

Non-Pharmacological Interventions Shown to be Effective in Valid Clinical Trials, Corresponding to Difficulties Suggested By BCFPI Profiles

- The following interventions were located in literature reviews, where they were found to be *probably efficacious* or *well established*.

The criteria for these categories (*probably efficacious* or *well established*) are listed in the special issues of the Journal of Consulting and Clinical Psychology, Journal of Abnormal Child Psychology, or the Journal of Clinical Child Psychology.

- Each of the summaries presented below has been reviewed by a team at least one recognized researcher in the field, one clinician, and one clinic administrator.
- In addition to being efficacious or well-established, interventions needed to be feasibly replicable, based on being described in manuals, accessible to readers, who can implement the described intervention, based on information provided in its manual.

To quickly locate an intervention for a given BCFPI concern, for a child or youth in a particular age group:

- Scan the 2nd column in the table below to find domain(s) whose scores are 70 or above on the BCFPI profile;
- Scan the age columns for the desired domain, to find those encompassing the subject child's;
- Click on the number in the column below to go directly to the desired intervention in this document.
- Review the description(s).
- Obtain further information, if desired, by clicking on the hot link(s) at the bottom of each description. They will take to related NLM abstracts or full articles regarding the cited intervention.



#	BCFPI score => 70 in...	Min age	Max age	M F B(oth)
13	Cooperation	3.0	7.0	B
15	Conduct and Cooperation	11.0	19.0	B
12	Conduct	12.0	19.0	B
14	Conduct and Cooperation	3.0	5.0	B
22	Conduct and Cooperation	12.0	18.0	B
5	Cooperation and Conduct	3.0	9.0	B
11	Cooperation and Conduct	3.0	7.0	B
4	Cooperation and Conduct	7.0	15.0	B
6	Managing Anxiety and Separation from Parents	8.0	15.0	B
16	Managing Anxiety and Separation from Parents	7.0	17.0	B
17	Managing Anxiety and Separation from Parents	8.0	13.0	B
18	Managing Anxiety and Separation from Parents	6.0	11.0	B
19	Separation from Parents and School Refusal	5.0	16.0	B
20	Separation from Parents and School Refusal	5.0	17.0	B
7	Managing Mood	9.0	14.0	B
10	Managing Mood	12.0	19.0	B
9	Managing Mood	14.0	19.0	B
8	Managing Mood	13.0	19.0	B
21	Managing Mood	10.0	18.0	B
2	Regulating Attention, Impulsivity, and Activity Level	3.0	12.0	B
3	Regulating Attention, Impulsivity, and Activity Level	5.0	13.0	B
1	Regulating Attention, Impulsivity, and Activity Level	7.0	9.0	B
23	Regulating Attention, Impulsivity, and Activity Level	12.0	18.0	B

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1 Regulating Attention, Impulsivity, and Activity Level

NOTE: The following services are listed as examples of the types of manualized evidence-based nonpharmacological interventions that might be considered if the problems noted in the Brief Child and Family Phone Interview are confirmed on clinical assessment. This does not represent an individualized service plan. An individualized service plan must be composed by a clinician who has completed a comprehensive assessment. Note this is not a comprehensive listing of evidence-based interventions. There are often several closely related versions of evidence-based interventions that may yield similar outcomes. These interventions require training, manuals, and expertise in each area. They are not successful with all children, may not result in complete problem resolution, and must often be combined with other services.

BCFPI Area of Concern	Regulation of attention, impulsivity, and activity level.	
Intervention Modality	Stimulant Medication (methylphenidate)	
Goal of Intervention	Improve the regulation of attention, overactivity, and impulse control	
Description of Intervention	Individually titrated doses of methylphenidate or alternative medications administered 3x daily.	
Age Group	7 to 9	This item is excluded from current sets of reports, in that it is a pharmacological
Efficacy of Intervention	Well Established	
Manual	Greenhill, L., Abikoff, H., Arnold, L.E., Cantwell, D.P., Conners, C.K., Elliot, G., Hechtman, L., Hinshaw, S.P., Hoza, B., Jensen, P.S., March, J.S., Newcorn, J., Pelham, W.E., Severe, J.B., Swanson, J.M., Vitiello, B., & Wells, K. (1996). Medication treatment strategies in the MTA: Relevance to clinicians and researchers. <u>Journal of the American Academy of Child and Adolescent Psychiatry</u> , 35, 444-454. http://tinyurl.com/jjjug	
Selected Outcome Studies & Hot Links	Conners, C., Epstein, J., March, J., Angold, A., Wells, K., Klaric, J., Swanson, J., Arnold, L., Abikoff, H., Elliott, G., Greenhill, L., Hechtman, L., Hinshaw, S., Hoza, B., Jensen, P., Kraemer, H., Newcorn, J., Pelham, W., Severe, J., Vitiello, B., & Wigal, T. (2001). Multimodal treatment of ADHD in the MTA: An alternative outcome analysis. <u>Journal of the American Academy of Child and Adolescent Psychiatry</u> , 40, 159-167. http://tinyurl.com/fg6zg MTA Cooperative Group (1999). 14-Month randomized clinical trial of treatment strategies for attention deficit hyperactivity disorder. <u>Archives of General Psychiatry</u> , 56, 1073-1086. http://tinyurl.com/hovvx	
		Item ID#: 1:drop

