jurisdictional snapshot

VIRTUAL FAMILY SUPPORTS: A JURISDICTIONAL SCAN

November 2021 | Sarah Mackey

A scan of health policies and practices implemented outside Newfoundland and Labrador

Newfoundland & Labrador Centre for APPLIED HEALTH RESEARCH
www.nlcahr.mun.ca

Table of Contents

To support our Health System Partners, NLCAHR's Contextualized Health Research Synthesis Program (CHRSP) has produced this Snapshot Report of healthcare practices, programs, and policies inside and outside of Canada. NLCAHR designed Snapshot Reports to inform decision makers about the healthcare landscape across jurisdictions, particularly with respect to practice variation and policy initiatives. Snapshot Reports might also help guide topic selection for other CHRSP products, such as our Evidence in Context and Rapid Evidence Reports.

1. About *Snapshot* Reports

Snapshot Reports provide health system decision makers with a brief scan of health practices, models of care, programs, or policies, and a summary of established or emerging interventions from jurisdictions outside of Newfoundland and Labrador (NL) on the issue in question. NLCAHR created these reports to meet health system demand for timely information about practices/programs/policies that might potentially be adapted for use in Newfoundland and Labrador. Each *Snapshot Report* responds to a specific request from CHRSP's health system stakeholders for information on a topic identified as being of priority interest. The results of a given *Snapshot Report* may provide these stakeholders with all the information they require; the reports may also be a catalyst for more in-depth study on the issue, possibly in the form of a CHRSP *Evidence in Context Report* or *Rapid Evidence Report.*

Snapshot Reports are not a comprehensive or exhaustive evaluation of the practice or policy under study; rather, they offer a brief overview that includes:

- an executive summary;
- an overview of the research objective with a clear description of the policy or practice under consideration;
- a statement of the focus and scope of the report;
- a summary of key descriptive findings;
- tables listing the practices/policies/models identified in other jurisdictions, with web links to each where available; and
- appendices containing more detailed information.

Given the limitations of this approach, decision makers should not construe this *Snapshot Report* as a recommendation for or against the use of any particular healthcare intervention or policy.

2. Executive Summary

Topic: Upon a request from health system partners in Newfoundland and Labrador, researchers from the Contextualized Health Research Synthesis Program (CHRSP) carried out a jurisdictional scan of Canadian provinces and selected international jurisdictions to identify programs that offer virtual family supports, or family supports with virtual components (hereinafter called *virtual programs*), that address and prevent child and youth maltreatment. The information gathered for this *Snapshot Report* will help inform decisions on potential virtual programs for use in Newfoundland & Labrador that could support children and youth who are at risk or who are currently receiving protective care, and their families.

Study approach: For this study, we searched research databases and other websites to identify programs that address and prevent child and youth maltreatment by providing virtual support (e.g., telehealth, teleconferencing, videoconferencing, apps, etc.) or that use these virtual components in combination with in-person support. In particular, we looked for programs that sought to improve family interactions, parenting skills, and child behavior. Our search extended to programs offered elsewhere in Canada and in select international jurisdictions.

Key findings: Our jurisdictional scan identified 14 virtual programs of interest. We also found two relevant telehealth services that may be of interest to decision makers. Some noteworthy features of the programs included in this report are:

- **Overlapping program components:** While we found variation among programs in terms of their included service components and the breadth of services offered, we did note a number of components that were common to several programs. These include using a behavioral model, conducting assessments, using observation and feedback, and interventions designed to improve parenting skills.
- **A variety of service users:** The programs included in this report target children/youth, parents/caregivers, and families. Most programs are intended for children and youth at specific age ranges and for service users who meet defined criteria/levels of risk.
- **A variety of care providers:** Care providers in the reported programs come from a range of disciplines and are described using a variety of titles, such as: Family Child Worker, Parent Coach, Family Coach, Therapist, Interventionist, Child Psychiatrist, Psychologist, Family Preservation & Reunification Specialist, Counselor, and Trainer.
- **Referral:** Online materials did not consistently outline the referral processes required to access virtual supports; however, some programs did mention referrals from Child Welfare or other formal agencies.
- **Reported outcomes:** Some included programs have explored outcomes for virtual delivery in a preliminary way; however, more evaluation will be required for decision makers to gain a comprehensive understanding of the benefits and challenges of virtual family supports, especially in terms of their benefits for higher-risk cases.

3. Background & Research Objective

Background

The Department of Children, Seniors and Social Development's (CSSD) has a mandate to foster social development and diversity, build inclusive communities, and ensure the delivery of critical services to protect children and vulnerable adults. A key objective of CSSD involves creating safe environments that foster healthy child and youth development and ensuring the delivery of critical services to protect children, youth and adults from abuse or neglect across the province (1).

More specifically, the Child and Youth Services Branch of the Department is responsible for the safety and well-being of children and youth in need of protective intervention through child protection, kinship services, in care, or youth services programs under the Children, Youth and Families Act. To fulfill this mandate, staff at Child and Youth Services assess and respond to referrals of child maltreatment and directly provide in-person intervention services (including collaboration with other departments and community agencies) to support children, youth and families, and to help prevent, reduce, and/or address future child maltreatment.[1] However, challenges often arise in providing uninterrupted access to in-person support services, including access challenges for individuals living in remote areas of the province, access challenges related to recent COVID-19 public health measures, or challenges that may arise as the result of individual family circumstances. One potential way to address these challenges and to provide equitable services is the use of virtual family supports that would supplement, or provide an alternative to, in-person family services and supports.

Decision makers in Newfoundland and Labrador are interested in better understanding potential opportunities to offer virtual family supports (or family supports that include virtual components) for children, youth and their families in need of protection.

Research Objective

The main research objective of this *Snapshot Report* is to find out how other jurisdictions provide virtual family support programs, or programs that contain virtual components, to address and prevent child/youth maltreatment.

[1] According to the Public Health Agency of Canada, "Child maltreatment refers to the harm, or risk of harm, that a child or youth may experience while in the care of a person they trust or depend on, including a parent, sibling, other relative, teacher, caregiver or guardian. Harm may occur through direct actions by the person (acts of commission) or through the person's neglect to provide a component of care necessary for healthy child growth and development (acts of omission)" (2).

4. Focus & Scope of this report

In its scan of virtual family supports from other jurisdictions, our researchers looked for examples of virtual programs that are:

- intended to prevent and address child and youth maltreatment;
- directed towards children and youth receiving protective care; and
- accessed by families who are at risk of involvement, or are already involved with, the child welfare system.

We focused mainly on programs offering secondary or tertiary prevention for children rather than including programs that offer primary prevention approaches for parents at the prenatal stage.

Search parameters

The search parameters outlined in Table 1 below were defined in consultation with the Department of Children, Seniors and Social Development.

Table 1: Overview of search parameters, inclusion criteria, and exclusion criteria

Parameter	Inclusion criteria	Exclusion criteria
Population Served	• Children, youth aged 0 to 18 years and families at risk (e.g., children and youth under protective care, children and youth at risk of child maltreatment, families at risk of, or involved in, the child welfare system)	• General population • Eligibility restricted to pregnant women only
Program Components	• Support services/intervention programs that prevent and/or address child and youth maltreatment • Behavioral support for children and youth and their families • Parenting skills and support • Home visiting combined with any of the components above	• Parenting programs for the general population • Independent counselling services for mental health
Program Delivery	• Delivered virtually via teleconference or with a mixture of in-person plus virtual components • Delivered by a trained professional overseeing intervention services	• Delivered by volunteers • Self-directed courses online
Program Duration	• Averaging about 1-2 years (minimum of 10 weeks)	• A few weeks or a few hours
Jurisdictions	• Canadian provinces and territories • USA, Australia, United Kingdom, Norway, Sweden, Finland	• Other Jurisdictions
Timeframe	• Programs that are active	• Programs that are no longer active

Search strategy

We used the following key strategies to search for relevant virtual programs:

1) We completed a literature search using PubMed, Google Scholar, and Cochrane databases. We combined search terms (e.g., "online," "telehealth", "teleconference," "virtual," "behavior," "parenting skills," "intervention," "support", "home visiting", "child welfare", "child maltreatment") with one another and with jurisdictions of interest. We found some relevant published literature using these search terms that led to information about related programs.
2) We also searched publicly available websites using search terms similar to those listed above. We combined these terms with each jurisdiction of interest. We conducted a more general Canada-wide search and considered programs in the USA, Finland, Sweden, Norway, Australia, and the United Kingdom.
3) Additionally, whenever we would find a helpful search term, organization, or website we would follow-up or cross-reference previous searches.
4) We completed a final search of PubMed with adjustments to search terms based on the terms we found throughout the search process.

In total, we identified 14 virtual programs and two relevant telehealth services. Of the 14 included programs, one originated in Canada and 13 originated in the United States. Readers should note, however, that many of these programs are available in other countries, including the United Kingdom, Finland, Sweden, and Australia. Of the two relevant telehealth services we found, one is offered in Australia and the other is offered in the United States.

Key features of these programs are outlined in the following pages. Appendix A of this report (page 33) includes detailed data for all included programs as well as available references and links about each of the 14 virtual programs and the two relevant telehealth services.

The following parameters of interest are included in the tables that follow:

- program jurisdiction,
- program description,
- program components,
- service users,
- service providers,
- referral method,
- outcomes,
- program contacts, and
- any related links or references.

5. Summary of Key Findings

VIRTUAL FAMILY SUPPPORTS INCLUDED IN THS REPORT

VIRTUAL PROGRAMS

1. Stop Now and Plan (SNAP), Virtual Delivery, Child Development Institute, Canada & International jurisdictions
2. Attachment and Behavioral Catch-up (TeleABC), University of Delaware, USA
3. Behavioral Health Virtual Therapy Services, KVC Kentucky, USA
4. Child First via Telehealth, Connecticut, USA
5. Families Actively Improving Relationships (FAIR), Oregon Social Learning Center, USA
6. Family Check-up Online, USA
7. Family Preservation and Reunification Virtual Therapy Services, KVC Kentucky, USA
8. Functional Family Therapy Online (FFT Online), FFT LLC, USA & International jurisdictions
9. GenerationPMTO via Telehealth, USA & International jurisdictions
10. Healthy Families America, Virtual Home Visit, USA
11. Incredible Years Online (IY Online), USA and International jurisdictions
12. Internet-Based Parent-Child Interaction Therapy (I-PCIT), USA & International jurisdictions
13. Project 12 –Ways via Telehealth, Southern Illinois University, USA
14. SafeCare, Virtual Delivery, USA and other International jurisdictions

RELEVANT TELEHEALTH SERVICES

1. Telepractice for Parenting Support, Australia
2. Child Protection Team Telemedicine Services, Children's Medical Services, Florida, USA

Overall, we found that organizations that regularly provide prevention and intervention programs/ services have taken considerable measures to adapt their in-home/ in-person approaches to virtual formats during the COVID-19 pandemic so that they can continue to support families, children and youth along the prevention continuum.

Various programs that typically involve in-person interactions with behavioral professionals or clinicians have now been adapted for virtual delivery, most often as the result of public health measures during the COVID-19 pandemic. Of the virtual programs we found, only a handful offered telehealth delivery as an option prior to COVID-19. We have included as many details about these virtual adaptations as are presently available; however, we expect that more in-depth analyses of the benefits and challenges of adapting these programs and supports to virtual platforms will emerge in the future.

As we collected data on the relevant programs for this report, we categorized the included programs by their country of origin but also indicated whether such programs are available in other international jurisdictions as well. Given that most programs were adapted to virtual delivery as the result of the COVID-19 pandemic, it is not always clear in the information we located whether all other international sites that carry these programs have made the same virtual adaptations.

Of the 14 virtual programs we found, 13 originated in the USA and one in Canada. It is noteworthy that seven of the 14 of programs originating in the USA are also offered in other countries, including Canada, Sweden, Norway, Finland, UK, Australia, and others.

We have also included two telehealth services that may be of interest:

- Australia offers a service called "Telepractice" that facilitates the remote delivery of parenting support programs.
- In the USA, telemedicine is used to facilitate assessments for Florida's Child Protection Team.

Please see Appendix A on Page 33 for additional programs that did not meet our inclusion criteria but that may include some relevant features that would be of interest to decision makers.

In summarizing the 14 virtual programs and two telehealth services listed in the Sidebar on Page 8, we have identified the following common features:

Key program/service components

Programs offering virtual family supports included in this report aim to improve skills and behaviors that strengthen families and their relationships. While there is considerable variation in program and services descriptions and in the overall breadth of the services offered, the programs/services we found often included one or more of the following key components:

- **A foundational model**: Most included programs have a behavioral model as the basis for the intervention and use descriptors such as 'behavioral model,' 'behavioral intervention,' 'behavioral family systems intervention,' 'behavioral health service,' 'dyadic behavioral intervention,' and 'behavioral parent training model' or they indicate that behavioral training is offered for children, parents or families. Other included programs, although fewer in number, describe their interventions more broadly as 'family interventions,' 'parenting interventions,' or 'home visiting programs.' More often than not, programs will include components such as parent management training, helping to develop parenting skills, child behavior improvement, or will aim to improve child-parent relationships.

- **Assessment:** Eight programs and one telehealth service included an assessment process. Of these, most used an initial assessment to identify the needs of the child, parent, or family prior to providing supports (Child First, FAIR, Family Check-up Online, FFT Online, and Behavioral Health Virtual Therapy Services).

  Two use assessments as a way to gauge skill or behavioral improvements over time (I-PCIT and Project 12-Ways). Similarly, SafeCare uses an initial assessment at the beginning of the program to get a baseline of a caregivers' initial knowledge and skills, followed by reassessment of caregivers' skill acquisition in the last session of each of its six program modules.

  A telehealth service from Florida called the Child Protection Team uses telecommunications technology to facilitate child abuse assessments remotely.

- **Observation and feedback**: Eight programs use observation and some form of feedback (coaching, role-play, modeling or practice) to teach or improve behaviors and reinforce positive parenting practices. For example, some programs use real-time observation to coach participants as they interact with their families (TeleABC, Healthy Families America, and I-PCIT). Others teach skills during weekly sessions to practice throughout the week (GenerationPMTO). SafeCare uses modeling. Both SafeCare and SNAP use role-playing to develop skills.

- **Parent training/help to improve parenting skills**: The majority of programs commonly include a parent training or parenting skills component described using terms such as "parent training management" (FAIR and Family Check-up Online), "parent training" (Generation PMTO), "Contextually Valid Family Training" (Project 12-Ways), or "parenting skills" (FFT Online).

  Six programs incorporate positive parenting practices or build positive parent-child interactions (GenerationPMTO, Healthy Families America, IY Online, Family Preservation and Reunification Virtual Therapy Services, I-PCIT, and SafeCare). Others teach parents how to nurture their children or foster nurturing relationships in general as part of their aim to improve family or caregiving relationships (TeleABC, Child First and IY Online). SNAP uses family sessions to help children and parents learn how to regulate emotions and deal with difficult situations. TeleABC helps parents recognize and enhance their child's behavioral and regulatory capabilities. Additionally, the Healthy Families America program includes a parenting curriculum as a program feature. I-PCIT Online offers relationship enhancement and discipline skills to participants.

  Other content such as website materials (e.g., Family Check-up Online), experiential video vignettes, white board or notes pages (IY Online) are available to facilitate learning and the acquisition of new skills.

- **Other Components**: Programs with more comprehensive supports offer a wider variety of components. For example:
  - FAIR integrates treatment for mental health and substance use along with parent training. It also provides resource building, ancillary supports, and help to parents through shared activities;
  - KVC Kentucky's Family Preservation and Reunification Virtual Therapy Services provides support for household management. Their Behavioral Health Virtual Therapy Services offer case management, comprehensive community support services, and psychiatry services; and
  - Safecare offers modules in Child Health and Home Safety as well as Parent-Child Interaction.

Service users

The majority of programs target children, youth, parents/caregivers and families. The programs often define a suitable age range for the children or youth targeted by the interventions, in combination with certain risk factors (e.g., behavioral problems, adverse life circumstances, risk for child abuse and neglect, or involvement in the child welfare system). Some programs focus on the parents of children and youth at defined ages while others holistically encompass children and families.

A broader age range is more common in programs that explicitly target children, youth and families involved in the child welfare system or those who are at risk for child abuse and neglect, adverse childhood experiences, out-of-home placement or maladaptive behaviors. Examples of these programs include FAIR, FFT Online, GenerationPMTO, Family Preservation and Reunification Virtual Therapy Services, Behavioral Health Virtual Therapy Services, and Project 12-Ways. Common age ranges cited for these programs are 0-18 years of age, 2-18 years of age, or 0-17 years of age.

Other programs are not only age-specific, but are geared towards families or children with specific risk factors (e.g., early adversity or behavioral problems). For example:

- SNAP and I-PCIT focus mainly on the child's behavioral problems. SNAP is intended for children ages 6-11 and their parents while I-PCIT focuses on families with children ages 2-7 with emotional and behavioral disorders;
- TeleABC targets parents, primary caregivers/legal guardians of children between 6 months and 2 years old that experience early adversity;
- Child First and Family Check-up Online focus on those at risk for various target concerns (includes behavioral or abuse/neglect plus other risk factors). Child First targets children aged 0-5 and their families, while Family Check-up Online has mainly been studied in middle school students from economically disadvantaged families; and
- IY Online parenting program targets parenting skills for children aged 0-12 years.

In addition, we should note that some organizations have developed various versions of a their in-person programs to accommodate families, children or youth with differing levels of risk (Incredible Years, FFT-Child Welfare, and Healthy Families America). However, it is quite often unclear whether new virtual adaptations have been made to all versions of these programs.

It is notable that program materials for FAIR, Family Check-Up Online, FFT Online, Project 12 Ways, and I-PCIT, acknowledge the benefits of virtual application for rural contexts or are concerned with improving access to family support programs for rural users. We also found two related telehealth services that specifically aim to improve access to services and programs for rural and remote populations that are worth mentioning:

1) The Child Protection Team in Florida provides telemedicine services that improve access for children in rural areas in need of Child Protection Team medical evaluations; and

2) In Australia, telepractice is used to deliver parenting support and other services remotely to those who live in rural areas or to reach those who need an alternative to in-person services.

Referral methods

Specific details on the referral methods of different programs are often unclear, especially in the case of programs newly adopting virtual adaptations. When information on referrals was available, we expect that the method of referral for virtual services would be similar to the stated method for the regular in-person programming.

We found that eight of the programs require referrals from Child Welfare or a formal agency (SNAP, Child First, FAIR, FFT Online, Healthy Families America, Behavioral Health Virtual Therapy Services, Family Preservation and Reunification Virtual Therapy Services, and Project 12-Ways). Referral processes for remaining programs are not described.

Service providers

Programs used a variety of titles for service providers that work directly with children, youth and families (e.g., Family Child Worker, Parent coach, Family coach, Therapist, Interventionist, Child Psychiatrist, Psychologist, Family Preservation & Reunification specialist, Counselor, Trainer).

Service providers in many programs were expected to have an undergraduate or Master's degree, or to be licensed mental health service providers. Many are expected to also undergo program-specific training. Generally, as the intensiveness of the program or the level of risk to included families increased, so did the expected level of qualification for service providers. A minority of included programs required only program-specific training or did not offer sufficient detail in the program description about the required qualifications for service providers. Often, a case manager or a supervisor were involved in program delivery. Sometimes, other support staff were available to provide support, oversee the program, or help coordinate access to other services.

Program delivery

As previously noted, many of the programs included in this report were adapted from in-person delivery to virtual methods as a direct response to the COVID-19 pandemic (SNAP, TeleABC, Child First, FAIR, Healthy Families America, IY Online and Project 12-Ways). A few programs, (Family Check-up, Online, I-PCIT, and SafeCare) had already explored virtual applications prior to implementation of pandemic-related public health measures.

Programs that offered virtual delivery to some degree prior to the COVID-19 pandemic were well-positioned to accelerate the use of virtual programming to all clients, allowing for some adjustments at sites that had not used virtual platforms before. For example:

- FFT permitted use of teletherapy as an option prior to the pandemic (although this option was rarely used);
- Generation PMTO developed telehealth for certain sites in 2015;

- KVC Kentucky's Behavioral Health Services and Family Preservation and Reunification Services offered telehealth sites prior to the COVID-19 pandemic but accelerated the use of virtual therapy to all clients during the pandemic.

Program duration and frequency

Descriptions for virtual adaptions in included programs did not always specify the duration and frequency of program delivery. However, since most of the included programs were adaptations that were intended to be comparable to regular in-person programming, in cases where the duration and frequency of delivery were not explicitly stated, we would expect the duration of virtual programs to be similar to regular in-person delivery.

Since our inclusion criteria required that programs offer services for at least 10 weeks, the programs included in this report have durations that typically range between 10 weeks and 9 months. A few of the more intensive programs offer services for a few years or are based on need and do not specify a time limit. The average frequency of service delivery is approximately one hour per week. Whereas a few other programs start more intensely with more sessions per week and then taper the frequency of sessions over weeks or months. Table 2 below summarizes virtual delivery components for included programs.

Table 2: Summary of Virtual Delivery Components for Included Programs

Program	Total Program Duration	Frequency	Session Length	Technology Used
SNAP (Virtual)	13 weeks	• 1x/week	Not clear	Online, video & tele-counselling
TeleABC	10 weeks	• 1x/week for 1 hour	1 hr.	Telehealth
Behavioral Health Virtual Therapy Services	Not specified; likely "as needed"	• Not stated	Not stated	Virtual telehealth with use of internet capable device
Child First via Telehealth	6-12 months or longer	• 2x/week for 1 month– Assessment phase • 1x/week or more (depending on need)	1-1.5 hrs.	Telehealth (video conferencing)
FAIR	9 months average	• 1st 3 weeks: 5-7 days a week • 4th week: 3x/week tapering to 2x/week • Final month: 1x/week	• 1st 3 weeks: 30 min.-2hours • 4th week: 15min-2 hours • Final month: 1-2 hours	HIPAA compliant video-chat application

Program	Total Program Duration	Frequency	Session Length	Technology Used
Family Check-up Online	1-4 months in studies (but not clear in real life application)	• Coach calls at least 2 times to establish goals and support them through the process.	30 min. calls or less	Online website Coaching calls
Family Functional Therapy Online	5-7 months for more intense cases 3-5 months for less intense cases	• 30 sessions: 1x/week for challenging cases	45-60 min.	Telehealth
Family Preservation and Reunification Virtual Therapy Services	Not specified; likely "as needed"	• Not stated	Not stated	Virtual therapy through digital information and communication technologies
Generation PMTO Telehealth	3-6 months or longer depending on circumstances	• 10-25 sessions: 1x/week	60 min.	Telehealth (includes online, video, Zoom)
HFA Virtual Home Visit	Min. of 6 months Offered prenatally until the child is at least 3 and may be offered until 5 yrs.	• Tapers from biweekly visits to monthly visits to quarterly visits over time • During time of crisis families may be seen 2 or more times in a week	50- 60 min.	Virtual Home visits via phone/video conference platform (Zoom, FaceTime)
IY Online	Depending on the program and level of risk, the length typically varies 14-30 weeks (3.5-7.5 mons.)	• Typically, the Parent Program = 1, session per week.	2 hours	Online platform, video delivery format
I-PCIT	Typically delivered over 12-20 sessions (3-5 months)	• Weekly, but the exact treatment length varies based on the needs of the child and family	1 hour	Video platform, Bluetooth device or headphones connected to a cell phone
Project 12- Ways	Not stated	• 1-2 x/ week	Not stated	Telehealth
Safecare (Virtual)	18- 20 weeks (5 months)	• 18 sessions (6 sessions per module), 1x per week	1-1.5 hours	Virtual delivery used Zoom, FaceTime, & Google Duo

Reported outcomes

Where possible, we looked for evaluation studies or recent reports on the virtual family support programs included in this report. We found that reported outcomes are not yet available for most of the programs covered in this review.

Some programs have started to report preliminary outcomes, either through recently published studies or through surveys of staff and program users (Child First, FAIR, Family Check-up Online, Functional Family Therapy Online, Generation PMTO, I-PCIT, Project 12 Ways and SafeCare). When measuring outcomes, several programs noted logistical benefits to virtual delivery: convenience, saving time and money on travel costs, flexibility and increased reach. Some notable challenges included a lack of access to telehealth resources for some families, the challenge of replicating in-person relationship-building on a virtual platform, the challenge of targeting skills modeling in a virtual format, and challenges related to conducting virtual assessments.

6. Summary Tables

The following tables provide a summary of the 14 virtual family support programs and two telehealth services included in this jurisdictional scan:

- Table 3 summarizes programs that originated in Canada;
- Tables 4- 16 summarize programs that originated in United States; and
- Table 17 -18 summarize relevant telehealth services from Australia and the United States.

Appendix A provides more detailed program descriptions and their components as well as any specific research or additional program links.

Appendix B includes related references and websites.

Table 3: Stop Now and Plan, Virtual Delivery, Child Development Institute (Canada & International jurisdictions) | See Page 33 for details

Stop Now and Plan (SNAP), Virtual Delivery, Child Development Institute, Ontario (Canada & International jurisdictions)

- An evidence-based behavioural model that provides a framework for teaching children struggling with behaviour issues, and their parents, effective emotional regulation, self-control and problem-solving skills. The primary goal of SNAP is to keep children in school and out of trouble by helping them make better choices "in the moment."
- The core SNAP programs, SNAP Boys and SNAP Girls, are gender-specific programs for children ages 6-11 experiencing disruptive behaviour problems. **These programs have moved to virtual platforms during COVID-19** (LINK).
- Affiliate locations across Canada, USA, Netherlands, Scotland, Norway and Grand Cayman.

Program Components	Service Users	Service Providers	Program Delivery	Outcomes
• Children attend either SNAP Boys or SNAP Girls groups, Parents attend SNAP parenting sessions • Use role-plays, home practice assignments & joint family sessions, both children & parents learn how to deal with difficult situations. • 1-on-1 family counselling, individual counselling/ mentoring for boys or girls	• Boys and girls, ages 6-11, experiencing serious behavioral problems at home, at school, with persons in authority, and in the community and their parents • Referral: e.g., teachers, social workers, police and other service providers may facilitate a referral with written consent from the parent or legal guardian	• Family Child workers • Dedicated Clinical Manager (advise that their staff is highly trained)	**Virtual switch for COVID-19** • Moved to video & tele-counselling services • Parent/caregivers group meets weekly, separately from children groups • Parents can also meet one-on-one with clinician as needed • Clinicians connect weekly with participants for check-ins • Online resources are available to children and their families e.g., modeling and role-play, and problem-solving techniques. • **Duration:** Typically, 13 weeks, 1x per week, but not specified for virtual programming	**Regular program**[2] Child outcomes: • Better emotion regulation, self-control, problem-solving skills, pro-social communication, executive functioning and social competency • Less antisocial behaviour, rule breaking, depression, anxiety and police contact Parent outcomes: • effective child management strategies, +ve support systems, coping abilities and communication skills, lower distress, increased parental competency

[2] No data available yet on outcomes for virtual delivery so used outcomes from the regular program delivery stated in program materials.

Table 4: Attachment and Behavioral Catch-up, University of Delaware (USA & International jurisdictions) | See Page 37 for details

Attachment and Behavioral Catch-up (Tele ABC), University of Delaware (USA)

- ABC is a home visiting, evidence-based parenting intervention for caregivers of infants and toddlers who have experienced early adversity. It helps caregivers nurture and respond sensitively to their infants and toddlers to foster their development and form strong and healthy relationships. Developed in Delaware, USA but used across various US states and internationally (e.g., Sweden, Canada, Norway, and Australia). Also piloted in Canada through Ryerson University's Child and Family WISE lab.
- Tele ABC is a telehealth version of the program adapted for COVID-19 with the goal of providing supportive guidance for parents to provide nurturing, sensitive care to young children during these stressful times (LINK).

Program Components	Service Users	Service Providers	Program Delivery	Outcomes
Help caregivers: • 1) Re-interpret children's behavioral signals to provide nurturance, with a focus on how the fear, uncertainty, and increased stress can decrease parental resources and increase stress and irritability. • 2) Provide a responsive, predictable, warm environment that enhances young children's behavioral and regulatory capabilities, • 3) Decrease caregivers' behaviors that could overwhelm or frighten a child. • Parent coach uses video feedback and homework to improve caregiver responses.	Not specified for Tele ABC but assume the same as regular ABC: • Typically for parents of infants between 6-24 months of age (ABC-Infant), and for toddlers between 24-48 months (ABC-Toddler). • Any parent, primary caregiver, or legal guardian who has a child or children between the ages of 6 months - 48 months can participate in ABC. • Research has studied regular ABC in high-risk families in protective services (see appendix for details) • Referral process unclear	ABC-certified parent coaches: • No educational level requirement for parent coaches. • Potential parent coaches participate in a screening prior to training. If they pass the short screening, coaches attend a 2-day training and a year of supervision. • Team of staff, researchers and scientists also support the program	• Created protocols for conducting ABC sessions, including live commenting & manual content, through telehealth platforms • TeleABC helps parents recognize cues for nurturance, even when they are not clear. • **Duration**: not specified for Tele ABC but usually 10 sessions, 1x/week for 1hr.	• Effectiveness of ABC is currently limited to in-person implementation. But suggest when taking clinical and ethical considerations into account, if the active ingredient, In the Moment (ITM) commenting, can be done well through a video platform, then it is reasonable to think behavioral change for parents would be seen.

Table 5: Behavioral Health Virtual Therapy Services, KVC Kentucky (USA) | See Page 40 for details

Behavioral Health Virtual Therapy Services, KVC Kentucky, USA (LINK)

- KVC Kentucky is a 501(c) 3 non-profit child welfare and behavioral healthcare organization that provides behavioral health services, foster care, family preservation and reunification, and other family-related services. Services are in-home, strengths-based, and driven by a focus on the safety, permanency, and wellbeing of the child and family. Each year, KVC Kentucky serves more than 12,000 children and families in eight regions of the state.
- Evidence-based behavioral health services are delivered in client's homes and communities including 7 telehealth sites across Kentucky.

