorally dysregulated; it also focuses on environments that are unsafe and/or environments that are not ready which includes:

- Caregivers are insufficiently helpful and protective for the child/youth
- Home and community is dangerous and triggering the child/youth

How to Make a Referral?

Referrals for services may be initiated by the following:

a) Parents/Legal Guardians
b) CFSA Social Worker
c) Mental Health Professional
d) Walk-Ins (self-referrals)
e) The Office of Victims Services
f) Mental Health Core Services Agencies (CSA)
g) District of Columbia Public Schools (DCPS)
h) Community Agencies

To receive DBH trauma services an enrollment in the DBH System of Care for Mental Health Rehabilitation Services (MHRS) must be initiated by the parent/legal guardian.

How to Make a Referral to a Trauma Model if a Child is in Foster Care

1. If the consumer is not already enrolled in a trauma model but in active treatment with a CSA, the assigned social worker must submit the Mental Health Referral form to CFSA Clinical Services Unit (CSU).

2. Upon receipt in CSU, the referral form is reviewed by a DBH co-located clinician to determine that all pertinent information is present.
3. The completed form is submitted to the appropriate CSA trained to deliver the identified trauma model.
4. CSU will inform the referring social worker of the CSA to which the child/youth was assigned and contact person for the trauma model.

How to Make a Referral to a Trauma Model if a Child has no CSA

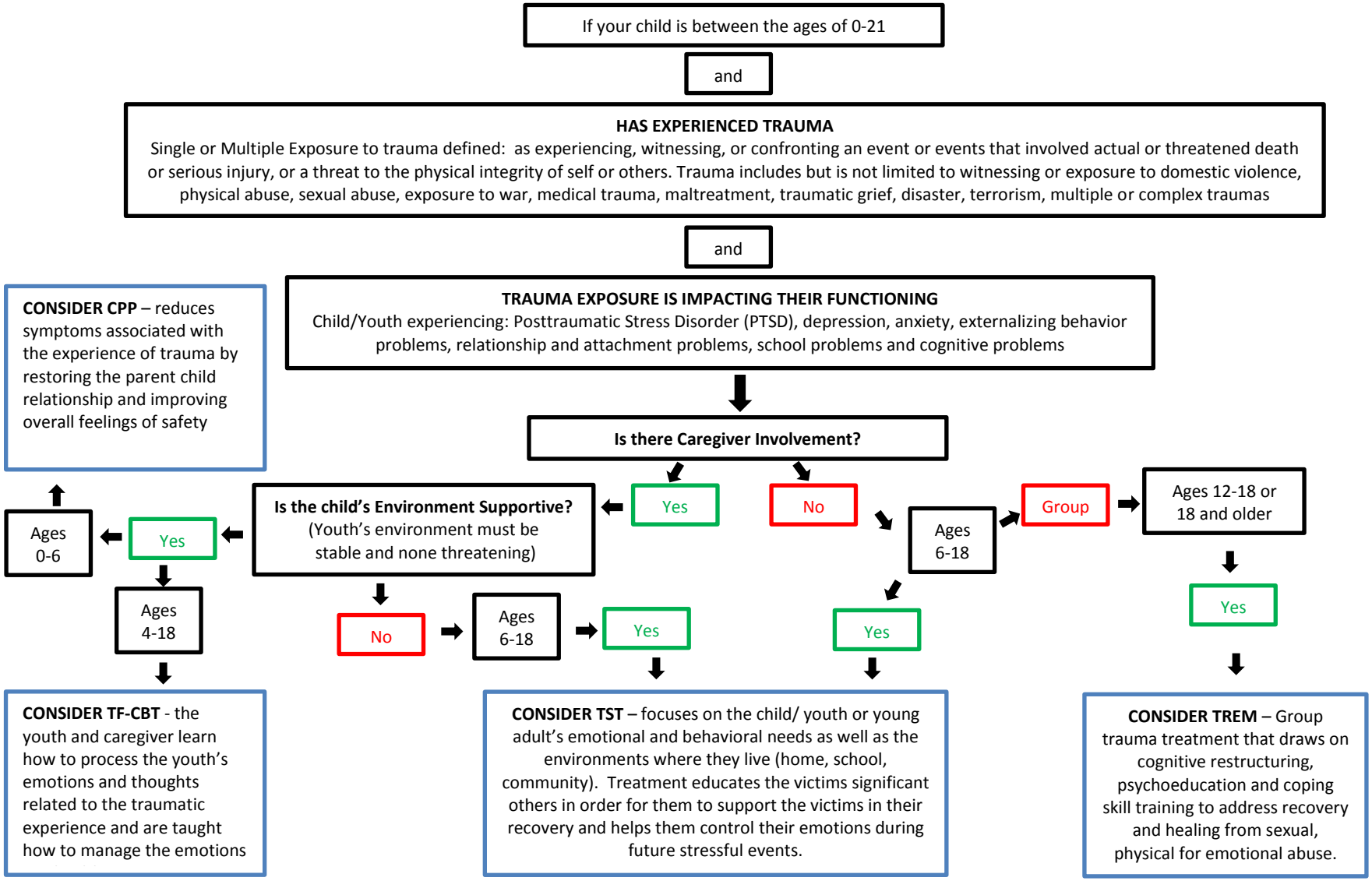
1. The Mental Health professional and/or Child Welfare social worker will call the DBH Access Helpline (AHL) at 1(888)7WE-HELP or 1-888-793-4357 to begin linkage to the CSA.
2. It is recommended but not mandatory that when selecting a CSA chose from the agencies that specialize and offer one of the trauma models on page 2 of this document. See EBP Fact Sheet for a list of the agencies offering trauma models.
3. If you are choosing a CSA that offers a trauma model please advise the AHL staff person of the CSA and request the AHL to schedule the initial intake appointment.
4. The Caregiver and/or Child Welfare social worker (if the child is involved with CFSA) must follow-up with the CSA to confirm the appointment.
5. If the AHL is unable to schedule the initial intake appointment, the Caregiver and/or Child Welfare social worker must contact the assigned CSA to schedule the intake appointment.
6. The CSA and potential trauma model should notify the CFSA social work team (worker, supervisor and CSU) to discuss the case.