2 Regulating Attention, Impulsivity, and Activity Level

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BCFPI Area of concern	Regulation of Attention, Impulsivity, and Activity Level	
Intervention Modality	Parent Training	
Goal	Improve parenting skill; Reduce parental stress; Improve the regulation of attention, impulsivity and activity level	
Description	Individual (1 hour) or group sessions (2-2.5 hours) using discussion, modeling, role playing, and homework projects help parents develop and use more effective interaction and child management strategies. The program typically includes 9 to 12 weekly sessions with groups of 6 to 10 families. A small number of individual in-clinic sessions with the child may also be incorporated.	
Age Group	Preschool to age 11 years	
Efficacy of Intervention	Well Established	
Manual	Barkley, R. A. (1997). <u>Defiant children: A clinician's manual for assessment and parent training</u> . 2 nd Edition. New York: Guilford. -Available at Chapters.Indigo.ca (http://tinyurl.com/cte2j). Approx. cost (Sept 2006) \$47.95	
Selected Outcome Studies & Hot Links	Anastopoulos, A. D., Shelton, T. L., DuPaul, G. J., Guevremont, D. C (1993). Parent training for attention deficit hyperactivity disorder. Its impact on parent functioning. <u>Abnormal Child Psychology</u> , 21, 581-596. http://tinyurl.com/epg79 Pisterman, S., McGrath, P., Firestone, P., Goodman, J. T., Webster, I. & Mallory, R. (1989). Outcome of parent-mediated treatment of preschoolers with attention deficit disorder with hyperactivity. <u>Journal of Consulting and Clinical Psychology</u> , 57, 636-643. http://tinyurl.com/k9s77	
		Item ID#: 2

3 Regulating Attention, Impulsivity, and Activity Level

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BCFPI Area of Concern	Regulation of attention, impulsivity, and activity level.
Intervention Modality	Classroom Behaviour Management
Goal of Intervention	Improve the regulation of attention, overactivity, and impulse control
Description	Classroom management strategies focus on teaching children a set of skills and adaptive behaviours to replace problem behaviours. The program targets academic performance, and common problem situations (e.g., transition times or on-task behaviour). Proactive strategies include displaying classroom rules or rule-prompts as visual reminders, instructional modifications, workload adjustment, and peer tutoring (e.g., match child with a study mate for academic tutoring; can include a point system and reversal of tutor/tutee roles). Frequent, immediate consequences for behaviours and incentives with sufficient reinforcement value assist the child in adhering to classroom rules. Effective consequences include token reinforcement (i.e., child earns special privileges/activities based on meeting identified behaviour goals), response cost (i.e., loss of privileges/reinforcers as consequence of inappropriate behaviour), and self-management strategies designed to improve self-control (e.g., self-monitoring, self-reinforcement, self-instruction & problem solving approaches).
Age Group	ages 5 to 12 years
Efficacy of Intervention	Well Established
Manual	DuPaul, G. J., & Stoner, G. (2003). <u>ADHD in the schools: Assessment and intervention strategies</u> . 2 nd Edition. New York: Guilford Press. -Available through Guilford Press (http://tinyurl.com/c4udh). Approx. cost (Sept 2006): paperback (Oct., 2004) \$28.00US; hardcover (Mar., 2003) \$48.00US
Selected Outcome Studies & Hot Links	Hoffman, J. B. & DuPaul, G. J. (2000). Psychoeducational interventions for children and adolescents with attention-deficit hyperactivity disorder. <u>Child and Adolescent Psychiatry Clinics of North America</u> , 9, 647-661. http://tinyurl.com/hvbzq Pelham, W. E., Wheeler, R. Chronis, A. (1998). Empirically supported psychosocial treatments for attention deficit disorder. <u>Journal of Clinical Child Psychology</u> , 27, 190-205. http://tinyurl.com/lyfld
Item ID#: 3	

4 Cooperation and Conduct

NOTE: The following services are listed as examples of the types of manualized evidence-based nonpharmacological interventions that might be considered if the problems noted in the Brief Child and Family Phone Interview are confirmed on clinical assessment. This does not represent an individualized service plan. An individualized service plan must be composed by a clinician who has completed a comprehensive assessment. Note this is not a comprehensive listing of evidence-based interventions. There are often several closely related versions of evidence-based interventions that may yield similar outcomes. These interventions require training, manuals, and expertise in each area. They are not successful with all children, may not result in complete problem resolution, and must often be combined with other services.

BCFPI Area of Concern	Cooperation & Conduct	
Intervention Modality	Child-Focused Problem-Solving Skills Training & Behavioural Parent Training	
Goal of Intervention	Improve problem solving skills; Improve parental contingent management strategies; Decrease maternal stress; Improve family functioning; Improve child's functioning at home, school, and in the community; Reduce child's antisocial behaviour	
Description	<p>Child Problem-Solving Skills Training: Child training consists of 20 weekly 40-50 minute sessions. Parents join occasional sessions to learn the steps and develop skills as a problem-solving coach. Child intervention focuses on the development of five problem-solving steps through self-statements, e.g., identification/ defining the problem ("What am I supposed to do?"). Children use problem-solving steps to generate and enact solutions to a range of interpersonal problems or situations. Treatment incorporates in-session therapist modeling of steps, role-playing, and a response-cost token reinforcement system. Between sessions children complete homework assignments practicing the application of problem-solving skills in everyday situations.</p> <p>Parent Management Training: Parent training consists of 16, 1 to 2 hour sessions focusing on the development of behaviour change skills and child management strategies that can be used at home and school. Parents are taught specific strategies (e.g., positive reinforcement) using therapist modeling and role-playing. The program can be tailored to the needs of each family. School personnel identify and monitor problems at school and parents deliver home-based consequences.</p>	
Age Group	ages 7 to 14 years	
Efficacy of Intervention	Probably Efficacious	
Manual	<p>Kazdin, A.E. (2005). <u>Parent Management Training. Treatment for Oppositional, Aggressive and Antisocial Behavior in Children and Adolescents</u>. Oxford University Press, USA</p> <p>-Available at Chapters.Indigo.ca (http://tinyurl.com/ck2ll) Approx. cost (Sept 2006): \$79.50</p>	
Selected Outcome Studies & Hot Links	<p>Kazdin, A., Esveldt-Dawson, K., French, N.H., & Unis, A.S. (1987). Effects of parent management training and problem-solving skills training combined in the treatment of antisocial child behaviour. <u>Journal of The American Academy of Child & Adolescent Psychiatry</u>, <i>26</i>, 416-424. http://tinyurl.com/evss2</p> <p>Kazdin, A., Siegel, T.C., & Bass, D. (1992). Cognitive problem solving training and parent management training in the treatment of antisocial behaviour in children. <u>Journal of Consulting and Clinical Psychology</u>, <i>60</i>, 733-747. http://tinyurl.com/z7ffg</p>	
		Item ID#: 4