Program Components	Service Users	Service Providers	Program Delivery	Outcomes
Virtual therapy components: • **Assessment** of child's presenting problems • **Therapy** at freq., schedule and location based on child's needs • **Case management**: (advocacy, resource development, team development, conducting collaborative service team meetings, medical, social, educational or other support services, interagency service coordination) • **Comprehensive community support services** (provide targeted, strengths-based skill-building to support and enhance youth and adults) • **Psychiatry** (consultation, evaluation, medication management)	• Children, adults and families • Serve individuals experiencing depression, anxiety, suicidal thoughts, substance use, child behavior challenges and more • Anyone can refer including agencies	Skilled and professional Master's level therapists and case managers • Board certified Child Psychiatrist • Service Team model: KVC therapists, KVC Case Managers, community support associates, staff psychiatrist	• Recently accelerated use of virtual therapy to all clients • Services are offered over the phone or through virtual telehealth with the use of an internet-capable device Participants of virtual therapy need: • Device such as computer, Chromebook, cellphone with camera and Internet access • Stable and secure Internet connection • Confidential space • Natural supports to use in case of emergency • Sessions must be held within State of Kentucky • If technology is a barrier, try to find a way to assist participants **Duration:** unclear	• Nothing formal for virtual services

Table 6: Child First via telehealth, Connecticut (USA) | See Page 42 for details

Child First (CF) via telehealth, Connecticut (USA) (LINK)

- CF is a two-generation, home-based mental health intervention that works with very vulnerable young children and families, providing intensive, home-based services. CF adapted to offering services via telehealth during COVID-19 and hope to integrate various aspects of CF via telehealth that best serve families after the pandemic has passed.

Program Components	Service Users	Service Providers	Program Delivery	Outcomes
COVID adaptation: • Providing parents with resources for games & activities, helping them: develop structure and routines, effectively de-escalate sibling conflict, sooth & calm children, & have positive interaction. • Continuing therapeutic parent-child work when & if appropriate with key components: engage with family, assess child & family, develop child & family plan of care, parent-child psycho-therapeutic intervention, enhance executive functioning, early care consult.	Children & their families with the following characteristics: • Age of child: 0-5 at the onset of services Target concerns: • Children with emotional/behavioral or developmental/learning problems • Families with multiple challenges (such as extreme poverty, maternal depression, domestic violence, substance use etc.) • No exclusions other than the specific geographic area served by CF. Families needing less intensive intervention may be triaged to other services. • Referrals defined by Affiliate Agency with CF recommendations	CF organizational structure: • National Program Office • Affiliate Agencies • Child First Team Structure (within Affiliate Agencies) • Community Advisory Boards (Child welfare is a required collaborator) Typically: Each affiliate site has a CF Clinical Director/Supervisor and 2-6 clinical teams. CF team consists of a licensed, Master's level Mental Health/ Developmental Clinician and Bachelor's level Care Coordinator, both with significant expertise with very young children and vulnerable families. They work together in the home with the family.	Virtual Adaptations: • CF teams of Care Coordinators & Mental Health Clinicians are using telehealth (video-conferencing when possible, if not, by phone), contacting families one or more times each week, depending on the unique family needs. • CF network helping families get remote capability (both devices & internet access), State Clinical Directors increased intensive support of the staff. • **Typical Duration**: 6-12 mon., 1-1.5hrs per week	CF telehealth survey finds: • Lack of access to telehealth resources presents a major challenge and an issue of equity for mental health service delivery via telehealth • Can be an effective way to engage caregivers, when it is a preferred method of communication, & have access to tech. • Challenges in providing dyadic treatment via telehealth • Challenge to provide a private and therapeutic environment at times. • ↑ability to reschedule appointments and reduces travel time and expense

Table 7: Families Actively Improving Relationships, Oregon Social Learning Center (USA) | See Page 47 for details

Families Actively Improving Relationships (FAIR) – Virtual Adaptation, Oregon Social Learning Center (USA)

- FAIR is an intensive, outpatient, home- and community-based program designed for parents experiencing challenges related to parenting, substance use, and mental health problems. It integrates two evidence-based behavioral interventions including **parent management training and reinforcement based therapy**. Many parents who receive FAIR services are involved with child welfare for neglect and substance use. Our model is strengths-based, trauma-informed, and integrates treatment for mental health, substance use, and parent-training into each session. Adapted to virtual delivery when possible during COVID-19 with some in-person interaction (LINK).

Program Components	Service Users	Service Providers	Program Delivery	Outcomes
• **Typical components**: substance abuse treatment, & mental health treatment (includes behavioral strategies), teaching and supporting parenting skills, resource building, and provision of ancillary supports • **Maintained most core treatment components through virtual sessions:** clinicians continued to engage with clients doing shared activities (folding laundry, washing dishes, or cooking while talking on video technology), clinicians continued to support clients with parenting skills by observing and reinforcing parent-child interactions through video technology. • In-person interactions were limited to initial assessments, crisis situations, and clients unable to access technology	• Parents with parental rights for at least one of their minor children, in utero to age 17, who have been referred to the child welfare system or at-risk for referral to it	**FAIR clinicians**: maintain one of two licensures in compliance with state standards: Qualified Mental Health Professional (QMHP) or Qualified Mental Health Associate (QMHA). **FAIR team**: licensed clinical supervisor, another QMHP, and a # of highly supervised QMHAs are assigned as the primary clinician for each client. Clients receive exposure to more than one clinician to facilitate clinical coverage, flexible scheduling, comprehensive support, and role stratification.	• Clinical procedures quickly moved to virtual treatment using a HIPAA-compliant video-chat application • Transitioned clients to platform when possible and if not used in-person protocols (mainly for initial assessments, crisis situations, clients unable to access tech.). • **Duration (assume similar for virtual delivery):** avg. of 9 mons., (several times a week at the start then tapering after 3 weeks from 2-1 over time), session length between 15min -2hrs.	• Clinics able to successfully engage clients in a complex intervention and continue achieving positive clinical outcomes in the context of environmental changes (e.g., COVID-19 restrictions). • Found possibility of FAIR's effectiveness under hybrid remote/in person model • Outcomes from the pilot suggest that these efforts were successful with 94% of participants randomized to FAIR engaging in treatment and 87% completing the full course of treatment.

Table 8: Family Check-up Online, Prevention Science Institute (USA) | See Page 52 for details

Family Check-Up (FCU) Online, Prevention Science Institute (PSI), Oregon (USA)

- FCU is a strengths-based, family-centered intervention that promotes family management and parent skill enhancement and addresses child and adolescent adjustment problems. Components include (1) an ecological strengths-based self-report assessment of child behavior, parenting skills, family dynamics, and life stressors, followed by focused feedback; and (2) parent management training, which focuses on supporting positive behavior, setting healthy limits, supervision, and building relationships.
- Prior to COVID-19, PSI researchers adapted FCU for online use. Below we used information from an intervention of FCU online with coaching support described in Danaher, 2018 & Stormshak, 2019. During the pandemic, FCU Online has gained real-life use in Oregon.

Program Components	Service Users	Service Providers	Program Delivery	Outcomes
Assessment & feedback: parents complete 88-item, 23-webpage online & receive printout indicating treatment options, strengths & improvements, then family coach reviews via phone/ video conferencing **Parent Management Training (parent website)**: set of 4 Web-based skills sessions e.g., +ve parenting, setting limits, monitoring, communication **Engagement activities**: videos, library etc.	• Regular FCU has preventive option and intensive intervention for high-risk families • **FCU Online:** research studied families of middle school students • Intention is to deliver to a much broader audience (e.g., rural & underprivileged families where access to services may be difficult)	• Studies of FCU Online cite staff, family coach, designated guest users • In-person FCU program has been implemented by community practitioners in schools, community health centers, and government agencies. The required skill level is master's level (MSW, MS, MA, and M.Ed.) with some clinical experience. Paraprofessionals may be trained as providers; however, this requires more intensive post training consultation (assume same for FCU online).	• Integrated technology architecture for the FCU Online website, its administration website, and coach portal, which involved sharing a common database. • Administrative website allows study administration and staff to view user profiles • Coaches only see assigned cases in the coach portal, guest users only able to review certain features of the website • Users receive email introducing them to the parent website and complete FCU assess, receive feedback and access skills session website. Also assigned a coach that calls at least 2 times to establish goals and support them through the process. Calls typically less than 30 min. each or longer based on need.	**From Stormshak, 2019** • FCU Online with coaching support was associated with reduced emotional problems for children & improved parental confidence and self-efficacy when compared with waitlist controls • At-risk youth showed stronger effects than did those with minimal risk • Future research is needed to test the efficacy of the FCU Online intervention with more diverse samples.

Table 9: Family Preservation and Reunification Virtual Therapy Services, KVC Kentucky (USA) | See Page 56 for details

Family Preservation and Reunification Virtual Therapy Services, KVC Kentucky, USA (LINK)

- KVC Kentucky's Family Preservation & Reunification Services help to strengthen families and keep children safely at home rather than entering into foster care. Preservation and reunification services are available to children who are at risk of out-of-home placement or are reunifying home from foster care or residential care.
- KVC Kentucky has recently accelerated our use of virtual therapy in response to COVID-19 to provide virtual therapy to families served within KVC's Family Preservation and Reunification Services (LINK).

Program Components	Service Users	Service Providers	Program Delivery	Outcomes
Virtual therapy provides therapeutic services, resources and support to families, wraparound services designed to build supports for each family and teaches parenting, household management, relationship-building and other skills to family members, strengthening family members' voices in their own treatment and goals, and collaborate with community partners to coordinate care for families.	• Children who are at risk of out-of-home placement or are reunifying home from foster care or residential care & families • Referrals made by Department for Community Based Services (DCBS), as eligibility requires the family to have an open case with the Cabinet for Health & Family Services.	• Utilize a service team approach to develop a collaborative care plan that is designed to help children live successfully at home and in the community. Team members meet frequently to assess progress, develop goals and interventions, and put crucial support systems in place. • Family Preservation & Reunification specialists are trained in a number of evidence-based practices (Trauma Focused- Cognitive Behavior Therapy, Trauma Systems Therapy, Motivational Interviewing) • Collaboration between DCBS and KVC Kentucky, funded through the state of Kentucky and federal funding.	• Virtual therapy through digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage your behavioral health care needs To participate need: • Device such as computer, Chromebook, cellphone with camera and Internet access • Stable and secure Internet connection • Confidential space • Natural supports to use in case of emergency • Sessions must be held within State of Kentucky **Duration:** unclear	• Nothing formal for virtual services

Table 10: Functional Family Therapy Online, FFT LLC (USA & International jurisdictions) | See Page 58 for details

Functional Family Therapy (FFT) Online, FFT LLC, (USA & International locations)

- FFT is an evidence-based family therapy that has been used with youth and families in juvenile justice, child welfare, mental health, and school settings. FFT LLC, an organization that disseminates FFT into community settings, currently supports over 350 community-based agencies that deliver FFT globally (includes training in 45 US states, Canada, Norway, Australia, Scotland, and Britain plus others. Supports FFT implementation in Sweden). Program adaptations for different populations include FFT for low-risk and high-risk child welfare clients.
- Historically, FFT LLC has permitted the use of teletherapy services (e.g., video conferencing) in exceptional circumstances; however, 2020 represented the first consistent and wide-spread utilization of tele-services by FFT LLC (see Robbins, 2021 for recently published study on telehealth program delivery during COVID-19).

Program Components	Service Users	Service Providers	Program Delivery	Outcomes
• FFT high-risk model includes 5 phases: 1) engagement, 2) motivation, 3) relational assessment, 4) behavior change & 5) generalization. • Involves a strong cognitive/attributional component integrated into systemic skill-training in family communication, parenting skills, conflict management skills and numerous other skills	• Youth (0-18 years old) and families in child welfare settings • Services provided through two tracks: a Low Risk track provided by interventionists based on Functional Family Probation (FFP®) model, and a High Risk track based on standard FFT model. Services linked through a triage process that matches youth to appropriate level of services based on level of youth and family risk.	Robbins, 2021 cites FFT therapists, supervisors, interventionists Child welfare model regular delivery: high-risk track • Therapists = master's degree • Site supervisors = master's degree or above. • Experience in family therapy and/or work in child welfare settings preferred low-risk track • interventionists = bachelor's degree at a min.	**From Robbins, 2021:** • During COVID-19 tele-health sessions required orgs. to secure/redirect resources to support tele-health services e.g., laptops, smartphones, tablets, internet access, tech training for therapists, developed specific safety protocols • Clinical changes: ↑ # of contacts/week, held shorter sessions more frequently, engaged families using whiteboards, clips, memes, and visuals. • Didn't specify in Robbins, 2021 but usually treatment is provided up to 30 sessions for challenging cases, 1x per week for 45-60 min., and can include multiple family members.	**From Robbins, 2021:** • +ve reports from FFT LLC expert trainers, experts, therapists, and supervisors from community-based partners Benefits of webinar format • Using multi-media during training, sharing multiple screens, scheduling training, and decreased travel-related costs Challenges of webinar format • Relationship-building aspects of in-person training harder to replicate • Role plays and practicing skills do not have the same intensity & learning potential in a webinar format

Table 11: GenerationPMTO via Telehealth (USA & International jurisdictions) | See Page 63 for details

GenerationPTMO via Telehealth (Individual Delivery Format), (USA & International locations)

- GenerationPMTO is an evidence-based, structured intervention program designed to help parents strengthen families at all levels. It promotes social skills and prevents, reduces and reverses the development of moderate to severe conduct problems in children and youth.
- Intervention has been provided to individual families, in parent groups, and through telehealth delivery and has been adapted for child welfare and other populations with trauma issues. Have various formats (e.g., in-person, video conference, telephone) to accommodate different situations (LINK). During COVID-19 many sites shifted from in-person format to virtual delivery.
- Originated from USA and formats offered internationally in Norway, Iceland, the Netherlands, Denmark, Canada, Mexico, and Uganda.

Program Components	Service Users	Service Providers	Program Delivery	Outcomes
Parent training intervention • Skill encouragement, teaching positive behavior • Systematic, mild consequences for negative behavior • Monitoring and supervision • Interpersonal problem solving • Increasing positive parenting practices **Supporting components** • Providing clear directions • Observing and recording behavior • Identifying and regulating emotions • Fostering effective communication • Promoting school success	• Parents with children ages 2-18yrs and can be used in family contexts including two biological parents, single-parent, re-partnered, grandparent-led, reunification, adoptive parents, and other primary caregivers	• Practitioners may have Bachelor's, Master's, or Doctorate level degrees as entry qualifications. Certified Generation PMTO specialists complete an extensive training program. No other specialized training is required. Practitioners serve in a wide variety of delivery systems including child welfare, juvenile justice, and child mental health.	• **Virtual format**: Online, Telephone, Video, Zoom, etc. • Weekly home practice assignments tailored for family context; parents practice in session before trying it out at home. Mid-week calls are conducted to troubleshoot and promote success. • **Duration:** 3-6 months or longer (depending on circumstances), 10-25 individual/family sessions (depending on severity), 1x/week for 60-minutes per session • Sessions video recorded and uploaded to HIPAA-compliant website for coaching/ supervision, fidelity rating, and certification. Video recording equipment, computer, and high speed internet access are required.	**Benefits of Telehealth** • ↑ participation, convenient, flexible hours, secure & private HIPAA-compliant portal and platform (connect by phone and use computer for real-time sessions), save time & money, extended reach **Child/youth outcomes** • ↓: depression, substance use, noncompliance, delinquent behaviors, internalizing behaviors, out-of-home placement, deviant peer assoc., arrest rates/severity of crime; ↑: academic performance, social skills **Parent outcomes** • ↓ poverty, depression, arrest Rates, coercive Parenting; ↑: +ve Parenting, standard of living, marital satisfaction, marital adjustment

Table 12: Healthy Families America, Virtual Home Visit (USA) | See Page 67 for details

Healthy Families America (HFA), Virtual Home Visit (USA)

- Located in 11 States in USA, HFA promotes child well-being and prevents the abuse and neglect of children in communities around the world through family-focused and empathic support provided in the home. HFA has 3 main protocols including a HFA Child Welfare Protocol (identified as high-risk, referred from child welfare).
- Introduced virtual home visiting during COVID-19 (phone and video visits count as virtual home visits, not clear if this will remain an option post COVID-19) (LINK). Focused on HFA Child Welfare Protocols as much as possible below (assume these are included in virtual offerings).

Program Components	Service Users	Service Providers	Program Delivery	Outcomes
• Adapted to remote support through phone and video calls **Areas covered in virtual home visits**: Promotion of positive parent-child interaction/ attachment, promotion of healthy childhood growth & development, enhancement of family functioning. **Components**: scheduled visit, be present and work with family based on needs, observe parent-child interaction and discuss/reflect, use parenting curriculum, community resources and screening tools.	• Families who are at-risk for child abuse and neglect and other adverse childhood experiences. • Typically initiated prenatally or within 3 mon. after the birth of the baby (extended in the case of HFA Child Welfare Protocols where initial outreach can occur up to 24 months of age) up to 5 yrs., (assume same for virtual home visits).	**Direct Service Staff** • High school diploma or equivalent with experience working/providing services to children and families **Supervisors** • Master's in human services or fields related to working with children and families, or Bachelor's degree with 3 yrs. experience **Program Managers** • Master's public health /human services admin. or working with children & families, or a Bachelor's degree with 3 years of relevant experience	• Virtual home visits conducted via phone/ video conference platform (Zoom, FaceTime) must be consistent with existing HFA Best Practice Standards • HFA regards virtual home visits and in-home visits equally, when conducted in accordance with existing home visit definition criteria and guidance. Choice of delivery based provider assessment of community conditions, family needs, & individual staff & family health & safety issues. • **Duration** (assume same as in-person): min. of 6 months, tapering down from biweekly visits of 50-60 min to monthly and quarterly visits, offered from when child is 0-3/5 years of age.	• Nothing specific to virtual home delivery **General program outcomes** • Studies show HFA has early impacts on child maltreatment prevention among children ages 1-3 yrs. old including: ↓ substantiated reports with families who engage in services, ↓ harsh discipline & ↓ physical abuse, ↓ emotional abuse & ↓ neglect, ↓hospitalizations for child abuse • ↓ child behavioral & developmental problems **Parental outcomes** • ↑ +ve parenting practices, ↑parental confidence, +ve interactions with their children, ↑ +ve parental discipline

Table 13: Incredible Years Online (USA and International jurisdictions) | See Page 72 for details

Incredible Years (IY) Online (USA and International Locations)

- IY is a series of three separate, multifaceted, and developmentally based curricula for parents, teachers, and children. This series is designed to promote emotional and social competence; and to prevent, reduce, and treat behavior and emotional problems in young children. The parent, teacher, and child programs can be used separately or in combination. There are treatment versions of the parent and child programs as well as prevention versions for high-risk populations. **Below we focus on the parent training program series.**
- Have developed IY Online as a response to COVID-19. People or agencies can sign up for the parenting/certain series content. Since COVID-19, IY has developed tips for leaders offering online tele-sessions (LINK).
- IY programs have been applied in more than twenty countries including Canada, England, Wales, Scotland, Norway, Palestine, New Zealand, Ireland, Portugal, Australia, Denmark, The Netherlands, Russia, Finland, Sweden, and more.

Program Components	Service Users	Service Providers	Program Delivery	Outcomes
• There are 5 levels of intervention based on population risk • Parent programs strengthen parent-child interactions, nurture relationships, reducing harsh discipline, and fostering parents' ability to promote children's social, emotional, and language development. • **For tele sessions:** recommend using experiential video vignettes, white board or notes page for learning and discussion, review of prior material, use notes to guide weekly goal setting, set short term goals, & help manage parent stress.	• Individualized approach recommended for high-risk families, though group formats available for parenting program • IY basic Parent Training Program targets parents of high-risk children and those displaying behavior problems • Parenting program is for parents of children ages 0-12 yrs.	• Dependent on the level of intervention – higher risk populations or behavioral interventions may require Family Service Workers, School Counselors, Teachers, Social Workers, Psychologists, Therapists, and Special Ed Teachers depending on the program	• Can be delivered in group or individual format • Have adapted to provide support through video tele-sessions • Also have a IY Online delivery format (pre COVID) that agencies and leaders can use • **Duration Parent Program** (assume same as in-person): 14-30 weeks (depending level of risk), 1x per week, for 2hrs.	Nothing specific to online/ tele session but claim programs have been found to be effective in strengthening teacher and parent management skills, improving children's social and emotional competence and school readiness, and reducing behavior problems.

Table 14: Internet-Based Parent-Child Interaction Therapy (USA & International jurisdictions) | See Page 77 for details

Internet-Based Parent-Child Interaction Therapy (I-PCIT), USA & International jurisdictions

- Parent Child Interaction Therapy (PCIT) is a dyadic behavioral intervention for children (ages 2 – 7 years) and their parents or caregivers that focuses on decreasing externalizing child behavior problems (e.g., defiance, aggression), increasing child social skills and cooperation, and improving the parent-child attachment relationship. It teaches parents traditional play-therapy skills to use as social reinforcers of positive child behavior and traditional behavior management skills to decrease negative child behavior.
- Internet-based PCIT (I-PCIT) is an internet-delivered version of traditional PCIT with adaptations to suit a virtual format (LINK).
- Internationally PCIT certified therapists are in various international locations: Canada, Australia, New Zealand, Norway and many others.

Program Components	Service Users	Service Providers	Program Delivery	Outcomes
• Systematic use of real-time, in-session parent coaching • Progress through treatment is typically not time-limited, continues until success criteria have been achieved • Emphasizes the parent-child relationship, uses in vivo feedback (using technology e.g., computer tablet), and monitors client progress in treatment with weekly assessments of parent skill use and child behavior problems Approach • 1) parents are taught relationship enhancement or discipline skills that they will practicing in session and at home with their child • 2) therapists coach caregivers in the application of specific therapy skill	• Children (ages 2-7 years) and their parents or caregivers • Less clear if child welfare populations have been specifically targeted for I-PCIT but regular PCIT has been studied for child welfare population.	PCIT Therapists: individuals must be a licensed mental health provider with a master's degree (or higher) in a mental health field or a 3rd psychology doctoral student who works under the supervision of a licensed mental health service provider. Individuals must also complete 40-hr of training with PCIT trainers & approved materials. Although online-based trainings are offered, at least 30/40 required hours must be in face-to-face training.	• Therapists use a video platform in which therapists and caregivers utilize either a laptop computer, tablet, or cell phone device positioned in a way that enables therapists to see the child and caregiver interacting • Caregiver receives in vivo coaching via either a Bluetooth device directly connected to the visual interface (i.e., computer, tablet, or cell phone screen) or headphones connected separately to a cell phone • **Duration**: Typically 12-20 sessions, 1x per week for 1-2 hr sessions	• I-PCIT has been studied prior to COVID-19 for feasibility; and, there have been a number of studies examining use of I-PCIT during COVID-19 • More flexible Telehealth policies during COVID- 19 have made it more feasible to switch to I-PCIT • PCIT has been used for at-risk families with success; however, no studies have specifically studied I-PCIT yet. (See appendix for specific I-PCIT references and examples)

Table 15: Project 12-Ways via Telehealth, Behavioral Sciences Unit (USA) | See Page 82 for details

Project 12-Ways via Telehealth, Behavioral Sciences Unit, Southern Illinois University, Carbondale (USA)

- A state-funded service delivery program that is funded by the Title XX Purchase of Service Contract and the Illinois Department of Public Aid and delivered by the behavioral sciences unit at Southern Illinois University, Carbondale. Project 12-Ways works directly with parents indicated for the neglect and abuse of their children and utilizes a molar or ecological approach focusing on the broader context of parenting behavior. In addition to examining the functional relations between parents' behavior and the contextual variables mentioned, this treatment model also evaluates parent behavior and how it affects others in context (LINK).

Program Components	Service Users	Service Providers	Program Delivery	Outcomes
• Use behavioral parent training model: emphasizes assessment and training within the context of a family's daily routine(s) called Contextually Valid Family Training™ • Provides support based in the home • Staff collect data and provide family with specific feedback on progress • Assessment process allows staff to measure parent's ability to maintain skills across time and in challenging circumstances	• Client referrals come from 5 state and not-for-profit agencies within a specifically defined rural area. • Referral leads to investigation to verify program eligibility. Eligibility: 1) family's protective status (determined by a suspicion of abuse or neglect as ascertained by a formal investigation 2) family's socioeconomic status (determined when mothers or fathers lack support in parenting their children & present with a very high risk for potential child abuse	• Counselor • Case worker • University research support staff • Program has about 8 graduate students working in the field providing contextually based behavioral treatments to parents	Usually in-home but adapted to Telehealth (see Britwum, 2020) • Used clinical expertise available & outlined specific steps to engage in prior to the session to ensure that effective telehealth visit (e.g., detailed description of session structure prior to the session, review of platform access for the session, discussions on how to identify right physical environment with/without children, review & discussion regarding goals for the session, modification of lang. for interview assessments to fit telehealth delivery of interviews, review of data collection sheets and feedback tools used during the session • Active support model adapted for use with parent-training model • Duration: Typically meet 1-2 times a week (not clear the duration, likely as needed)	Not yet measured for recent telehealth adaptation but an older videoconferencing pilot found: • Success in at supporting needs of families with very young children and those with adolescents with special needs • Demonstrated efficiency and portability of telehealth applications • Professionals and families agreed that interactive medium facilitated comparable service delivery to traditional home visits

Table 16: SafeCare, Virtual Delivery (USA and other International jurisdictions) | See Page 85 for details

Safecare (SC), Virtual Delivery, USA and other International jurisdictions

- SC is an evidence-based parenting program for families with children 0-5. It is a structured parenting program that addresses proximal behaviors that can lead to child neglect and physical abuse. Note: Based on Project 12-Ways.
- Regular program involves in-home delivery but has been virtually adapted for COVID-19 (LINK).

Program Components	Service Users	Service Providers	Program Delivery	Outcomes
• 18 in home sessions covering 3 modules (6 sessions each) • Baseline observational assessment with follow-up assessments in the last session of each module. **Modules:** • Child Health, • Home Safety, and • Parent-Child Interaction (seeks to build +ve parent-child relationship through psychoeducation and providers modeling +ve parent-child interactions to the caregiver and then the observation of caregiver practicing these skills as they engage in daily activities/play with child) • Families receive all 3 modules – in any order	Designed for parents of children aged 0–5 years, targeting proximal risk factors for physical abuse and neglect	A Bachelor's degree in human services is preferable as the min. qualification, then specific training is provided to become a) **SC Provider**: 32 hours during 4 consecutive days of workshop training, followed by observations of at least nine sessions by a certified SafeCare Coach or Trainer b) **SC coach**: need to be a certified SafeCare Coach & attend additional 16 hrs of workshop training over 2 days, plus a 4-5 day observation of a Provider Workshop	• Typically delivered weekly in the home over 18 sessions by a trained SC Provider (6 sessions per module or vary based on progress - 1 session per week) **Based on Self-Brown, 2020** • SC providers quickly adapted to technology-based delivery, and the purveyors of SC developed best practice guidelines for virtual delivery to allow for the continuation of services during COVID-19 • Most commonly used applications for virtual delivery were Zoom, FaceTime, & Google Duo • Many providers used smartphones for session delivery, many families owned a smart device to use	**Based on Self-Brown, 2020** • SC module that is the most didactic, Child Health, was the easiest to deliver virtually, while the two modules with more modeling and active role-play, Home Safety and Parent-Child Interaction, were more challenging. • Suggest it will be key for purveyors of programs & service providers to become more systematic in delivery of virtual programs **Family engagement & program effectiveness** • SC provider responses were mainly positive • Parent target skill mastery took longer to achieve but does occur • Seen as less intrusive by families • Virtual challenges: tech reliability, targeting skill modeling in this format, conducting accurate virtual assessments

Telehealth Services

Table 17: Telepractice for Parenting Support (Australia) | See Page 91 for details

Telepractice for Parenting Support, Australia (LINK)

- Telepractice is the use of telecommunications to deliver parenting support and other services remotely. It draws upon experiences in the delivery of telehealth and can include synchronous (e.g., virtual home visits) and asynchronous (e.g. email, text) approaches.
- Use the term telepractice rather than telehealth to avoid the perception that these modes of service delivery are restricted to healthcare settings. Used to deliver parenting support and other services remotely.

Program Examples	Service Users	Service Providers	Program Delivery	Outcomes
Examples of Evidence based parenting programs delivered online using telepractice include: • Triple P • Parent Child Interaction Therapy • Cognitive Behavioural Therapy • Psycho-education	• Those who are hard to reach – either physically or otherwise based on a variety of key factors e.g., family factors, individual factors, practitioner factors, use of technology, service or program factors	• Parenting programs may vary in how easily and effectively they can be delivered online. • Advise that practitioners be sufficiently trained in the program itself and seek advice from the developers or qualified trainers in how to proceed.	**Synchronous (interactive) services:** delivered in real time with an individual or group of clients e.g., telephone consultations and support lines, videoconferencing or webinar technology, internet chatroom platforms. **Asynchronous:** info/ advice shared over time with clients or digital conversations occur e.g., email & text messaging, social media platforms, digital delivery of guided self-help content where online materials such as reading or videos are supplemented by practitioner contact via email, phone or video conferencing.	General benefits • Convenience, access to services, participant choice and quality of care Logistical benefits • Time and cost savings from reduced travel • ↓ inconvenience for those supporting participants Participant benefits • ↑ choice and preference, ↓ stigma Service benefits • ↑ service reach, flexibility & quality • Extension of services beyond office hours • Provide skilled practitioners to remote and rural areas

Table 18: Child Protection Program Team Telemedicine Services, Children's Medical Services (USA) | See Page 94 for details

Child Protection Team (CPT) Telemedicine Services, Children's Medical Services', Florida, USA (LINK)

- The CPT is a medically directed multi-disciplinary program that works with local Sheriff's offices and the Department of Children and Families in cases of child abuse and neglect to supplement investigative activities.
- The telemedicine network facilitates child abuse assessments via telecommunications technology. Hub sites are comprehensive medical facilities with a wide range of medical and multidisciplinary staff while remote sites are limited in diversity and medical expertise in evaluating suspected cases of child abuse.

Program Components	Service Users	Service Providers	Program Delivery	Outcomes
CPT provides telemedicine exam to assess physical abuse, sexual abuse, and medical neglect cases that follows the same general protocol as a traditional face-to-face medical examination. • Medical evaluation of child's medical, developmental, and family history, • Assessment of the child's behavior and social risk factors and obtaining photographs Other: peer review and consultation	• Children suspected to be victimized who reside in rural areas	Hub site: The physician, physician assistant, or Advanced Registered Nurse Practitioner, the medical provider of record, is located at the hub site while a registered nurse and social worker engage with the child at the remote site during the medical evaluation.	• CPT patient is seen at a remote site & a registered nurse assists with the medical exam. A physician or Advanced Registered Nurse Practitioner is located at the hub site and has responsibility for directing the exam. • Hub-and-spoke system connects specialized child abuse pediatricians in urban areas to surrounding counties where expertise is lacking. On-site nurses use advanced image capture & other telemedicine equipment to assist the remote doctors in conducting exams.	• No study has evaluated the child and non-offending caregivers' satisfaction with telemedicine for child abuse evaluations. However, child and parent satisfaction with telemedicine utilized by other medical subspecialties has been promising.