How to refer to a trauma model if a child is connected to a CSA (if that CSA does not have the desired Trauma Model)

1. The Clinical Home (CSA) should identify what trauma model is needed and identify what agency provides the model. (See EBP Fact Sheet)
2. The Clinical Home (CSA) should contact the identified trauma model provider and discuss the case.
3. If the identified trauma model is TST, discuss the phase of treatment that is needed.
4. If the Safety Phase of TST is needed inquire if the agency also offers CBI II & III.
5. If the Trauma Model provider accepts the case, the Clinical Home should add the Trauma Model provider to the child/youths' team in iCAMS.
6. If the Trauma Model provider accepts the case, the Clinical Home should contact the AHL, via email to Kendra Dinkins and request that the Trauma Model provider be added to the child/ youths team in iCAMS.

Document 2: Decision Tree for Trauma Models for Children and Youth (Age 0-18)

*Youth in CFSA care ages 2-20 qualify to receive the below trauma models
**TREM is a group model offered to youth 12-18 and adults over 21



Document 3: How to Make a Referral for Non-Trauma Models (excluding MST & FFT)

What Criteria Is Required for Each Model?

Below is a chart that provides basic information on the models supported in the District for children and youth who have externalizing behavioral challenges. This chart is a quick reference guide to help a professional scan the high level model criteria.

EBP	PCIT	MST-PSB	ACRA	TIP
AGE RANGE	2-6	10-17	12-22	14-29
CAREGIVER PARTICPATION	Required	Required	Not Required	Not Required
INDIVIDUAL vs. GROUP	Individual	Individual	Individual	Individual
KEY COMPONENTS	A supported treatment that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns	• An intensive family and community based treatment program that addresses the factors that influence problem sexual behavior • Focus on the influence of the offender's home, family, school, neighborhood and peers	Behavioral intervention that seeks to replace environmental influences that have supported alcohol or drug use with prosocial activities and behaviors that support recovery.	• Prepares youth/young adults for the transition to adult roles by engaging them in their own futures planning while providing developmentally appropriate supports. • It involves their families and other key players in a process that facilitates movement towards greater self-sufficiency and successful achievement of their goals.
DIAGNOSIS	Yes	Yes	Yes	Yes

How to Make a Referral?

Referrals for services may be initiated by the following:

a) Parents/Legal Guardians

b) CFSA Social Worker
c) Mental Health Professional
d) Walk-Ins (self-referrals)
e) The Office of Victims Services
f) Mental Health Core Services Agencies (CSA)
g) District of Columbia Public Schools (DCPS)
h) Community Agencies

To receive DBH treatment services an enrollment in the DBH System of Care for Mental Health Rehabilitation Services (MHRS) must be initiated by the parent/legal guardian.

How to Make a Referral to a Trauma Model if a Child is in Foster Care

1. If the consumer is in active treatment with a CSA, the assigned social worker must submit the Mental Health Referral form to CFSA Clinical Services Unit (CSU).
2. Upon receipt in CSU, the referral form is reviewed by a DBH co-located clinician to determine that all pertinent information is present.
3. The completed form is submitted to the appropriate CSA trained to deliver the identified treatment model.
4. CSU will inform the referring social worker of the CSA to which the child/youth was assigned and contact person for the treatment model.

How to Make a Referral to a Treatment Model if a Child has no CSA

1. The Mental Health professional and/or Child Welfare social worker will call the DBH Access Helpline (AHL) at 1(888)7WE-HELP or 1-888-793-4357 to begin linkage to the CSA.
2. It is recommended but not mandatory that when selecting a CSA, chose from the agencies that specialize and offer one of the treatment models on the previous page of this document.
3. If you are choosing a CSA that offers a treatment model please advise the AHL staff person of the CSA and request the AHL to schedule the initial intake appointment.
4. The Caregiver and/or Child Welfare social worker (if the child is involved with CFSA) must follow-up with the CSA to confirm the appointment.
5. If the AHL is unable to schedule the initial intake appointment, the Caregiver and/or Child Welfare social worker must contact the assigned CSA to schedule the intake appointment.
6. The CSA and potential trauma model should notify the CFSA social work team (worker, supervisor and CSU) to discuss the case.

How to refer to a trauma model if a child is connected to a CSA (if that CSA does not have the desired Treatment Model)

1. The Clinical Home (CSA) should identify what treatment model is needed and identify what agency provides the model.
2. The Clinical Home (CSA) should contact the identified treatment model provider and discuss the case.
3. If the Treatment Model provider accepts the case, the Clinical Home should add the Treatment Model provider to the child/youths' team in iCAMS.
4. If the Treatment Model provider accepts the case, the Clinical Home should contact the AHL, via email to Kendra Dinkins and request that the Treatment Model provider be added to the child/ youths team in iCAMS.

Document 4: Community Based Intervention (CBI) Referral Form (includes MST & FFT)

See Separate Word document file named “DBH CBI Referral Form”. MST and FFT are included in the referral documentation for CBI services. CBI II & III are also offered in the District through DBH but are not a part of the Families First Program of services.

Document 5: Decision Tree for non-Trauma Models (includes MST & FFT) for Children and Youth (Age 2-29*)

*Youth in CFSA care ages 2-20 qualify to receive the below non-trauma models