5 Cooperation and Conduct

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BCFPI Area of Concern	Cooperation & Conduct	
Intervention Modality	Group-Based Parent Training, Child Training and Teacher Training; Video Modeling	
Goal of Intervention	Improve child management strategies; Increase positive family communication and problem solving skills; Reduce conduct problems at home and school; Improve child's problem solving skills & social and emotional skills; Increase collaboration between parents & teachers	
Description	<p>Video-modeling - Participants view videotaped examples of interactions that promote prosocial behaviour and decrease inappropriate behaviour.</p> <p>Parent Training: The BASIC & ADVANCE parent training program consists of 22 to 24 weekly 2 hour sessions, conducted by 2 therapists with 10 –12 parents. Programs focus on play involvement, praise and rewards, limit setting, discipline, anger management, communication, problem solving, and giving or receiving support.</p> <p>Child Training: The 20-22 week Dina Dinosaur child training intervention is typically conducted in conjunction with the parent group. In 2-hour sessions, 2 therapists work with a group of 6 children. Child training uses video-modeling & imaginary play to improve social skills, problem-solving skills, anger management, and classroom behaviour (e.g., compliance, listening).</p> <p>Teacher Training: Teacher training focuses on praise, rewards & consequences, proactive classroom strategies & communication skills.</p>	
Age	ages 3 to 8 years	
Efficacy of Intervention	Well Established	
Manual	<p>Parent Skills Training Videotape Modeling Program Approximate cost (Sept 2006):</p> <ul style="list-style-type: none"> - BASIC (ages 2-7) Programs 1-4 \$1300 US; - ADVANCE (ages 4-10) Programs 5-7 \$775 US; - SCHOOL AGE (ages 5-12) Programs 8-10 \$995 US - BASIC & ADVANCE Programs 1-7 \$1800 US; <li style="padding-left: 40px;">Programs 1-10 \$2695 US <p>Dina Dinosaur Child Training Program (ages 4-8) Programs 1-6 \$975 U.S Teacher Classroom Management Training Programs (ages 4-10) Programs 1-5 \$975 US</p> <p>-Available through www.incredibleyears.com</p>	
Selected Outcome Studies & Hot Links	<p>Webster-Stratton, C., Reid, M.J., & Hammond, M.. (2004). Treating children with early-onset conduct problems: intervention outcomes for parent, child and teacher training. <u>Journal of Clinical Child and Adolescent Psychology</u>, 33, 1, 105-124. http://tinyurl.com/hzja7</p> <p>Webster-Stratton, C. & Hammond, M. (1997). Treating children with early-onset conduct problems: A comparison of child and parent training interventions. <u>Journal of Consulting and Clinical Psychology</u>, 65, 93-109. http://tinyurl.com/k3fje</p>	
	Item ID#: 5	

6 Managing Anxiety and Separation from Parents

NOTE: The following services are listed as examples of the types of manualized evidence-based nonpharmacological interventions that might be considered if the problems noted in the Brief Child and Family Phone Interview are confirmed on clinical assessment. This does not represent an individualized service plan. An individualized service plan must be composed by a clinician who has completed a comprehensive assessment. Note this is not a comprehensive listing of evidence-based interventions. There are often several closely related versions of evidence-based interventions that may yield similar outcomes. These interventions require training, manuals, and expertise in each area. They are not successful with all children, may not result in complete problem resolution, and must often be combined with other services.

BCFPI Area of Concern	Managing Anxiety and Separation from Parents
Intervention Modality	Cognitive Behavioural Therapy (CBT): 'Coping Cat' Program individual or group treatment program
Goal	Reduce anxious avoidant behavior by improving problem solving skills, teaching relaxation skills, restructuring anxious cognitions, and teaching children to master increasingly anxious situations (exposure).
Description	The 18-session 'Coping Cat' program treats anxious children and young adolescents. 1 to 1.5 hour sessions are conducted in either a group or individual format. When offering the program in a group format, single-gender groups of approximately 3-5 children are recommended. The intervention integrates behavioral strategies (e.g., relaxation training, exposure, role plays, modeling, & contingent reinforcement) with cognitive approaches (e.g., cognitive restructuring, developing coping self talk & actions, & problem solving skills). Children use the 'Coping Cat Notebook & Workbook' to facilitate their learning.
Age group	ages 8 to 14
Efficacy of Intervention	Well Established
Manual	<p>Kendall, P. (2005). <u>Coping Cat Workbook & Notebook</u>. 2nd. Ed. Admore, PA: Workbook Publishing.</p> <p>Flannery-Schroeder, E. & Kendall, P. (1996). <u>Cognitive-Behavioral Therapy for Anxious Children</u> (Therapist Manual for Group Treatment). Admore, PA: Workbook Publishing.</p> <p>Kendall, P. (2005). <u>Cognitive-Behavioral Therapy for Anxious Children</u> (Therapist Manual) 3rd Ed. Admore, PA: Workbook Publishing. (individual program)</p> <p>-Workbook Publishing, Inc., online order form: http://www.workbookpublishing.com/form1.pdf</p> <p>-Canadian Distributors: Caversham, 1-800-361-6120 (416-944-0962) http://tinyurl.com/bhktv Approx. cost (Sept 2006) workbook \$34.50, therapist manual \$21.95</p>
Selected Outcome Studies & Hot Links	<p>Flannery-Schroeder, E., Choudhury, M. & Kendall, P. (2005). Group and individual cognitive-behavioral treatments for youth with anxiety disorders: 1 year follow-up. <u>Cognitive Therapy and Research</u>, 29, 2, 253-259.</p> <p>Flannery-Schroeder, E. & Kendall, P. (2000). Group and individual cognitive-behavioral treatments for youth with anxiety disorders: a randomized clinical trial. <u>Cognitive Therapy and Research</u>, 24, 3, 251-278. http://tinyurl.com/fam4k</p> <p>Flannery-Schroeder, E. Suveg, C., Safford, S., Kendall, P. and Webb, A. (2004). Comorbid externalizing disorders and child anxiety treatment outcomes. <u>Behavior Change</u>, 21, 1, 14-25. http://tinyurl.com/kh3yu</p> <p>Kendall, P. C., Flannery-Schroeder, Panichelli-Mindel, S.M., Southam-Gerow, M., Henin, A., & Warman, M. (1997). Therapy for youths with anxiety disorders: a second randomized clinical trial. <u>Journal of Consulting and Clinical Psychology</u>, 65, 3, 366-380. http://tinyurl.com/k9qb5</p> <p>Kendall, P. & Southam-Gerow, M. (1996). Long-term follow-up of a cognitive-behavioral therapy for anxiety-disordered youth. <u>Journal of Consulting and Clinical Psychology</u>, 64, 4, 724-30. http://tinyurl.com/jnleg</p>
	Item ID#: 6