Appendix A: Data Extraction

This section is a companion to the Summary Tables from the main report. The data extraction tables below contain detailed information from online program materials. Available website links and references are included. Information was obtained from websites, reports, and published literature associated with the programs. As much as possible information included in the data extraction tables is verbatim from program materials in full or shortened form.

Data Extraction – Canada

Stop Now and Plan, Virtual Delivery, Child Development Institute (Canada & International jurisdictions)

Program Name	**Stop Now and Plan (Snap), Virtual Adaptation (LINK)**
Jurisdiction	• Child Development Institute, Toronto, Canada • Affiliate locations across Canada, USA and also European locations such as the Netherlands, Scotland, Norway and Grand Cayman: https://childdevelop.ca/snap/sites/default/files/PDF_SNAPWebsiteList_2020_12_15.pdf
Brief Program Description	SNAP Virtual Adaptation during COVID-19 • SNAP® Girls and SNAP® Boys programs for children ages 6-12 [most other materials say 6-11] have moved to virtual platforms to continue offering our specialized SNAP model to children in need. SNAP Program general • SNAP®, which stands for Stop Now And Plan, is an evidence-based behavioural model that provides a framework for teaching children struggling with behaviour issues, and their parents, effective emotional regulation, self-control and problem-solving skills. The primary goal of SNAP is to keep children in school and out of trouble by helping them make better choices "in the moment." • The core SNAP programs, SNAP Boys and SNAP Girls, are gender-specific programs for children ages 6-11 experiencing disruptive behaviour problems.
Program Goals	SNAP Regular Program • The primary goal of SNAP is to help children to stop and think before they act, and keep them in school and out of trouble. ○ Increase emotion-regulation and self-control skills in children and their parents ○ Reduce aggression, bullying and antisocial behaviour ○ Increase social competency ○ Improve academic success by decreasing behavioural issues at school ○ Engage high-risk children and their families in service ○ Connect children and parents to community-based resources ○ Prevent delinquency, school drop-out and teen pregnancy
Program Components	SNAP regular program components (assume is the same for virtual – no differences indicated)

	• Over the course of 13 weeks, children attend either SNAP Boys or SNAP Girls groups while their parents attend SNAP parenting sessions.* Through role-plays, home practice assignments and joint family sessions, both children and parents learn how to deal with difficult situations by: ○ Stopping themselves (e.g., by counting to 10 or taking a deep breath) as soon as their body begins to react (e.g., throbbing head, tension, feeling hot). We call these reactions body cues. ○ Identifying any hard thoughts (e.g., "he's doing that to make me mad") and replacing them with helpful/realistic coping statements, or cool thoughts (e.g., "I can handle this"). ○ Picking a plan that meets these three criteria: 1) makes the problem smaller instead of bigger, 2) doesn't hurt anyone or anything, and 3) makes them feel okay. • Regular SNAP Boys 5 key components (LINK): ○ SNAP Boys Club – A structured group that meets weekly for 13 weeks and teaches boys self-control, problem-solving and emotion-regulation skills ○ A concurrent SNAP Parenting (SNAPP) Group that teaches parents effective child management strategies ○ One-on-one family counselling based on the SNAPP Skills Guide ○ Individual counselling/mentoring for boys who require extra support ○ School advocacy and teacher support to assist boys who are struggling behaviourally and/or not performing at their age-appropriate grade level at school ○ Other components of the program that may be used, based on assessed level of risk and need, and where appropriate, include academic tutoring, victim restitution, community connections and long-term continued care services. ○ As well, a parent problem-solving group is offered several times each year to support parents who have completed the SNAP Parenting group. • Regular SNAP Girls 6 key components (LINK) ○ The program components are similar to the SNAP Boys program, but there are important differences based on research and best practices for treating girl aggression. In SNAP Girls, for example, there is greater emphasis on communication and relationship-building. ○ SNAP Girls Club – a structured group that meets weekly for 13 weeks and teaches girls the SNAP technique to achieve emotion-regulation, self-control, realistic thinking and problem-solving skills ○ A concurrent SNAP Parenting (SNAPP) Group - teaches parents the SNAP technique in conjunction with effective child management strategies ○ Girls Growing up Healthy – typically offered after SNAP groups are completed. The caregiver-daughter group aims to strengthen this essential relationship at the critical pre-teen stage, and to address issues related to physical development and healthy relationships ○ Family counselling based on SNAPP (Stop Now and Plan Parenting) ○ Individual counselling/mentoring for girls who require extra support ○ School advocacy and teacher support to assist girls who are struggling behaviourally and/or not performing at their age-appropriate grade level at school
Program Delivery	Offering Virtual Delivery for COVID-19 Early Intervention Services • Program service delivery moved to video and tele-counselling services delivered by clinicians and psychologists

	• Virtual groups meet weekly – participants connect and share experiences with each other while learning the steps of the SNAP program
	  ○ Parent/caregivers group meets weekly, separately from children groups
	  ○ Parents can also meet on a one-on-one basis with clinician as needed
	  ○ Clinicians connect weekly with participants for check-ins
	  ○ Online resources are available to children and their families
	  ○ Families can also access SNAP's online resources that focus on key elements of the SNAP program, including modeling and role-play to practice and reinforce SNAP emotion regulation and problem-solving techniques.

Service Users	Snap Virtual • Specified boys and girls ages 6-12 Snap Regular • Boys and girls, ages 6-11, experiencing serious behavioural problems at home, at school, with persons in authority, and in the community can benefit from the SNAP Boys/SNAP Girls programs. • SNAP works with both children and parents.
Service Providers	• Experienced and highly-trained SNAP staff work with parents to assess problems and create and evaluate treatment/action plans. • Family Child Workers and a dedicated Clinical Manager
Referral Method	Regular Snap Program (assume the same for virtual adaptation): • In Toronto, parents are encouraged to contact the Intake Line at 416-603-1827, ext. 3143. The intake worker will ask you a series of questions to determine eligibility for SNAP. • Children under 12 who have had contact with the law can be directly referred by police through the Toronto Centralized Services Police Protocol intake line at 416-654-8989. Many other communities have modelled their police-community referral processes after the Toronto model. • Teachers, social workers, police and other service providers may facilitate a referral with written consent from the parent or legal guardian.
Outcomes	*No information on virtual SNAP but list below outcomes based on research of non-virtual Snap SNAP proven outcomes: • Increased emotion regulation, self-control, problem-solving skills, pro-social communication, executive functioning and social competency • Decreased antisocial behaviour, rule breaking, depression, anxiety and police contact • Enhanced ability to make better choices in peers • Improved success at school, including a decrease in disciplinary issues • Increased connection to positive community activities • Development of effective child management strategies, positive support systems, coping abilities and communication skills • Decreased parental distress and increased parental competency • Development of positive pro-social values and conduct Long-term outcomes (12+ months)

	• Maintenance of post-group achievements • Continued improvement in the parent's ability to use effective child management strategies • No involvement with the criminal justice system • Delayed and less frequent trouble with the police/delayed entry into the youth justice system • Continued improvement in the child's executive functioning Other • Recent research indicates that 68% of SNAP® participants will not have a criminal record by age 19. • Early cost savings for SNAP® are showing an average return of $7 for every $1 spent in the first year.
Contacts	• LAugimeri@childdevelop.ca
References	Snap (Non-virtual) ○ **Augimeri, 2011**, Rolling out SNAP an evidence-based intervention: A summary of implementation, evaluation, and research (LINK) ○ **Burke, 2015,** The effectiveness of the Stop Now and Plan (SNAP) Program for boys at risk for violence and delinquency (LINK) ○ **Burke, 2015,** The effectiveness of the Stop Now and Plan (SNAP) Program for boys at risk for violence and delinquency (LINK) ○ **Byrd, 2018,** Boys with conduct problems and callous-unemotional traits: Neural responses to reward and punishment and associations with treatment response (LINK) ○ **Lipman, 2008,** Evaluation of a community-based program for young boys at risk of antisocial behaviour: Results and issues (LINK) ○ **Snap Research Brief** (LINK) Related Program • **Child Development Institute, 2012,** Intensive Community and Home Services (ICHS) A Preliminary Evaluation, 2011 (LINK)
Related Web Links	Virtual Adaptation for COVID see post for **Friday, Oct 9, 2020 - COVID-19 Response: CDI Virtual Programming** on this page: https://www.childdevelop.ca/coronavirus SNAP, Virtual in Thunder Bay: https://anishinabeknews.ca/2020/11/19/focused-intervention-program-for-children-recognized-for-its-role-in-the-thunder-bay-area-community/ Regular Snap Program (non-virtual) • Snap Services Brochure for Parents: https://childdevelop.ca/snap/sites/default/files/CDI-SNAP-ResourceGuide-DIGITAL-FINAL_02.pdf • Child Development Institute Overview of Snap: https://www.childdevelop.ca/programs/snap • Other Snap Programs: https://childdevelop.ca/snap/snap-programs/other-snap-programs • Snap Media Publications: https://childdevelop.ca/snap/media-publications • SNAP Boys CEBC: https://www.cebc4cw.org/program/snap-boys/

Data Extraction – USA and other International Jurisdictions

Attachment & Biobehavioral Catch-up, University of Delaware (USA & International jurisdictions)

Program Name	Attachment and Biobehavioral Catch-up (Tele ABC) (LINK)
Jurisdiction	• Originated in Delaware, USA but used across USA and internationally (e.g., Sweden, Canada, Norway, Australia). • Also piloted in Canada through Ryerson University's Child and Family WISE lab (LINK)
Brief Program Description	• A home visiting, evidence-based parenting intervention for caregivers of infants and toddlers who have experienced early adversity. It helps caregivers nurture and respond sensitively to their infants and toddlers to foster their development and form strong and healthy relationships. • Tele ABC is a telehealth version of the program adapted for COVID-19 with the goal of providing supportive guidance for parents to provide nurturing, sensitive care to young children during these stressful times
Program Goals	Regular ABC • Increase caregiver nurturance, sensitivity, and delight • Decrease caregiver frightening behaviors • Increase child attachment security and decrease disorganized attachment • Increase child behavioral and biological regulation TeleABC • TeleABC's goal is to provide supportive guidance for parents to provide nurturing, sensitive care to young children during these stressful times.
Program Components	Regular ABC Program • The first intervention component helps caregivers to re-interpret children's behavioral signals so that they provide nurturance even when it is not elicited. Nurturance does not come naturally to many caregivers, but children who have experienced early adversity especially need nurturing care. Thus, the intervention helps caregivers provide nurturing care even if it does not come naturally. • Second, many children who have experienced early adversity are dysregulated behaviorally and biologically. The second intervention component helps caregivers provide a responsive, predictable, warm environment that enhances young children's behavioral and regulatory capabilities. The intervention helps caregivers follow their children's lead with delight. • The third intervention component helps caregivers decrease behaviors that could be overwhelming or frightening to a young child • While ABC is a manualized intervention that also incorporates video-feedback and homework, the most crucial aspect of the intervention is the parent coach's use of "In the Moment" comments that target the caregiver behaviors of nurturance, following the lead with delight, and non-frightening behaviors. These are used throughout the home visiting session while working with the parent.
Program Delivery	**TeleABC** • Created protocols for conducting ABC sessions, including live commenting and manual content, through telehealth platforms. Children can express their stress or feelings in confusing ways, such as acting angry or disruptive when feeling confused or upset, or turning or pulling away from a parent who is trying to comfort them. As with in-home ABC, TeleABC helps parents recognize cues for nurturance, even when they are not clear. In typical conditions ABC sessions include conversation about what can make it harder to nurture your distressed child and follow the lead during play, and what kind of circumstances and history make it easier to frighten

	your infant or toddler. TeleABC includes this outlook as well, with a focus on how the fear, uncertainty, and increased stress can decrease parental resources and increase stress and irritability.
	
	Regular ABC Program
	• Services Involve Family/Support Structures: This program involves the family or other support systems in the individual's treatment: The child is involved in the home visits to help the parents use new skills in the moment, and the parents are expected to observe and note the child's behavior and practice new skills them with between sessions.
	• Recommended Intensity: Weekly one-hour sessions
	• Recommended Duration: 10 sessions
	• Delivery Settings: Adoptive Home, Birth Family Home, Foster / Kinship Care
	• Resources Needed to Run Program:
	  ○ Audiovisual Needs: Laptop computer, Video camera, Webcam for supervision
	  ○ Personnel: Clinician with excellent interpersonal skills
	  ○ Space: Must be conducted at caregivers' homes; this can include shelters or other temporary living situations

Service Users	Not specified for Tele ABC but usually - • Any parent, primary caregiver, or legal guardian who has a child or children between the ages of 6 months and 48 months can participate in ABC who has experienced early adversity • For infants between 6 and 24 months of age (ABC-Infant), and for toddlers between 24 and 48 months (ABC-Toddler).

Service Providers	**TeleABC**
	○ Reference ABC-certified parent coaches and parent coaches in training have access to the TeleABC guidance
	○ More details available for regular delivery of in person ABC (see below)
	
	Regular ABC (assume these apply for TeleABC)
	• Prerequisite/Minimum Provider Qualifications:
	  ○ There is no educational level requirement for parent coaches. Potential parent coaches participate in a screening prior to training. If they pass the short screening, coaches attend a 2-day training and a year of supervision.
	• Training Type/Location:
	  ○ Training is held at University of Delaware for individuals or small groups or training. On-site training is held for larger groups. Weekly supervision is conducted through videoconferencing.
	  ○ Number of days/hours: 2 days of training to become a Parent Coach then followed by 1 year supervision (1.5 hours weekly, including group supervision and individual supervision in In the Moment commenting) to become a Certified Parent Coach
	• Formal Support for Implementation:
	  ○ Supervision is conducted for one year via video conferencing using Zoom (HIPAA-compliant video conference software that the program provides).

	○ Parent coach trainees have 2 supervision meetings per week, General Clinical Supervision and "In the Moment Commenting" Supervision: General Clinical supervision is 1-hour per week group supervision conducted in groups of 2 or 3, with an expert-level supervisor. ○ Supervision includes video review each week. "In the Moment Commenting" supervision is a 30-minute session per week conducted by staff members at the University of Delaware. A 5-minute segment from the parent coach's case is assigned to the parent coach and staff member for coding prior to the supervision session. The supervision is directed at enhancing coding reliability (so that parent coaches will learn to identify triggers for comments and components of comments) and at enhancing comment quality and frequency. ○ After a year of supervision, parent coaches' adherence and fidelity are evaluated for certification. If they pass, coaches are certified for 2 years, after which time adherence and fidelity are reevaluated.
Referral Method	• No clear referral but says that - Any parent, primary caregiver, or legal guardian who has a child or children between the ages of 6 months - 48 months can participate in ABC.
Outcomes	**TeleABC** • Our evidence that ABC is an effective intervention is limited to in-person implementation. However, there is reason to think that video telehealth could be an effective method of implementing evidence-based interventions **Regular ABC** • Children are more likely to be securely attached to their caregivers • On average, children develop more normative stress hormone patterns (see right) • Children develop better impulse control • Children are less likely to show anger during a challenging task • Children have an easier time switching between complex tasks (executive functioning) • Children have more advanced receptive language abilities • Parents respond to their young children with more sensitivity Research Page for ABC notes evidence for families involved in Child Welfare (http://www.abcintervention.org/research/): • Tested efficacy of the ABC Intervention through randomized clinical trials with birth parents involved in the child welfare system as part of a foster care diversion program, with foster parents, and with parents adopting internationally. In each study, parents have been randomly assigned to receive the ABC intervention or a control intervention. Parents and evaluators have been blind to the experimental condition. Most of the findings described are from the high-risk Child Protective Services (CPS) involved families, which is our longest running study. ○ Found evidence supporting the efficacy of ABC in these three independent samples, suggesting that ABC is effective in improving attachment and helping regulate both biology and behavior in at-risk children. Also found early evidence supporting the efficacy of ABC at dissemination sites across the country. ○ **Attachment**: Among CPS-involved children, more of the children whose parents received the ABC intervention were classified as having secure attachments than those in the control group (52% of children receiving ABC vs. 33% of children receiving a control intervention). In addition, fewer of the children in the ABC intervention group had disorganized

	attachments than those in the control group (only 32% of ABC children were classified as disorganized vs. 57% of children in the control group) ○ **Cortisol regulation:** Children who received the ABC intervention had a more normative diurnal pattern of cortisol production (steeper slopes and higher wake-up values of cortisol) than children who received the control intervention. When assessed three years after completing the ABC intervention, children who received the ABC intervention continued to have a more normative diurnal cortisol pattern than the children who had received the control intervention. ○ **Self-regulation: Emotion expression -** When children were between 24 and 36 months of age (1-2 years after the intervention), children participated in a challenging task designed to elicit frustration. Children who received the ABC intervention displayed less overall anger, and less anger towards their parents in particular, than children who received the control intervention. ○ **Self-regulation: Executive functioning & Inhibitory control -** Between 4 and 6 years of age (2-4 years after the intervention), foster children who received the ABC intervention had stronger executive functioning and better inhibitory control than foster children in the control group. In addition, when looking at these skills, the foster children who had received ABC did not differ significantly from the comparison group of children who had never been involved with the foster care system. ○ **Parental sensitivity**: Immediately following the intervention and three years after the intervention was completed, ABC parents showed higher sensitivity (followed their children's lead more), showed more positive affect (delight), were less detached, and were less intrusive than control intervention parents. ABC parents looked nearly indistinguishable from a low-risk comparison group of parents.
Contacts	• icp@psych.udel.edu • Caroline Roben, PhD Title: Director of ABC Dissemination Email: croben@udel.edu
References	**TeleABC** • Dozier, 2021, Pivoting to Telehealth Implementation of Attachment and Biobehavioral Catch-up PPT (LINK) **ABC regular programming (non-virtual)** • Ryerson University's Child and Family WISE lab Pilot of ABC (Canada) (LINK) - Virtual is an option for training • List of Publications ABC: http://www.abcintervention.org/publications/ • Research Support for ABC: http://www.abcintervention.org/researchsupport/
Related Web Links	• ABC Infant: https://homvee.acf.hhs.gov/effectiveness/Attachment%20and%20Biobehavioral%20Catch-Up%20%28ABC%29%20-Infant/Model%20overview • CEBC: https://www.cebc4cw.org/program/attachment-and-biobehavioral-catch-up/ • Sweden Kasam Familj ABC offering: https://www.kasamfamilj.se/attachment-and-biobehavioral-catch-up-abc/ • Germany: https://www.dji.de/ueber-uns/projekte/projekte/foerderung-positiver-bindungsbeziehungen-in-pflegefamilien.html

Behavioral Health Virtual Therapy Services, KVC Kentucky (USA)

Program Name	**Behavioral Health Virtual Therapy Services (LINK)**

Jurisdiction	• Kentucky, USA • Staff work from eight locations across Central, Eastern, Northeastern and Northern Kentucky to help strengthen the lives of individuals and families each day.
Brief Program Description	• KVC Kentucky, headquartered in Lexington, is a 501(c) 3 nonprofit child welfare and behavioral healthcare organization that provides behavioral health services, foster care, family preservation and reunification, and other family-related services. Services are in-home, strengths-based, and driven by a focus on the safety, permanency, and wellbeing of the child and family. Each year, KVC Kentucky serves more than 12,000 children and families in eight regions of the state. • Behavioral Health Virtual ○ Our innovative, evidence-based Behavioral Health Services are delivered in our client's homes and communities. Services include assessment, diagnosis, and developing plans for care that utilize Evidence Based treatment. Our Board Certified Child Psychiatrist is available to meet with clients in our Lexington office, as well as seven telehealth sites across Kentucky.
Program Goals	• KVC Kentucky offers behavioral healthcare services to children, adults and families. KVC's provision of virtual therapy is to best meet our client's needs and reduce barriers associated with office-based care.

Program Components	• Services Provided Through Virtual Therapy
	  ○ **Assessment**: Master's level clinicians are highly trained in comprehensive assessment techniques in order to develop an accurate analysis of a child's presenting problems.
	  ○ **Therapy**: Therapists work with the service team to identify specific evidence-based interventions and can provide therapy at a frequency, schedule and location based on the needs of the child.
	  ○ **Case Management**: KVC case managers work diligently and quickly to find the proper care and provide services, referrals and resource linkages that focus on the needs of the child and family. Case management includes advocacy, resource development, team development, conducting collaborative service team meetings, accessing any needed medical, social, educational or other support services, and coordinating services through inter-agency involvement and collaboration.
	  ○ **Comprehensive Community Support Services**: Community support associates work with the wraparound team to provide targeted, strengths-based skill-building to support and enhance youth and adult's ability to live independently in the community, improve coping strategies to reduce mental health symptoms, and maximize overall functioning and well-being.
	  ○ **Psychiatry:** Our psychiatrist is available to meet with clients to provide consultation, evaluation and medication management as needed.

Program Delivery	• Have recently accelerated use of virtual therapy and extended it to all clients in response to the current public health crisis. KVC Kentucky will be providing virtual therapy to our clients instead of providing services in the home, school and community with the aim of following the guidelines established by the CDC and the recommendations provided by State of Kentucky regarding minimizing risk of exposure and containing the spread of the coronavirus. Virtual therapy will allow our trained professionals to provide therapeutic services, resources and support anywhere in Kentucky. • We utilize a service team approach to develop a collaborative care plan that is designed to help children live successfully at home and in the community. Team members meet frequently to assess progress, develop goals and interventions, and put crucial support systems in place. • What You Need to Participate in Virtual Therapy ○ Device such as computer, Chromebook, cellphone with camera and Internet access

	○ Stable and secure Internet connection ○ Confidential space ○ Natural supports to use in case of emergency ○ Sessions must be held within State of Kentucky ○ If technology is a barrier, please let us know and we will try to find a way to assist you.
Service Users	• Youth, adults and families • Serve individuals experiencing depression, anxiety, suicidal thoughts, substance use, child behavior challenges and more. • Program provided by child welfare organization so assume this would be a part of service user characteristic
Service Providers	• Skilled and professional Master's level therapists and case managers • Board certified Child Psychiatrist • Service Team model: KVC therapists, KVC Case Managers, community support associates, staff psychiatrist)
Referral Method	• Anyone can refer including an agency • Referrals will be matched with a caring therapist who listens to you and is readily available at convenient times that work for you.
Outcomes	• Nothing formal other than endorsement: "Our in-home and community based services empower individuals and families daily to create positive changes in their lives. Always focused on our consumers, we are evolving to best serve Kentucky communities including such innovations as a Walk-In Assessment Clinic, school-based clinics and expanding substance use treatment services."
Contacts	• visit kentucky.kvc.org, • call 859-254-1035 or • email KYReferrals@kvc.org
References	None found
Related Web Links	• KVC Brochure In Home Behavioral Health Services: https://kentucky.kvc.org/wp-content/uploads/sites/4/2014/09/2017-BHS-Brochure-.pdf

Child First via telehealth, Connecticut (USA)

Program Name	**Child First (CF) (LINK) via telehealth (LINK)**
Jurisdiction	• Connecticut (CT), Florida, North Carolina, Colorado, USA • Today, CF has 15 affiliate program sites in CT, with 14 implementing agencies. The two major sources of sustainable funding come from the CT Department of Children and Families (child welfare) and Maternal, Infant, and Early Childhood Home Visiting (MIECHV), managed by the CT Office of Early Childhood. There is current capacity to serve 1,000 children and their families per year. • CF has now successfully expanded its model to other states, including urban and rural areas. In 2015, Child First began national replication in Palm Beach County, Florida in partnership with the Children's Services Council of Palm Beach County (CSCPBC). In 2016, the model was replicated in eastern North Carolina in partnership with Trillium Health Resources. Affiliates in Florida are funded by CSCPBC which has public funds as a special taxing district. Affiliates in eastern North Carolina bill Medicaid for Child First services using a special "in-lieu of" service definition
Brief Program Description	• Is a two-generation, home-based mental health intervention for the most vulnerable young children (prenatal through age five years) and their families, who likely have current or past Child Welfare Services involvement. It is designed for young children who have

	usually experienced trauma and/or have social-emotional, behavioral, developmental, and/or learning problems. Most live in environments where there is violence, neglect, mental illness, substance abuse, or homelessness. • In 2020, what was formerly the NSO solely for Nurse-Family Partnership joined forces with CF, a merger empowering two proven, evidence-based models to share complementary expertise, infrastructure and integrated support services. The resulting unified entity works to ensure that healthcare, early childhood development and the mental health of the entire family are delivered in proven ways to achieve long-term positive outcomes. • Helps struggling families build strong, nurturing relationships that heal and protect young children from the devastating impact of trauma and chronic stress. We use a two-generation approach, providing psychotherapy to parents and children together in their homes, and connecting them with the services they need to make healthy child development possible.
Program Goals	• CF intervention addresses the highest risk families, decreases stress within the family, increases stability, facilitates connection to growth-promoting services, and supports the development of healthy, nurturing, protective relationships. • CF helps to heal and protect children and families from the effects of chronic stress and trauma by fostering strong, nurturing, caregiver-child relationships, promoting adult capacity and connecting families with needed services and supports. • Goal to help parents and caregivers reflect on and understand the feelings and motivations underlying their child's behavior. • Goal of intervention is to enhance the parent's and caregiver's capacity to provide sensitive, age-appropriate care and protection, with mutual pleasure in the parent-child relationship.
Program Components	Assume CF program components are similar to telehealth adaptations (minus the addition of COVID-19 stress mitigation). Typical CF intervention components: • The intervention is conducted in the home with the child, parents or other primary caregivers, and other family members. Child First intervention addresses the highest risk families, decreases stress within the family, increases stability, facilitates connection to growth-promoting services, and supports the development of healthy, nurturing, protective relationships. • CF home-based intervention has seven major components: 1) **Engagement of Family:** The intervention begins with engagement and trust building. We begin by asking what we can do to help the family meet their own goals and listen closely to their concerns. The CF team members serve as family partners and advocates. 2) **Comprehensive Assessment of Child and Family**: The CF Team partners with the family to understand the child's health and development, the child's important relationships with parents as well as other individuals who care for the child (e.g., early care providers), child trauma and other stressors (e.g., violence and separation), and the multiple challenges experienced by the parents that interfere with their ability to protect, nurture, and support their child's development. Formal measures, conversations, observations, and records from other providers are included in the process. 3) **Development of Child and Family Plan of Care**: A family-driven plan consisting of comprehensive, well-coordinated, therapeutic intervention goals, supports, and services is developed in partnership with the parents or caregivers. This plan reflects the parents' goals, priorities, strengths, culture, and needs. This serves as the Medicaid-compliant treatment plan. 4) **Parent-Child Psychotherapeutic Intervention**: The promotion of responsive nurturing through a parent-child psychotherapeutic approach was designed to enhance the parent-child relationship as fundamental to the child's social-emotional health and cognitive development. Given the high level of risk and psychological challenges in the children and parents served by CF, an intensive approach that blended parent guidance and dyadic, psychotherapeutic treatment was deemed most appropriate to

	meet the needs of our multi-challenged families. This approach is highly individualized and driven by the child and family's unique strengths, needs, culture, and psychological availability. 5) **Enhancement of Executive Functioning**: CF Team promotes self-regulation and executive functioning capacity through both the psychotherapeutic intervention and the development and execution of the service plan. We mentor caregivers so that they are able to thoughtfully focus attention, plan, organize, problem solve, and succeed. Furthermore, this enables them to scaffold the development of executive functioning in their own children, which is essential to their children's educational success. 6) **Mental Health Consultation in Early Care and Education**: The Mental Health Clinician works with the early care and education environment to provide consultation to the teacher or caregiver. This is especially critical when there are challenging behaviors within the classroom. The Clinician conducts observations, discusses past and current behavior with the teacher, and helps the teacher understand the meaning of the child's behavior. Together they develop strategies that can meet the child's individual needs and coordinate efforts between early care and education and the home. 7) **Care Coordination**: The Care Coordinator facilitates the coordination of services and the family's access to multiple resources throughout the community, based on the collaborative planning with the parents. The Care Coordinator listens carefully, always reflecting on the meaning of the service for the family. The Care Coordinator provides hands on assistance obtaining information and partnering with community providers, researching program appropriateness and availability, and making and facilitating referrals to provider agencies. Though this process, she promotes the caregiver's executive functioning
Program Delivery	**Virtual delivery** • March 2020 Telehealth: CF teams of Care Coordinators and Mental Health Clinicians working remotely through telehealth (video-conferencing when possible, if not, by phone), contacting their families one or more times each week, depending on the unique needs of the family. CF network is helping to get families remote capability – both devices and internet access **Details about regular program delivery:** • **Staffing**: Each affiliate site has a CF Clinical Director/Supervisor and two to six clinical teams. The Child First team consists of a licensed, Master's level Mental Health/Developmental Clinician and Bachelor's level Care Coordinator, both with significant expertise with very young children and vulnerable families. They work together in the home with the family. • **Caseload**: Each CF team usually carries between 12 and 16 families, such that they are able to complete 12-14 home visits per 40-hour work week. However, this varies based on intensity of service need, success of planned visits, and travel time. • **Visits**: Families receive visits twice per week during the assessment period (first month) and then once a week or more, depending on the needs of the child and family. After assessment, Clinicians and Care Coordinators may visit together or separately, based on the individual family needs. Visits last 1- 1.5 hours. • **Duration of services**: Services generally continue for 6- 12 months, but may be longer based on individual family needs

Service Users	• Typically Children and their families prenatal through five years at the onset of services
	• Target concerns:
	  ○ Children with emotional/behavioral or developmental/learning problems
	  ○ Families with multiple challenges (such as extreme poverty, maternal depression, domestic violence, substance use, homelessness, abuse and neglect, incarceration, and isolation)

	• Eligibility: There are no exclusions other than the specific geographic area served by CF. Families needing less intensive intervention may be triaged to other services.

Service Providers	Team is made of:
	• A Child Development Clinician who understands children's behavior, development, and learning.
	• A Care Coordinator who connects families with services and supports (like food, housing, furniture, child care, health care, and job training).
	
