2020 REPORTING GUIDE

for Research and Evidence-based Practices in Children's Mental Health

Evidence Based Practice Institute EBPI
UNIVERSITY OF WASHINGTON

UW Medicine
DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES

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HOW TO USE THIS GUIDE

This guide provides instructions for how to report research– or evidence–based practices (hereafter, "EBP") for children's public mental health care (under 18 years of age) in Washington State. In this guide, we outline the eligible programs, encounter types, and documentation requirements for reporting an encounter as an EBP.

Washington State adopts an innovative approach to defining and reporting EBPs that reflect well–tested clinical treatments and the realities of real world implementation and quality monitoring. The approach emerged over multiple years of collaboration between UW and DBHR including BHO/HCA leaders, providers and researcher/experts in the field [Walker et al., 2015]. A key innovation in these guides is the use of generic treatment categories for EBP reporting.

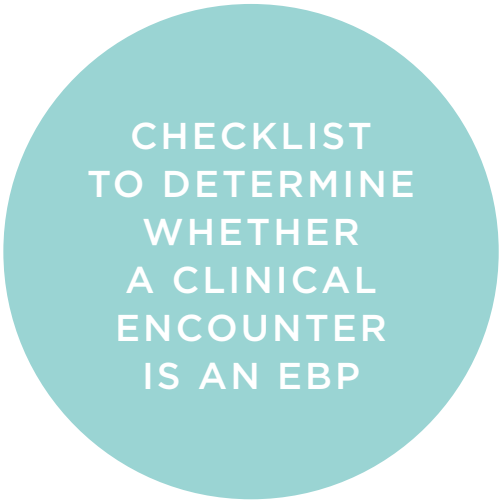
Generic treatment categories are treatment approaches that cover more than one specific intervention. Interventions within generic treatment categories share a common theory of change and common clinical practices. The use of these generic treatment categories allows the agency to identify and monitor the use of the clinical practices in a way that does not confine therapists to using clinical elements in a specific order. This helps to resolve one challenge healthcare systems face in tracking the use of EBPs. The figure below illustrates the relationship between a generic treatment category (CBT for Anxious Children) and the specific interventions falling within that category (Cool Kids, Coping Cat, CBT for Anxiety). The specific interventions all share common clinical practices and are defined by the use of core practices that are essential to the treatment category.

FIGURE 1: The Relationship among Generic Treatment Categories and EBPs

STEPS FOR REPORTING AN EBP

The steps for determining whether one is using an EBP are self–determined by the therapist. No additional documentation is required; however, agencies are encouraged to take steps to ensure that therapists understand these guidelines and use them appropriately.

FIGURE 2: Steps for Reporting EBPs



- ◯ **Training:** The provider has received an interactive training by an approved training entity.
- ◯ **Consultation:** The provider is up to date with the consultation requirements of the training entity, if required.
- ◯ **Treatment Plan:** The provider lists the brand name or generic model and at least one essential clinical element consistent with the model in the client treatment plan.
- ◯ **Progress Notes:** The provider lists at least one allowable clinical element in the progress notes for the indicated client session.

STEP ONE: Approved Training

Approved training entities include the developers of specific interventions as well as training organizations that cover the common clinical elements of a treatment category. Both types of training entities are listed in the Code Tables for the mental health diagnosis areas (page 10). The EBPI welcomes suggestions for expanding the training entities included on this list. Trainings must include an interactive component in which the trainee receives some feedback on their clinical skill. Eligible training entities include the following:

- The trainer has expertise in the treatment area and/or is certified by a training entity listed in the guides. Expertise is defined as an established history of training in the treatment category with a record of previous training in the treatment category area.
- If a trainer cannot point to a history of training on the topic area, the EBPI will review training curricula to ensure the training covers the essential and allowable elements of the clinical practice type in a structured format.
- To count towards an EBP, training received during graduate education must include a structured approach to a treatment category (e.g., CBT for Anxiety) that covers essential and allowable elements with supervised practice.

STEP TWO: Consultation Following Training

Therapists reporting the use of a manualized treatment (e.g. DBT) must be up to date with the respective training organization's requirements for ongoing consultation. If the training entity does not require ongoing consultation, the therapist can report the use of the manualized treatment as long as the other documentation requirements are met (below).

STEP THREE: Listing Essential Clinical Elements in the Treatment Plan

When documenting the use of an EBP, the provider should note the intended use of the EBP (treatment category or manualized treatment) and at least one essential clinical element in the treatment plan. The essential clinical elements are included in the Core Elements section (page 19). Essential elements are identified through systematic reviews of the research literature and in consultation with treatment experts.

STEP FOUR: Listing Allowable Elements in Progress Notes

When documenting the use of an EBP, the therapist should note the use of an allowable clinical element (listed in the Core Elements section on page 19) in the progress notes for the session.

Table 1 below provides an example of how an EBP can be documented in the treatment plan and progress notes.

TABLE 1: Examples of Treatment Plan and Progress Note Documentation *

	Manualized Treatment Reporting: TRAUMA	**Treatment Category Reporting: TRAUMA**
Treatment Plan	"TF-CBT to address trauma-specific impact. The treatment plan will follow the TF-CBT acronym PRACTICE and will include a trauma narrative and processing."	"CBT for trauma. Will include the components of psychoeducation, coping skills training and directly addressing the trauma through exposure."
Session Progress Note	"Psychoeducation and exposure: Presented rationale for the Trauma Narrative and began the Trauma Narrative."	"Psychoeducation: Discussed the rationale for directly addressing the client's trauma experience through processing and exposure exercise."

	Manualized Treatment Reporting: ANXIETY	**Treatment Category Reporting: ANXIETY**
Treatment Plan	"Coping Cat to address [specified anxiety disorder]. The treatment plan will follow the Coping Cat protocol."	"CBT for anxiety, specifically [specified anxiety disorder]. Will include the components of psychoeducation and exposure to the situation, worry, object or thing for which there is an unreasonable or inappropriate fear."
Session Progress Note	"Psychoeducation about anxiety", "Planned exposure"	"Psychoeducation about anxiety", "Planned exposure"

** Refer to the Client Friendly Language Guide for more examples of treatment plan language (coming spring 2020)*

ELIGIBLE ENCOUNTER CODES AND REPORTING OF EBPs

EBPs should only be reported for psychotherapy sessions. These include only a subset of 908XX encounters in the Service Encounter Reporting Instructions (SERI) (Table 2). The state monitors the number of sessions using an EBP, not the number of clients. Therefore, healthcare activities falling outside of psychotherapy sessions are not captured.