7 Managing Mood

NOTE: The following services are listed as examples of the types of manualized evidence-based nonpharmacological interventions that might be considered if the problems noted in the Brief Child and Family Phone Interview are confirmed on clinical assessment. This does not represent an individualized service plan. An individualized service plan must be composed by a clinician who has completed a comprehensive assessment. Note this is not a comprehensive listing of evidence-based interventions. There are often several closely related versions of evidence-based interventions that may yield similar outcomes. These interventions require training, manuals, and expertise in each area. They are not successful with all children, may not result in complete problem resolution, and must often be combined with other services.

BCFPI Area of Concern	Managing mood
Intervention Modality	Cognitive Behavioural Therapy (CBT)
Goal of Intervention	Reduce depressive symptoms by improving problem solving and coping skills, increasing participation in positive activities, restructuring depressive cognitions, improving social skills, and increasing positive family activities.
Description	<p>The program includes 18 to 21 1-hour group sessions with 4 to 8 children and 2 therapists. The program uses discussion, role playing, modeling, and homework assignments to increase knowledge of the links between thoughts, activities, and emotions, develop problem solving skills, strengthen coping strategies, increase participation in activities that promote positive affect, and restructure depressive cognitions.</p> <p>A series of approximately 11 family meetings help parents assist their children in applying new skills and increasing positive family activities.</p>
Age Group	ages 9 to 13 years
Efficacy of Intervention	Well Established
Manual	<p>Stark, K. & Kendall, P. (1996). <u>Treating Depressed Children: Therapists Manual for ACTION</u>. Ardmore, PA: Workbook Publishing. (http://tinyurl.com/al2qh)</p> <p>Stark, K., Kendall, P. et al. (1996). <u>Taking Action: A Workbook for Overcoming Depression</u>. Ardmore, PA: Workbook Publishing. (http://tinyurl.com/cbkcl)</p> <p>Stark, K. (1990). <u>Childhood Depression: School-Based Intervention</u>. New York: Guilford. (http://tinyurl.com/dz99r)</p> <p>-Workbook Publishing, Inc., online order form: http://www.workbookpublishing.com/form1.pdf</p> <p>-Canadian distributors: Caversham 1-800-361-6120 (416-944-0962) Approx. cost (Sept 2006) therapist manual \$16.95, workbook \$29.50, school text \$35.95</p>
Selected Outcome Studies & Hot Links	<p>Stark, K., Reynolds, W., & Kaslow, N. (1987). A comparison of the relative efficacy of self control therapy and behavioural problem-solving therapy for depression in children. <u>Journal of Abnormal Child Psychology</u>, <i>15</i>, 91-113. http://tinyurl.com/kyjhe</p> <p>Stark, K., Rouse, L., & Livingston, R. (1991). Treatment of depression during childhood and adolescence: Cognitive-behavioral procedures for the individual and family. In P. Kendall (Ed.), <u>Child and Adolescent Therapy</u> (pp. 165-206). New York: Guilford.</p>
	Item ID#: 7

8 Managing Mood

NOTE: The following services are listed as examples of the types of manualized evidence-based nonpharmacological interventions that might be considered if the problems noted in the Brief Child and Family Phone Interview are confirmed on clinical assessment. This does not represent an individualized service plan. An individualized service plan must be composed by a clinician who has completed a comprehensive assessment. Note this is not a comprehensive listing of evidence-based interventions. There are often several closely related versions of evidence-based interventions that may yield similar outcomes. These interventions require training, manuals, and expertise in each area. They are not successful with all children, may not result in complete problem resolution, and must often be combined with other services.

BCFPI Area of Concern	Managing Mood
Intervention Modality	Cognitive Behavioural Therapy (CBT)
Goal of Intervention	Reduce symptoms of depression by developing problem-solving, affect regulation, and social skills
Description	An adolescent adaptation of Beck's adult cognitive-behavior therapy model. The program includes 12-16 individual treatment sessions in which adolescents learn to monitor and modify automatic thoughts, assumptions, and beliefs. Using concrete examples, the program teaches problem-solving, affect regulation, and social skills. Includes 3 family psychoeducation sessions dealing with affective disorders, treatment options, and parental questions regarding depression in adolescents.
Age Group	13-18
Efficacy of Intervention	Probably Efficacious
Manual	Cognitive Therapy Treatment Manual: For Depressed and Suicidal Youth. Jamey Covalleski, STAR-Center Outreach. -Order form: http://tinyurl.com/kllgp Approx. cost (Sept 2006) \$10.00 US
Selected Outcome Studies & Hot Links	Brent, D.A., Holder, D., Kolko, D., Birmaher, B., Baugher, M, Roth, C., Iyengar, S., & Johnson, B.A.. (1997). A clinical psychotherapy trial for adolescent depression comparing cognitive, family and supportive therapy. <i>Archives of General Psychiatry</i> , 54, 9, 877-885. http://tinyurl.com/kllgp
	Item ID#: 8