	The CF Organizational Structure consists of the:
	• National Program Office
	• Affiliate Agencies [See here for requirements of Affiliate Agencies (LINK)]
	• Child First Team Structure (within Affiliate Agencies)
	• Community Advisory Boards (Child welfare is a required collaborator)
	• Each Component plays a key role in maintaining fidelity of the overall model.
	
	CF Team
	• Child First staff work in teams of a licensed Master's level, Mental Health/Developmental Clinician and a Bachelor's level Care Coordinator. Both must have substantial experience with very young children and with ethnically diverse, challenged families.
	• The Clinician's work with the parent and young child focuses on their relationship, while the Care Coordinator's work focuses on connecting the family with community-based services and supports. Staff must be multi-lingual, reflecting the ethnic composition of the community.
	
	CF Team Structure
	• A Clinical Team consisting of a licensed Mental Health /Developmental Clinician and a Care Coordinator is extremely effective with families because:
	  ○ Each individual has his/her own area of expertise and concentration, so therapeutic and service goals can proceed simultaneously.
	  ○ It provides two sets of eyes and two perspectives (based on individual culture and history) when working with families.
	  ○ It allows tremendous flexibility in roles and timing of interventions. (One can work with the child(ren) while the other is with the parent.)
	  ○ It is very efficient in terms of service cost.
	  ○ It allows parent-choice in terms of relationship-building.
	  ○ It provides an opportunity for Clinical Team members to work as therapist (Clinician) with therapeutic support (Care Coordinator) for extremely complex families.
	• Clinical Team members support and provide a "holding environment" for each other, especially with very challenging families. If one Clinical Team member cannot make an appointment (due to illness or vacation), the other can make the visit, providing important consistency.

	• The quality, experience, and maturity of staff is critical. Reflective, experienced, committed, flexible, culturally competent, multi-lingual, ethnically diverse, nurturing staff are essential. It is through the relationships they form with parents that change occurs. They need the capacity to reflect on their own strengths and weaknesses, motivations, and relationship history. • Staff should have had extensive experience working with very young children and ethnically diverse families. It is necessary to pay salaries that are high enough to recruit and retain high quality staff. • All the Mental Health/Developmental Clinicians and Care Coordinators should be co-located at the same organization so that they can build strong, trusting relationships with each other, and become a true team. The peer supervision and mutual support of the team members is critical to maintain high morale and the highest quality services when working with multi-challenged families. • Consistent, reflective, clinical supervision is essential, with an open door policy. Individual, team, and group supervision are necessary for all CF staff, including Clinicians and Care Coordinators.
Referral Method	Not specified for telehealth but assume the same as regular delivery* • Any child who is under six years of age may be referred to CF. This includes referrals for a woman during the prenatal period. Children are eligible if they have emotional or behavioral problems, developmental or learning problems, or come from environments in which there is considerable risk to their health and development. Formal screening does not have to occur prior to referral. There are no exclusion criteria, other than the specific geographic area served by the CF program. CF will serve families with parental mental illness, substance abuse, incarceration, domestic violence, living in shelters, or with undocumented status. It is expected that many of the families will have active involvement with child protective services (in Connecticut, the Department of Children and Families-DCF), including children in foster care. • Cost: Families are served without regard to insurance coverage, ability to pay, or legal status. A sliding payment scale may be established within a CF program. When available, medicaid or other insurance may be billed by the CF program. **Sources of Referrals** • CF receives referrals from a wide variety of sources, ranging from self-referrals to community agency referrals. Many of these referral sources are active participants in the CF Community Advisory Board. It is important that the sources of referrals be tracked to be sure that CF is reaching the most vulnerable populations. If not, then there is need for increased community outreach. **Referral Process** • The referral process is defined by the Affiliate Agency, with some recommendations provided by the CF National Program Office. Key elements of effective referral processes include: • Referrals may be made by a provider, parent, or other caregiver. However, there must be at least verbal permission granted by the parent/guardian prior to making the referral. The actual written permission will be obtained at the time of the first visit with the family or prior to the visit if the child protective services agency is the guardian. • Families do not need to come into the Affiliate Agency office prior to beginning CF intervention. This would eliminate some of our highest risk families from accessing our services. • If the referral appears to be an emergency, meaning the child must be seen within 24 hours, then the Clinical Director needs to call the referring agency or parent and recommend that an emergency service be contacted (e.g., Emergency Mobile Psychiatric Services in Connecticut). • A call to the referring source - agency or caregiver - is made within 24 to 48 hours of receipt of referral.

	• While generally children are served based on the time of referral (and placed on the waiting list accordingly), when there is an urgent need, these children and families are given priority. The CF Priority Procedure guides this process. In Connecticut, priority is also given to children and families who have current DCF involvement. To make a referral to CF, you can locate a program's contact information by selecting, and filling in the locator information at the State Affiliate site.
Outcomes	**Lessons from a survey of home visitors using CF telehealth since pandemic:** • Lack of access to telehealth resources presents a major challenge and an issue of equity for mental health service delivery via telehealth (need provision of appropriate tools i.e., tablets/ technology for families) • Telehealth can be an effective way to engage caregivers, when it is a preferred method of communication, and they have access to the technology (e.g., main facilitate conversations from some caregivers) • There are challenges in providing dyadic treatment via telehealth (keeping young children engaged, clinician difficulty reading body language, tracking parent/child interactions and observing environment, lack of therapeutic toys) • At times, ensuring a private and therapeutic environment is challenging (e.g., determining privacy for certain conversations/assessments) • Telehealth offers an increased ability to reschedule appointments and reduces travel time and expense. • In summary, although it is too early to tell how effective telehealth is, feedback from the use of telehealth appears to have both significant benefits and challenges for the delivery of the Child First Intervention. **Regular CF intervention** • Research shows that CF stabilizes families and improves the health and wellbeing of both parents and children. This proven intervention currently has affiliates throughout Connecticut, Florida, and North Carolina.
Contacts	email: info@childfirst.org
References	**Telehealth** • **Child First, June 8, 2020**, Child First and Telehealth during COVID (LINK) **Regular CF program (not telehealth)** • CF Research summarized: https://www.childfirst.org/our-impact/research • CF Evaluation data: https://www.childfirst.org/our-impact/evaluation • **Schwartz, 2018,** Preventing child maltreatment. Children's Health Policy Centre, Faculty of Health Sciences, Simon Fraser University (LINK)
Related Web Links	• **Child First, December 2020**, Nurse-Family Partnership Welcomes Child First Leadership as Part of Merger (LINK) • **Child First, March 2020,** Child First's COVID-19 Response & Resources (LINK) • **Connecticut Family Brochure:** https://www.childfirst.org/sites/default/files/NPO%20Family%20Brochure%20CT%2012.21.17.pdf • **CEBC:** https://www.cebc4cw.org/program/child-first/

Families Actively Improving Relationships, Oregon Social Learning Center, Oregon (USA)

Program Name	**Families Actively Improving Relationships (FAIR) – Virtual Adaptation (LINK)**
Jurisdiction	• Lane County, Oregon

Brief Program Description	• FAIR (Families Actively Improving Relationships) was designed to address the needs of parents referred to child welfare services for neglect and substance use, including their co-occurring parenting and substance use needs. Previous research suggests many families referred to child welfare for neglect and substance use experience co-occurring risk factors; accordingly, the FAIR program aims to address these risk factors. • Intensive, outpatient, home- and community-based program designed for parents experiencing challenges related to parenting, substance use, and mental health problems. Many parents who receive FAIR services are involved with child welfare for neglect and substance use. • Model is strengths-based, trauma-informed, and integrates treatment for mental health, substance use, and parent-training into each session. • Adapted for COVID – hybrid model. All adaptations listed below are based on Cruden, 2021 (see full article in references)
Program Goals	• FAIR is an ecological evidence based program that targets four domains of care: reducing substance use, improving mental health, building evidence-based parenting skills, and building resources for ancillary supports such as housing and employment o Reduce likelihood their child would be neglected and increase use of positive parenting o Increase likelihood of keeping their child in the home or reunifying with their child o Reduce substance use, cravings, and other problem drug behaviors o Eliminate intravenous (IV) drug use, if applicable o Reduce stress from parenting o Reduce depression and anxiety o Reduce trauma symptoms o Increase likelihood of being in stable housing o Increase days employed o Increase likelihood of successful child welfare case closure
Program Components	**Regular FAIR program components (virtual adaptations maintained most regular program components)** • FAIR is an intensive community-based treatment model that integrates components of two evidence-based behavioral interventions: o 1) **Parent Management Training** developed at the Oregon Social Learning Center (OSLC) to increase parenting skills, teach and support positive family interactions, and address mental health problems; and o 2) **Reinforcement Based Therapy** a community reinforcement approach of contingency management to address adult substance use. Behavioral principles from these evidence-based interventions are integrated to address parenting, parental substance use, and any ancillary needs presented by the family (e.g., mental health, housing, employment). Ongoing engagement efforts are utilized throughout the 8-month treatment. • The community-based, outpatient, intensive behavioral treatment involves five major components: o 1) Teaching and supporting parenting skills including nurturing and attachment, reinforcement, emotion regulation, supervision, non-harsh discipline, and nutrition; o 2) Delivering substance abuse treatment including contingency management, relationship building, day planning, healthy environments and peer choices, and refusal skills; o 3) Resource building and provision of ancillary supports including housing, employment, support with court and child welfare attendance;

	○ 4) Use of incentives (FAIR bucks to spend in the FAIR store) for success with all treatment components; and ○ 5) Ongoing engagement strategies. To implement and integrate these 5 components into one model, the FAIR team includes counselors, skills coaches, a resource builder, and a clinical supervisor.
Program Delivery	**FAIR Virtual Adaptations for COVID from Cruden, 2021:** • Clinical procedures quickly moved to virtual treatment using a HIPAA-compliant video-chat application. To facilitate this transition, the team created a written guide (4-page word document with video-chat application screenshots) to orient clinicians to the virtual platform, its interactive features, and tools for approximating in-person intervention strategies (e.g., use of emoticons on the screen to symbolize receipt of a FAIR Buck, distributed as an incentive for goal progress; FAIR Bucks are a non-monetary currency redeemable in the FAIR store for physical items such as household goods and children's toys). The FAIR virtual education guide included pragmatic instructions such as how to maintain protection of client confidentiality. The guide also included modules on logging in to the platform, creating secure meeting links, sharing links, and troubleshooting tips. The FAIR team received the document in electronic and hard copy form. Support staff provided technical assistance as necessary (e.g., how the platform might work on different cell phone types). • Once the clinicians were competent in their own use of the virtual platform and its capabilities, the team supported them in transitioning their clients to use the platform. For clients with reliable smartphone and internet access, the transition was relatively smooth. However, many clients involved in FAIR do not have reliable virtual technology capabilities, often relying on public access for internet needs. In such cases, clinicians problem-solved options for accessing virtual services with clients, ranging from identifying a support that would allow wireless internet use from outside their home while protecting their privacy, to loaning a device from a donor. In instances where a clinician did not identify an option and the client was in need of a session, in-person protocols were in place. Examples additional planning and adaptation to fully modify FAIR supports • Post-COVID-19 onset, clinicians were able to attend virtual court and case management sessions with clients, continuing a key engagement and treatment strategy. This continuation would not have been possible; however, had the local government not made sessions available through their own virtual platforms. • The move to virtual treatment delivery did not modify many core treatment components. For example, one advantage of meeting clients in their homes is the ability to spend session time improving the health and safety of the home while talking to clients about their treatment goals. Using virtual sessions, clinicians continued to engage with clients doing shared activities such as folding laundry, washing dishes, or cooking while talking on video technology. Further, clinicians continued to support clients with parenting skills by observing and reinforcing parent-child interactions through video technology. In-Home Visiting during COVID • In-person interactions were limited to initial assessments, crisis-situations, and clients unable to access technology. FAIR provided instructions for safe in-person interactions, consistent with state guidelines (Newsroom, S. of O, 2020) and best practices (World Health Organization, 2020), in writing and verbally to all clients. The FAIR leadership team maintained up-to-date knowledge about local policies and protocols, and availability of community resources to help support safe in-person interactions (e.g., locations of outdoor handwashing stations) to share with clinicians. • Because use of UA results is a key component of FAIR substance use treatment strategies and client engagement, the team implemented modified protocols due to the inability to conduct monitored UAs

	Billing Procedure Adaptations
	• First, a central administrator communicated with community care organizations contracted for state Medicaid service delivery to understand updated billing opportunities, such as new virtual-treatment CPT codes. This administrator then reviewed new and existing eligible billing codes as well as associated necessary changes in clinical documentation requirements by clinicians' certification (e.g., QMHA or QMHP) with the clinicians.
	
	Regular FAIR Program (virtual adaptation intends to keep most components)
	• Average length of treatment: 9 months
	• Average caseload size: 7-10 per clinician
	• Recommended Intensity:
	  ○ 5-7 days a week for 30 minutes to 2 hours for the first three weeks depending on severity and stability. In the 4th week, the sessions can be 15 minutes to 2 hours long and occur three times a week until the provider reduces them to two times a week. In the final month, it is 1 to 2 hours only once a week.
	• Services Involve Family/Support Structures:
	  ○ This program involves the family or other support systems in the individual's treatment: Children involved in family sessions and may be present during parent training focused sessions as well (if age appropriate) Immediate family members involved in family sessions Extended family members involved in family sessions Caseworkers/probation officers involved in coordination and collaboration Prosocial peer supports involved in supportive activities Additional community members (e.g., pastor, landlord) as appropriate – typically very limited involvement Teachers and school officials as appropriate to assist parents navigate the education system for their children Coordination with other health care providers and prescribers
	• This program is typically conducted in a(n):
	  ○ Birth Family Home
	  ○ Community Daily Living Setting
	  ○ Outpatient Clinic
	  ○ Community-based Agency / Organization / Provider

Service Users	• Parents with parental rights for at least one of their minor children, in utero to age 17, who have been referred to the child welfare system or at-risk for referral to it. • Individualized treatment plans include family, peer, and other service provider support. The mother and/or father of child(ren) of any age are eligible for treatment, including mothers who are pregnant. FAIR clients are referred or at-risk for referral to CW for the use of substances other than exclusively THC and/or alcohol in the past year, and either have maintained custody of, or are working toward reunification with, their child(ren).
Service Providers	• FAIR team includes counselors, skills coaches, a resource builder, and a clinical supervisor • FAIR clinicians maintain one of two licensures in compliance with state standards: Qualified Mental Health Professional (QMHP) or Qualified Mental Health Associate (QMHA). The FAIR team includes a licensed clinical supervisor, another QMHP, and a cadre of highly supervised QMHAs who are assigned as the primary clinician for each client. FAIR utilizes a team approach, in which clients

	receive exposure to more than one clinician to facilitate clinical coverage, flexible scheduling, comprehensive support, and role stratification.
	• Prerequisite/Minimum Provider Qualifications
	  ○ Supervisor – Masters degree or above in a behavioral health related field (e.g., psychology, social work, counseling) and licensed.
	  ○ Counselors – Bachelor's degree or above and experience with behavioral interventions preferred.
	  ○ Resource Builder (stocks and manages the FAIR store and secures other service donations for incentives) – High School or above

Referral Method	• Parents with parental rights for at least one of their minor children, in utero to age 17, who have been referred to the child welfare system or at-risk for referral to it • FAIR clients are referred or at-risk for referral to CW for the use of substances other than exclusively THC and/or alcohol in the past year, and either have maintained custody of, or are working toward reunification with, their child(ren)
Outcomes	**Outcomes from Virtual Adaptations for COVID from Cruden, 2021 (see reference below)** • Clinicians worked significantly more days per month during COVID-19 to maintain caseloads of a similar volume to pre-COVID-19 levels and to continue engaging clients with the same relative frequency during COVID-19 compared to pre-COVID-19. Increased service frequency led to lower billable time. Combined with fewer reimbursable services, such as UAs, these trends led to significantly lower monthly reimbursement for the FAIR team during COVID-19 when considering all services. However, when removing UAs, total reimbursement per clinician/month slightly increased during COVID-19 compared to pre-COVID-19. During the first five months of COVID-19, reimbursement per client/month was estimated to be approximately 69–74% of pre-COVID-19 levels. Findings suggest that client engagement was maintained through clinicians working more days per week. However, clients did not receive services significantly more frequently. The significant increase in clinician service delivery frequency can likely be attributed to meeting more clients within the same week. Overall, this study demonstrated that clinics are able to successfully engage clients in a complex intervention and continue achieving positive clinical outcomes in the context of environmental changes (e.g., COVID-19 restrictions). • …results point to the more generalized possibility of FAIR's effectiveness under a hybrid remote/in-person model. Such adaptations to infrastructure hold promise for the delivery of FAIR under a range of challenging contexts (e.g., rural environments), thereby expanding the potential range of clients that FAIR can serve. Without the external challenge that COVID-19 has imposed, adaptations to facilitate a transition to virtual treatment might not have been as urgent or possible, as some of the billing codes that facilitated virtual treatment might not otherwise have existed. Therefore, insurers might consider the clinical implications of maintaining these billing codes post-COVID-19.Regular Program (not virtual) • Outcomes from the pilot suggest that these efforts were successful with 94% of participants randomized to FAIR engaging in treatment and 87% completing the full course of treatment. • Across three rigorous clinical trials, FAIR significantly reduced intravenous and other drug use, drug cravings, neglectful parenting, depression and anxiety, and trauma symptoms, at 6, 12, and 24 months. While parenting stress showed significant reductions until 24 months, its increase at 24 months was not associated with an increase in other symptoms
Contacts	**Lisa Saldana** Agency/Affiliation: Oregon Social Learning Center

	Website: www.oslc.org/projects/fair Email: lisas@oslc.org Phone: (541) 485-6207
References	**FAIR Virtual Adaptation** • **Cruden, 2021**, Impact of COVID-19 on service delivery for an evidence-based behavioral treatment for families involved in the child welfare system (LINK) **FAIR Regular Program** • **Saldana, 2016,** Addressing the needs of families referred for neglect: The FAIR efficacy trial (LINK) • **Saldana, 2015,** An integrated intervention to address the comorbid needs of families referred to child welfare for substance use disorders and child neglect: FAIR Pilot Outcomes (LINK) • **Saldana, 2013,** Adolescent onset of maternal substance abuse: Descriptive findings from a feasibility trial (LINK)
Related Web Links	• FAIR Implementation Support: https://www.oslc.org/wp-content/uploads/2016/04/FAIR-information-and-cost-estimate-5.21.2020.pdf • CEBC: https://www.cebc4cw.org/program/families-actively-improving-relationships/detailed

Family Check-up Online, Prevention Science Institute, Oregon (USA)

Program Name	**Family Check-up (FCU) Online (LINK)**
Jurisdiction	• The in-person Family-Check-up intervention is currently in use across multiple clinics and schools in Eugene and Portland and has been researched for several decades at the Prevention Science Institute (PSI). • Researchers have recently explored offering FCU Online in publications from the **USA and Sweden** (see references below). • FCU Online has been used in **Oregon, USA** in a response to the COVID-19 pandemic.
Brief Program Description	• A universal prevention intervention that targets middle school children • A strengths-based, family-centered intervention that promotes family management and parent skill enhancement and addresses child and adolescent adjustment problems. • Following the success of Family Check-up, led by Dr. Beth Stormshak, researchers at PSI began to explore how FCU might be adapted to increase access for families. This led to the creation of Family Check-Up Online (FCU Online). • The proactive development of FCU Online prior to the sudden need created by the COVID-19 pandemic resulted in a readily available research-based tool. Family consultants were able to immediately use the FCU Online to support families under tremendous stress. Delivering the intervention online has allowed us to reach and serve families outside of the **Eugene and Springfield area [Oregon, USA**], where traveling long distances to the clinic previously would have been prohibitory for most families.
Program Goals	• Regular FCU model goals (assume the same for FCU online): ○ Improve children's social and emotional adjustment by providing assessment- driven support for parents to encourage and support positive parenting, and to reduce coercive conflict ○ Reduce young children's behavior problems at school ○ Reduce young children's emotional distress ○ Increase young children's self-regulation and school readiness ○ Improve parent monitoring in adolescence

	○ Reduce parent-adolescent conflict ○ Reduce adolescent depression ○ Reduce antisocial behavior and delinquent activity ○ Improve grades and school attendance
Program Components	• It has two components: (1) an ecological strengths-based self-report assessment of child behavior, parenting skills, family dynamics, and life stressors, followed by focused feedback; and (2) parent management training, which focuses on supporting positive behavior, setting healthy limits, supervision, and building relationships (can include the use of Everyday Parenting intervention). **Components as described by research into FCU online** Example of FCU Online as described in **Danaher et al. 2018 (USA)** • 1) Online Assessment and Feedback ○ 88-item, 23-webpage FCU assessment that participants complete as their initial step in the program that incorporates items and subscales from the Strengths and Difficulties Questionnaire augmented with additional items drawn from other sources and content developed internally by the Oregon group. Once participants submit their completed assessment, they receive feedback in a printout arranged according to major themes and 3 colors that convey how their child and family data compare with normative data (ie, normal, borderline, and clinical ranges). Feedback is guided by motivational interviewing principles, and it provides choices for treatment options and highlights strengths and potential areas of improvement. ▪ Green highlights a family's areas of strength that, when continued, will have a strong positive impact. ▪ Yellow signals that an area could use some attention. It does not always mean a significant problem but, if ignored, the problem behavior could escalate. ▪ Red indicates that an area may be a serious concern for their child or family. If no attempt is made to work on and improve serious concerns, the behavior is unlikely to improve on its own. Feedback also conveys practical changes parents can make to improve their child's behavior and the quality of their family's interactions. • 2) Web-based skills sessions ○ Set of 4 Web-based skills sessions designed to improve the ways in which they interact with their children through skills-based learning. The sessions provide the basis for personalized behavioral adjustments that can directly lead to improvement in overall family well-being. The skills sessions include skills for positive parenting, setting limits, monitoring, open communication that use online engagement activities that are designed to encourage the user to interact with, and be engaged with, the program. ○ Engagement activities include host videos, dyad videos that model right ways and wrong ways, animations (bear videos) that model right ways, and animated explanation of self-management and problem solving. The program also uses automated text messaging (short message service [SMS]) and emails to push or proactively send program content to users rather than relying only on the parents' initiative to access the intervention ○ Other features include a Library (on the Tab menu) that provides articles about relevant topics (eg, cyberbullying, sibling rivalry, and healthy courtship), videos drawn from the skills sessions, and information sheets that can be printed and saved to computer devices for later reference; a Profile (on the Tab menu) that enables participants to update their personal program information, which contains personal information used by the program (eg, names, addresses, passwords, and

	mobile phone number); and a checkup summary (button on the home page) that helps participants see how they score overall on their checkup assessment and on specific checkup items Family Check-Up Online Administration Website • Varies its display of program content on the basis of user credentials. Specifically, study administrators and staff are able to see a list of participants by their name, their unique study identifier, their phone number, their email address, the target child's name and school, and other descriptive fields. Coaches are able to view only their assigned cases in the coach portal (Figures 8 and 9). Designated guest users are able to review only the features of the website by examining a test case that was created solely for this purpose.
Program Delivery	**Family Check-up online** • FCU Online expanded the delivery of FCU from clinic or home-based settings led by family consultants to a parent-driven online tool with family consultants functioning as coaches. The FCU Online can be delivered to a much broader audience, particularly rural and underprivileged families where access to services may be difficult. • The proactive development of FCU Online prior to the sudden need created by the COVID-19 pandemic resulted in a readily available research-based tool. Family consultants were able to immediately use the FCU Online to support families under tremendous stress. Delivering the intervention online has allowed us to reach and serve families outside of the Eugene and Springfield area, where traveling long distances to the clinic previously would have been prohibitory for most families. **Online delivery based on research by Danaher et al. 2018** • Have tested eHealth FCU Online with coaching support and the FCU Online as a stand-alone web based model - not clear if this has been implemented in the real world as of yet other than for COVID but found the eHealth FCU Online with coaching support to have best outcomes so focused on this (see below). • In the FCU Online-only condition, participants receive a welcome email with an explanation about the website and instructions for logging in. Once they log in to the FCU Online website with their credentials, participants are able to complete the FCU assessment, receive feedback, and then access the skills session website, where they are provided with online tools to support their parenting in areas identified as challenges. These tools include videos, animated videos, parenting tips, and interactive activities (see Program Components section of this paper). Parents are also given the opportunity to practice parenting skills and track their progress. Parents can receive text messages that prompt them to try out new skills learned from the website. Parents can log in as often as they like and interact with any of the parenting skills sessions on the website. • **In the FCU Online + Coach condition**, participants receive a welcome email with an explanation about the website, instructions for logging in, and the name and email address of the coach who will be working with them. Participants in this condition log on to the same FCU Online program and follow the same procedure made available to participants in the online-only condition. However, they are also assigned a family coach who calls them at least two times to help establish goals, talks them through their results, offers support, and helps motivate parents to improve parenting practices. These coaching calls are intended to be brief and focused, and to last as long as necessary, but typically for less than 30 minutes. Coach calls are scheduled based on a family's availability, and they may be initiated by either the coach or parent. **Regular Family Check-up Program** • can be delivered as both a preventive checkup and as an intensive intervention for high-risk families.

	• Recommended duration for regular program is 1- 4 months
Service Users	• Typically For children/adolescents ages: 2 – 17 and For parents/caregivers of children ages: 2 – 17 • Studies of the online delivery have focused on middle school children and their parents ○ **Danaher et al. 2018**: families recruited from 8 economically disadvantaged middle schools in Oregon, USA ○ **Ghaderi et al. 2018**: families recruited from Gothenburg, Sweden ○ **Stormshak et al. 2019:** families recruited from middle school youth in Oregon, USA (Schools were chosen for participation in the project based on the percentage of students who qualified for free or reduced-cost lunch; this population ranged from 52% to 100%, with an average of 68%) ○ **Metcalfe et al. 2021**: Families were recruited from 8 economically disadvantaged middle schools in Oregon. Economically disadvantaged schools were defined as schools within the districts with high rates of free and reduced lunch, and an average of 68% of students receiving free and reduced lunch at the schools in this study.
Service Providers	**Online Delivery** • Staff, family coach, designated guest users **Regular Program** • For regular program (assume the same for online with coaching component): The FCU has been implemented by community practitioners in schools, community health centers, and government agencies. The required skill level is master's level (MSW, MS, MA, and M.Ed.) with some clinical experience. Paraprofessionals may be trained as providers; however, this requires more intensive post-training consultation.
Referral Method	**Online delivery** • Studies of online delivery have targeted middle school parents and children
Outcomes	**Stormshak et al. 2019 findings for online delivery** • In this efficacy trial, we randomly assigned middle school parents to receive either our eHealth FCU Online with coaching support, the FCU Online as a stand-alone web-based model, or school as usual. We found that the FCU Online with coaching support was the most effective approach to improving several key outcomes at posttest, including youth emotional problems and parent self-efficacy, with small to moderate effect sizes. We also found that families who reported higher levels of youth behavior problems at baseline responded to the FCU Online with improvements in youth behavior and in parenting that were significantly better than those of parents who had reported low levels of behavior problems, building on prior work suggesting that the FCU is more effective with high-risk than with low-risk youth and families • Our results show promise for the FCU Online as a potential program for wide-scale dissemination in schools. **Regular Family Check-UP Program** • The FCU intervention is successful at improving school performance and behavioral issues, decreasing childhood depression, reducing adolescent substance use, and increasing positive parenting
Contacts	• Beth Stormshak, PhD • Agency/Affiliation: University of Oregon • Website: fcu.uoregon.edu

	• Email: bstorm@uoregon.edu
References	Specific to Online delivery: • **Danaher, 2018**, The Family Check-Up Online Program for Parents of Middle School Students: Protocol for a Randomized Controlled Trial (LINK) • **Ghaderi, 2018,** Randomized effectiveness Trial of the Family Check-Up versus Internet-delivered Parent Training (iComet) for Families of Children with Conduct Problems (LINK) • **Stormshak, 2019**, Evaluating the efficacy of the Family Check-Up Online: **A school-based, eHealth model for the prevention of problem behavior d**uring the middle school years (LINK) • **Metcalfe, 2021,** Therapeutic alliance as a predictor of behavioral outcomes in a relationally focused, family-centered telehealth intervention (LINK) List of various research studies on Family Check-up over the years including regular delivery: • https://pubmed.ncbi.nlm.nih.gov/?term=%22family+check-up%22+FCU
Related Web Links	• Regular Family Check-up Program CEBC: https://www.cebc4cw.org/program/family-check-up/ • Regular Family Check-up website: https://fcu.uoregon.edu/program-overview • Reach Institute Arizona State University: https://reachinstitute.asu.edu/family-check-up/for-parents

Family Preservation and Reunification Virtual Therapy Services, KVC Kentucky (USA)

Program Name	Family Preservation and Reunification Virtual Therapy Services (**LINK**)
Jurisdiction	• Kentucky, USA • Staff work from 8 locations across Central, Eastern, Northeastern and Northern Kentucky to help strengthen the lives of individuals and families each day.
Brief Program Description	• Help to strengthen families and keep children safely at home rather than entering into foster care. • Preservation and reunification services are available to children who are at risk of out-of-home placement or are reunifying home from foster care or residential care. • KVC Kentucky has recently accelerated our use of virtual therapy in response to the current public health crisis.
Program Goals	• Help families remain safely together. • Divert children from being placed in foster care or a residential treatment center. • Assist in the reunification of children from out-of-home placement. • Improve family relationships

Program Components	• We utilize a service team approach to develop a collaborative care plan that is designed to help children live successfully at home and in the community. Team members meet frequently to assess progress, develop goals and interventions, and put crucial support systems in place.
	• By utilizing innovations in virtual therapy during the COVID-19 crisis, our skilled professionals are able to continue:
	  ○ Providing wraparound services designed to build supports for each family.
	  ○ Teaching parenting, household management, relationship-building and other skills to family members.
	  ○ Strengthening family members' voices in their own treatment and goals.