HCA reporting: To report EBPs for HCA claims, clinicians report only one type of EBP per encounter in the 2300 REF02 field of the 837 claim. The EBP number must be reported as a nine–digit number beginning with '860'. The next three digits must represent the appropriate EBP code as outlined in the SERI. The last three digits must be reported as '000'.

Example: CBT for Anxiety is: 860151000 with 151 representing the three–digit EBP code.

Table 5 on the pages 10–18 provides the list of codes for reporting EBPs. This crosswalk includes codes for manualized programs followed by generic trainings for each diagnosis area. Note that the generic training entities often train on more than one treatment type and the codes for the training entities will change depending on the generic treatment category/ diagnosis area. For example, if a provider received training through the CBT+ Learning Collaborative and was delivering CBT for Anxious Children, the provider would code the service as 151 (CBT for Anxious Children), and if the provider was delivering CBT for Depressed Children/Adolescents then the provider would code the service as 153 (CBT for Depressed Children/Adolescents).

TABLE 2: SERI Encounter Codes Eligible for EBP Reporting

Description	Encounter Code
Psychotherapy, 30 minutes with patient and/or family member	**90832**
Psychotherapy, 45 minutes with patient and/or family member	**90834**
Psychotherapy, 60 minutes with patient and/or family member	**90837**
Family psychotherapy without patient present	**90846**
Family psychotherapy (conjoint psychotherapy) with patient present	**90847**
Multiple–family group psychotherapy	**90849**
Group psychotherapy (other than of a multiple–family group)	**90853**
Psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure).	**90833**
Psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure).	**90836**
Psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service (list separately in addition to the code for primary procedure).	**90838**

UPDATES TO THE 2020 REPORTING GUIDE

As in previous years, the Evidence Based Practice Institute (EBPI) collaborated with the Washington State Institute for Public Policy (WSIPP) to review a number of new programs. EBPI also conducted a search of recent literature to identify systematic reviews of EBPs. Additonally, our team partnered with the Barnard Center for Infant Mental Health and Development at the University of Washington to add "Infant Mental Health" as a new treatment category including eligible training agencies. The following table lists specific changes that have been made to the 2020 Reporting Guide.

TABLE 3: Updates to the Reporting Guide

Specific Change	Section	Page
'Infant Mental Health' category has been added to the Reporting Guide	Codes for Evidence–Based Practices; Core Elements for Documenting EBPs	18 30–32
'Serious Emotional Disturbance' category has been removed and all programs previously listed under this category have been divided into three separate categories of 'Self–harm/Suicide', 'Eating Disorders' and 'Psychotic Disorders'	Codes for Evidence–Based Practices	16–17
23 new programs and training entities (including Infant Mental Health) have been added to the Reporting Guide	Codes for Evidence–Based Practices	10–18
** Refer to table 4 for the list of specific brand names and training entities*	New Programs and Training Entities	9
'Choice Theory/Reality Therapy' program has been removed from the Reporting Guide	Codes for Evidence–Based Practices	15
'Acceptance and Commitment Therapy (ACT)' program for the age group of 7–13 years has been removed from the Reporting Guide	Codes for Evidence–Based Practices	12
'Cognitive Behavioral Therapy in Prodromal/Early Episode Psychosis' program has been removed from the Reporting Guide	Codes for Evidence–Based Practices	17
'Individual Placement and Support for First Episode Psychosis' program has been removed from the Reporting Guide	Codes for Evidence–Based Practices	17
'Child–Parent Psychotherapy' program has been moved to the 'Infant Mental Health' section	Codes for Evidence–Based Practices	18
'Measurement–based Care' and 'Motivational Interviewing' have been added as allowable clinical elements	Core Elements for Documenting EBPs	20–29

TABLE 4: New Programs and Training Entities

Treatment/Diagnosis Category	Program and Training Entity	R/EBP Code	Source
ADHD	Child Life and Attention Skills (CLAS)	**300**	Evans et al. 2018, L1
	Plan My Life (PML)	**301**	Evans et al. 2018, L2
	Supporting Teens' Autonomy Daily (STAND)	**302**	Training Entity
Anxiety, OCD and Related Disorders	Exposure–Response Prevention (ERP) for youth with obsessive–compulsive disorder (OCD)	**311**	WSIPP 2019, R–based; Comer et al. 2019, L1
	The CALM Program	**312**	Comer et al. 2019, L1
	Being Brave	**313**	Comer et al. 2019, L1
	Integrated behavior therapy for selective mutism	**314**	Comer et al. 2019, L1
	Take Action Program	**315**	Comer et al. 2019, L2
	Confident Kids	**316**	Comer et al. 2019, L2
	Timid to Tiger	**317**	Comer et al. 2019, L2
	Turtle Program	**318**	Comer et al. 2019, L2
	Taming Sneaky Fears	**319**	Comer et al. 2019, L2
	Get Lost Mr. Scary Programme	**320**	Comer et al. 2019, L2
	FRIENDS Program	**321**	Comer et al. 2019, L2
	Seattle Children's OCD–Intensive Outpatient Program (OCD–IOP)	**311**	Training Entity
Disruptive Behavior	Multimodal therapy (MMT) for children with disruptive behavior	**330**	WSIPP 2019 , R–based
Eating Disorders	Seattle Children's Eating Disorder Clinic	**221**	Training Entity
Psychotic Disorders	University of Washington First Episode Psychosis/CBT for Psychosis Program	**240**	Training Entity
Trauma	Kids Club & Moms Empowerment	**340**	WSIPP 2019, R–based
Infant Mental Health	Infant–Parent Psychotherapy (IPP)	**351**	Training Entity
	Promoting First Relationships (PFR)	**352**	Training Entity
	Attachment and Biobehavioral Catch–up (ABC)	**353**	Training Entity
	National Child Traumatic Stress Network Learning Collaboratives	**354**	Training Entity

TABLE 5: Codes for Evidence-Based Practices

ATTENTION-DEFICIT/ HYPERACTIVITY DISORDER (ADHD)

Treatment Types	Program and Training Entity	R/EBP Code	Source
Parent Behavioral Therapy (PBT) with or without child	Barkley Model	**003**	WSIPP 2019, R–based
	Child Life and Attention Skills (CLAS)	**200**	Evans et al. 2014, L1
	Coaching Our Acting–Out Children: Heightening Essential Skills (COACHES)	**201**	Evans et al. 2014, L1
	Incredible Years	**073**	Evans et al. 2014, L1
	New Forest Parenting Program (NFPP)	**181**	WSIPP 2019, R–based; Evans et al. 2018, L1
	Strategies to Enhance Positive Parenting (STEPP)	**202**	Evans et al. 2018, L1
	Child Life and Attention Skills (CLAS)	**300**	Evans et al. 2018, L1
	Plan My Life (PML)	**301**	Evans et al. 2018, L2
	Harborview CBT+ Learning Collaborative	**148**	Training Entity
	University of Washington Certificate in EBP in Children's Behavioral Health	**148**	Training Entity
	University of Washington MA in Applied Child and Adolescent Psychology	**148**	Training Entity
Uncategorized Programs	Multimodal Therapy (MMT) for children with ADHD	**091**	WSIPP 2019, R–based
	Neurofeedback Training	**206**	Evans et al. 2018, L3
	Organizational Skills Training (OST)	**207**	Evans et al. 2014, L1
	Supporting Teens' Autonomy Daily (STAND)	**302**	Training Entity