9 Managing Mood

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BCFPI Area of Concern	Managing mood
Intervention Modality	Cognitive Behavioural Therapy (CBT) 'Coping with Depression – Adolescent' ('CWD-A')
Goal of Intervention	Reduce depressive symptoms by increasing participation in positive activities, improving social relationships, reducing depressive cognitions, and improving parenting-child relationships
Description	<p>A multiple component intervention with a focus on experiential learning & skills training</p> <p>Adolescent sessions: CBT consists of 16 2 hour group sessions over 8 weeks with 4 to 8 adolescents per group. Sessions use discussion, role playing, modeling, and homework assignments to help adolescents understand the link between thoughts, activities, and emotions, increase participation in pleasant activities, help children develop alternatives to depressive cognitions, build relaxation skills, improve social competence, & develop negotiation & problem solving skills.</p> <p>Parent sessions: 8 2 hour sessions teach parents skills to reinforce their adolescent's adaptive changes, promote generalization of new adolescent skills, & support the maintenance of improvements.</p>
Age Group	ages 14 to 18 years
Efficacy of Intervention	Well Established
Manual	<p>Clarke, G., Lewinsohn, P. & Hops, H. (1990). <u>Instructor's Manual for the Adolescent Coping with Depression Course.</u> <u>Therapist Manual - Adolescent Coping with Depression Course</u> http://www.kpchr.org/public/acwd/CWDA_manual.pdf</p> <p>Lewinsohn, P., Rohde, P., Hops, H. & Clarke, G. (1991). <u>Instructor's manual for course for parents of adolescents enrolled in the adolescent coping with depression course.</u> <u>Therapist Manual – Group for Parents of Depressed Youth</u> http://www.kpchr.org/public/acwd/CWDA_parent_manual.pdf</p> <p><u>Teen Workbook - Adolescent Coping with Depression Course</u> http://www.kpchr.org/public/acwd/CWDA_workbook.pdf</p> <p><u>Parent Workbook – Group for Parents of Depressed Youth</u> http://www.kpchr.org/public/acwd/CWDA_parent_wkbook.pdf</p> <p>-Updated manuals available online: http://www.kpchr.org/public/acwd/acwd.html</p>
Selected Outcome Studies & Hot Links	<p>Clarke, G.N., Rohde, P., Lewinsohn, P.M., & Seeley, J.R. (1999). Cognitive-behavioral treatment of adolescent depression: efficacy of acute group treatment and booster sessions. <u>Journal of the American Academy of Child and Adolescent Psychiatry.</u> 38(3), 272-279. http://tinyurl.com/hx23h</p> <p>Lewinsohn, P., Clarke, G., Hops, H., & Andrews, J. (1990). Cognitive behavioral treatment for depressed adolescents. <u>Behavior Therapy.</u> 385-401.</p> <p>Rohde, P., Clarke, G., Mace, D., Jorgensen, J. & Seely, J. (2004). An efficacy/effectiveness study of cognitive-behavioral treatment for adolescents with comorbid major depression and conduct disorder. <u>Journal of the American Academy of Child and Adolescent Psychiatry,</u> 43(6), 660-668. http://tinyurl.com/jfm5a</p>
	Item ID#: 9

10 Managing Mood

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BCFPI Area of Concern	Managing mood
Intervention Modality	Interpersonal Therapy (IPT-A)
Goal of Intervention	Reduce depressive symptoms by improving social relationships
Description	Interpersonal Psychotherapy for adolescents is an extension of similar brief time limited adult models. Adolescents meet weekly for 12 individual sessions with the therapist to work on agreed-upon current issues. The first 4 weeks of treatment include once weekly additional telephone contacts between therapist and teen. In sessions adolescents work on their relationship with the therapist or involve significant others to develop solutions to and understand the link between their symptoms and issues such as grief, interpersonal role disputes, role transitions, and role deficits.
Age Group	ages 12 to 18 years
Efficacy of Intervention	Well Established
Manual	Mufson, L., Moreau, D., Weissman, M., & Kerman, G. (2004-revised). <u>Interpersonal Psychotherapy for Depressed Adolescents</u> . New York: Guilford. -Available at Chapters.Indigo.ca (http://tinyurl.com/aowkm). Approx. cost (Sept 2006): \$47.50
Selected Outcome Studies & Hot Links	Mufson, L., Dorta, K., Wickramaratne, P., Nomura, Y., Olfson, M., & Weissman, M. (2004). A randomized effectiveness trial of interpersonal psychotherapy for depressed adolescents. <u>Archives of General Psychiatry</u> , <u>61</u> , 6, 577-584. http://tinyurl.com/zd3lq Mufson, L., & Fairbanks, J. (1996). Interpersonal psychotherapy for depressed adolescents: A one-year naturalistic follow-up study. <u>Journal of the American Academy of Child and Adolescent Psychiatry</u> , <u>35</u> , 1145-1155. http://tinyurl.com/l59lf Mufson, L., Weissman, M., Moreau, D., & Garfinkel, R. (1999). Efficacy of interpersonal psychotherapy for depressed adolescents. <u>Archives of General Psychiatry</u> , <u>56</u> , 573-579. http://tinyurl.com/hzovd Rossello, J. & Bernal, G. (1999). The efficacy of cognitive-behavioral and interpersonal treatments for depression in Puerto Rican adolescents. <u>Journal of Consulting and Clinical Psychology</u> . <u>67</u> , 5. 734-745. http://tinyurl.com/j7fbj
	Item ID#: 10

11 Cooperation and Conduct

NOTE: The following services are listed as examples of the types of manualized evidence-based nonpharmacological interventions that might be considered if the problems noted in the Brief Child and Family Phone Interview are confirmed on clinical assessment. This does not represent an individualized service plan. An individualized service plan must be composed by a clinician who has completed a comprehensive assessment. Note this is not a comprehensive listing of evidence-based interventions. There are often several closely related versions of evidence-based interventions that may yield similar outcomes. These interventions require training, manuals, and expertise in each area. They are not successful with all children, may not result in complete problem resolution, and must often be combined with other services.