	○ Collaborating with community partners to coordinate care for families
Program Delivery	• KVC Kentucky will be providing virtual therapy to families served in our Family Preservation and Reunification Services program during this time with the aim of following the guidelines established by the CDC and the recommendations provided by State of Kentucky regarding minimizing risk of exposure and containing the spread of the coronavirus. The use virtual therapy will allow our trained professionals to provide therapeutic services, resources and support to families across all of KVC Kentucky's service regions. • What You Need to Participate in Virtual Therapy ○ Device such as computer, Chromebook, cellphone with camera and Internet access ○ Stable and secure Internet connection ○ Confidential space ○ Natural supports to use in case of emergency ○ Sessions must be held within State of Kentucky ○ We understand that life is busy and it can be difficult to get to appointments in an office. KVC Kentucky works to find ways to make services accessible and is excited to offer virtual therapy to our clients to eliminate the barriers to accessing needed care and support.
Service Users	• children who are at risk of out-of-home placement or are reunifying home from foster care or residential care and their families
Service Providers	• KVC Kentucky is built on a foundation of quality services by highly skilled specialists. KVC Kentucky emphasizes the importance of training and values the opportunity to provide employees with continuing education that will enhance the work they are doing with Kentucky's children and families. We emphasize the importance of utilizing evidence-informed practices in all programs. In addition to the Homebuilders Model prescribed for **Family Preservation services across the state, KVC provides training in Child Adult Relationship Enhancement (CARE) Skills, 1-2-3 Magic, and Nurturing Parenting Program.** ○ *Nurturing Parenting Program is the only one that has options for longer than 6 months • Considering the clinical nature of Family Preservation and Reunification, our specialists are also trained in a number of evidence-based and promising practices including Trauma Focused-Cognitive Behavior Therapy, Trauma Systems Therapy, and Motivational Interviewing. Diversion Specialists also participate in monthly Peer Review groups which frequently explore additional treatment interventions including Collaborative Problem Solving by Ross Greene and Scott Sells' "Treating the Tough Adolescent." • Virtual Therapy: Utilize a service team approach to develop a collaborative care plan that is designed to help children live successfully at home and in the community. Team members meet frequently to assess progress, develop goals and interventions, and put crucial support systems in place. • Collaboration between DCBS and KVC Kentucky, funded through the state of Kentucky and federal funding.
Referral Method	• Family Preservation and Reunification Services are a collaboration between DCBS and KVC Kentucky. All referrals are made by DCBS. • *Family Preservation & Reunification Services is a collaboration between Department for Community Based Services (DCBS) and KVC Kentucky, funded through the state of Kentucky and federal funding.
Outcomes	• Nothing formal other than an endorsement: Our in-home and community-based services empower individuals and families daily to create positive changes in their lives. Always focused on our consumers, we are evolving to best serve Kentucky communities including such innovations as a Walk-In Assessment Clinic, school-based clinics and expanding substance use treatment services. • General impact overview: https://kentucky.kvc.org/impact/impact-overview/
Contacts	• KVC Kentucky

	• 2250 Thunderstick Dr., Ste. 1104 • Lexington, KY 40505 • (859) 254-1035 Phone • hr@kvc.org
References	None
Related Web Links	None

Functional Family Therapy Online, FFT LLC (USA & International jurisdictions)

Program Name	**Functional Family Therapy Online** (LINK)
Jurisdiction	• FFT LLC, an organization that disseminates FFT into community settings, currently supports over 350 community-based agencies that deliver FFT globally (includes training in 45 US states, Canada, Norway, the Netherlands, Denmark, New Zealand, Australia, Scotland, Britain and the Republic of Singapore, support FFT implementation in that country in Sweden). • FFT LLC had developed adaptations for different populations including FFT for low-risk and high-risk child welfare clients. • FFT-Child Welfare® (FFT-CW) model is currently being implemented in all five boroughs of New York City with 25 teams (not clear if any of these sites are set up for teletherapy services online). **(LINK)** • Historically, FFT LLC has permitted the use of teletherapy services (e.g., video conferencing) in exceptional circumstances. • It is not clear how commonly FFT Online has been adopted as a method of delivery at international sites*
Brief Program Description	• Have a few different programs streams based on different population needs. • Functional Family Therapy through Child Welfare (FFT-CW®) is an adaptation of Functional Family Therapy (FFT) that was designed to provide services to youth (0-18 years old) and families in child welfare settings. • Used study by Robbins, 2021 to populate FFT telehealth adaptations below where possible.
Program Goals	General program goals • Reduce/eliminate within family violence, child abuse, harsh/punitive discipline practices, and family conflict • Prevent youth/family member outplacement • Prevent intensification/escalation of services • Improve parenting practices • Improve family communication • Develop specific skills to address risk/protective factors that are associated with abuse/neglect, such as (but not limited to) emotion regulation, coping, anger management, problem-solving, and decision-making
Program Components	**Family Functional Therapy- Child Welfare (FFT-CW)** • The FFT model is adapted for Child Welfare clients by incorporating a developmental focus to meet the needs of youths across the entire age range (0–18). FFT-CW® is a relational approach that matches interventions to the relational configurations of families. With delinquent or substance abusing adolescents, this approach often involves accommodating to families in which the youth's problem behaviors have considerable power to engage and motivate family members into treatment. However, with younger children in FFTCW®, it is necessary to implement more "parent-driven" intervention strategies to build skills and create a family context in which youth can flourish. Another adaptation involves expanding the primary treatment focus from a target youth (e.g.,

	delinquent adolescent) to multiple family members. **The specific services received through the FFT-CW® program address mental health, substance abuse, domestic violence, and other needs of family members and tailors treatment to their risks** • Services are provided through two tracks: a Low Risk (LR) track provided by interventionists based on our Functional Family Probation (FFP®) model (see FFP® tab), and a High Risk (HR) track based on our standard FFT model. Services are linked through a triage process that matches youth to appropriate level of services based on level of youth and family risk. **FFT-CW®, Low Risk (FFT-LR)** • is implemented in three distinct phases: Engagement/Motivation, Support/Monitor and Generalization. ○ 1) Engagement/Motivation: the focus is on engaging and motivating youth and families to be a part of a change process by decreasing family conflict and blame and increasing their hope about the possibility for change. Interventionists are also expected to gather information to utilize risk/needs assessments and to complete an assessment of the relational functions (interpersonal payoffs) for maladaptive behaviors. ○ 2) Support-Monitor: FFT-LR case managers focus is to identify resources and interventions best suited to youth/families and support linkages to those change programs. Interventionists are expected to utilize their case management skills to maintain and enhance the impact of evidence-based interventions on family members. ○ 3) Generalization: In the final phase of treatment, the focus is on helping youth/families to generalize change into other systems and to anticipate and plan for potential barriers or challenges that youth and families may face in the future. • FFT-LR impacts youth and families through a family focus. Interventionists meet with families from the beginning and learn to view youth through relational systems, as well as apply assessments, so they can better match families to community-based interventions and monitor participation with programs in a way that enhances the chance for success. Interventionists become stronger advocates of effective services; in turn, they play a more effective part in assessment, referral, monitoring and maintenance of change brought about by effective programs and interventions. Interventionists then work with both families and the community providers to help the family purposefully generalize the skills learned to other systems involved with the family. **FFT-CW®: High Risk (FFT-HR)** • FFT-HR uses traditional FFT, an empirically grounded, well-documented and highly successful family intervention for at-risk and juvenile justice involved families. The FFT-HR model includes five phases: (1) Engagement, (2) Motivation, (3) Relational Assessment, (4) Behavior Change and (5) Generalization. Each phase includes specific techniques of intervention, as well as therapist goals and qualities. The intervention involves a strong cognitive/attributional component integrated into systemic skill-training in family communication, parenting skills, conflict management skills and numerous other skills linked to a variety of syndromes and referral problems. • Each phase includes specific techniques of intervention involving a strong cognitive component which is integrated into systemic training in effective family communication, parenting skills, conflict management, and numerous other coping strategies linked to a variety of syndromes and referral problems. FFT focuses on in-session therapist techniques and family interaction processes, which are predictive of positive change. One notable process change appears in family communications, especially negative/blaming patterns • Behavior change focus: ○ Goal: Facilitate individual and interactive/ relational change

	○ Risk and Protective Factors Addressed (note: below are examples, not an exhaustive list of potential factors that might be addresses in this phase): ○ Youth temperament ○ Parental pathology ○ Beliefs and values ○ Developmental level ○ Parenting skills ○ Conflict resolution/negotiation skills ○ Level of family support ○ Peer refusal skills • The FFT-CW® model is currently being implemented in all five boroughs of New York City with 25 teams (12 HR, 13 LR).
Program Delivery	**Regular in-person delivery** • Treatment is provided in 12–14 sessions on average and up to 30 sessions with challenging cases and is expected to be relatively brief (e.g., 3–5 months). Sessions include multiple family members and are usually conducted in the family home and are usually 45–60 min. • **Recommended intensity**: One weekly 45-60 minute session on average • **Recommended Duration**: 5-7 months on average (average of 60 to 240 days for FFT-CW®) • **Delivery Settings**: This program is typically conducted in a(n): Birth Family Home, Foster / Kinship Care, Outpatient Clinic, Community-based Agency / Organization / Provider • **Typical resources for implementing the program**: ○ A good quality speakerphone for conducting weekly clinical consultation ○ Provision for therapist/interventionist transportation and cellular phone if home-based services are being conducted ○ Ample meeting space for conducting family therapy if conducting services in an office/clinical setting ○ Adequate computer and internet access for each FFT - CW® therapist **Tele-session adaptation for COVID-19** (see Robbins, 2021 for more details) • During 2020, FFT LLC supported therapists who served over 11,000 families and conducted over 35,000 tele-sessions with families • Historically, FFT LLC has permitted the use of teletherapy services (e.g., video conferencing) in exceptional circumstances. For example, in one state-wide initiative that included many rural locations, tele-sessions were supported as an option when there were significant weather-related barriers to meet in person, but this option was rarely used. Thus, 2020 represented the first consistent and wide-spread utilization of tele-services by FFT LLC. • On March 8, FFT LLC distributed a letter providing specific recommendations and guidance to sites, including (a) support for the clinical delivery of sessions via tele-services in later phases of treatment, (b) support for therapists joining weekly consultation sessions via a web-based platform rather than in person, (c) flexibility about scheduled onsite training (e.g., delaying training to a later date), and (d) a commitment to continue offsite training activities for community agencies that wanted to proceed with in-person training. • The leadership team decided to switch from a flexible approach to a more fixed set of recommendations because it was determined that maintaining a flexible approach to working with sites would lack consistency, and it would become unwieldy in the face of the

	variability in how local communities, states, and countries were responding. As such, on March 20, 2020, a revised letter was issued that (a) extended the support for delivering FFT via tele-sessions over all phases of treatment, (b) increased the timeframe for supporting tele-services to the end of May 2020, and (c) suspended all FFT-related travel until the end of April 2020.
	• Pivoted to webinar based training and consultation:
	• To support the transition to tele-services, the key leaders at FFT LLC immediately established communication loops within the organization and between the organization and community providers.
	  ○ add the option of "tele-session" to the web-based Client Service System (CSS) to capture data on various aspects of model delivery. The ability to track these sessions allowed timely feedback to funders to support this modality.
	• The transition to tele-services also required facilitative administration at local sites.
	  ○ Organizations needed to secure or redirect resources to support tele-services. This support included meeting basic requirements, such as providing equipment to therapists and families with laptops, smartphones, or tablets. It also involved developing agency policies to support tele-services (e.g., working from home policies, technological troubleshooting, and fail plans). Facilitative administration also involved creative strategies to fund these resources. For many organizations, facilitative administration was further enhanced through systems-level interventions targeting increased collaboration with community stakeholders to support tele-services by maintaining the model and providing tangible resources (computers, free Wi-Fi, community hot spots) to the families they referred. Many families did not have reliable internet access, and agencies/communities were creative to find ways to ensure that access was not an issue. Some agencies converted unused therapists mileage/travel budgets to pay for smartphones, tablets, and laptops. One agency created a local hotspot outside of their community center. Also, multiple communities provided free internet access to lower-income families.
	• Extensive coaching and support were provided to therapists to transition to tele-services by leadership at community agencies and FFT LLC experts.
	• The shift to tele-services required additional training to ensure that therapists were proficient in the new technology.
	• FFT LLC added guidance about areas to consider when organizing sessions and introducing tele-services to families. This guidance included essential elements like internet access, equipment, camera placement, setting up and logging into a service, and general recommendations about the clinical work itself.
	• One final part of organizing tele-services involved developing specific safety protocols to manage a variety of situations, such as a) family members argued and, in turn, shut down the link to the session, b) a family member was suicidal or homicidal, or c) there was suspected abuse or neglect. These included having back-up numbers for family members and direct communication about safety plans at the start of every session in high-risk families.
	• Facilitative leadership and systems-level interventions made it possible to provide the space for therapists to increase their proficiency in the use of tele-services by engaging in the types of activities described above. For example, many agencies altered their policies and productivity requirements to allow more time to complete initial paperwork and assessments.
	• Additional services adaptation
	  ○ Rather than waiting for skills to develop and then generalizing the skills to new situations, therapists started to pull in services that might have been left to the final treatment sessions. For example, appropriate referrals might include a referral for psychiatric treatment for anxiety or depression, Alcoholics Anonymous, or bringing in extended family members to assist with childcare or household responsibilities.

	• Clinical accommodations
	  ○ Many therapists reported increasing the number of contacts per week and conducting shorter but more frequent sessions. In part, these changes were due to the new medium; however, this was also driven by new clinical challenges that were emerging during COVID-19 (see next section for more detail)
	  ○ One of the ways in which an increase in contact has occurred is that therapists have used intake and other assessments as opportunities for face-to-face contact. (e.g., dropping off forms to client mailboxes)
	  ○ Over time, therapists reported finding many creative ways to involve family members in tasks in sessions, such as using whiteboards or other features available on most tele-platforms, playing clips available online to illustrate a key concept or skill, and using memes and other visuals to make the sessions more engaging and lively.

Service Users	• Over the past two decades (2000 to 2020), FFT LLC has supported the implementation of the FFT model as well as promising variations, including FFT-Child Welfare, FFT-Gang, and FFT-Probation Services. Annually, FFT LLC supports over 3000 therapists, supervisors, and administrators/managers implementing FFT, FFT-CW®, FFT-G®, and FFP® with more than 20,000 youth and families in 10 countries. • For FFT Child Welfare serve youth (0-18 years old) and families in child welfare settings

Service Providers	• Not a lot of detail in Robbins, 2021 on the telehealth adaptation but mention Interventionists and therapists as well as involvement from administrators/managers from community-based agencies and governmental organizations
	
	FFT Child Welfare Model regular delivery
	• Prerequisite/Minimum Provider Qualifications
	  ○ In the high-risk track, the therapists should have a master's degree. Site supervisors must hold a master's degree or above. Previous experience in family therapy and/or work in child welfare settings is preferred.
	  ○ In the low-risk track, interventionists should have at least a bachelor's degree.
	• Training for service providers is 3 phases:
	  ○ Phase 1 training entails the following: One 1-day on-site stakeholder orientation, One 2-day on-site clinical training, Weekly telephone consultation, Three 2-day on-site follow-up trainings, Off-site externship for Site Supervisor (Three 3-day events)
	  ○ Phase 2 training entails the following: Two 2-day off-site FFT Lead/Supervisor Trainings, Bi-monthly telephone consultation with Lead/Supervisor, One 1-day on-site follow-up training
	  ○ Phase 3 training entails the following: One 1-day on-site follow-up training, Monthly phone consultation with Lead/Supervisor

Referral Method	• Not specified in Robbins, 2021 telehealth adaptation but for the FFT Child Welfare model, high-risk cases being referred from child welfare systems
Outcomes	**Robbins, 2021 (online adaptation)** • During 2020, FFT LLC supported therapists who served over 11,000 families and conducted over 35,000 tele-sessions with families. Overall, results showed similar completion rates (79% vs. 75%), therapist fidelity (3.77 vs. 3.94), and therapist-reported outcomes in 2019 and 2020 (respectively), suggesting that delivering the FFT model can be implemented with fidelity using teletherapy formats. • Reports from FFT LLC expert trainers, experts, therapists, and supervisors from community-based partners have been overwhelmingly positive. Aspects of the webinar format have been beneficial, such as using multi-media during training, sharing

	multiple screens, scheduling training, and decreased travel-related costs. Nonetheless, the feedback has been that the experiential, relationship-building aspects of in-person training are more challenging to replicate in a virtual webinar space. Likewise, role plays and practicing skills do not have the same intensity and learning potential in a webinar format. **Turner et al. 2017 regular FFT-CW** • FFT-CW® was significantly better than alternative services on a number of variables, including a) rapidly engaging youth and families into services, b) a significantly shorter treatment duration, c) meeting all treatment goals, and d) preventing recurring allegations, return to services, and youth outplacements. Thus, FFT-CW® was able to get families out of harm's way faster and achieve changes more rapidly than alternative services, and – more importantly – was more effective in keeping youth and families together by achieving clinically meaningful outcomes for youth and families. • This study was the first large scale evaluation of the implementation of FFT-CW® program in a community based child welfare setting. The findings indicated that FFT-CW® was more efficient in completing service, and more effective than UC in meeting treatment goals while also avoiding adverse outcomes in a child welfare setting. Further research is needed to evaluate longer term results, to assess the sustainability of the treatment gains, and to compare the outcomes for other evidence based models and in other communities
Contacts	Holly DeMaranville www.fftllc.com holly@fftllc.com
References	**FFT Telehealth** • **Robbins, 2021**, Adapting the Delivery of Functional Family Therapy Around the World During a Global Pandemic (LINK) – ONLINE ADAPTATION **FFT Child Welfare regular program** • **Turner, 2017,** Summary of comparison between FFT-CW® and Usual Care sample from Administration for Children's Services (LINK) – FFTCW NON- ONLINE PROGRAM • Model effectiveness: https://www.fftllc.com/fft-child-welfare/model-effectiveness.html
Related Web Links	• Clinical Model: https://www.fftllc.com/fft-child-welfare/clinical-model.html • CEBC: https://www.cebc4cw.org/program/functional-family-therapy-child-welfare/

GenerationPMTO via telehealth (USA & International Jurisdictions)

Program Name	**GenerationPMTO via telehealth** (LINK)
Jurisdiction	• Originated from research in the USA but now in various jurisdictions: U.S.— in New York, Missouri, Michigan, Minnesota, Kansas, Oregon, and Utah—and internationally in Norway, Iceland, the Netherlands, Denmark, Canada, Mexico, and Uganda
Brief Program Description	• Generation PMTO is an evidence-based, structured intervention program designed to help parents strengthen families at all levels. Based on more than 50 years of ongoing research, it promotes social skills and prevents, reduces and reverses the development of moderate to severe conduct problems in children and youth. • Intervention has been provided to individual families, in parent groups, and **through telehealth delivery** and **has been adapted for child welfare** and other populations with trauma issues

	• This behavioral family systems intervention can be used as a preventative program and a treatment program. It can be delivered through individual family treatment in agencies or home-based and via telephone/video conference delivery, books, audiotapes and video recordings. Generation PMTO interventions have been tailored for specific child/youth clinical problems, such as externalizing and internalizing problems, school problems, antisocial behavior, conduct problems, deviant peer association, theft, delinquency, substance abuse, and child neglect and abuse.
Program Goals	• Increasing positive parenting practices • Reducing coercive family processes • Reducing and preventing internalizing and externalizing behaviors in youth • Reducing and preventing substance use and abuse in youth • Reducing and preventing delinquency and police arrests in youth • Reducing and preventing out-of-home placements in youth • Reducing and preventing deviant peer association in youth • Increasing academic performance in youth • Increasing social competency and peer relations in youth • Promoting reunification of families with youngsters in care

Program Components	• Parents are the focus of the GenerationPMTO intervention because they are the presumed agents of change; however, parents, focal children/youth, and the family should all benefit from the intervention and all can participate in the intervention.
	• Core components of GenerationPMTO
	  ○ Skill encouragement, teaching positive behavior
	  ○ Systematic, mild consequences for negative behavior
	  ○ Monitoring and supervision
	  ○ Interpersonal problem solving
	  ○ Positive involvement
	• Supporting components of GenerationPMTO
	  ○ Providing clear directions
	  ○ Observing and recording behavior
	  ○ Identifying and regulating emotions
	  ○ Fostering effective communication
	  ○ Promoting school success
	• Important therapeutic strategies in Generation PMTO focus on:
	  ○ Identifying and building on strengths
	  ○ Supporting and encouraging effective parenting skills
	  ○ Using sophisticated clinical practices to build therapeutic alliance, provide a supportive environment for change, and engage in treatment completion
	  ○ Preventing and managing resistance
	  ○ Supporting couples, divorced parents, other caregivers to work toward common goals such as a united parenting front for the positive adjustment of their children

	○ Active teaching that includes modeling, role play, problem solving, and other experiential exercises that provide opportunity for practice with coaching ○ Promoting positive family system changes ○ Incorporating effective interpersonal problem solving skills ○ Prompting goal behaviors from parents ○ Supporting parents as their children's most important teachers
Program Delivery	• There are different formats of the program available but information below pertains to the individual format that can be delivered at Home, Office or Clinic Tele-delivery • Telehealth delivery system was developed in 2015 for implementation site in Vancouver, British Columbia; however, during COVID-19 many places shifted to virtual delivery, which required changes for those places offering in-person delivery. Specific Examples of places pivoting to virtual delivery for COVID-19 • Michigan created new 17-session telehealth manual specific to needs of Michigan clinicians • BC Confident Parents: Thriving Kids PMTO program **General Program Delivery Pre COVID (includes Telehealth)** • Services Involve Family/Support Structures: ○ This program involves the family or other support systems in the individual's treatment: Children/adolescents participate in individual family sessions as appropriate or desired. Other family members can be part of the intervention in family sessions. ○ Weekly home practice assignments are tailored for family context; parents practice in session before trying it out at home. Mid-week calls are conducted to troubleshoot and promote success. • **Recommended Intensity**: 60-minute weekly individual/family sessions • **Recommended Duration**: 10-25 individual/family sessions, depending on severity; 3-6 months or longer, depending on circumstances. For mild problems or prevention, 6-8 sessions. • **Delivery Settings**: This program is typically conducted in a(n): ○ Adoptive Home ○ Birth Family Home ○ Community Daily Living Setting ○ Outpatient Clinic ○ Community-based Agency / Organization / Provider ○ **Virtual (Online, Telephone, Video, Zoom, etc.)** • **Resources Needed to Run Program** ○ The typical resources for implementing the program are: ○ All sessions are video recorded and uploaded to HIPAA-compliant website for coaching/supervision, fidelity rating, and certification. Thus, video recording equipment, computer, and high-speed internet access are required.
Service Users	• **Target Population**: Parents of children/youth 2-18 years of age with disruptive behaviors such as conduct disorder, oppositional defiant disorder, and anti-social behaviors

	• Parents of youngsters with or at risk for internalizing and externalizing behaviors, substance use and abuse, delinquency, police arrests, out-of-home placement, and deviant peer association; parents who may be depressed, highly stressed, living in poverty or high-crime neighborhoods, Spanish-speaking immigrants, families with a military parent returning from war (e.g., Iraq/Afghanistan) who may be experiencing posttraumatic stress disorder (PTSD), families living in shelters or supportive housing because of homelessness or domestic violence, birth parents whose children are in care because of abuse/neglect, and families with transitions such as divorce, single parenting, and step-families
Service Providers	**Prerequisite/Minimum Provider Qualifications** • Qualifications depend on the agencies that employ them. Practitioners may have Bachelor's, Master's, or Doctorate level degrees as entry qualifications. To become certified GenerationPMTO specialists, they must complete an extensive training program. No other specialized training is required. Practitioners serve in a wide variety of delivery systems including **child welfare**, juvenile justice, and child mental health. **Training Type/Location**: • During the workshop training, active teaching techniques provide abundant opportunity for practice (e.g., modeling, video demonstrations, role play, problem solving, experiential exercises, and video-recording of practice followed up with direct feedback). Throughout the course of training, candidates are required to record their sessions with training families. These video materials are uploaded onto a secure portal so that training mentors and coaches can view their sessions and provide detailed coaching feedback. • GenerationPMTO training is supported with regular coaching. Coaching takes place by phone, through videoconferencing, in written format, in person, individually, and in group. The strengths-based coaching is designed to provide the practitioner with support for effective practice in terms of content and therapeutic process using a suite of active teaching strategies. The group reflective coaching process benefits all in training who view video, identify strengths, and role play new strategies. Candidates receive a minimum of 12 coaching sessions based on direct observation of their therapy sessions with training families. There is also an extensive certification process to ensure fidelity. **Number of days/hours**: • A typical training program for Generation PMTO specialists includes 3 workshops for a total of 10 workshop days plus up to 12 coaching sessions, booster workshops and completing the process of certification. The workshop training program, which is designed to promote competent adherence and sustained model fidelity, is tailored for the implementation site. See the implementation section below for more details.
Referral Method	• Not really specified in the overall program outline, seems to depend on the site of implementation. In BC for example, a physician referral form is available.
Contacts	10 Shelton McMurphey Blvd Eugene OR 97401 USA Email: annas@generationpmto.org
Outcomes	Benefits of Telehealth • ↑ participation, convenient, flexible hours, secure & private HIPAA-compliant portal and platform (connect by phone and use computer for real-time sessions), save time & money, extended reach **General Outcomes of Program**

	• GenerationPMTO alters family dynamics and opens doors to healthy social environments. The results are long lasting with far-reaching family eff ects. The core GenerationPMTO components are universal. **CHILD & YOUTH OUTCOMES** • Decreases: Depression, Substance Use, Noncompliance, Delinquent Behaviors, Internalizing Behaviors, Out-of-Home Placement, Deviant Peer Association, Arrest Rates/Severity of Crime • Increases: Academic Performance, Social Skills **PARENT OUTCOMES** • Decreases: Poverty, Depression, Arrest Rates, Coercive Parenting • Increases: Positive Parenting, Standard of Living, Marital Satisfaction, Marital Adjustment
References	• **Askeland, 2019**, Scaling up an Empirically Supported Intervention with Long-Term Outcomes: the Nationwide Implementation of GenerationPMTO in Norway (LINK) • **Chamberlain, 2016**, Implementation and evaluation of linked parenting models in a large urban child welfare system (LINK) • **Forgatch, 2016,** Parent Management Training-Oregon Model: Adapting Intervention with Rigorous Research (LINK) – Norway implementation • **Publication List: https://www.generationpmto.org/pubs**

Related Web Links	• Shift to telehealth: https://www.generationpmto.org/post/shifting-to-telehealth
	• Telehealth and phone delivery: https://www.generationpmto.org/post/telehealth
	• Generation PMTO Info Sheet: https://74a48169-56d4-4c92-b6b5-c45abd10e460.filesusr.com/ugd/633a4a_ac5624ea989f4bfc894913ef011c1583.pdf
	• Implementation sites: https://www.generationpmto.org/implementation-sites
	  ○ BC: Confident Parents: Thriving Kids (CPTK) - https://www.cmha.bc.ca/how-we-can-help/children-families/confident-parents
	• Kansas PMTO: https://kansas.kvc.org/services/family-preservation/kansas-pmto/
	  ○ Denmark: https://socialstyrelsen.dk/tvaergaende-omrader/Udviklings-og-Investeringsprogrammerne/dokumenterede-metoder-born-og-unge/om-dokumenterede-metoder-born-og-unge/pmto
	  ○ Kansas: https://kansas.kvc.org/services/family-preservation/kansas-pmto/
	  ○ Michigan: https://michiganpmto.com/resources-for-families/how-pmto-can-help/
	  ○ Netherlands: https://www.pmto.nl/ouders
	  ○ Norway: https://www.pmto.no/
	• CEBC: https://www.cebc4cw.org/program/the-oregon-model-parent-management-training-pmto/

Healthy Families America, Virtual Home Visit (USA)

Program Name	Healthy Families America (HFA) (LINK), Virtual Home Visit (LINK)
Jurisdiction	• USA located in 11 states
Brief Program Description	• HFA is one of the leading family support and evidence-based home visiting programs in the United States. • HFA model serves families with varying needs, and has since inception been specifically designed to **serve families with high levels of stress including those referred from child welfare**.

	• HFA approach is relationship-based, culturally respectful, family-centered, and grounded in the parallel process: the relationships we build with parents and families serve as a model for the supporting, positive relationships we help them cultivate with their children. • HFA is the nationally recognized, evidence-based home visiting program of Prevent Child Abuse America. HFA builds a strong foundation for safe and secure relationships between caregiver and child, maximizing opportunities for all children to reach their full potential. Families enroll voluntarily in HFA as early as prenatally or at birth and work one-on-one with a Family Support Specialist in the home, receiving services tailored to their needs. • Introduced virtual home visiting during COVID-19 (phone and video visits count as virtual home visits), not clear if this will remain an option after COVID-19.
Partners	• HFA partners with other local community organizations to provide referrals to medical providers, child development specialists, legal services, career development services, educational services, and much more e.g., Alliance for the Advancement of Infant Mental Health, Erikson Institute, National Alliance of Home Visiting Models
Program Goals	• Build and sustain community partnerships to systematically engage overburdened families in home visiting services prenatally or at birth • Cultivate and strengthen nurturing parent-child relationships • Promote healthy childhood growth and development • Enhance family functioning by reducing risk and building protective factors

Program Components	• **Three main protocols:**
	  ○ HFA Accelerated Protocols (identified as low-risk, less time needed in the program)
	  ○ Signature HFA Protocols (general HFA referral, base program)
	  ○ **HFA Child Welfare Protocols (identified as high-risk, referred from child welfare, extended intake age available)**
	• Once a family becomes interested in receiving services, HFA staff will reach out to learn more about their current needs, and also explore their strengths.
	• The first job of staff is to build a strong connection with the families being served.
	• HFA staff will recommend services for families based on their needs—from home visiting to additional community connections. Regardless of the recommendations our staff offer, HFA is always voluntary.
	• Should home visiting services be recommended, HFA staff will work with families long-term. Most families are offered services for a minimum of three years, and are visited weekly at the start. Services are culturally respectful, and home visitors are chosen on the basis of their ability to establish trusting relationships with participating families.
	• Programs are designed to incorporate a wide range of tools proven to help cultivate health parent-child relationships including
	  ○ **Child Development resources**: information about child development milestones.
	  ○ **Family Goal Planning**: Home visitors and parents collaborate to set meaningful and attainable goals, taking into consideration family values and their hopes and dreams for the future.
	  ○ **Prenatal Support**: HFA staff help families build a strong foundation for parenthood
	  ○ **Maternal and Child Healthcare:** HFA staff work to remove barriers in accessing healthcare, enabling families to obtain health insurance, connect to primary care providers, and travel to the doctor when necessary.
	  ○ **Service Planning**: Based on the initial conversation with families, a personalized service plan will be created for each family. This ensures all questions and concerns don't get lost along the way.