Table cont'd ⟶

ANXIETY, OCD AND REALATED DISORDERS

Treatment Types	Program and Training Entity	R/EBP Code	Source
Cognitive Behavioral Therapy (CBT) for anxiety, OCD and related disorders	Acceptance and Commitment Therapy (ACT) for children with anxiety	**151**	WSIPP 2019, R–based
	Cool Kids	**032**	WSIPP 2019, R–based
	Coping Cat	**035**	WSIPP 2019, R–based
	Coping Cat/Koala book based model	**157**	WSIPP 2019, R–based
	Coping Koala	**158**	WSIPP 2019, R–based
	Parent cognitive behavioral therapy (CBT) for children with anxiety	**187**	WSIPP 2019, R–based
	Modularized Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH–ADTC)	**085**	WSIPP 2019, E–based
	Exposure–Response Prevention (ERP) for youth with obsessive–compulsive disorder (OCD)	**311**	WSIPP 2019, R–based; Comer et al. 2019, L1
	The CALM Program	**312**	Comer et al. 2019, L1
	Being Brave	**313**	Comer et al. 2019, L1
	Integrated behavior therapy for selective mutism	**314**	Comer et al. 2019, L1
	Take Action Program	**315**	Comer et al. 2019, L2
	Confident Kids	**316**	Comer et al. 2019, L2
	Timid to Tiger	**317**	Comer et al. 2019, L2
	Turtle Program	**318**	Comer et al. 2019, L2
	Taming Sneaky Fears	**319**	Comer et al. 2019, L2
	Get Lost Mr. Scary Programme	**320**	Comer et al. 2019, L2
	FRIENDS Program	**321**	Comer et al. 2019, L2
	Effective Child Therapy/Society of Clinical Child and Adolescent Psychology	**151**	Training Entity
	Harborview CBT+ Learning Collaborative	**151**	Training Entity

Table cont'd ⟶

ANXIETY, OCD AND RELATED DISORDERS (cont'd)

Treatment Types	Program and Training Entity	R/EBP Code	Source
	Managing and Adapting Practice (MAP)	**151**	Training Entity
	The Reach Institute (CATIE trainings)	**151**	Training Entity
	University of Washington Certificate in EBP in Children's Behavioral Health	**151**	Training Entity
	University of Washington MA in Applied Child and Adolescent Psychology	**151**	Training Entity
	Seattle Children's OCD–Intensive Outpatient Program (OCD–IOP)	**311**	Training Entity

DEPRESSION

AGE 7 TO 13			
Treatment Types	**Program and Training Entity**	**R/EBP Code**	**Source**
Cognitive Behavioral Therapy (CBT) for depression	Modularized Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH–ADTC)	**085**	WSIPP 2019, E–based
	Primary and Secondary Control Enhancement Training (PASCET)	**209**	Weersing et al. 2017, L3
	Managing and Adapting Practice (MAP)	**153**	Training Entity
	Harborview CBT+ Learning Collaborative	**153**	Training Entity
	University of Washington MA in Applied Child and Adolescent Psychology	**153**	Training Entity
	University of Washington Certificate in EBP in Children's Behavioral Health	**153**	Training Entity
	Effective Child Therapy / Society of Clinical Child and Adolescent Psychology	**153**	Training Entity
	The Reach Institute (CATIE trainings)	**153**	Training Entity

Table cont'd →

DEPRESSION (cont'd)

AGE 14 TO 24			
Treatment Types	**Program and Training Entity**	**R/EBP Code**	**Source**
Cognitive Behavioral Therapy (CBT) for depression	Acceptance and Commitment Therapy (ACT) for children with depression	**153**	WSIPP 2019, R–based
	Coping With Depression - Adolescents	**159**	WSIPP 2019, R–based; Weersing et al. 2017, L1
	Modularized Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH–ADTC)	**085**	WSIPP 2019, E–based
	Primary and Secondary Control Enhancement Training (PASCET)	**153**	Training Entity
	Managing and Adapting Practice (MAP)	**153**	Training Entity
	Effective Child Therapy / Society of Clinical Child and Adolescent Psychology	**153**	Training Entity
	Harborview CBT+ Learning Collaborative	**153**	Training Entity
	The Reach Institute (CATIE trainings)	**153**	Training Entity
	University of Washington MA in Applied Child and Adolescent Psychology	**153**	Training Entity
	University of Washington Certificate in EBP in Children's Behavioral Health	**153**	Training Entity
Interpersonal Psychotherapy (IPT)	Individual–based IPT (12 sessions)	**210**	Weersing et al. 2017, L1
	Interpersonal Psychotherapy–Adolescent Skills Training (IPT–AST)	**211**	Weersing et al. 2017, L2
Uncategorized Programs	Attachment–Based Family Therapy	**212**	Weersing et al. 2017, L3
	Blues Program	**149**	WSIPP 2019, R–based

Table cont'd →

DISRUPTIVE BEHAVIOR (OPPOSITIONAL DEFIANT DISORDER OR CONDUCT DISORDER)

Treatment Types	Program and Training Entity	R/EBP Code	Source
Parent Behavioral Therapy (PBT) with or without child	Brief PMTO	**188**	Kaminski & Claussen 2017, L2
	Communication Method Program (COMET)	**148**	Kaminski & Claussen 2017, L1
	Coping Power Program	**148**	WSIPP 2019, R–based
	Enhanced Behavioral Family Intervention	**213**	Kaminski & Claussen 2017, L3
	First Step to Success	**215**	Kaminski & Claussen 2017, L2
	Incredible Years Basic	**073**	WSIPP 2019, R–based; Kaminski & Claussen 2017, L1
	Incredible Years: Parent training + Child training	**076**	WSIPP 2019, R–based
	Oregon Social Learning Program (OSLO)	**148**	Kaminski & Claussen 2017, L1
	Parent Management Training Oregon (PMTO)	**188**	WSIPP 2019, R–based; Kaminski & Claussen 2017, L1
	Parent Management Training (PMT)	**188**	Kaminski & Claussen 2017, L1
	Parent–Child Interaction Therapy (PCIT)	**186**	WSIPP 2019, R–based
	Social Learning Parent Training (Hanf model)	**214**	Kaminski & Claussen 2017, L1
	Stop Now and Plan (SNAP)	**148**	WSIPP 2019, E–based; Kaminski & Claussen 2017, L2
	Triple–P Positive Parenting Program: Level 4, Group	**139**	WSIPP 2019, E–based; Kaminski & Claussen 2017, L1