BCFPI Area of Concern	Cooperation & Conduct
Intervention Modality	Parent-Child Interaction Therapy (PCIT)
Goal(s) of Intervention	Reduce oppositional behavior and conduct problems by improving parenting skills and parent-child relationships
Description	<p>This intervention has two phases.</p> <p>Child-Directed Interaction: Child directed interaction focuses on changing the quality of the parent-child relationship. Parents learn nondirective play skills such as eye contact, describing the child's activities, and rewarding positive behaviour.</p> <p>Parent-Directed Interaction: Parent directed interaction teaches parents to direct the child's behaviour with clear, age-appropriate instructions & consistent consequences (e.g., praise for compliance; time-out for noncompliance). Skills are introduced through instruction, modeling, and role-playing with the therapist. In subsequent sessions, each parent practices with the child while being observed by the other parent and the therapist through a one-way mirror. The therapist coaches the parent through a bug-in-the-ear microphone.</p> <p>At the beginning of each session, the therapist codes the parent-child interaction for five minutes to assess the target skills. At the end of the session, the therapist and parents review each week's coded data to track their progress. Daily practice sessions take place at home between sessions. As parents become proficient in the use of new skill, they are encouraged to apply these throughout the day. Treatment terminates when the parents have demonstrated skill mastery and report that the presenting problems are resolved.</p>
Age	ages 3 to 6 years
Efficacy of Intervention	Well Established
Manual	<p>Eyberg, S.M., & Durning, P. (1994). <u>Parent-Child Interaction Therapy: Procedures Manual</u>. Unpublished manuscript, University of Florida. -(Eyberg manual not available). PCIT literature (http://www.hp.ufl.edu/~seyberg/literature.htm)</p> <p>Eyberg, S.M., Edwards, D., Bessmer, J., & Litwins, N. (1994). <u>The Workbook: A Coder Training Manual for the Dyadic Parent-Child Interaction Coding System II</u>. -Coding manual available online: http://www.hp.ufl.edu/~seyberg/DPICSfiles/dpicsmanual.pdf</p> <p>Hembree-Kigin, T. & McNeil, Cheryl Bodiford. (1995). <u>Parent-Child Interaction Therapy</u>. Plenum Press, New York. -Available at Chapters.Indigo.ca (http://tinyurl.com/a3gkr) Approx. cost (Sept 2006) \$43.95</p>

Selected Outcome Studies & Hot Links	<p>Bodiford McNeil, C.B., Eyberg, S., Eisenstadt, T.H., Newcomb, K., & Funderburk, B.W. (1991). Parent-child interaction therapy with behavior problem children: Generalization of treatment effects to the school setting. <u>Journal of Clinical Child Psychology</u>, <u>20</u>, 140-151.</p> <p>Eyberg, S.M., Boggs, S., & Algina, J. (1995). Parent-child interaction therapy: a psychosocial model for the treatment of young children with conduct problem behaviour and their families. <u>Psychopharmacology Bulletin</u>, <u>31</u>, 83-91. http://tinyurl.com/h8554</p> <p>Nixon, R., Sweeney, L., Erickson, D. & Touyz, S. (2003). Parent-child interaction therapy: a comparison of standard and abbreviated treatments for oppositional defiant preschoolers. <u>Journal of Consulting and Clinical Psychology</u>, <u>71</u>, 2, 251-260. http://tinyurl.com/e8med</p> <p>Nixon, R., Sweeney, L., Erickson, D. & Touyz, S. (2004). Parent-child interaction therapy: one and two year follow-up of standard and abbreviated treatments for oppositional preschoolers. <u>Journal of Abnormal Child Psychology</u>, <u>32</u>, 3, 263-71. http://tinyurl.com/ztsza</p> <p>Schumann, E., Foote, R., Eyberg, S., Boggs, S. & Algina, J. (1998). Efficacy of parent-child interaction therapy: Interim report of a randomized trial with short-term maintenance. <u>Journal of Clinical Child Psychology</u>, <u>27</u>, (1), 34-45. http://tinyurl.com/gdqfy</p>	
		Item ID#: 11

12 Conduct

NOTE: The following services are listed as examples of the types of manualized evidence-based nonpharmacological interventions that might be considered if the problems noted in the Brief Child and Family Phone Interview are confirmed on clinical assessment. This does not represent an individualized service plan. An individualized service plan must be composed by a clinician who has completed a comprehensive assessment. Note this is not a comprehensive listing of evidence-based interventions. There are often several closely related versions of evidence-based interventions that may yield similar outcomes. These interventions require training, manuals, and expertise in each area. They are not successful with all children, may not result in complete problem resolution, and must often be combined with other services.