	○ **Trusted Support**: With HFA, families will always have 'someone in their corner' to support them as they navigate the joys and struggles of parenthood. ○ **Relationship Building:** HFA staff are relationship builders. They build strong bonds with families and teach parents how to develop strong and secure connections with their children**.** ○ **Parent Support Groups**: Ongoing access to parent support groups helps combat depression due to isolation and promotes positive parenting practices. ○ **Referrals to Community Resources:** HFA partners with other local community organizations to provide referrals to medical providers, child development specialists, legal services, career development services, educational services, and much more
Program Delivery	**Virtual home visiting** • introduced virtual home visiting during COVID-19 (phone and video visits count as virtual home visits), not clear if this will remain an option post COVID-19. • HFA provides clear guidelines to explain what constitutes a home visit (LINK) • HFA continues to allow, and highly recommends, the continued use (for as long as needed) of virtual home visits conducted via phone or ideally, a video conference platform like Zoom, FaceTime, etc., for all families, consistent with existing HFA Best Practice Standards. • From a fidelity perspective, HFA regards virtual home visits and in-home visits equally, when conducted in accordance with existing home visit definition criteria and guidance. We trust local service providers to make the best decision on which visit format to utilize given community conditions, family needs, and individual staff and family health and safety issues. **Regular In-Home Visiting** • Delivery Setting: Birth Family home • Recommended intensity: ○ Families are offered weekly home visits for a minimum of six months after the birth of the baby. Home visits typically run 50-60 minutes. Upon meeting the defined criteria for family functioning, visit frequency is reduced to biweekly visits, monthly visits, and quarterly visits and services are tapered off over time. Typically, during pregnancy, families receive 2-4 visits per month. During times of crisis families may be seen 2 or more times in a week • **Recommended duration:** Services offered prenatally or at birth until the child is at least three years of age and can be offered until they are five years of age.
Service Users	• Families who are at-risk for child abuse and neglect and other adverse childhood experiences; home visiting services are initiated prenatally or within three months after the birth of the baby (however this is extended in the case of HFA Child Welfare Protocols where initial outreach can occur up to 24 months of age) • HFA Accelerated and Child Welfare Protocols provide affiliates the flexibility intended to bring HFA services to families as effectively as possible.
Service Providers	• **Direct Service staff**, qualifications include ○ Experience in working with or providing services to children and families ○ An ability to establish trusting relationships ○ Acceptance of individual differences

	○ Experience and willingness to work with the culturally diverse populations that are present among the program's target population ○ Knowledge of infant and child development ○ Open to reflective practice (i.e. has capacity for introspection, communicates awareness of self in relation to others, recognizes value of supervision) ○ Minimum of a high school diploma or equivalent ○ Infant Mental Health endorsement preferred • **Supervisors**, qualifications include: ○ A solid understanding of and experience in supervising and motivating staff, as well as providing support to staff in stressful work environments ○ Knowledge of infant and child development and parent-child attachment ○ Experience with family services that embrace the concepts of family-centered and strength-based service provision ○ Knowledge of maternal-infant health and dynamics of child abuse and neglect ○ Experience in providing services to culturally diverse communities/families ○ Experience in home visiting with a strong background in prevention services to the 0-3 age population ○ Master's degree in human services or fields related to working with children and families, or Bachelor's degree with 3 years of relevant experience ○ Experience with reflective practice preferred ○ Infant Mental Health endorsement preferred • **Program managers**, qualifications include: ○ A solid understanding of and experience in managing staff ○ Administrative experience in human service or related program(s), including experience in quality assurance/improvement and program development ○ Master's degree in public health or human services administration or fields related to working with children and families, or a Bachelor's degree with 3 years of relevant experience
Referral Method	**Nothing specific to virtual so assume the same as regular in-home visits**: • Dependent on family risk ○ For HFA Signature Model and HFA Accelerated Protocols referral can be from anywhere (including voluntary) ○ For HFA Child Welfare referral is from Child Welfare • HFA services are offered voluntarily, intensively, and over the long-term (3 to 5 years after the birth of the baby). Additionally, and with National Office approval, HFA sites may voluntarily enroll families referred from Child Welfare/Children's Protective Services with a child up to 24 months of age, offering services for a minimum of three years subsequent to enrollment. • HFA provides sites with extra technical assistance to support community level work with child welfare referred families. This ensures sites will maintain the expected rigor and fidelity requirements providers have expected from HFA for almost 30 years. HFA sites that utilize the protocols for working with families referred from child welfare are able to extend enrollment for families with a child up to 24 months of age referred by the child welfare system. This is in keeping with the model's original design to offer services up to the

	time the child is five years of age. Consistent with HFA requirements, voluntary services will be offered for a minimum of three years, regardless of the age of the child at intake, and support will be tailored to the unique needs of each family.

Outcomes	**General HFA program outcomes**
	• Notable statistics include: First time moms who enrolled in HFA early in pregnancy were 49% less likely to experience an indicated Child Protective Services (CPS) report. Evidence also demonstrates that HFA prevents the recurrence of child maltreatment by 1/3 among families with prior CPS involvement.
	• Eight studies show that HFA has early impacts on child maltreatment prevention among children ages 1-3 years old including
	  ○ Fewer substantiated reports with families who engage in services
	  ○ Less harsh discipline and less physical abuse
	  ○ Less emotional abuse and less neglect
	  ○ Fewer hospitalizations for child abuse
	• HFA increase positive parenting practices
	• HFA parents had more confidence in themselves as parents and did more to promote health child development, such as having more positive interactions with their children
	• HFA parents also used more positive discipline with less yelling and less physical punishment
	Impact on Children
	• HFA participation is correlated with healthier birth rates, lower complications, and reductions in child neglect and abuse.
	• HFA children score higher on tests measuring cognitive development and improve academic performance
	• HFA children exhibit fewer behavioral and developmental problems.
	• HFA also improves access to health care, helping parents obtain insurance coverage and establish a medical care routine.
	
	Impact on Parents and Families
	• HFA parents show improvements in scores measuring child sensitivity and responsiveness.
	• HFA parents make significant advances in their education and gain employment more often.
	• HFA parents are more successful in creating a responsive and developmentally-stimulating home.
	• HFA parents experience reduced stress and depression levels and achieve greater financial security.
	
	Impact on Communities
	• Parents show dramatic gains in education, leading to increased family income and tax revenues
	• Child maltreatment is reduced in both parent self-reported and substantiated studies.
	• Access to HFA before the third trimester improves birth weight and lowers complications, reducing healthcare costs.
	• HFA's communities' costs for related outcomes indicate dramatic savings compared to state costs.

Contacts	• hfamail@preventchildabuse.org
References	• Healthy Families American, Child Welfare Single Pager (LINK) • Evaluations by the state-level: https://www.healthyfamiliesamerica.org/our-impact/state-evalutations/ Recent Publications

	• **Easterbrooks, 2019**, Recurrence of maltreatment after newborn home visiting: A randomized controlled trial. American Journal of Public Health, 109(5), 729-735 (LINK) • **Lee, 2018,** Reducing maltreatment recurrence through home visitation: A promising intervention for child welfare involved families. Child Abuse & Neglect, 86, 55-66 (LINK)
Related Web Links	• Virtual Home Visit Guidance: https://www.healthyfamiliesamerica.org/hfa-response-to-covid-19/what-makes-a-virtual-home-visit-a-visit/ • Guidance for HFA sites in response to COVID-19 **General Links** • About HFA: https://www.healthyfamiliesamerica.org/about/ • HFA Protocols: https://www.healthyfamiliesamerica.org/protocols-child-welfare/ • https://www.healthyfamiliesamerica.org/our-impact/evidence-of-effectiveness/ • CEBC: https://www.cebc4cw.org/program/healthy-families-america-home-visiting-for-prevention-of-child-abuse-and-neglect/ • Example: Health Families Indiana - https://www.in.gov/dcs/2459.htm

Incredible Years Online (USA & International jurisdictions)

Program Name	Incredible Years (IY) Online (LINK)
Jurisdiction	• USA model origin but used around the world in various forms • Incredible Years® programs have been applied in more than twenty countries. Canada, England, Wales, Scotland, Norway, Palestine, New Zealand, Ireland, Portugal, Australia, Denmark, The Netherlands, Russia, Finland, Sweden, and more.
Brief Program Description	• IY is a series of three separate, multifaceted, and developmentally based curricula for parents, teachers, and children. This series is designed to promote emotional and social competence; and to prevent, reduce, and treat behavior and emotional problems in young children. The parent, teacher, and child programs can be used separately or in combination. There are treatment versions of the parent and child programs as well as prevention versions for high-risk populations. There are treatment versions of the parent and child programs as well as prevention version for high-risk populations. Series includes Incredible Years Parents, Incredible Years Teachers and Incredible Years Children. ○ designed by levels of intervention ○ program chosen by your agency for dissemination will depend on the characteristics of the population served. • IY Online is for agencies and IY Leaders to utilize video streaming for parent vignettes- developed for COVID-19. • Since COVID-19 IY has developed tips for leaders offering online tele-sessions. ○ The webinar reviews how to help families prepare for these video tele-sessions. The group leaders will learn the format for delivering the program including how to use the IY methods in a video tele-session, IY principles of video-based discussions, role play practices, number and length of sessions, and experiential learning. Pertinent topics are discussed related to coping with social distancing for the parents themselves as well as their children. This webinar also allows time for questions, discussion, and practice of these skills with the webinar participants
Program Goals	• Goal is to deliver evidence-based programs and materials that develop positive parent-teacher-child relationships and assist in preventing and treating behavior problems and promoting social, emotional, and academic competence before a child becomes an adult.

	• The Incredible Years® Parents, Teachers, and Children Training Series has two long-range goals.
	• To provide cost-effective, early prevention programs that all families and teachers of young children can use to promote social, emotional, and academic competence and to prevent children from developing conduct problems.
	• To provide comprehensive interventions for teachers and parents that are targeted at treating and reducing the early onset of conduct problems in young children
	
	Individual Program Series Goals:
	IY Child Program: Promote child competencies and strengthen child social and emotional skills:
	• Strengthen children's social skills and appropriate play skills (turn taking, waiting, asking, sharing, helping, complimenting).
	• Promote children's use of self-control strategies such as effective problem solving steps.
	• Increase emotional awareness by labeling feelings, recognizing the differing views of oneself and others and enhancing perspective taking.
	• Boost academic success, reading and school readiness.
	• Reduce defiance, aggressive behavior, and related conduct problems such as noncompliance, peer aggression and rejection, bullying, stealing and lying.
	• Decrease children's negative cognitive attributions and conflict management approaches.
	• Increase child self-esteem, self-confidence, and positive relationships with parents.
	
	IY Parent Program
	• Parent training is the single most effective strategy for preventing behavior problems and promoting children's social and emotional competence
	• Promote parent competencies and strengthen families:
	  ○ Increase positive and nurturing parenting.
	  ○ Reduce critical and violent discipline approaches by replacing spanking with positive strategies such as ignoring, using logical and natural consequences, redirecting, adequate monitoring, and problem-solving.
	  ○ Improve parents' problem-solving skills, anger management, and communication skills.
	  ○ Increase family support networks and school involvement.
	  ○ Help parents and teachers work collaboratively to ensure consistency across settings.
	  ○ Increase parents' involvement in children's academic-related activities at home.
	
	IY Teacher
	Promote teacher competencies and strengthen home-school connections:
	• Strengthen teachers' effective classroom management skills, including proactive teaching approaches.
	• Increase teachers' use of effective discipline strategies.
	• Increase teachers' collaborative efforts with parents and promotion of parents' school involvement.
	• Increase teachers' ability to teach social skills, anger management, and problem-solving skills in the classroom.
	• Decrease levels of classroom aggression.

	• Increase teachers' enjoyment of teaching and positive relationships with students
Program Components	• Overall, the Incredible Years Series is part of a series of 3 interlocking training programmes for parents, children and teachers. The parenting programs span the age range of 0-12 years. The child and teacher programs span the age range of 3 – 8 years. • Online individual and group parenting sessions available. Focused on the individual parent sessions in the content below. **Parenting Programs** • parenting programs are grouped according to age: babies (0-12 months), toddlers (1-3 years), preschoolers (3-6 years), and school age (6-12 years) • Sessions range from 8-12 depending on the series/ level of risk • Parenting Program Content (depending on age range) includes: o Respect and understanding children and their developmental abilities, modelling social skills, child-directed play, balancing power, descriptive commenting, academic, social, emotion and persistence coaching, differential attention, ignoring, modelling principle, having fun. o Having developmentally appropriate expectations for child –depending on child's age, temperament and developmental abilities. o Positive parenting, controlling emotions and improving relationships, effective communication skills, family problem solving, enhancing children's learning, anger management, and managing conflict. o Establishing rules, predictable routines and children's responsibilities as well as ongoing monitoring and supporting children's academic achievement through by coaching children's homework and partnering with teachers. **Targeted Risk and Protective Factors** • Parenting Practices. Harsh or ineffective parenting skills (such as spanking or smacking), a lack of parental monitoring and nurturing relationship with children and low involvement in school-related activities are related to the development of children's aggressive behavior, poor social skills, and academic underachievement (which in themselves are important risk factors for the development of violence, delinquency, and substance abuse). Training in effective parenting can not only reduce violence and boost parents' self-confidence but also contribute to children's enhanced social competence, which will then in turn promote stronger bonding and relationships with parents (which are linked to positive child outcomes). **Targeted Outcome Variables** • Young children with high rates of aggressive behavior problems have been shown to be at greatest risk for continuing on the trajectory to deviant peer groups, school drop out, delinquency, substance abuse, and violence. Ultimately, the aim of the teacher, parent and child training programs is to prevent and reduce the occurrence of aggressive and oppositional behavior, thus reducing the chance of developing later delinquent behaviors. Each of the programs in the Incredible Years® Series seeks to alter the quality of relationships between parents and children, teachers and children, teachers and parents, group facilitators and parents, and children with their peers **Child Training Programs**

	Note: Children can also receive training in small groups or classrooms by trained teachers or therapists and learn how to follow rules and cooperate, express emotions, problem-solve, manage anger, and make good friends. However, these appear to be in groups and in the classroom – not sure if there is any online offering (LINK): ○ The child treatment program (Small Group Dinosaur) is used by counselors and therapists in a small group setting to treat children with conduct problems, ADHD, and internalizing problems. The small group treatment program is delivered in 18-22 weekly 2-hour sessions. ○ The Classroom Dinosaur School child prevention program consists of 60+ classroom lesson plans for children 3-8 years old. Lessons are divided into three "levels" so that teachers/group leaders can determine what is the most developmentally appropriate material for their class. Teachers/Group Leaders use the program as a prevention program for an entire classroom of students. The program curriculum sessions are delivered by the teacher twice weekly and sustained over consecutive years.
Program Delivery	**Regular IY Programs** **Recommended Intensity:** • One two-hour session per week (parent and child component); classroom program offered 2-3 times weekly for 60 lessons; teacher sessions can be completed in 5-6 full-day workshops or 18-21 two-hour sessions. **Recommended Duration:** • The Basic Parent Training Program is 14 weeks for prevention populations, and 18 - 20 weeks for treatment. The Child Training Program is 18-22 weeks. For treatment version, the Advance Parent Program is recommended as a supplemental program. Basic plus Advance takes 26-30 weeks. The Child Prevention Program is 20 to 30 weeks and may be spaced over two years. The Teachers Program is 5 to 6 full-day workshops spaced over 6 to 8 months. **Online Videostreaming** • Videos have been uploaded at 720p • Agency can purchase program packages • developed a webinar/in-service to help support agencies that are providing IY in a video tele-session format (either individually or in groups) • recommend setting up regular calls with each household, including partners and grandparents when possible. **Tips for tele session delivery of the parenting program** • For higher risk families or families with children with diagnoses: ○ Recommend individualized approach. • **Assess family situation first**: Use an individual call to check in on the family's current situation; that is, who is at home, whether parents are working from home, if someone is sick, whether child care is available, financial difficulties, stress level, whether they are involved in home schooling, and level of support. If families were previously in an Incredible Years group, you can ask them if they would like to continue these sessions via group. If so, follow your agency rules about being HIPPA compliant and getting parent consent.

	• **Continue using video vignettes for experiential learning**: In these telecommunication group sessions, it is important to continue the experiential learning by discussing vignettes and setting up practices. In a 1-hour session, there should be time to show and discuss 2-3 vignettes; so chose your vignettes carefully. As you would do in a group, pause vignettes for discussion, ask questions to solicit parents' ideas, and pull out principles. Script a practice of the skill and have parents practice this during the call. Since role plays will be harder in this online format, think ahead about ways to keep the role plays simple and clear. Parents can practice skills like descriptive commenting, labeled praise, using a when/then command, talking to a child about corona virus, or setting up a schedule for the day. There is even the possibility for a parent to make a video of something they did well and share these during the group or individual calls. • **Use white board to record principles**: Most video platforms have a built in white board or notes page that can serve as a way to list the parents' principles or key points learned from their discussions and problem solving. • **Review of prior material versus new content**: During your first few meetings, you will want to review prior material in light of the new home and work situation. Once parents are back on track with skills that they have already learned, the group can continue with the program sequence as group leaders introduce the new content. During this corona virus time, it is likely that most of the content you are talking about will be tailored to this new living situation. • **Highlight refrigerator notes:** Share your screen to highlight refrigerator notes as a summary of what has been covered in a session. Use the notes as a guide for parent weekly goal-setting. You can even use the white board to write down each parent's goals for the week. You will find refrigerator notes by topic on the parent section of our web site. http://www.incredibleyears.com/parents-teachers/articles-for-parents/ • **Short Term Goal Setting**: End your individual or group sessions by asking parents to identify their goals for the week. Encourage parents to set up a goal to practicing certain skills and to reading IY book chapters. Make sure these goals are realistic and manageable. • **Be sure to focus on parent stress management** in every session • **Be sure to focus on parent self-care**: Discuss with parents their ideas for making a place for themselves in achieving "essential" self-care actions such as: exercise, eating healthy, health care, maintaining social contacts, meditation, time alone and making time for children.
Service Users	No details on tele sessions but assume the same as regular Parenting Programs: • Parent programs are for parents with children ages 0-12 and grouped according to child age (0-12 mons), 1-3 years, 3-6 years and 6-12 years • Incredible Years Series has been tested in multiple randomized control studies with 2- to 12-year-old children diagnosed with conduct problems (i.e., having high rates of aggression, defiance, oppositional, and impulsive behaviors) and attention deficit disorder. It has also been evaluated as a prevention program with children 2 to 7 years old, who are at high risk because of family or demographic factors such as poverty, parental mental health problems, or poor parenting skills. The new baby program (6 weeks to 18 months) is currently undergoing evaluations.
Service Providers	• Dependent on the level of intervention and IY program but higher risk populations or behavioral interventions and may require Family Service Workers, School Counselors, Teachers, Social Workers, Psychologists, Therapists, and Special Ed Teachers
Referral Method	• Not clear

Outcomes	• Nothing specific to online/ tele session but generally programs have been found to be effective in strengthening teacher and parent management skills, improving children's social and emotional competence and school readiness, and reducing behavior problems.
Contacts	• incredibleyears@incredibleyears.com
References	**IY Online** • **Casey Family Programs, October 2020,** What do we know about services administered virtually? (LINK) **Regular IY programs** • IY Research all: https://incredibleyears.com/category/research-library/audience-research-library/all-audience-research-library/ • **Nystrand, 2019,** Cost-effectiveness analysis of parenting interventions for the prevention of behaviour problems in children (LINK) • **Taylor, 2008**, Computer-based intervention with coaching: an example using the Incredible Years program (LINK) **Child Welfare Context** • **Marcynyszyn, 2010,** Getting with the (evidence-based) program: An evaluation of the Incredible Years Parenting Training Program in child welfare (LINK) • **Karjalainen, 2021,** Parent- and teacher-reported long-term effects of parent training on child conduct problems in families with child protection and other support services: a randomized controlled trial (LINK) • **Webster-Stratton, 2010**, Adapting the Incredible Years, an evidence-based parenting programme, for families involved in the child welfare system (LINK) • **Webster-Stratton, 2013**, Incredible Years Parent and child programs for maltreating families (LINK)
Related Web Links	• IY Resources for Group Leaders Working Remotely: https://incredibleyears.com/resources/gl/resources-for-group-leaders-working-remotely/ • IY Series info: https://incredibleyears.com/about/incredible-years-series/ • CEBC profile regular IY program: https://www.cebc4cw.org/program/the-incredible-years/ • IY Implementation: https://incredibleyears.com/programs/implementation/

Internet-Based Parent-Child Interaction Training (USA & International jurisdictions)

Program Name	**Internet Based Parent-Child Interaction Training (I-PCIT) (LINK)**
Jurisdiction	• Parent-Child Interaction Therapy (PCIT) international is located in Florida, USA • PCIT International was created to promote fidelity in the practice of Parent-Child Interaction Therapy through well-conducted research, training, and continuing education of therapists and trainers. By creating an interface between the scholarly activities of PCIT researchers and the expertise of front-line clinicians, PCIT International promotes healthy family functioning. • Internationally PCIT certified therapists are in various international locations including Canada, Australia, New Zealand, Norway and many others.
Brief Program Description	• PCIT is an evidence-based behavior parent training treatment for young children with emotional and behavioral disorders that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. Children and their caregivers are seen together in PCIT. • Has been studied in child welfare populations.

	• Internet-based Parent-Child Interaction therapy (I-PCIT) has been studied over the last few years and guidelines for the adoption of I-PCIT have emerged during the COVID-19 pandemic.
Program Goals	• PCIT is done across two treatment phases. The first phase of treatment focuses on establishing warmth in your relationship with your child through learning and applying skills proven to help children feel calm, secure in their relationships with their parents, and good about themselves. o Desired outcomes of the first phase of treatment in PCIT include: ▪ Decreased frequency, severity, and/or duration of tantrums ▪ Decreased activity levels ▪ Decreased negative attention-seeking behaviors (such as whining and bossiness) ▪ Decreased parental frustration ▪ Increased feelings of security, safety, and attachment to the primary caregiver ▪ Increased attention span ▪ Increased self-esteem ▪ Increased pro-social behaviors (such as sharing and taking turns) • The second phase of treatment will equip you to manage the most challenging of your child's behaviors while remaining confident, calm, and consistent in your approach to discipline. In this phase, you will learn proven strategies to help your child accept your limits, comply with your directions, respect house rules, and demonstrate appropriate behavior in public. o Desired outcomes of the second phase of treatment in PCIT include: ▪ Decreased frequency, severity, and/or duration of aggressive behavior ▪ Decreased frequency of destructive behavior (such as breaking toys on purpose) ▪ Decreased defiance ▪ Increased compliance with adult requests ▪ Increased respect for house rules ▪ Improved behavior in public ▪ Increased parental calmness and confidence during discipline
Program Components	• PCIT is based on many of the same theoretical underpinnings as other parent training models. However, the treatment format differs from many other behavior parent training programs that take more of a didactic approach to working with families. Specifically, parents are initially taught relationship enhancement or discipline skills that they are actually going to be practicing in session and at home with their child. • In subsequent sessions, most of the session time is spent coaching caregivers in the application of specific therapy skills. Therapists typically coach from an observation room with a one-way mirror into the playroom, using a “bug-in-the-ear” system for communicating to the parents as they play with their child. • More recent advances in technology have allowed for coaching via video feed from another room which has reduced the need for adjoining clinical spaces. Concluding each session, the therapist and caregiver together decide which skills to focus on most during daily 5-minute home practice sessions the following week.

	• Traditional PCIT also differs from other parent training treatment strategies in that treatment is not session-limited. Specifically, families graduate from treatment when parents demonstrate mastery of skills and rate their child's behaviors as being within normal limits.

Program Delivery	**Regular PCIT (assume same for I-PCIT just adjusted to application over video conferencing)**
	Recommended Intensity
	• PCIT is typically delivered over 12-20 weekly hour-long sessions, but the exact treatment length varies based on the needs of the child and family. Treatment is considered complete when a positive parent-child relationship is established, the parent can effectively manage the child's behavior, and the child's behavior is within normal limits on a behavior rating scale.
	Recommended Locations/Delivery Settings
	• PCIT is usually delivered in playroom settings where therapists can observe behaviors through a one-way mirror. By using the one-way mirror therapists can provide verbal direction and support to the parent using a wireless earphone. **Video technology can also be used to deliver the program in other environments such as the home.**
	• In I-**PCIT, therapists use a video platform in which therapists and caregivers utilize either a laptop computer, tablet, or cell phone device positioned in a way that enables therapists to see the child and caregiver interacting**
	• **Caregiver receives in vivo coaching via either a bluetooth device directly connected to the visual interface (i.e., computer, tablet, or cell phone screen) or headphones connected separately to a cell phone**
	
	I-PCIT Delivery Examples
	• Example from Ensemble Therapy in Texas (LINK)
	  ○ In this practice, therapists work with families remotely to do the exact same treatment. Families receive therapy services in their home by setting up their phone, tablet, or computer in a way that allows the therapist to see the parent and child play during the therapy session. Using a wireless headset, therapists coach families through the structured sessions in the same way they would in an office setting. And what's remarkable with this modality is that research is showing comparable or better outcomes compared to in-office PCIT!
	• Example from Mailman Center for Child Development University of Miami Miller School of Medicine (LINK)
	  ○ During the COVID-19 national emergency, which also constitutes a nationwide public health emergency, covered health care providers subject to the HIPAA Rules may seek to communicate with patients, and provide telehealth services, through remote communications technologies. Some of these technologies, and the manner in which they are used by HIPAA covered health care providers, may not fully comply with the requirements of the HIPAA Rules under typical circumstances when there is no national emergency declaration.
	  ○ Under this Notice, covered health care providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, or Skype, to provide telehealth without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency.
	  ○ Under this Notice, however, Facebook Live, YouTube Live, Twitch, TikTok, and similar video communication applications are public facing, and should not be used in the provision of telehealth by covered health care providers.