Table cont'd →

DISRUPTIVE BEHAVIOR (OPPOSITIONAL DEFIANT DISORDER OR CONDUCT DISORDER) (cont'd)

Treatment Types	Program and Training Entity	R/EBP Code	Source
	Triple–P Positive Parenting Program: Level 4, Individual	**140**	WSIPP 2019, R–based
	Triple P Precursor	**140**	Kaminski & Claussen 2017, L1
	Tuning Into Kids	**148**	Kaminski & Claussen 2017, L2
	Child Parent Relationship Therapy	**148**	WSIPP 2019, E–based
	Multimodal therapy (MMT) for children with disruptive behavior	**330**	WSIPP 2019 , R–based
	Helping Noncompliant Child	**171**	Training Entity
	Harborview CBT+ Learning Collaborative	**148**	Training Entity
	Managing and Adapting Practice (MAP)	**148**	Training Entity
	Research Units in Behavioral Intervention (RUBI)	**148**	Training Entity
	STAY	**148**	Training Entity
	The Reach Institute (CATIE trainings)	**148**	Training Entity
	University of Washington MA in Applied Child and Adolescent Psychology	**148**	Training Entity
	University of Washington Certificate in EBP in Children's Behavioral Health	**148**	Training Entity
Child Behavioral Therapy (Individual)	Problem Solving Skills Training	**216**	Kaminski & Claussen 2017, L2
Uncategorized Programs	Brief Strategic Family Therapy (BSFT)	**010**	WSIPP 2019, R–based

Table cont'd →

DISRUPTIVE BEHAVIOR (OPPOSITIONAL DEFIANT DISORDER OR CONDUCT DISORDER) (cont'd)

Treatment Types	Program and Training Entity	R/EBP Code	Source
	Modularized Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH–ADTC)	**085**	WSIPP 2019, E–based
	Adlerian Play Therapy	**217**	Kaminski & Claussen 2017, **L2**
	Group Activity Play Therapy	**218**	Kaminski & Claussen 2017, **L2**

SELF-HARM/SUICIDE

Treatment Types	Program and Training Entity	R/EBP Code	Source
	Dialectical Behavior Therapy (DBT) for adolescent self–harming behavior	**160**	WSIPP 2019, R–based
	Multisystemic Therapy (MST) for youth with serious emotional disturbance (SED)	**180**	WSIPP 2019, E–based
	Collaborative Assessment and Management of Suicidality (CAMS)	**220**	Training Entity

EATING DISORDERS

Treatment Types	Program and Training Entity	R/EBP Code	Source
	Family–Based Treatment (FBT) for Eating Disorders	**221**	WSIPP 2019, E–based
	Seattle Children's Eating Disorder Clinic	**221**	Training Entity

Table cont'd →

PSYCHOTIC DISORDERS

Treatment Types	Program and Training Entity	R/EBP Code	Source
Cognitive Behavioral Therapy (CBT) for psychosis	University of Washington First Episode Psychosis/CBT for Psychosis Program	**240**	Training Entity

TRAUMA

Treatment Types	Program and Training Entity	R/EBP Code	Source
Cognitive Behavioral Therapy (CBT) for trauma	Classroom–based intervention for war–exposed children	**013**	WSIPP 2019, E–based
	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	**016**	WSIPP 2019, E–based; Dorsey et al. 2017, L1
	Enhancing Resiliency Among Students Experiencing Stress (ERASE–Stress)	**162**	WSIPP 2019, E–based
	Narrative Exposure Therapy (KID–NET)	**079**	WSIPP 2018, E–based; Dorsey et al. 2017, L1
	Prolonged Exposure for Adolescents (PE–A)	**223**	Dorsey et al. 2017, L1
	Risk Reduction through Family Therapy (RRFT)	**224**	Dorsey et al. 2017, L1
	Support for Students Exposed to Trauma (SSET)	**225**	Dorsey et al. 2017, L1
	Teaching Recovery Techniques (TRT)	**155**	Dorsey et al. 2017, L1
	Trauma Focused CBT for children	**136**	WSIPP 2019, E–based; Dorsey et al. 2017, L1; Comer et al. 2019, L1
	Trauma Grief Component Therapy	**137**	WSIPP 2019, E–based
	Modularized Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH–ADTC)	**085**	WSIPP 2019, E–based
	Kids Club & Moms Empowerment	**340**	WSIPP 2019, R–based

Table cont'd →

TRAUMA (cont'd)

Treatment Types	Program and Training Entity	R/EBP Code	Source
	Managing and Adapting Practice (MAP)	**155**	Training Entity
	Harborview CBT+ Learning Collaborative	**155**	Training Entity
	The Reach Institute (CATIE trainings)	**155**	Training Entity
	University of Washington MA in Applied Child and Adolescent Psychology	**155**	Training Entity
	University of Washington Certificate in EBP in Children's Behavioral Health	**155**	Training Entity
Uncategorized Programs	Eye Movement Desensitization and Reprocessing (EMDR)	**043**	Dorsey et al. 2017, L2
	Group Mind–Body Skills	**222**	Dorsey et al. 2017, L3
	Trauma Affect Regulation: Guide for Education and Therapy (TARGET)	**226**	Dorsey et al. 2017, L3

INFANT MENTAL HEALTH

Treatment Types	Program and Training Entity	R/EBP Code	Source
	Child–Parent Psychotherapy (CPP)	**350**	WSIPP 2019, R–based
	Infant–Parent Psychotherapy (IPP)	**351**	Training Entity
	Promoting First Relationships (PFR)	**352**	Training Entity
	Attachment and Biobehavioral Catch–up (ABC)	**353**	Training Entity
	National Child Traumatic Stress Network Learning Collaboratives	**354**	Training Entity

CORE ELEMENTS FOR DOCUMENTING EBPs

This section highlights the essential and allowable clinical elements within each of the six treatment families listed below. These are included to guide the documentation of EBPs in treatment plans and progress notes and should not be viewed as a clinical guide. Clinical guidance should be obtained by a qualified trainer. Each treatment family included in this guide includes two sections. The first section provides the clinical elements determined by EBPI to be "essential" to the treatment approach. These elements were selected after reviewing the research literature and consulting with clinical experts. The provider should select at least one essential element to document in the treatment plan when reporting an EBP. The second section within each treatment family provides all of the allowable clinical elements. Allowable elements are all of the common elements across different manualized treatments within the same treatment family. At least one allowable element should be documented in the session progress note for any encounters reported as EBPs. In general, allowable elements should last approxiamately 20 minutes in order to be adequately addressed in session. Documentation should include the name of the element, *(e.g., praise, psychoeducation)*, or include a description of the activity that closely follows the definition provided in these guides.