BCFPI Area of Concern	Conduct
Intervention Modality	Multisystemic Therapy (MST)
Goal of Intervention	To intervene directly within systems and processes known to be related to antisocial behaviour (e.g., parental discipline, family affective relations, peer associations, and school performance).
Description	MST is an individualized home-based family treatment. The program provides comprehensive services, using a family preservation model (e.g. a commitment to maintaining children in their homes and a family systems perspective). Therapists conduct treatment using a range of strategies (e.g. cognitive-behavior therapy and structural family therapy) according to 9 MST principles. Goals are established by the family and treatment is tailored to the strengths of each family. Treatment contracts are time-limited, ranging from 5 to 23 weeks with individual sessions lasting up to 90 minutes. Therapists provide 24-hour coverage. The frequency of sessions varies (e.g. daily to once per week) with the stage of treatment. Sessions are conducted at convenient times in the family's home or community locations.
Age	adolescence
Efficacy of Intervention	Well Established
Manual	Henggeler, S.W., Schoenwald, S.K., Borduin, C.M., Rowland, M.D., & Cunningham, P.B. (1998). <u>Multisystemic treatment of antisocial behavior in children and adolescents</u> . New York: Guilford Press. -Available at Chapters.Indigo.ca (http://tinyurl.com/76r22) Approx. cost (Sept 2006) \$48.95
Selected Outcome Studies & Hot Links	Borduin, C.M., Mann, B.J., Cone, L.T., Henggeler, S.W., Fucci, B.,R., Blaske, D.M., & Williams, R.A. (1995). Multisystemic treatment of serious juvenile offenders: Long-term prevention of criminality and violence. <u>Journal of Consulting and Clinical Psychology</u> , <u>63</u> , 569-678. http://tinyurl.com/j9kqt Henggeler, S.W., Melton, B.G., & Smith, L.A. (1992). Family preservation using Multisystemic Therapy: An effective alternative to incarcerating serious juvenile offenders. <u>Journal of Consulting and Clinical Psychology</u> , <u>60</u> , 953-961. http://tinyurl.com/hdkmv
	Item ID#: 12

13 Cooperation

NOTE: The following services are listed as examples of the types of manualized evidence-based nonpharmacological interventions that might be considered if the problems noted in the Brief Child and Family Phone Interview are confirmed on clinical assessment. This does not represent an individualized service plan. An individualized service plan must be composed by a clinician who has completed a comprehensive assessment. Note this is not a comprehensive listing of evidence-based interventions. There are often several closely related versions of evidence-based interventions that may yield similar outcomes. These interventions require training, manuals, and expertise in each area. They are not successful with all children, may not result in complete problem resolution, and must often be combined with other services.

BCFPI Area of Concern	Cooperation
Intervention Modality	Parent training: 'Community Parent Education Program' (COPE)
Goal of Intervention	Reduce oppositional and conduct problems by improving parenting skills, strengthening parent-child relationships, building problem solving skills, improving family functioning, developing supportive networks, and increasing utilization of local resources
Description	11 to 12 weekly large group (15 to 25 participants) sessions designed to help parents develop skills to improve relationships with their child, encourage positive behavior, manage transitions, plan for potentially difficult situations, and respond to antisocial behavior. In each session, parents review homework successes, formulate solutions to videotaped child management errors, observe the leader demonstrating new skills, brainstorm application to problems at home, rehearse the application of the sessions' strategies to situations at home, set specific home work goals, and monitor implementation during the week.
Age Group	ages 3 to 6 years
Efficacy of Intervention	Promising
Manual	Cunningham, C.E., Bremner, R.B. & Secord-Gilbert, M. (2000). <u>COPE: The Community Parent Education Program: A School based family systems oriented workshop for parents of children with disruptive behaviour disorders (Leader's Manual & Videotape Analogues)</u> . Hamilton: COPE Works. -Approx. cost \$200.00, On-line order form: http://www.communityed.ca/training/cope/Order Form - May 2003.PDF Cheque or money order payable to 'Community Parent Education (COPE)', Community Parent Education (COPE) Program, King's Crossing, 354 King St. West, Room G23A, McMaster Children's Hospital, Box 2000, Hamilton, ON L8N 3Z5 905 521-2100 x77312, fax 905-577-8453
Selected Outcome Studies & Hot Links	Cunningham, C.E., Bremner, R.B. & Boyle, M. (1995). Large group community-based parenting programs for families of preschoolers at risk for disruptive behaviour disorders: Utilization, cost effectiveness and outcome. <u>Journal of Child Psychology and Psychiatry</u> , 36, (7), 1141-1159. http://tinyurl.com/l5kur
	Item ID#: 13

14 Conduct and Cooperation

NOTE: The following services are listed as examples of the types of manualized evidence-based nonpharmacological interventions that might be considered if the problems noted in the Brief Child and Family Phone Interview are confirmed on clinical assessment. This does not represent an individualized service plan. An individualized service plan must be composed by a clinician who has completed a comprehensive assessment. Note this is not a comprehensive listing of evidence-based interventions. There are often several closely related versions of evidence-based interventions that may yield similar outcomes. These interventions require training, manuals, and expertise in each area. They are not successful with all children, may not result in complete problem resolution, and must often be combined with other services.

BCFPI Area of Concern	Conduct, Cooperation, & Regulation of Attention, Impulsivity, and Activity Level.
Intervention Modality	Parent training: 'Triple P'
Goal of Intervention	Increase prosocial behaviour and reduce oppositional behavior or conduct problems by improving parenting skills and parent-child relationships
Description	<p>Self-Directed Triple P: 10-week self-help parenting workbook consisting of structured reading and practice tasks. Designed for families in rural or remote areas and families wanting a self-help program. The video, 'Every Parent's Survival Guide', can be used as part of the program.</p> <p>Level 4 - Standard Triple P: 10 -1 hour individual parenting skills sessions using videotapes, discussion, modeling, role playing, feedback, and homework tasks to build 17 child management strategies. 'Every Parent's Group Workbook' includes practical information on positive parenting strategies.</p> <p>Level 4 - Group Triple P: 8-weeks - four 2-hour group sessions using videotapes, discussion, modeling, role playing, feedback, and homework tasks to build parenting skills. Includes four 15-30 minute individual telephone sessions. 'Every Parent's Group Workbook' gives practical information on positive parenting strategies.</p> <p>Level 5 - Enhanced Triple P: Based on Standard or Group Triple P but individualized to each family, with an additional focus on partner support skills, social support for single moms, & cognitive, coping, or mood management skills as appropriate.</p>
Age Group	ages 3 to 4 years
Efficacy of Intervention	Probably Efficacious
Manual	<p>Sanders, M.R. (1992). <u>Every Parent: A positive guide to children's behaviour</u>. Sydney, N.S.W. Australia: Addison Wesley. (\$39.95CA)</p> <p><u>Every Parent's Survival Guide</u> – video. (\$149.95 CA)</p> <p>Markie-Dadds, C., Sanders, M.R., & Turner, K.M.T. (1999). <u>Every parent's self-help workbook</u>. Brisbane, Queensland, Australia: Families International. (\$25.95 CA)</p> <p>Standard Triple P Practitioner's Kit (manual & <u>Every Parent's Family Workbook</u>). (\$124.95 CA)</p> <p>Group Triple P Facilitator's Kit (manual, overheads, <u>Every Parent's Group Workbook</u>). (\$124.95CA)</p> <p>Enhanced Triple P Practitioner's Kit (manual & <u>Every Parent's Supplementary Workbook</u>). (\$124.95CA)</p> <p>-Available from Triple P International Pty Ltd. P.O. Box 1300, Milton, QLD, Australia www.triplep.net email info@triplep.net for order form</p>