	○ Covered health care providers that seek additional privacy protections for telehealth while using video communication products should provide such services through technology vendors that are HIPAA compliant and will enter into HIPAA business associate agreements (BAAs) in connection with the provision of their video communication products. The list below includes some vendors that report that they provide HIPAA-compliant video communication products and that they will enter into a HIPAA BAA. List of vendors that report that they provide HIPAA-compliant video communication products and that they will enter into a HIPAA BAA: Skype for Business/Microsoft Teams, Updox, VSee, Zoom for Healthcare, Doxy.me, Google G Suite Hangouts Meet, Cisco Webex Meetings/Webex Teams , Amazon Chime, GoToMeeting, Spruce Health Care Messenger • Example Koflhoff, 2019 I-PCIT in rural Australia ○ Using VTC, the PCIT therapist is able to deliver the preliminary didactic teaching sessions and subsequent coaching sessions remotely by observing the parent and child through the computer screen, instead of a one-way mirror, and speaking to the parent using bluetooth wireless headset technology. • Example from Fleming, 2021 Rural Australia ○ In the current study, PCIT was adapted for online delivery using encrypted person-to-person VTC technology. Families were required to supply their own computing device with in-built camera but were provided with a wireless headset and, if required (n = 5), broadband Internet dongle. Assessment and treatment sessions were conducted via Health Direct teleconferencing software. All but two families participated from their homes, one of whom participated from a community health center and the other from the mother's workplace.
Service Users	• PCIT is typically appropriate for families with children who are between 2-7 years old and experience emotional and behavioral problems that are frequent and intense. • Has been studied in high-risk populations for regular PCIT (those involved with child welfare) – see references section; however, Comer, 2015 cautioned at the time of the study that certain high-risk families may be inappropriate for I-PCIT, e.g., those with a history of self-harm or abuse. More recently, I-PCIT has been successfully studied in rural areas for children with conduct disorders.
Service Providers	PCIT therapist • To become a certified PCIT therapist, individuals must be a licensed mental health provider with a master's degree (or higher) in a mental health field or a third year psychology doctoral student who works under the supervision of a licensed mental health service provider. Individuals must also complete 40-hours of training with PCIT trainers and approved materials. Although online-based trainings are offered, at least 30 of the 40 required hours must be in face-to-face training. • Additional information about these trainings can be found on the PCIT International website.
Referral Method	• Not clear, depends how and who delivers the service
Outcomes	**Effectiveness of PCIT in at-risk families from Child Information Gateway 2013:** • At least 30 randomized clinical outcome studies and more than 10 true randomized trials have found PCIT to be useful in treating at-risk families and children with behavioral problems. Research findings include the following: Trauma adaptation, reductions in the risk of child abuse, improvements in parenting skills and attitudes, improvements in child behavior, benefits for parents and other caregivers, lasting effectiveness, usefulness in treating multiple issues, adaptability for a variety of populations

	Effectiveness of I-PCIT in Rural Australia (Kohlhoff, 2019) • Three overarching themes were identified in posttreatment interviews: positive outcomes, valuable program components and challenges and acceptability of internet delivery. Results demonstrate that consumers from regional, rural and remote NSW view I-PCIT as an acceptable and effective treatment of childhood DBD, bolstering preliminary evidence about the utility of internet technologies to deliver the high-quality results of PCIT. While internet connection issues were a hindrance to treatment for some participants, all parents reported meaningful positive outcomes for both child and parents. **Effectiveness of I-PCIT from Rural Australia (Fleming, 2021)** • I-PCIT was associated with significant improvement of large to very large effect size in the frequency and problematic nature of parent-rated conduct problems from baseline to posttreatment, while a significant improvement of small effect size was found for observed child compliance. There were also significant improvements of large effect size in both positive and negative observed parenting behaviors. As hypothesized and consistent with previous studies conducted in the same community-based early childhood clinic using in-clinic PCIT (Kohlhoff & Morgan, 2014; Phillips et al., 2008), treatment retention was adequate, with an attrition rate of 37%. Treatment completers were highly satisfied with the process and outcome of therapy and completed homework activities at a high rate (73%). • Overall, current findings indicate that community-delivered I-PCIT is effective and engaging for families of young children with conduct problems living rurally. In particular, this is the first study to demonstrate positive outcomes when online PMT is assessed via objective indictors of treatment success, including improvement in observed child compliance and parenting practices and good rates of homework compliance.
Contacts	• pcit.international@gmail.com
References	I-PCIT ○ **Barnett, 2021** Therapist Experiences and Attitudes About Implementing Internet-Delivered Parent-Child Interaction Therapy During COVID-19 (LINK) ○ **Comer, 2017**, Remotely delivering real-time parent training to the home: An initial randomized trial of Internet-delivered parent-child interaction therapy (I-PCIT) (LINK) • **Comer, 2015**, Rationale and Considerations for the Internet-Based Delivery of Parent-Child Interaction Therapy (LINK) • **Fleming, 2021**, An Effectiveness Open Trial of Internet-Delivered Parent Training for Young Children With Conduct Problems Living in Regional and Rural Australia (LINK) • **Flujas-Contreras, 2019**, Technology-based parenting interventions for children's physical and psychological health: A systematic review and meta-analysis (LINK) • **Garcia, 2021**, Rapid, Full-Scale Change to Virtual PCIT During the COVID-19 Pandemic: Implementation and Clinical Implications (LINK) • **Gurwitch, 2020**, Leveraging parent–child interaction therapy and telehealth capacities to address the unique needs of young children during the COVID-19 public health crisis (LINK) • **Kawasaki, 2020**, Internet-delivered Parent-Child Interaction Therapy (I-PCIT) in Japan: Case Report of Application to a Maltreating Parent-Child Dyad (LINK) • **Kohlhoff, 2019,** Feasibility and acceptability of internet-delivered parent-child interaction therapy for rural Australian families: a qualitative investigation (LINK)

	• **Peskin, 2020,** Internet Based-PCIT (I-PCIT): Recommendations for Service Delivery Prepared in Response to COVID-19 (LINK) **PCIT Regular Program** • PCIT International: http://www.pcit.org/pcit-research.html • See CEBC section on evidence: https://www.cebc4cw.org/program/parent-child-interaction-therapy/ **PCIT with at-risk Families** • Johnson, 2020, Trajectories of Change in Parent Skill Acquisition During the CDI Phase of Parent-child Interaction Therapy for Child Welfare-involved Families: A Preliminary Investigation (LINK) • Child Information Gateway, 2013, Parent-Child Interaction Therapy With At-Risk Families (LINK)
Related Web Links	I-PCIT • PCIT via telehealth: https://prezi.com/v/kgp6qo6_fu_8/pcit-via-telehealth/ ; https://www.youtube.com/watch?v=ICL198XRZ1w • I-PCIT Milestones psychology: https://www.milestonespsychology.com/i-pcit • I- PCIT Ensemble Therapy: https://www.milestonespsychology.com/i-pcit • Article by Comer: https://www.apa.org/pi/families/resources/newsletter/2019/05/parenting-intervention-technology PCIT • CEBC: https://www.cebc4cw.org/program/parent-child-interaction-therapy/ • Title IV_E Prevention Services Clearinghouse: https://preventionservices.abtsites.com/programs/258/show • UC Davis Health: https://pcit.ucdavis.edu/about-us/

Project 12-Ways, Behavioral Sciences Unit (USA)

Program Name	**Project 12-Ways (LINK)/ University based social services training model, Telehealth adaptation (LINK)**
Jurisdiction	• Illinois, USA • One of the many challenges faced by Project 12 Ways is overcoming the time and distance difficulties associated with performing case management responsibilities over an area with a radius of nearly 160 miles.
Brief Program Description	• Project 12-ways is a state-funded service delivery program that is funded by the Title XX Purchase of Service Contract and the Illinois Department of Public Aid and delivered by the behavioral sciences unit at Southern Illinois University, Carbondale. Project 12-ways works directly with parents indicated for the neglect and abuse of their children and utilizes a molar or ecological approach focusing on the broader context of parenting behavior. • In addition to the examining of the functional relations between parents' behavior and the contextual variables mentioned, this treatment model also evaluates parent behavior and how it affects others in context (e.g. their children's social skills). • Since its inception in 1979 Project 12-Ways has operated under the auspices of the Behavior Analysis & Therapy Program which is part of the Rehabilitation Institute at Southern Illinois University. Many families served by Project 12-Ways are involved with the Illinois Department of Children & Family Services because of a history or serious risk of child maltreatment.
Program Goals	• Improve social functioning by meeting individualized treatment goals • Improve the capacity of the parents to raise and manage their children

	• Reduce child behavior problems • Increase the likelihood that families will remain intact **Parent Training goals** • Parent-training goals are derived from assessments, and counselors review these goals with parents to ensure parents agree with the identified treatment targets before parent training begins. • Some common parent-training goals within the program include safety and supervision skills, establishing time in, parent communication skills, bedtime routines, spoon feeding skills, implementing time-out, a child management skills. Baseline data are collected prior to intervention, and parent progress on parent-training goals are monitored subsequently after training begins. Continuous data monitoring allows parent targets to be modified, and procedures are altered to achieve program outcomes of reuniting families
Program Components	• Project 12-Ways utilizes a behavioral parent-training model that emphasizes assessment and training within the context of a family's daily routine(s). This approach is formally called Contextually Valid Family Training (CVFT™). We use the model to ensure parents are being supported in the environment they raise their children (e.g., family home) versus receiving support in a classroom setting. The model also allows for our staff to collect data and provide the family with specific feedback on their progress versus the more traditional approach that is based on subjective opinion. In addition, the assessment process allows for our staff to measure a parent's ability to maintain their skills across time and during progressively challenging circumstances.

Program Delivery	• Project 12-Ways receives funds from Title XX (of the Social Security Act) through an agreement with the Illinois Department of Children and Family Services (DCFS) and the Illinois Department of Human Services (IDHS).
	• The university-based, state-funded service delivery program works directly with parents indicated for the neglect and abuse of their children and utilizes a molar or ecological approach focusing on the broader context of the parent behavior in question.
	• Often the telephone is used as a substitute for face-to-face interactions because of the distance covered and logistics involved in servicing the area.
	In-home delivery
	• Once eligibility is verified, the case is assigned to a counselor who schedules a meeting to review client files with the caseworker. After the file is read, an introductory meeting is scheduled with the caseworker and the clients in their home. Following this initial meeting, counselors schedule follow-up meetings during which assessments of needs are conducted in the clients' homes. These assessments address physical home conditions, household routines, and family interactions. Parent-training goals are derived from these assessments, and counselors review these goals with parents to ensure parents agree with the identified treatment targets before parent training begins.
	• Staff meet with the families in their homes one or two times per week to implement the strategies outlined in their treatment plans. Staff engage in a collaborative process to achieve and maintain the family's goals.
	• Staff do not engage in the following service provisions:
	  ○ Recommendations about parent rights or termination of rights
	  ○ The mission of the project is to help families remain intact. The Department of Children and Family Services and the courts are responsible for making decisions about parents' rights.
	• Diagnostic services

	○ Project staff do not make mental health or medical diagnoses. • Psychological Evaluations ○ Project staff do not conduct psychological evaluations. Any and all psychological evaluations must be completed by another provider. • Have previously studied telebehavior analysis and case management using videoconference (see references) **Telehealth Adaptation for COVID-19** (see Britwum, 2020 for more detail) • The program had to consider important ethical values related to the fairness of service provision to all clients in light of the fidelity in adhering to their obligations to provide these services targeted at reuniting families. With multiple response options to consider with varying consequences for each, the program had to carefully evaluate the consequences of each response option to ensure that the chosen course of action would foster beneficence while decreasing nonmaleficence. In preparing for sessions, the clinician needed to include: ○ a detailed description of the session structure prior to the session; & a review of information on how to access the platform for the session; & discussions on how to identify the right physical environment with or without children; & a review and discussion regarding goals for the session; & modification of language for interview assessments to fit telehealth delivery of interviews; and & a review of data collection sheets and feedback tools used during the session. ○ Consideration was also given to conceptualizing the telehealth visit to clarify or elaborate on the information provided, such as by providing the parent a debrief of sessions, reflecting positively on things completed correctly during the session, and providing opportunities for parents to ask clarifying questions and provide feedback. ○ Applied principle of fairness and fidelity (to create a foster a safe and conducive environment for interactions during the sessions) ○ Considered parent competence • Adapted model using active support: ○ The principles utilized in this approach include the following: (a) every moment has potential, (b) little and often, (c) graded assistance to ensure success, and (d) maximizing choice and control. ○ For our program's purposes, some active support elements were modified to fit program-specific values.
Service Users	• at-risk families in 11 Southern Illinois counties
Service Providers	• Counselor, Case worker and University research support staff mentioned • Currently, the program has about eight graduate students working in the field providing contextually based behavioral treatments to parents with the ultimate goal of reuniting families separated by a parental history of child abuse and neglect.
Referral Method	**Nothing specified for Telehealth adaptation so assume the same as regular in-home delivery** • Client referrals for this program come from five state and not-for-profit agencies within a specifically defined rural area. When a referral is received, an investigation is conducted to verify Title XX eligibility. Two main factors are used to determine a family's eligibility for Title XX services. The first is the family's protective status, which is determined by a suspicion of abuse or neglect as ascertained by a formal investigation. The second is the family's socioeconomic status, which is determined when mothers or fathers lack support in parenting their children and present with a very high risk for potential child abuse that warrants preventative services.

Outcomes	**Telehealth Adaptations for COVID-19** • No measured outcomes for recent telehealth adaptation for COVID-19 but recommendations and considerations made (see Britwum, 2020 in reference section below) **Case study of videoconference pilot for families found:** • The pilot conducted in cooperation with Project 12 Ways demonstrated the utility of interactive video technology in supporting unique and challenging case management scenarios. The medium proved equally successful at supporting the needs of families with very young children and those with adolescents with special needs. The study also demonstrated the efficiency and portability of telehealth applications, as the families and professional were linked quickly and easily via relatively inexpensive residential broadband data services (less than $75 per month). Lastly, the professionals and the families served each agreed that the interactive medium facilitated service delivery in a manner and quality comparable to traditional home visits, an important assessment for determining the viability of the medium in satisfying case management needs. **Regular in-home model** • Since 1992 this model has been successful with helping parents utilize child management techniques that increase positive interactions between the children and parents, increasing parents' skills needed to protect against exploitation, and helping families remain intact.
Contacts	• p12ways@siu.edu
References	• **Britwum, 2020**, A University-Based Social Services Parent-Training Model: A Telehealth Adaptation During the COVID-19 Pandemic. (LINK) • Project 12 Ways videoconference pilot: https://static1.squarespace.com/static/55199b5ee4b0dfcc47c70cf5/t/56152b6ae4b0c059bbb8171c/1444227946964/Project+12+Ways+Case+Studies+1508.pdf
Related Web Links	• About Project 12 Ways: https://project12-ways.siu.edu/about/ • Services Project 12 Ways: https://project12-ways.siu.edu/services/ • CNOW Inc. Telehealth Solutions: https://rocketreach.co/cnow-inc-profile_b5c8b362f42e35ea

Safecare, Virtual Delivery (USA & International jurisdictions)

Program Name	**Safecare (SC), Virtual Delivery (LINK)**
Jurisdiction	• Originally developed from the National SafeCare Training and Research Center in Georgia, USA but the model has been adapted for use in Belarus, United Kingdom, Spain, Canada, Israel and Australia
Brief Program Description	• Seems to be a more refined Project 12 Ways program (see NSW reference linked below) • Evidence-based parenting program for families with children 0 to 5. • Structured parenting program that addresses proximal behaviors that can lead to child neglect and physical abuse. • Regular program does not involve online delivery but there have been studies done to adapt the implementation using virtual components.

	• SafeCare adapted to virtual delivery during the COVID-19 pandemic. • Research has also involved this model for child welfare populations.
Program Goals	• Focus on three key factors that are universally important for all families: improving the relationship between parents and their children and keeping homes safe and children healthy.

Program Components	**Regular Program**
	• SafeCare relies primarily on social learning principles and as such, includes ongoing behavioral observations by providers, skill development through behavioral rehearsal, performance of skills to a level of mastery, and the use of operant principles to reinforce behaviors
	• Each family receives three out of four modules of the SafeCare Program:
	  ○ **Parent Child or Infant Interaction Module**: Targets risk factors associated with neglect and physical abuse. This module focuses on parent- infant interactions (PII: up to 18 months) and parent-child interactions (PCI: 18 month through 5 years old). Parents learn to increase positive interactions with their infant/child and how to structure daily activities by providing engaging and stimulating activities. PCI also helps parents to reduce challenging child behavior.
	  ▪ seeks to build a positive parent-child relationship through positive interactions, and teach parents to structure activities to prevent challenging child behaviors.
	  ○ **Home Safety Module**: Targets risk factors for environmental neglect and unintentional injury. The focus of this module is to help parents identify and eliminate common household hazards. Parents learn how to eliminate home hazards and the importance of age-appropriate supervision.
	  ○ **Health Module**: Targets risk factors for medical neglect. The focus of this module is to help parents identify and eliminate common household hazards. Parents learn how to eliminate home hazards and the importance of age-appropriate supervision
	• Each module begins with a baseline observational assessment to determine caregivers' initial knowledge and skills. Following several sessions of explaining, modeling, and role-playing the skills and also receiving feedback, the last session of each module involves another assessment to evaluate caregivers' level of skill acquisition
	• Program Structure
	  ○ Asessment 1, Sessions 2-5, Session 6 Re-assessment

Program Delivery	**Regular Program**
	• SafeCare Providers meet with parents for 6 sessions per module, depending on the parents' skills at baseline. Each module begins with an observational assessment to determine parents' current skills and to identify which skills to focus on during training. Providers work with parents during the training sessions until they have mastered the module skills. SafeCare Providers conduct a final assessment to confirm parents' uptake of skills.
	• Training sessions use principles from well-established social learning theory and research. Parenting skills are taught by:
	  ○ Explaining the skills and why they are important
	  ○ Demonstrating how to do each skill;
	  ○ Having parents practice the skills; and
	  ○ Providing positive and corrective feedback to parents on their use of skills.
	• This program is typically conducted in a(n): Adoptive Home, Birth Family Home, Foster / Kinship Care

	• Recommended Intensity: Weekly sessions of approximately 1-1.5 hours each
	• Recommended Duration: 18-20 weeks
	• Resources required
	  ○ Transportation for in-home sessions
	  ○ Audio recorders (one for each Provider so that they can audiotape each session for the purpose of coaching) or Android or iOS devices that support the SafeCare mobile application unless SafeCare coach directly observes session
	  ○ Dolls (used dolls are fine) to use during role-plays with the parents
	  ○ Tape measure (used during the Safety module; provided by SafeCare)
	  ○ No choke test tube (used during the Safety module; provided by SafeCare)
	  ○ Bag or plastic bin (to carry and organize materials; bag provided by SafeCare)
	  ○ Clipboard (for assessments and taking notes)
	  ○ Coloring sheets and crayons (for children during sessions)
	  ○ Toys (for infants and children during sessions)
	  ○ Safety First Kit (or cabinet latches, door knob holders, outlet covers)
	  ○ Screwdriver (to assist family in installing safety latches)
	  ○ No choke test tube/Small parts tester (to leave with family)
	  ○ Digital thermometer with cover (to leave with family)
	
	Virtual delivery Safecare (Self-Brown, 2020)
	• When the COVID-19 pandemic struck, SafeCare Providers quickly adapted to technology-based delivery, and the purveyors of SafeCare developed best practice guidelines for virtual delivery to allow for the continuation of services in this very vulnerable time
	• The most commonly used applications for virtual delivery were Zoom (50%), FaceTime (19%), and Google Duo (15%). Providers overwhelmingly reported using their smartphones for session delivery (n = 202, 66%). In terms of family technology access, participants indicated that the majority of the families they serve own a smart device (n = 258, 87.8%) and reported that the parents they served had the skills to use the smart device to engage effectively in a SafeCare session (n = 231, 89.9%). Providers noted that approximately 21% of the families they serve do not have a sufficient data plan to allow them to use the device effectively for SafeCare sessions.
	• Provider responses indicated that the SafeCare module that is the most didactic, Child Health, was the easiest to deliver virtually, while the two modules with more modeling and active role play, Home Safety and Parent-Child Interaction, were more challenging.
	
	Self-Brown, 2017, Web based Safecare (Safecare Takes Care)
	• the delivery of SafeCare was adapted to include technology assistance delivered on a tablet via a web-based SafeCare program entitled SafeCare Takes Care. SafeCare Takes Care includes a combination of video, audio narration, and engaging questions and was developed through an alpha and beta testing process with parenting experts and parents similar in education and socioeconomic status to the parents served with the SafeCare program. The videos are presented in a manner similar to a talk show. For each module and session, the host of SafeCare Takes Care presents a new topic (i.e., the session content for that day) with video modeling of the skills from ‘‘at-home viewers.’’

	• uses an open-source systems and languages to input text, picture, and video-related content into website interventions. All text was narrated to minimize literacy requirements. The architecture is based on the Python programming language using a Django web framework and Foundation (http://foundation.zurb.com), an advanced responsive front-end framework, to ensure mobile friendliness. This framework consists of Cascading Style Sheets and Javascript to ensure proper display of the web application across multiple devices with differing screen sizes and resolutions. SafeCare Takes Care was hosted at Oregon Research Institute (ORI) on a Linux server with MySQL, an open-source language for relational database development. Data collection components were securely transmitted to ORI servers using Secure Sockets Layer protocol. • SafeCare providers assigned to the SC-TA condition participated in the standard SafeCare workshop and also received training in the technology-mediated approach to SafeCare delivery. The technology training took approximately 2 hr and focused on how the provider utilizes the technology in each session. Specifically, after greeting the parent, the provider was instructed to connect the parent to the web-based program, during which the parent participates in the multimodal learning (e.g., explanation and modeling of skills) of SafeCare target skills. When the parent completes the web-directed portion of the session, the provider is prompted by the web-based program to take over the session delivery, revisit any explanation and modeling the parent has questions about, and then engage the parent in live practice of the skills presented in the web program. Lastly, the provider offers positive and constructive feedback about the practice and closes the SafeCare session. • there were some slight adaptations to the scoring instructions of the Safe-Care Fidelity checklist for the SC-TA to accommodate the use of the web-based program into the session • Providers in both groups participated in coaching calls with their assigned SafeCare coach following the coach's scoring of fidelity, as is the protocol for SC-IU. **Cellular phone-supported version (PCI-C) of the Parent-Child Interactions (PCI) of SafeCare® (Lefever, 2017)** • Used mobile phone enhancements involving frequent voice and text messaging (cell-phone supported) on parenting skills for the Parent Child Interaction Component of Safecare • In the PCI-C condition, parents were provided with a cell phone and free service to use throughout the intervention phase. Mothers received twice-daily text messages and at least one phone call between home visits. The text messages were typically linked to the mos recent intervention visit and were a planned mix of PCI-related questions, prompts to use the PCI skills, and supportive messages. • There were two components of the cellular phone enhancement that promoted more frequent contact between the family coaches and the mothers: (1) twice-daily text messages and (2) phone calls between home visits. Family coaches sent text messages twice per day, 5 days per week. Text message content was individualized for each mother and related to the current focus of the intervention taking place during the home visit that week. The majority of the text messages were questions pertaining to the intervention or prompts to use the newly learned skills. Interspersed were messages that did not pertain directly to the intervention, such as suggestions for free- or low-cost activities within the community, or supportive messages to the mother (e.g., messages of encouragement, community resources). In addition to text messages, family coaches conducted a weekly check-in phone call between home visits to inquire about PCI use, mother and child activities, and child behavior.
Service Users	• for families with children 0 to 5 (targets proximal behaviors known to lead to neglect)

Service Providers	• A SafeCare Provider
	• A SafeCare Coach
	• Prerequisite/Minimum Provider Qualifications
	  ○ A bachelor's degree in human services is preferable [less education is acceptable with work experience in child development and parenting]. Also, staff should be comfortable delivering interventions to families in the home setting, open to learning and implementing new curricula or intervention programs, open to or has prior experience in delivering a highly structured intervention protocol, understands the importance of program fidelity, and open and responsive to coaching and constructive feedback.
	  ○ To become a SafeCare Provider, the required training is conducted over 32 hours during 4 consecutive days of workshop training, followed by observations of at least nine sessions by a certified SafeCare Coach or Trainer. To become a SafeCare Coach, one needs to be a certified SafeCare Provider and attend an additional 16 hours of workshop training over 2 days, plus observations of at least six coaching sessions by a certified SafeCare Trainer. To become a SafeCare Trainer, one needs to be a certified SafeCare Coach and attend an additional 16 hours of workshop training over 2 days, plus a 4-5 day observation of a Provider Workshop.

Referral Method	• Voluntary for the regular program but seem to be options for other agencies or health care providers to refer • Some studies look at the child welfare context but not clear how these families would get involved with the program
Outcomes	**Remote delivery Safecare during COVID-19 (From Self-Brown, 2020)** • In terms of family engagement and program effectiveness, SafeCare Providers' responses were mostly positive, suggesting that families are actively engaged and making positive progress in target skills. Providers reported several considerations and augmentations they were implementing to ensure positive engagement, with flexibility of session delivery time (evening and weekend delivery) and chunking of one session into multiple shorter sessions being two very commonly implemented strategies. • While parent target skill mastery is reportedly taking longer to achieve via virtual delivery, Providers reported that parents are continuing to achieve skill mastery and success with this delivery format. Interestingly, some Providers commented on the increased opportunity that parents have to practice and implement the SafeCare skills they learn in session during the pandemic, and that the increased time with children appears to positively impact parent motivation to use the skills they are learning. Additionally, some Providers noted that the virtual delivery is perceived as less intrusive by parent program participants, given they can get the benefit of the service without allowing a provider into their home. • Virtual delivery challenges were also noted, with the unreliability of technology being the most commonly reported. Other challenges include Providers struggling with target skill modeling and conducting accurate assessments, given the lack of best practice guidelines for how to navigate these skills over technology. **Self-Brown, 2017**, Web based Safecare (Safecare Takes Care) • confirmed feasibility of the technology-assisted approach to SafeCare delivery (despite a few technological issues) • very well received by families in most cases and extremely helpful in circumstances where parents had identified literacy and learning challenges. • providers in the SC-TA condition reported spending significantly less time overall in preparation for and in follow-up to SafeCare sessions as well as reductions in assessment and parent training time during session delivery.

	• this approach may reduce the initial implementation barriers newly trained providers experience when implementing a new practice, which can enhance the likelihood of sustaining the new intervention
	• providers spent more time on average with the initial greeting of their families and answering questions. SC-TA providers indicated that they paid significant attention to building rapport with families each week, given that the parent spent much of the session engaging with the technology. Consequently, these providers spent more time interacting with parents at the opening of SafeCare sessions and offered more time for questions related to both the content parents were exposed to in the webbased content and the skills practiced in partnership with the home visitor.
	
	Cell phone PCI Adaptation (Lefever, 2017)
	• Moreover, mothers in the cell phone–enhanced condition were more likely to demonstrate generalization of their newly learned parenting skills to an untrained activity (picking up toys after free play) than were mothers in the traditional (noncell phone) intervention
	• Another positive long-term effect noted only in the cell phone condition were sizable improvements in children's behaviors: Those in the PCI-C group were found to be more cooperative and have lower levels of reported externalizing behavior than children in the WLC control. This same effect was not found for children in the PCI group
	• initially found that mothers in the cell phone–supported condition had the largest declines in depression during the intervention period
	• rate of attrition was much lower for the PCI-C group than the PCI group.
	
	Regular Program (Focused on studies that examined the child welfare context in the bullet points below)
	• Over 30 years of scientific research and numerous studies support SafeCare's effectiveness at improving positive parenting skills and at reducing and preventing abuse and neglect
	• Study by Romano, 2020 from Ontario Canada examining Safecare in Child Welfare context
	  ○ improvements in caregiver anxious/depressed symptoms after SafeCare
	  ○ Most caregivers did not report elevated anxiety/depression pre-SafeCare.
	  ○ There were no significant improvements in caregiver aggressive behavior.
	• Study by **Gallitto, 2021** from Ontario Canada examining Safecare in Child Welfare context
	  ○ Findings indicated a significant decrease in caregivers' self-reported neglectful parenting from pre- to post-intervention and from post-intervention to 3-month followup.
	  ○ Caregivers also reported a significant decrease in the use of physical punishment and a significant increase in positive disciplinary practices.
	  ○ The current results also indicate that the SafeCare program may be effective in reducing physical punishment, thereby extending its beneficial effects to "milder" forms of physical violence.
	  ○ Results indicated a statistically significant increase in caregivers' use of non-confrontational conflict resolution strategies (i.e., reasoning, distraction) following SafeCare completion, and these gains were maintained at 3-month follow-up.
	  ○ Contrary to expectations, caregivers in our sample did not report statistically significant decreases in the use of psychological aggression following completion of the SafeCare program.

	○ The current results suggested various parenting benefits for child welfare-involved caregivers following completion of the SafeCare program. • Study by **Whitaker, 2020** from US from childwelfare context ○ Results indicated that SafeCare had small to medium effects for improving several parenting outcomes including supporting positive child behaviors (d = 0.46), proactive parenting (d = 0.25), and two aspects of parenting stress (d = 0.28 and .30). No differential change between groups was found for other indicators, including all indicators of neglect.
Contacts	• Email: safecare@gsu.edu • Phone: 404.413.1387
References	**Adapted or Virtual Safecare** • **Lefever 2017**, Long-term impact of a cell phone-enhanced parenting intervention (LINK) • **Self-Brown, 2017**, A Technology-Mediated Approach to the Implementation of an Evidence-Based Child Maltreatment Prevention Program (LINK) • **Self-Brown, 2020,** The Impact of COVID-19 on the Delivery of an Evidence-Based Chilld Maltreatment Prevention Program: Understanding the Perspectives of SafeCare® Providers (LINK) **Regular Safecare Child Welfare context** • **Chaffin, 2012**, A statewide trial of the SafeCare home-based services model with parents in child protective services (LINK) • **Romano, 2020**, Does the SafeCare parenting program impact caregiver mental health? (LINK) • **Gallito, 2020**, Investigating the impact of the SafeCare program on parenting behaviours in child welfare-involved families (LINK) • **Whitaker, 2020,** Effect of the SafeCare® intervention on parenting outcomes among parents in child welfare systems: A cluster randomized trial (LINK) • **NSW Government, 2020**, Does SafeCare® prevent child abuse and neglect from reoccuring? (LINK) Other • List of more references: https://safecare.publichealth.gsu.edu/safecare/safecare-research/publications/
Related Web Links	• CEBC regular program: https://www.cebc4cw.org/program/safecare/ • Ontario Project: https://strongfamilies.ca/projects/safecare-program/; https://socialsciences.uottawa.ca/children-well-being/activities • Child Welfare Information Gateway: https://www.childwelfare.gov/topics/preventing/prevention-programs/homevisit/homevisitprog/safe-care/ • Safecare Australia: https://www.parentingrc.org.au/programs/safecare/

Data Extraction – Telehealth Services

Telepractice for Parenting Support, Australia

Program Name	**Telepractice for Parenting Support (LINK)**
Jurisdiction	• Australia

Brief Program Description	• Telepractice is the use of telecommunications to deliver parenting support and other services remotely. It draws upon experiences in the delivery of telehealth and can include synchronous (e.g. virtual home visits) and asynchronous (e.g. email, text) approaches. • Use the term telepractice rather than telehealth to avoid the perception that these modes of service delivery are restricted to healthcare settings.
Program Goals	• Deliver parenting support and other services remotely

Program Components	• Modes of telepractice can be categorised as:
	  ○ Synchronous (interactive) in which services are delivered in real time with an individual or group of clients, for example through:
	  ○ telephone consultations and support lines
	  ○ videoconferencing or webinar technology
	  ○ internet chatroom platforms.
	• Asynchronous where information or advice is shared over time with clients or digital conversations occur, for example by:
	  ○ email and text messaging
	  ○ social media platforms
	  ○ digital delivery of guided self-help content where online materials such as reading or videos are supplemented by practitioner contact via email, phone or video conferencing.
	• Examples of Evidence based parenting programs delivered online include
	  ○ Triple P
	  ○ Parent Child Interaction Therapy
	  ○ Cognitive Behavioural Therapy
	  ○ Psycho-education

Program Delivery	• For people to use online support services, there are three things that service providers can often help with:
	  ○ affordable data plans
	  ○ access to the internet on suitable devices
	  ○ the skills to use technology effectively.
	  ○ These conditions for digital inclusion are lowest for some of the key populations who access social services, in particular low-income households (income < $35,000 per annum), mobile-only households and people aged over 65 years.
	• Affordability has improved only marginally since 2014 and is the starkest problem for low-income families. One contributing factor is a reliance on mobile phones, which may be perceived as cost effective but can be constrained by limited data plans. Single parents with school-aged children are one group that are more likely to be mobile-only reliant. The size of a mobile screen also limits navigation and engagement with many services.
	• Accessibility is also a problem for some low-income families, particularly those living in multi-dwelling units where NBN 'fibre to the basement' is the infrastructure for internet connectivity. Due to the construction of some multi-dwelling units, Wi-Fi connectivity is limited, meaning there are barriers to some solutions (e.g. Wi-Fi to each floor). The responsibility rests with the owner or household to connect into the home.
	• Solutions to issues such as accessibility are often policy-based and reliant on accepting that internet access is an essential service. However, there are some things that service providers can help with.

	• Telecommunications companies have programs to assist those on a low income or facing financial hardship – information on this and consumer rights can be found at www.accan.org.au.
Service Users	• Those who are hard to reach – either physically or for other reasons • Give several factors that may be worth considering: ○ Family Factors, individual factors, practitioner factors, use of technology, service or program factors
Service Providers	• Parenting programs may vary in how easily and effectively they can be delivered online. Practitioners will need to make sure that they are sufficiently trained in the program itself and seek advice from the developers or qualified trainers in how to proceed.
Referral Method	• Dependent on program offered

Outcomes	• Telepractice offers practitioners and participants a range of valuable benefits relating to convenience, access to services, participant choice and quality of care.
	• **Logistical benefits**
	  ○ Neither participant nor practitioner needs to travel, which leads to time and cost savings. This is particularly beneficial for those with mobility impairments or other health complications.
	  ○ It reduces inconvenience for those who are supporting participants – such as carers, family members and parents – in relation to time, travel and work commitments.
	• **Increased participant choice and preference**
	  ○ Telepractice can help to reduce feelings of stigma involved in visiting a therapist or receiving home visits.
	  ○ Participants who feel uncomfortable or self-conscious in a face-to-face situation may find it easier to build a trusting relationship with a practitioner.
	  ○ Telepractice can increase participants' independence and sense of control; for example, participants have more choice over the environment for support sessions (e.g. home, workplace) and can fit sessions around their day.
	• **Increased service reach**
	  ○ With telepractice, services can extend support beyond office hours (also increasing convenience for participants).
	  ○ Services can cross geographic boundaries, particularly beneficial to rural and regional areas where access to a wide range of skilled practitioners can be limited.
	  ○ Services can support more participants as a result of these and the logistical benefits.
	• **Increased service flexibility and quality**
	  ○ Improved logistics and flexibility enable increased flexibility and responsiveness to workforce needs.
	  ○ For services that are traditionally offered at the service location (not in the home), telepractice enables practitioners to assess and support participants in their natural environment.
	  ○ Practitioners are better able to offer shared care, consultation and collaboration with specialists – a benefit for rural and remote areas in particular.