PARENT BEHAVIORAL THERAPY (PBT) WITH OR WITHOUT CHILD p. 20
COGNITIVE BEHAVIORAL THERAPY (CBT) FOR ANXIETY p. 22
COGNITIVE BEHAVIORAL THERAPY (CBT) FOR DEPRESSION p. 24
INTERPERSONAL PSYCHOTHERAPY (IPT) F OR DEPRESSED ADOLESCENTS p. 26
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PARENT BEHAVIORAL THERAPY (PBT) WITH OR WITHOUT CHILD

TREATMENT FAMILY DESCRIPTIONS

Group or Individual Parent Behavior Training: A training that teaches caregivers skills for managing child behaviors (e.g. differential reinforcement, use of rewards/consequences, praise) without child participation.

Group or Individual Parent Behavior Training with Child Participation: A training that teaches caregivers skills for managing child behaviors with the child present. This can involve live action coaching of the caregiver to enhance the caregiver/child relationship or coaching the caregivers on behavior management techniques such as differential reinforcement.

ESSENTIAL CLINICAL ELEMENTS FOR TREATMENT PLANS

a. Praise

Description: Parental praise involves providing the rationale regarding the value of praise, demonstrating how to use labeled praise in interactions with their child, how to praise (tone of voice), and how to identify opportunities for praise (e.g. following good behavior).

b. Commands

Description: Therapist provides the caregiver with strategies to clearly and consistently communicate instructions to the child.

c. Psychoeducation for parents

Description: Psychoeducation for caregivers involves educating the caregiver about how, for example, ADHD, ODD and other disruptive disorders work.

ALLOWABLE CLINICAL ELEMENTS FOR PROGRESS NOTES

a. Praise

Description: Therapist provides the rationale regarding the value of praise, demonstrating how to use labeled praise in interactions with their child, how to praise (tone of voice), and how to identify opportunities for praise (e.g. following good behavior).

b. Commands

Description: Therapist provides the caregiver with strategies to clearly and consistently communicate instructions to the child.

c. Psychoeducation for parents

Description: Psychoeducation for caregivers involves educating the caregiver about how, for example, ADHD, ODD and other disruptive disorders work.

d. Tangible Rewards

Description: Caregivers are taught to provide rewards when the child exhibits desired behaviors.

e. Relaxation skills

Description: Introducing relaxation skills involves talking about what relaxation is, increasing the child's awareness about his or her own tension, demonstrating what relaxation feels like in session, and teaching the child how to relax on demand in anxious situations.

f. Time out

Description: Time out involves the caregiver providing a rationale for the timeout, removing the child from all activities and attention, and revisiting the intended target behavior they need to see to avoid future consequences.

g. Problem solving — for the child

Description: Therapist teaches the child how to clearly define the problem, generate possible solutions, examine the solutions, pick one to try out and then examine the effects.

h. Self-reward/self-praise

Description: Therapist helps the child to identify opportunities which increase self−praise or self−reward and to increase their effort and performance of desirable behaviors.

i. Differential Reinforcement

Description: Teaching caregivers to remove attention and rewards from minor disruptive behaviors and to provide increased attention and rewards for appropriate behaviors.

j. Monitoring

Description: Observing and monitoring target behaviors which illuminate areas of concern and provide important information about treatment progress to the caregiver.

k. Therapist Praise/Rewards

Description: Similar to how caregivers use praise, therapists can use this as a mechanism for working on treatment goals, and to increase self−esteem and the child's/family's commitment to therapy. This can also be used with the caregiver to encourage participation.

l. Stimulus Control or Antecedent Management

Description: Therapist assists the caregiver in identifying events that may lead to appropriate or inappropriate behavior.

m. Self-verbalization

Description: Teaching the youth to reinforce or praise him or herself for on−task performance, how to use verbal instructions to guide task performance (saying tasks out loud), and to help the youth to work independently and improve performance by means of self−instruction.

n. Measurement-based Care

Description: Measurement based care (MBC) is a care delivery approach involving the regular use of standardized measures in routine mental health care to inform treatment and to identify individuals not improving as expected and to encourage treatment changes. It may be added to or integrated with any model of practice.

o. Motivational Interviewing

Description: Motivational Interviewing is a client−centered, directive therapeutic approach that focuses on helping clients resolve ambivalent feelings and discover internal motivation to change their behavior. It is a short−term therapeutic approach that is focused and goal−directed. It may be integrated with any therapeutic model.

COGNITIVE BEHAVIORAL THERAPY (CBT) FOR ANXIETY

TREATMENT FAMILY DESCRIPTION

Cognitive behavioral therapy focuses on the interrelationship among thoughts, feelings, and behaviors, and is based on the premise that changes in any one domain can improve functioning in the other domains. CBT focuses on challenging and changing unhelpful or inaccurate cognitions (e.g. thoughts, beliefs, and attitudes), changing behaviors, improving emotional regulation, and the development of personal coping strategies that target solving current problems. CBT approaches for anxiety include imaginal and in vivo exposure, psychoeducation, and creating opportunities for new learning about the client's ability to tolerate anxiety/distress, cognitive restructuring, and coping skills (e.g., relaxation skills training).

ESSENTIAL CLINICAL ELEMENTS FOR TREATMENT PLANS

a. Exposure

Description: Exposure is a practice to decrease anxiety associated with thoughts related to worry, objects or situations that are not dangerous. The child learns through practice to tolerate facing up to non−dangerous thoughts, objects or situations until the anxious feelings decrease or can be tolerated.

b. Cognitive Restructuring

Description: Cognitive restructuring involves teaching children how thoughts can influence anxiety and helping them come up with more accurate and helpful thoughts.

ALLOWABLE CLINICAL ELEMENTS FOR PROGRESS NOTES

a. Exposure

Description: Exposure is a practice to decrease anxiety associated with thoughts related to worry, objects or situations that are not dangerous. The child learns through practice to tolerate facing up to non−dangerous thoughts, objects or situations until the anxious feelings decrease or can be tolerated.

b. Cognitive Restructuring

Description: Cognitive restructuring involves teaching children how thoughts can influence anxiety and helping them come up with more accurate and helpful thoughts.

c. Psychoeducation for Children

Description: Psychoeducation is providing information to children about anxiety and the CBT based model for treatment.

d. Psychoeducation for Caregivers

Description: Psychoeducation is providing information to caregivers about anxiety and the CBT based model for treatment.

e. Relaxation

Description: Teaching the child through modeling and practicing the difference between being relaxed and tense and how to induce a state of relaxation using breathing, tensing and relaxing muscle groups, guided imagery, and mindfulness.

f. Cognitive Coping

Description: Teaching the child to use self-talk or reappraisal to overcome, manage or tolerate anxious/worry thoughts.

g. Mood or Emotion Self-monitoring

Description: Self-monitoring involves teaching children to identify fear/anxiety/worry emotional states and develop a rating scale (feelings thermometer) for the intensity of the emotional state.

h. Self-reward/Self-praise

Description: Self-reward/self-praise involves helping the child attend to and acknowledge efforts to face up to and handle their fears/ anxieties/worries.

i. Rewards/Reinforcement

Description: Caregivers acknowledge, praise or give tangible rewards to the child for taking steps towards overcoming or managing their fears/anxieties/worries.

j. Measurement-based Care

Description: Measurement based care (MBC) is a care delivery approach involving the regular use of standardized measures in routine mental health care to inform treatment and to identify individuals not improving as expected and to encourage treatment changes. It may be added to or integrated with any model of practice.

k. Motivational Interviewing

Description: Motivational Interviewing is a client-centered, directive therapeutic approach that focuses on helping clients resolve ambivalent feelings and discover internal motivation to change their behavior. It is a short-term therapeutic approach that is focused and goal-directed. It may be integrated with any therapeutic model.

COGNITIVE BEHAVIORAL THERAPY (CBT) FOR DEPRESSION

TREATMENT FAMILY DESCRIPTION

Cognitive behavioral therapy emphasizes the interrelationship among thoughts, feelings, and behaviors, and is based on the premise that changes in any one domain can improve functioning in the other domains. CBT for Depression involves behavioral activation/pleasant activity scheduling, psychoeducation, goal setting, and problem solving. CBT also focuses on challenging and changing unhelpful cognitions (e.g. thoughts, beliefs, and attitudes), changing unhelpful behaviors, improving emotional regulation, and developing personal coping strategies that target solving current problems.

ESSENTIAL CLINICAL ELEMENTS FOR TREATMENT PLANS

a. Behavioral Activation

Description: The child engages in specific activities that lift mood or change child's negative, unhelpful and unrealistic thoughts. Activity scheduling involves planning and carrying out mood–elevating activities in child's day. Activities should be those which emphasize the link between positive activities and feeling good.

b. Problem Solving

Description: Problem solving involves teaching the child how to clearly define their problem, generate possible solutions, examine the solutions, pick one to try out and then evaluate the effects.

c. Cognitive Restructuring

Description: Cognitive restructuring involves teaching the youth how to identify and counter negative thoughts that interfere with mood or motivation or functioning.

ALLOWABLE CLINICAL ELEMENTS FOR PROGRESS NOTES

a. Behavioral Activation

Description: The child engages in specific activities that lift mood or change child's negative, unhelpful and unrealistic thoughts. Activity scheduling involves planning and carrying out mood–elevating activities in child's day. Activities should be those which emphasize the link between positive activities and feeling good.

b. Problem Solving

Description: Problem solving involves teaching the child how to clearly define their problem, generate possible solutions, examine the solutions, pick one to try out and then evaluate the effects.

c. Cognitive Restructuring

Description: Cognitive restructuring involves teaching the youth how to identify and counter negative thoughts that interfere with mood or motivation or functioning.

c. Psychoeducation for Children

Description: Psychoeducation is providing information to children about depression and the CBT based model for treatment.

d. Psychoeducation for Caregivers

Description: Psychoeducation is providing information to caregivers about depression and the CBT based model for treatment.

f. Mood or Emotion Self-monitoring

Description: Self−monitoring involves teaching children to identify emotional states of being down or feeling pumped up and develop a rating scale (feeling thermometer) for the intensity of the emotional state.

g. Goal Setting

Description: A means to identify goals that are important to the child and a step by step process to achieve their desired outcomes.

h. Social Skills Training

Description: Therapist uses modeling and practice to teach the child basic skills to develop positive peer relationships.

i. Self-reward/Self-praise

Description: Self−award/self−praise involves helping the child attend to and acknowledge efforts to get active, solve problems or take steps towards goals.

j. Talent or Skill Building

Description: Assisting children in developing talents and skills that will induce positive self−regard.

k. Caregiver Coping

Description: Teaching the caregiver skills or strategies for reducing distress and managing feelings related to their child's depression symptoms.

l. Rewards/Reinforcement

Description: The caregiver acknowledges, praises or gives tangible rewards to the child for getting active, taking steps toward goals, problem solving.

m. Measurement-based Care

Description: Measurement based care (MBC) is a care delivery approach involving the regular use of standardized measures in routine mental health care to inform treatment and to identify individuals not improving as expected and to encourage treatment changes. It may be added to or integrated with any model of practice.

n. Motivational Interviewing

Description: Motivational Interviewing is a client−centered, directive therapeutic approach that focuses on helping clients resolve ambivalent feelings and discover internal motivation to change their behavior. It is a short−term therapeutic approach that is focused and goal−directed. It may be integrated with any therapeutic model.

INTERPERSONAL PSYCHOTHERAPY (IPT) FOR DEPRESSED ADOLESCENTS

TREATMENT FAMILY DESCRIPTION

Interpersonal Psychotherapy is a brief, attachment–focused psychotherapy that centers on resolving interpersonal problems and symptomatic recovery. IPT is based on the principle that relationships, life events and mood are interrelated.