Contacts	• https://www.parentingrc.org.au/contact-us/
References	Australian telepractice • **Joshi, 2021**, The use of telepractice in the family and relationships sector. Melbourne, Australia: Australian Institute of Family Studies (LINK)

	General for tech-based programs
	• **Florean**, **2020**, The efficacy of internet-based parenting programs for children and adolescents with behavior problems: A meta-analysis of randomized clinical trials (LINK)
	  ○ Includes Triple P, PCIT, iComet, Behavioral Parent Training
	• **Flujas-Contreras, 2019,** Technology-based parenting interventions for children's physical and psychological health: a systematic review and meta-analysis (LINK)
	  ○ Includes Triple P, PCIT, CBT
	• **Harris, 2020**, Technology-assisted parenting interventions for families experiencing social disadvantage: A meta-analysis (LINK)
	  ○ Includes ezParent program, Triple P, PCI-C,

Related Web Links	○ Is telepractice a preferred and/or viable option? (LINK) ○ Telepractice: https://re-imagine.com.au/practitioner/telepractice/

Child Protection Team (CPT) Telemedicine Services, Children's Medical Services, Florida (USA)

Program Name	**Child Protection Team (CPT) (LINK)**
Jurisdiction	• Children's Medical Services, Florida (USA)
Brief Program Description	• In 1998, Children's Medical Services (CMS) in Florida implemented a real-time telemedicine project, linking "hub" sites with "remote" or satellite service locations such as public health departments and child advocacy centers (Figure 1). The purpose of this telemedicine network was to improve access for children suspected to be victimized who resided in rural areas to the Child Protection Team medical evaluations. • The Child Protection Team (CPT) program at the University of Florida is a medically directed, multidisciplinary program based on the idea that child abuse and neglect involve complex issues and require the expertise of many professionals to protect children. It is one of twenty-four legislatively mandated teams of its kind throughout the state of Florida. • Real-time CPT telemedicine services for the evaluation of children suspected to be abused or neglected has been implemented in rural or remote areas.
Program Goals	• to improve access for children suspected to be victimized who resided in rural areas to the Child Protection Team medical evaluations.
Program Components	• Hub sites are comprehensive medical facilities with a wide range of medical and multidisciplinary staff while remote sites are limited in diversity and medical expertise in evaluating suspected cases of child abuse. Medical providers located at hub sites have the expertise needed to evaluate this population. • A telemedicine exam follows the same general protocol as a traditional face-to-face medical examination provided by the Child Protection Team. Thus, the medical evaluation includes the child's birth, past and current medical, developmental, and family history, an assessment of the child's behavior and social risk factors and obtaining photographs; all the components of a comprehensive abuse assessment. Examinations are utilized to assess physical abuse, sexual abuse, and medical neglect cases. • In addition to using telemedicine for real-time child medical evaluations, the technology can also be useful for peer review and consultation. Several Child Protection Teams in Florida also use the technology to conduct quarterly peer review of complex cases among the child abuse experts at various sites. The providers are able to present cases, share images of physical findings and participate in discussion simultaneously without delay. While these peer reviews are conducted in real-time, another application

	known as store and forward consultations, involves the transmission of still images from a practitioner to a data storage device which can then be retrieved by the expert medical professional and reviewed at a later time. The expert can then view the images remotely to give his/her opinion. • Live telemedicine consultations are another option for remote providers to access child abuse experts at a distance. Providers at remote sites where a patient presents with an allegation of abuse can connect with experts at a tertiary care center agreeing to provide the consultation. Live consultations have shown to reduce cost in other types of medical conditions by reducing the number of patients taken by aeromedical transport to larger medical centers
Program Delivery	(**From Arnold, 2013**) • The physician, physician assistant, or Advanced Registered Nurse Practitioner, the medical provider of record, is located at the hub site while a registered nurse and social worker engage with the child at the remote site during the medical evaluation. • Computer integration allows for the storage of images taken by either the hub or remote site. A telemedicine exam follows the same general protocol as a traditional face-to-face medical examination provided by the Child Protection Team. Thus, the medical evaluation includes the child's birth, past and current medical, developmental, and family history, an assessment of the child's behavior and social risk factors and obtaining photographs; all the components of a comprehensive abuse assessment. Examinations are utilized to assess physical abuse, sexual abuse, and medical neglect cases. • Live, simultaneously transmitted telemedicine exams are preferable compared to the store and forward application. While both methods accomplish the goal of having a child's injuries evaluated by an expert in the field of child abuse live examinations allow the medical provider access to information that can not be captured by a still image. During the live telemedicine evaluation the medical provider is able to observe the child's body language, interact with the child, observe the child's reactions to the physical examination, and is able to ask additional questions of the child and/or non offending caregiver if needed. • The UFCPT's current network is Secure Integrated Services Digital Network operating at 384kbps transmission speed. A Tandberg Intern was previously used and the Polycom Practitioner Cart is now located at the remote sites (Figure 2 and 3). The hub site also requires a Polycom Practitioner Cart with integrated computer and software. Second Opinion Professional is the current software being used. An AMD General Exam Camera with 50X magnification and a Welsh-Allyn or Leisgang colposcope is used to capture physical findings. The Florida Department of Health Information Technology personnel provide technical support to the CPT Telemedicine program statewide. Consultation with IT support familiar with telemedicine should be initiated in the very early stages of planning.
Service Users	• children suspected to be victimized who resided in rural areas
Service Providers	• Group of people recommended for setting up services: hub site medical personnel, local child protective services personnel, local law enforcement investigating crimes involving children, state or district attorney involved in prosecution, local health department and hospital personnel, and the local Child Advocacy Center. • The performance of a telemedicine exam requires a minimum of two medical professionals who have specific child abuse training and training in conducting telemedicine examinations; the medical provider of record (physician, physician assistant, or ARNP) and a registered nurse. The University of Florida Child Protection Team also has a social worker present during the medical evaluation. This individual has usually already conducted a thorough forensic interview with the child prior to the medical examination unless due to the child's young age/development this was not feasible. The social worker's presence during the exam helps to make the child comfortable and also provides continuity for the child while at the clinic or Child Advocacy Center. In addition, the social worker

	operates the hand held camera that captures the images in order to allow the registered nurse to act as the medical provider's "hands" during the examination. All images and video are available to the medical provider simultaneously. All personnel located at the remote site act under the direction of the medical provider. • The history provided to the social worker is relayed to the medical provider via telephone before the exam begins. Prior to the child's examination the registered nurse will explain to the child and family how the exam will be conducted and provide an opportunity for questions to be asked. Families and the child most often want to be reassured that the examination is confidential and cannot be observed by an outside party. The personnel explain that the examination is conducted over secure telecommunications lines and that only the examiner at the hub site is being transmitted the encounter. The child and caregiver are shown the telemedicine equipment and explained that the utilization of the equipment avoids lengthy travel and provide them access to an expert more easily. The child's medical history is gathered from the caregiver accompanying the child to the appointment, if available. The caregiver is asked to leave the room when the examiner obtains history from the child specific to the alleged abuse. Following the medical history, the child is asked whom if any of the individuals that accompanied them to the appointment would they prefer to remain with them during the medical examination. The UFCPT program has found that often with adolescents they prefer to be examined alone. • Only CPT medical providers approved as CMS medical providers and are specifically trained to do telemedicine exams can perform exams at the hub site. Only registered nurses trained to assist in telemedicine exams can participate in the CPT medical exam at the remote site. All persons at remote site must act under the direct supervision of the telemedicine physician or physician extender.
Referral Method	• Assume reports from Child Protective Services precede assessment
Outcomes	• To our knowledge, no study has evaluated the child and non-offending caregivers' satisfaction with telemedicine for child abuse evaluations. However, child and parent satisfaction with telemedicine utilized by other medical subspecialties has been promising.
Contacts	• https://cpt.pediatrics.med.ufl.edu/contact-us/
References	• **Arnold, 2013,** Telemedicine: Reducing Trauma in Evaluating Abuse (LINK) • **Casey Family Programs, JULY 14, 2020.** How can child protection agencies use telehealth to increase service access for children and families? (LINK)
Related Web Links	• Child Protection Team, University of Florida: https://cpt.pediatrics.med.ufl.edu/about-us/ ○ Services: https://cpt.pediatrics.med.ufl.edu/our-services/ • https://melniklegal.com/programs/weblog.cgi?showpage=1401115424_Telemedicine • https://mtelehealth.com/wp-content/uploads/2020/10/State-Telehealth-Laws-and-Reimbursement-Policies-Fall-2020-Florida.pdf

Data Extraction - Promising Programs

The programs listed in this section did not meet important inclusion criteria but may contain some features of interest.

eConnect, Simon Fraser University, British Columbia (Canada & International Jurisdictions)

Program Name	**eConnect (LINK)**
Jurisdiction	• Initially developed with rural BC in mind • Our international network for the eConnect Online project has grown rapidly, with new sites in Mexico and South Africa ready to implement the intervention, along with our existing international implementation sites in Sweden, Italy, and Australia. Phase 2 of the project could involve further expansion of the program to the US and the UK.
Brief Program Description	• The eConnect Online program is an adaptation that builds on the strong evidence of the broadly implemented in-person Connect program. We have adapted the program to be delivered online using a secure videoconferencing platform. This supports caregivers from different locations to come together online for highly interactive and engaging sessions with group facilitators and other caregivers, in real-time to learn about attachment and to practice how to apply this understanding to challenges they experience in their own families every day. • eConnect Online is part of a research initiative at Simon Fraser University. As such, program evaluation on the training experience, implementation experience and client outcomes is an integral part of the project. Both service providers who receive the training and caregivers who enrol in future eConnect Online groups will be asked to participate in the research project. Participation is voluntary • Regular Connect program description: Connect is a 10-week program to support parents and caregivers of pre-teens and teens with behavioural and emotional problems. Parents meet in small groups with two trained group leaders for 90 minutes each week. Each session provides parents with a new perspective on parent-teen relationships and adolescent development. Parents watch role-plays and try exercises that encourage more choices for responding to their teens' difficult behaviour.
Program Goals	• The development of this program began with the goal of bringing our evidence-based program to families with at-risk teens in rural communities and small towns in BC who do not have sustainable access to the program in-person. However, with the spread of COVID-19 limiting face-to-face contact, we have been working hard to expedite the development of eConnect Online to address the urgent need for accessible mental health interventions for vulnerable youth and families. We are also working on revising the content of Connect to target specific COVID-19 stressors, while still retaining the core attachment- and trauma-focused principles underlying Connect's success across cultures and populations over the past two decades. Our goal is to mitigate the short-term and long-term negative consequences of COVID-19 for vulnerable teens and families during this stressful time.
Program Components	• 10 session virtual parent group that addresses the unique challenges faced by teens and their families by improving attachment security

Program Delivery	• Videoconferencing platform
	• Caregivers join the group from their own home
	• Each group can accommodate 6-8 households (up to 2 caregivers per household)
	• Note: There is an alternative hybrid version of eConnect Online where small groups of caregivers join the group from satellite sites in their community.
	• Equipment and Resource requirements for staff
	  ○ Stable internet (min of 1.5 Mps for upload and download)
	  ○ Windows or Mac computers with webcam (one for the tech facilitator, one or two for the group facilitators)

	○ Speaker and microphone (built-in speaker and microphone in the computer are sufficient, but wireless headphones/earphones are recommended) ○ One Pro Zoom account or Zoom for Healthcare account* ▪ * If your agency requires the use of an alternative videoconferencing platform, please contact us to obtain the documents needed to evaluation the fit of your videoconferencing platform with eConnect Online. • Requirements for caregivers to join ○ Willingness to receive videoconferencing-based services ○ Availability to attend all group sessions ○ Ability to join the group privately and safely ○ Stable internet (a minimum of 1.5 Mps for upload and download) ○ Access to a computer with a webcam ○ A pair of earphones or headphones are recommended Duration • No info on duration of eConnect but regular program suggests 1.5hrs a week so likely the same.
Service Users	eConnect ○ Vulnerable Teens and their families Regular Connect • Parents/caregivers of pre-teens (8-12) and teens (13-17)
Service Providers	• 3 staff are required to run eConnect Online group ○ 2 act as group facilitators ○ One acts as the tech facilitator ○ All are required to complete eConnect Online training prior to running groups Training • Certified Connect Facilitator best suited to receive the top-up training to be certified to run eConnect Online groups as group facilitators. The top-up training includes: ○ A half-day workshop on eConnect Online ○ Completion of an online tech training module ○ Reading relevant program and training materials, including the flip-chart templates that will be provided as part of the program ○ Demonstration of competence via a partial mock run session ○ Completing supervision sessions for 2-3 group sessions, which involves reviewing recordings of the group sessions • Experienced child and youth clinicians without prior training in Connect are eligible to receive the full training in eConnect Online. This includes: ○ A three-day Connect facilitator training workshop ○ A half-day workshop on eConnect Online

	○ Completion of an online tech training module ○ Reading relevant program and training materials, including the flip-chart templates that will be provided as part of the program ○ Demonstration of competence via a partial mock run session ○ Recording every group session for one or more ○ eConnect Online groups and reviewing the recordings ○ Weekly supervision sessions with a Connect supervisor who has experience with eConnect Online ○ Facilitators with less experience in running Connect groups (in-person or online) are required to run their first eConnect Online group with a certified eConnect ○ Online facilitator or with a seasoned Connect facilitator. • Tech facilitator eligibility and training ○ Be tech competent and familiar with common computer applications and functions ○ Have the ability to listen to parent responses and type them up at an adequate speed ○ Have the ability to monitor multiple sources of input (facilitator requests, parent responses, text messages etc) at once and respond as appropriate ○ Have training or experience in the field of child/adolescent/family mental health and be familiar with interventions and the importance of communication, rapport and group processes • Ideally, the tech facilitator will have completed the three-day Connect facilitator training workshop. If not, they will be required to complete one. Other training components include a half-day workshop on eConnect Online, completion of an online tech training module, thorough review of program materials, one-on-one consultation sessions with certified tech facilitator prior to group, shadowing certified tech facilitator in group and engage in supervised tech facilitator work as required for certification.
Referral Method	• Not clear but state that Connect is available throughout British Columbia through mental health clinicians and social services in your community or through your schools. Access to the program is free of charge when offered by these agencies to their clients.
Outcomes	**eConnect Online** • Treatment outcomes associated with eConnect Online are currently being evaluated around the world **Regular in-person Connect Program** • Parents: Parents that complete the evaluation for Connect report that they feel more competent and effective in parenting and improvements in mood and decreases in levels of strain are seen. • Children: Parents report improvements in children's functioning; See decreases in internalizing problems (e.g., anxiety) and externalizing problems (e.g., conduct disorder).
Contacts	• Currently running the pilot group for eConnect Online. If your agency is interested in running eConnect Online groups, please download the information package here to learn about the program requirements and training components. For inquiry within BC, please contact Lesley Nicholas-Beck at Lesley.NicholasBeck@gov.bc.ca ; For inquiry outside of BC or Canada, please contact Lin Bao at lin_bao@sfu.ca .
References	• List of Research from Connect Programs: http://connectattachmentprograms.org/research/

	○ Ozturk, Y., Moretti, M., & Barone, L. (2019). Addressing parental stress and adolescents' behavioral problems through an attachment-based program: An intervention study. International Journal of Psychology & Psychological Therapy, 19(1), 89-100. (LINK)
Related Web Links	• eConnect Online: http://connectattachmentprograms.org/connect-online/ • eConnect Online, eConnect Online at home Information package (LINK) • Regular Connect Program ○ Connect brochure (regular program) (LINK) ○ California Evidence-Based Clearinghouse for Child Welfare, Connect: An Attachment-Based Program for Parents and Caregivers (LINK)

Family Partner™ & E-partner™, Finland

Program Name	Family Partner™ (LINK)
Jurisdiction	• Finland
Brief Program Description	• Intended for families in great need who have not benefited from the service they have received. Service is based in Helsinki, Varkaus, Vantaa, Finland, Lohja and Kemiönsaari. • E-partner™ provides support to families remotely after the end of more intensive support provided by the Family Partner™ service.
Program Goals	**Family Partner™** • helps families with the support that works best for individual challenges. The service provides information on changes in family well-being. • works with the family to find the root causes of the problems and creates a comprehensive support plan based on the needs of the family. **e-partner ™** • supports the whole family in maintaining the well-being already achieved and guides the families to find the right services. • Families receive support, guidance and counseling centrally from one person who supports them
Program Components	**Family Partner™** • The family only has access to services that benefit them. • The family's confidence in the help available is strengthened. • The resources and well-being of families are increasing. • The family gets the right kind of help. • Families feel that they are heard and they are active actors in their own lives. **e-PartnerTM** • Families' own ability to act in everyday life is strengthened. • Families receive support, guidance and counseling centrally from one person who supports them. • The family is helped to find the right services.

	• Through the e-partner ™ service, families can take advantage of the remote support package in SIB programs on a family-oriented website. The site contains links that benefit families with children, current information for families with children and the Material Bank. Families also have the opportunity to participate in peer-to-peer group chats.
Program Delivery	**Family Partner™** • Depends on services needed by individual families for Families **e-partner ™ service** • families can take advantage of the remote support package in SIB programs on a family-oriented website • site contains links that benefit families with children, current information for families with children and the Material Bank. Families also have the opportunity to participate in peer-to-peer group chats.
Service Users	• intended, for example, for families in great need who have not benefited from the support they have received.
Service Providers	• Not clear
Referral Method	• Not clear
Outcomes	**Family Partner™** • well-being of families increased by 18% • Families rated their life situation as improved • A holistic, family-friendly way to work effectively saves social costs.
Contacts	• Managing Director of SOS Lapsikyla Mikaela Westergård 044 761 4157 mikaela.westergard@sos-lapsikyla.fi
References	• Not clear on website
Related Web Links	• Not clear on website

iComet/iKomet, City of Stockholm and Karolinska Institutet, Sweden

Program Name	**iComet/iKomet (LINK) – Online version is 7 sessions**
Jurisdiction	• Sweden
Brief Program Description	• iKomet has been developed by the City of Stockholm and Karolinska Institutet as an Internet-based version of Komet for parents with children ages 3-11 years . The program extends over 10 weeks. The sections contain information in the form of text, films and questions as well as exercises and planning to help parents in everyday life. • It is an adaptation of a Swedish Parent Management Training program (Comet) based on social learning theory/ cognitive-behavior therapy
Program Goals	• Focuses on parenting skills such as positive behavior support, communication, problem solving and parents' management of their own dysfunctional emotions

Program Components	• The course consists of 7 sections that take about 1-1.5 hours to go through at a time. In total, they work with iKomet for 10 weeks. The sections contain information in the form of text, films and questions as well as exercises and planning to help parents in everyday life.
	• Overview of the content of the program ...
	  ○ Section 1 - Socializing and Attention
	  ○ Section 2 - Preparation and Calls
	  ○ Section 3 - Encouragement
	  ○ Section 4 - Routines and responsibilities
	  ○ Section 5 - Choose battles
	  ○ Section 6 - Troubleshooting
	  ○ Section 7 - Rules and emergency brake
	  ○ The follow-up section - How do you make changes last in the long run?
	• The major themes covered: positive parenting, communication, positive reinforcement, while response-cost of problematic child behavior is given less attention

Program Delivery	• Internet based course with 7 sections that take about 1-1.5 hrs. = about 10 weeks • The iComet is provided individually to parents with fewer sessions (7 sessions) compared to Comet (11 sessions) that is implemented in group-format • The iComet is a 7-session parent training program, delivered through a secure website under 10 weeks. The program contains text, videos of interactions between a parent and a child, illustrations, and multiple-choice questions about the content of each session. Parents received immediate feedback by the program as to whether the answers they provided were right or wrong, by means of reinforcing statements and explanations. The interaction scenes illustrated both nurturing parent/child interactions with positive reinforcement and positive parenting skills, as well as less optimal interactions. The aim in scenes with less optimal interactions was to stimulate the parents to reflect on what could have been done differently. Each session on the Internet took about 1.5h to complete for the parent
Service Users	• Has been tested in research for parents with children aged 3 to 11 years and also 10 -13
Service Providers	• Therapist
Referral Method	• Not clear, seems to be part of research to see if an online version of the Comet/Komet program in Sweden can be adapted to online version so unsure if this is set. For example in one study families with children ages 10-13 living in different city areas in Gothenburg were invited to participate in one study (Bjornsdotter, 2020). Another study examined families with children 3-12 (Enebrink, 2012). • Regular Comet program is administered by the Stockholm Social Services Administration
Outcomes	**From Ghaderi, 2018** • To conclude, this effectiveness trial of FCU and iComet showed that both parenting programs reduced child conduct problem behaviors, as well as inattention, impulsivity and hyperactivity problems. The parent ratings also showed that peer problems and emotional symptoms decreased and prosocial behaviors increased from pre- to post-treatment assessment. These improvements were generally either retained or continued to improve to the 2-years follow-up. At the 2-years follow-up, the majority of the children had further decreased their conduct problem behaviors, and many of them had made a clinically significant change,

	particularly those in the FCU. The FCU and iComet might be employed in a stepped-care context, or depending on family interests and possibility for participating in face-to-face or internet-based treatments.
Contacts	• Probably the researchers involved in these studies
References	• **Bjornsdotter, 2020,** Cluster Analysis of Child Externalizing and Prosocial Behaviors in a Randomized Effectiveness Trial of the Family-Check Up and Internet-Delivered Parent Training (iComet) (LINK) • **Ghaderi, 2018,** Randomized effectiveness Trial of the Family Check-Up versus Internet-delivered Parent Training (iComet) for Families of Children with Conduct Problems (LINK) • **Enebrink,** 2012, Internet-based parent management training: a randomized controlled study (LINK) • Full list of Randomized Controlled Trial of Comet Via the Internet or in Group Format. https://clinicaltrials.gov/ct2/show/NCT03465384
Related Web Links	• https://ki.se/en/research/parent-support-in-focus-a-coherent-national-approach-is-required • https://www.ipsykologi.se/ikometinfo

Appendix B:
Other References and Sources

Below are a list of references from journal articles and organizations that relate to virtual program delivery. We also include a list of relevant websites. Please refer to the data extraction tables in Appendix A for specific references for the programs we included in the report.

Journal Articles

Alfredsson, 2018, Parenting programs during adolescence: Outcomes from universal and targeted interventions offered in real-world settings (LINK)

Breitenstein, 2014, Digital Delivery Methods of Parenting (LINK)

Corralejo, 2018, Technology in Parenting Programs: A Systematic Review of Existing Interventions (LINK)

Cross-Technology Transfer Center (TTC) Workgroup on Virtual Learning, 2021, Virtual reality for behavioral health workforce development in the era of COVID-19 (LINK)

Dodge, 2019, Universal Reach at Birth: Family Connects (LINK)

Flannery, 2021, Digital-Based Parent Intervention Randomized Control Trial Meta-Analysis and Systematic Review (LINK)

Levine, 2020, Child safety, protection, and safeguarding in the time of COVID-19 in Great Britain: Proposing a conceptual framework (LINK)

Marshall, 2020, Statewide Implementation of Virtual Perinatal Home Visiting During COVID-19 (LINK)

Ondersma, **2017,** Technology to Augment Early Home Visitation for Child Maltreatment Prevention: A Pragmatic Randomized Trial (LINK)

Posick, 2020, Child Victim Services in the Time of COVID-19: New Challenges and Innovative Solutions (LINK)

Racine, 2020, Telemental health for child trauma treatment during and post-COVID-19: Limitations and considerations (LINK)

Richards, 2020, Virtual Communities of Practice in Child Welfare: A Review of the Literature (LINK)

Ros-DeMarize, 2021, Pediatric behavioral telehealth in the age of COVID-19: Brief evidence review and practice considerations (LINK)

Singer, 2020, Virtual parent-child visitation in support of family reunification in the time of COVID-19 (LINK)

Thongseiratch, 2020, Online parent programs for children's behavioral problems: A meta-analytic review (LINK)

Traube, 2020, Telehealth Training and Provider Experience of Delivering Behavioral Health Services (LINK)

Children with Autism

Colombo, 2020, An Essential Service Decision Model for ABA Providers During Crisis (LINK)

Gerow, 2021, Parent-implemented brief functional analysis and treatment with coaching via telehealth (LINK)

Rodriguez, 2020, Maintaining Treatment Integrity in the Face of Crisis: A Treatment Selection Model for Transitioning Direct ABA Services to Telehealth (LINK)

Romani, 2018, Ethical Considerations When Delivering Behavior Analytic Services for Problem Behavior via Telehealth (LINK)

Schieltz, 2020, Functional assessment and function-based treatment delivered via telehealth: A brief summary **(**LINK**)**

Tomlinson, 2018, Training Individuals to Implement Applied Behavior Analytic Procedures via Telehealth: A Systematic Review of the Literature (LINK)

Tsami, 2019, Effectiveness and acceptability of parent training via telehealth among families around the world (LINK)

Organizational Reports/Articles

Baginsky, 2020, Child protection conference practice during COVID-19: reflections and experiences (rapid consultation September-October 2020). London: Nuffield Family Justice Observatory (LINK)

Canadian Medical Association, 2019, Virtual Care in Canada: Discussion paper (LINK)

Casey Family Programs

- **Casey Family Programs, December 15 2020,** How can child welfare systems support families in rural communities? (LINK)
- **Casey Family Programs, October 2020,** What do we know about services administered virtually? (LINK)
- **Casey Family Programs, July 14 2020,** How can child protection agencies use telehealth to increase service access for children and families? **(LINK)**
- **Casey Family Programs, July 14 2020,** Where can child protection leaders learn more about implementing telehealth for behavioral health services? (LINK)

Centre for Surveillance and Applied Research, Public Health Agency of Canada, 2020, Child Maltreatment Surveillance Indicator Framework (CMSIF) Data Tool, 2020 Edition (LINK)

Child Welfare Information Gateway, 2018, Issue Brief – Rural Child Welfare Practice (LINK)

Gaffney, 2021, Parenting Programmes Toolkit technical report. Campbell Collaboration (LINK)

Ghiara, 2020, Reducing parental conflict in the context of Covid-19: Adapting to virtual and digital provision of support**.** Early Intervention Foundation (LINK)

Harker, 2020, Should virtual child protection conferences become the new normal? (LINK)

HIPPY USA, 2021, Best Practice Guidance for Virtual Operations for Home Visiting in Response to the Coronavirus Pandemic (LINK)

Joshi, 2021, The use of telepractice in the family and relationships sector. Australian Institute of Family Studies (LINK)

LaMendola, 2011, CW 360: Child Welfare and Technology. Center for Advanced Studies in Child Welfare, School of Social Work, University of Minnesota (LINK)

Martin, 2020, Covid-19 and early intervention: Evidence, challenges and risks relating to virtual and digital delivery. Early Intervention Foundation. London, UK (LINK)

Milne, 2020, Translating Knowledge for Child Welfare Organizations Across the Prairies: Managing the Impacts of COVID-19 on the Mental Health of Children, Families, and Workers Canadian Institutes for Health Research Rapid Response Knowledge Synthesis (LINK)

Morrison, 2021, Engaging families in home visiting: Perspectives from the field, National Home Visiting Resource Center Data in Action Brief (LINK)

National Collaborating Centre for Determinants of Health, 2009, Pan-Canadian Inventory of Public Health Early Child Home Visiting (LINK)

National Home Visiting Resource Center, 2017, Technology in Home Visiting: Strengthening Service Delivery and Professional Development Using Virtual Tools (LINK)

Rural Health Information Hub

- **Rural Health Information Hub, 2018,** Telehealth Models for Increasing Access to Behavioral and Mental Health Treatment (LINK)
- **Rural Health Information Hub, 2019,** Barriers to Telehealth in Rural Areas (LINK)
- **Rural Health Information Hub, 2019,** Rural Health ToolKit (Telehealth) (LINK)
- **Rural Health Information Hub, 2019,** Telehealth Use in Rural Healthcare (LINK)

Shea Crowne, 2021, Findings from the First 5 California Home Visiting Workforce Study (LINK)

Sistovaris, 2020, Child Welfare and Pandemics, Fraser Mustard Institute of Human Development, University of Toronto (LINK)

Supplee, 2020, During the COVID-19 pandemic, telehealth can help connect home visiting services to families, Child Trends (LINK)

Tomer, 2020, Digital prosperity: How broadband can deliver health and equity to all communities (LINK)

Websites

California Evidence-Based Clearinghouse for Child Welfare (LINK)

Canadian Child Welfare Research Portal (LINK)

Casey Family Programs (LINK)

Center for Child & Family Health (LINK)

Child Development Institute (LINK)

Children's Health Policy Centre (LINK)

Child Welfare Information Gateway (LINK)

Early Intervention Foundation (LINK)

European Commission Employment, Social Affairs & Inclusion (LINK)

Evidence Based Practices (European Platform for Investing in Children) (LINK)

Home Visiting Evidence of Effectiveness (U.S. Department of Health & Human Services) HomVEE (LINK)

Institute for the Advancement of Family Support Professionals, Rapid Response Virtual Home Visiting (LINK)

National Alliance of Home Visiting Models (LINK)

National Home Visiting Resource Center (LINK)

Nuffield Family Justice Observatory (LINK)

Oregon Social Learning Center (LINK)

Quality Improvement Center for Adoption & Guardianship Support and Preservation, Intervention and Program Catalog (LINK)

Rural Health Information Hub (LINK)

References

1. Government of Newfoundland and Labrador. Welcome to Children, Seniors and Social Development [Internet]. Children, Seniors and Social Development. [cited 2021 Sep 10]. Available from: https://www.gov.nl.ca/cssd/

2. Public Health Agency of Canada. Child Maltreatment in Canada [Internet]. 2012 [cited 2021 Sep 10]. Available from: https://www.canada.ca/en/public-health/services/health-promotion/stop-family-violence/prevention-resource-centre/children/child-maltreatment-canada.html