ESSENTIAL CLINICAL ELEMENTS FOR TREATMENT PLANS

a. Developing an Interpersonal Formulation

Description: Therapist assists/helps the adolescent in seeing the relationship between their depressed mood and one of four identified interpersonal problem areas [grief, interpersonal disputes (role disputes), role transitions, interpersonal sensitivity (interpersonal deficits)].

b. Clarifying Roles

Description: Therapist helps the adolescent understand expectations that both sides have in a relationship and addresses whether or not those expectations need to be revised or reduced to alleviate depression. Also helps the client understand the roles in relationships and their contribution to depression. Therapist may help the adolescent to consider letting go of old roles, accepting new roles, renegotiating aspects of the role, and developing a sense of mastery over the new role.

c. Cognitive Restructuring

Description: Therapist helps the adolescent become aware of unhelpful, negative thoughts. Then, identifies strategies to develop more helpful thoughts that contribute to adaptive functioning

ALLOWABLE CLINICAL ELEMENTS FOR PROGRESS NOTES

a. Developing an Interpersonal Formulation

Description: Therapist assists/helps the adolescent in seeing the relationship between their depressed mood and one of four identified interpersonal problem areas [grief, interpersonal disputes (role disputes), role transitions, interpersonal sensitivity (interpersonal deficits)].

b. Clarifying Roles

Description: Therapist helps the adolescent understand expectations that both sides have in a relationship and addresses whether or not those expectations need to be revised or reduced to alleviate depression. Also helps the client understand the roles in relationships and their contribution to depression. Therapist may help the adolescent to consider letting go of old roles, accepting new roles, renegotiating aspects of the role, and developing a sense of mastery over the new role.

c. Cognitive Restructuring

Description: Therapist helps the adolescent identify, acknowledge and accept painful thoughts and develop new thoughts that may help lead to growth and change.

d. Conduct an Interpersonal inventory

Description: Therapist conducts an interpersonal inventory through a review of the patient's patterns in relationships, capacity for intimacy and an evaluation of the quality of current relationships. This inventory can be done using the Closeness Circle where the therapist works with the client to identify and place all people with whom the adolescent has a relationship into the circles depending on degree of closeness that the adolescent feels with the person. The person in the circle could also be deceased, like a grandparent. Therapist may also use a "depression circle" that concretely documents the relationship between client's emotions/feelings (depressed mood) and events in client's interpersonal relationships.

e. Psychoeducation about depression and IPT

Description: Therapist gives information about depression, such as information about rates of depression, common symptoms and co-occurring problems, impact on functioning and effective treatment strategies.

f. Communication Analysis

Description: Therapist helps change adolescent's indirect verbal and nonverbal communication to more direct, less ambiguous verbal communication.

g. Communication Skills

Description: Therapist teaches the adolescent effective communication strategies, including: communicating feelings, expectations and opinions directly and clearly; clarifying misperceptions made by the other person; seeing another person's point of view and using empathy appropriately; communicating when calm rather than when angry; and using "I statements" to express feelings.

h. Problem-solving

Description: Therapist helps the adolescent with making decisions related to the identified interpersonal problem area. This involves helping the client consider a range of alternative behaviors/action that they can take in interpersonal problem areas and to assess the possible consequences associated with each of those actions. This may also be called Decision Analysis.

i. Measurement-based Care

Description: Measurement based care (MBC) is a care delivery approach involving the regular use of standardized measures in routine mental health care to inform treatment and to identify individuals not improving as expected and to encourage treatment changes. It may be added to or integrated with any model of practice.

j. Motivational Interviewing

Description: Motivational Interviewing is a client-centered, directive therapeutic approach that focuses on helping clients resolve ambivalent feelings and discover internal motivation to change their behavior. It is a short-term therapeutic approach that is focused and goal-directed. It may be integrated with any therapeutic model.

COGNITIVE BEHAVIORAL THERAPY (CBT) FOR TRAUMA

TREATMENT FAMILY DESCRIPTION

Individual CBT: Cognitive behavioral therapy focuses on the interrelationship among thoughts, feelings, and behaviors, and is based on the premise that changes in any one domain can improve functioning in the other domains. CBT for trauma impact focuses on helping the child to face up to and manage distressing trauma–related memories and reminders and challenging and changing unhelpful or inaccurate cognitions (e.g. thoughts, beliefs, and attitudes) related to the trauma. Child–focused CBT approaches for trauma include psychoeducation, coping skills, imaginal and in vivo exposure to reduce avoidance and maladaptive associations with trauma, and cognitive processing. CBT for trauma may also address changing unhelpful behaviors, improving emotional regulation, and the development of personal coping strategies that target solving current problems.

Individual CBT with Parent: Individual CBT with parent includes mostly separate parallel sessions with parents. Parent sessions include same treatment elements as child sessions. Some treatment sessions include parent and child together.

ESSENTIAL CLINICAL ELEMENTS FOR TREATMENT PLANS

a. Exposure

Description: Exposure is a practice to decrease anxiety associated with remembering the trauma or reminders of the trauma (people, places, objects, situations). The child learns through practice to tolerate remembering the trauma and to face non–dangerous reminders of the trauma.

b. Cognitive Processing

Description: Cognitive processing involves identification of untrue and/or unhelpful thoughts about the trauma and its aftermath and adopting more helpful ways to think about the trauma and its aftermath.

ALLOWABLE CLINICAL ELEMENTS FOR PROGRESS NOTES

a. Exposure

Description: Exposure is a practice to decrease anxiety associated with remembering the trauma or reminders of the trauma (people, places, objects, situations). The child learns through practice to tolerate remembering the trauma and to face up to non–dangerous reminders of the trauma in vivo.

b. Cognitive Processing

Description: Cognitive processing involves identification of untrue or unhelpful thoughts about the trauma and its aftermath and adopting more helpful ways to think about the trauma and its aftermath.

c. Psychoeducation for Children

Description: Psychoeducation is providing information to children about trauma, trauma impact and the CBT based model for treatment.

d. Psychoeducation for Caregivers

Description: Psychoeducation is providing information to caregivers about trauma, trauma impact and the CBT based model for treatment.

e. Relaxation

Description: Teaching the child though modeling and practice the difference between being relaxed and tense and how to induce a state of relaxation using breathing, tensing and relaxing muscles groups, guided imagery, and mindfulness.

f. Cognitive Coping

Description: Teaching the child to use self−talk or reappraisal to overcome, manage or tolerate fearful/anxious/worry thoughts related to the trauma.

g. Mood or Emotion Self-Monitoring

Description: Self−monitoring involves teaching children to identify trauma−related fear/anxiety/worry emotional states and develop a rating scale (feeling thermometer) for the intensity of the emotional state.

h. Self-reward/Self-praise

Description: Involves helping the child attend to and acknowledge efforts to face up to and handle their fears/anxieties/worries about the trauma.

i. Rewards/Reinforcement

Description: Caregivers acknowledge praise or give tangible rewards to the child for taking steps towards overcoming or managing their trauma−related fears/anxieties or worries about the trauma.

j. Personal Safety Skills

Description: Helping the child understand issues related to personal safety and teaching them to assess risk and develop strategies for maintaining personal safety.

k. Measurement-based Care

Description: Measurement based care (MBC) is a care delivery approach involving the regular use of standardized measures in routine mental health care to inform treatment and to identify individuals not improving as expected and to encourage treatment changes. It may be added to or integrated with any model of practice.

l. Motivational Interviewing

Description: Motivational Interviewing is a client−centered, directive therapeutic approach that focuses on helping clients resolve ambivalent feelings and discover internal motivation to change their behavior. It is a short−term therapeutic approach that is focused and goal−directed. It may be integrated with any therapeutic model.

INFANT MENTAL HEALTH

TREATMENT FAMILY DESCRIPTION

Infant–early childhood mental health is defined as the developing capacity of the child from birth to 5 years of age to form close and secure adult and peer relationships; experience, manage, and express a full range of emotions; and explore the environment and learn – all in the context of family, community and culture. Infant mental health treatment is designed to alleviate the distress and suffering of the infant, or young child's mental health problems, and support the return to healthy development and behavior by enhancing the quality of the caregiver–child relationship. Infant mental health treatment is dyadic.

ESSENTIAL CLINICAL ELEMENTS FOR TREATMENT PLANS

a. Build Reflective Capacity

Description: Therapist asks the caregiver to reflect on the child's potential feelings or needs, and how feelings and needs are connected to child's behavior and experience, and caregivers' parenting behavior or experience. Provider assists the caregiver in understanding how feelings and needs motivate behavior, often out of conscious awareness or intention.

b. Support Safe and Attuned Caregiver Behaviors

Description: Therapist helps the caregiver identify safety needs of the child, helps the caregiver provide safe, attuned and predictable care, and helps the caregiver nurture the child by attuned care which includes attention to rupture and repair in moment to moment interaction. Attunement is defined as an observable pattern of dyadic interaction that is mutually regulated, reciprocal, and harmonious. Therapist teaches the caregiver to recognize behaviors and cues of the child and then assists the caregiver in identifying ways to respond to the child that increases their safety, attunement, and predictability.

c. Affect Regulation

Description: Therapist assists the caregiver to recognize, experience, express, and manage a wide range of emotions. Therapist assists the caregiver in responding to the child's emotions with attuned sensitivity such that the child can begin to learn to manage their feelings and actions with reliance on caregivers for regulatory assistance and for the development of autonomy.

ALLOWABLE CLINICAL ELEMENTS FOR PROGRESS NOTES

a. Build Reflective Capacity

Description: Therapist asks the caregiver to reflect on child's potential feelings or needs, and how feelings and needs are connected to child's behavior and experience, and caregivers' parenting behavior or experience. Provider assists the caregiver in understanding how feelings and needs motivate behavior, often out of conscious awareness or intention.

b. Support Safe and Attuned Caregiver Behaviors

Description: Therapist helps the caregiver identify safety needs of the child, helps the caregiver provide safe, attuned, and predictable care, and helps caregiver nurture the child by attuned care which includes attention to rupture and repair in moment to moment interaction. Attunement is defined as an observable pattern of dyadic interaction that is mutually regulated, reciprocal, and harmonious. Therapist teaches the caregiver to recognize behaviors and cues of the child and then assists the caregiver in identifying ways to respond to the child that increases their safety, attunement, and predictability.

c. Affect Regulation

Description: Therapist assists the caregiver to recognize, experience, express, and manage a wide range of emotions. Therapist assists the caregiver in responding to child's emotions with attuned sensitivity such that the child can begin to learn to manage their feelings and actions with reliance on caregivers for regulatory assistance and for the development of autonomy.

d. Psychoeducation

Description: Therapist helps the caregiver understand the elements of early child development. Psychosocial education may include information on how infants and young children communicate to caregivers about needs; information on interaction rupture and repair; how caregiver behavior supports child's sense of safety and safety in child's environment; how adults support the development of children's emotional regulatory capacity; how infants send communication signals and react to caregiver responses (attuned interaction); and information on typical and atypical development, functional problems (e.g., disorders in the regulation of sleeping, feeding, and emotional expression, etc.), and developmental impacts of grief, loss, and stress (for both child and caregiver).

e. Reflective Observation

Description: Therapist elicits and supports reflection in the caregiver about child's needs, feelings and behavior by asking the caregiver open-ended questions, repeating a reflection, showing positive acknowledgement of a reflection or praising a reflection. Reflective observation may include content on: regulation, feelings and needs, behavior, non-verbal communication, developmental capacity, attunement, rupture and repair, safety and caregivers' responsiveness.

f. Perspective Taking

Description: Therapist uses role-play to help the caregiver understand the perspective of the child and practice new skills. This may include therapist talking from child's perspective or therapist talking from parents' perspective.

g. Modeling

Description: Therapist models for the caregiver a parenting skill.

h. Observation and Coaching

Description: Therapist coaches the caregiver during an interaction with the child, or therapist video records the caregiver and the child during an interaction, plays back the video with the caregiver and provides reflective and supportive feedback.

j. Explore Caregivers' Negative Child Attributions

Description: When the caregiver expresses a negative attribution of child's behavior, personality, or feelings, therapist explores the meaning of this attribution with the caregiver. Therapist helps the caregiver reflect on the origins of the attribution, the basis of the attribution, and the impact it may have on the child. Therapist may also explore with the caregiver other possible perspectives of said attribution.

k. Joint Construction of Family Narrative Including Trauma Narrative

Description: Therapist supports the caregiver and/or child in developing narratives, which include how infants and young children carry their history of stress and trauma in their bodies. The trauma narrative creates a coherent story to help the caregiver and/or child integrate significant experiences.

l. Dyadic Play and/or Trauma Play

Description: Therapist facilitates and follows play between the caregiver and the child or solo child play. Therapist uses this mechanism to identify attunement or misattunement, relational health, developmental needs, themes, explore significant experiences, and highlight integration of past significant experiences.

m. Management of Affect and Affective Regulation

Description: Therapist teaches the caregiver and/or child relaxation or mindfulness skills. May also include strategies to regulate affective or sensory experience and supporting caregivers' capacity to provide affective or sensory containment.

n. Promote Caregiver Competence and Confidence

Description: Therapist observes the caregiver–child interaction and verbally identifies and acknowledges the strengths, skills, and gains the caregiver has made. Therapist also leverages caregivers' cultural context, resources, and personal history in promoting caregiver competence and confidence.

o. Measurement-based Care

Description: Therapist uses the screening and assessment tools to establish baseline function (symptoms, development, diagnosis, identify referral needs, caregiver–child relationship quality) and treatment targets.

p. Engagement

Description: Therapist builds engagement by working to establish a trusting relationship with family, clarifying goals and expectations, clarifying partnership in treatment by gathering family history, child history, social, structural, and cultural factors significant to the child/caregivers' family and community.

q. Elicit Parent History

Description: Therapist helps the caregiver identify protective and adverse aspects of his/her history that may impact the current relationship and their parenting.

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