Selected Outcome Studies & Hot Links	<p>Bor, W., Sanders, M., & Markie-Dadds, C. (2002). The effects of the triple p-positive parenting program on preschool children with co-occurring disruptive behavior and attentional-hyperactive difficulties. <i>Journal of Abnormal Child Psychology</i>, 30, 6, 571-587. http://tinyurl.com/zchrt</p> <p>Morawska, A & Sanders, M. (2006). Self-administered behavioral family intervention for parents of Toddlers: Part I: efficacy. <i>Journal of Consulting and Clinical Psychology</i>, 74, 1, 10-19. http://tinyurl.com/fkbru</p> <p>Sanders, M.R., Markie-Dadds, C., Tully, L.A., & Bor, W. (2000). The Triple P-Positive Parenting Program: A comparison of enhanced, standard, and self-directed behavioral family intervention for parents of children with early onset conduct problems. <i>Journal of Consulting and Clinical Psychology</i>, 68, 624-640. http://tinyurl.com/jcc2q</p>
	<p style="text-align: right;">Item ID#: 14</p>

15 Conduct and Cooperation

NOTE: The following services are listed as examples of the types of manualized evidence-based nonpharmacological interventions that might be considered if the problems noted in the Brief Child and Family Phone Interview are confirmed on clinical assessment. This does not represent an individualized service plan. An individualized service plan must be composed by a clinician who has completed a comprehensive assessment. Note this is not a comprehensive listing of evidence-based interventions. There are often several closely related versions of evidence-based interventions that may yield similar outcomes. These interventions require training, manuals, and expertise in each area. They are not successful with all children, may not result in complete problem resolution, and must often be combined with other services.

BCFPI Area of Concern	Conduct, Cooperation
Intervention Modality	Functional Family Therapy
Goal of Intervention	Reduce oppositional behavior and conduct problems by improving parenting skills, developing problem solving skills, helping families deal with and utilize community resources, improving youth and family communication, and adopting positive solutions to family problems.
Description	Short-term (8-12 one hour sessions), behaviourally specific, family intervention program. Each family member identifies personal behavioral objectives and reinforcers as a part of a family Token Economy. Family members learn constructive strategies for negotiating change, conducting solution-oriented discussions, making requests, and providing positive feedback. Functional Family Therapy can be conducted either as an outpatient therapy or as an in-home model.
Age Group	adolescents age 11-18
Efficacy of Intervention	Probably Efficacious
Manual	'Functional Family Therapy' (FFT), (Book Three) Blueprints for Violence Prevention -order form: http://www.colorado.edu/cspv/publications/blueprints/BP-003.html \$12.00 US
Selected Outcome Studies & Hot Links	Parsons, B. & Alexander, J. 1973. Short-term family intervention: a therapy outcome study. Journal of Consulting and Clinical Psychology, 41, 2, 195-201. Functional Family Therapy http://fftinc.com/index.php
	Item ID#: 15

16 Managing Anxiety and Separation from Parents

NOTE: The following services are listed as examples of the types of manualized evidence-based nonpharmacological interventions that might be considered if the problems noted in the Brief Child and Family Phone Interview are confirmed on clinical assessment. This does not represent an individualized service plan. An individualized service plan must be composed by a clinician who has completed a comprehensive assessment. Note this is not a comprehensive listing of evidence-based interventions. There are often several closely related versions of evidence-based interventions that may yield similar outcomes. These interventions require training, manuals, and expertise in each area. They are not successful with all children, may not result in complete problem resolution, and must often be combined with other services.

BCFPI Area of Concern	Managing Anxiety and Separation Anxiety
Intervention Modality	Cognitive Behavioural Therapy (CBT): 'Cool Kids Program - Family Version'
Goal	Reduce anxious avoidant behavior by educating parents and children, developing alternatives to anxious thoughts, motivating children to successfully approach fearful situations, and improving family communication and problem solving skills.
Description	The 'Cool Kids' program is an adaptation of the 'Coping Koala' program (Heard, Dadds, & Rapee), which in turn was based on Kendall's "Coping Cat" program. Because the inclusion of parents improves outcomes for the 'Coping Koala' and 'Coping Cat' programs, the 'Cool Kids - Family Version' was developed. 'Cool Kids' uses cognitive restructuring, role-playing, peer modeling, relaxation training, homework projects, self-evaluation, and self-reward to teach children alternatives to anxious thoughts and encourage them to master anxiety provoking situations (exposure). Parents learn problem solving skills, motivational strategies (praise, natural consequences, & planned ignoring), conflict resolution, and anxiety self-management skills. The program runs for 9 sessions, over 11 or 12 weeks. Child groups consist of 4 to 7 children from a similar age band (e.g. 7-9, 10-12, 13-15). At least one parent and the child attend all sessions. The parent and child components can be run sequentially (i.e. 75 minutes for the child and 75 minutes for the parent) or simultaneously if multiple therapists are available. Can be conducted as either a group or individual program.
Age group	ages 7 to 16
Efficacy of Intervention	Probably Efficacious
Manual	<p>Rapee, R. & Wignall, A. <u>'Cool Kids' Child and Adolescent Anxiety Group Treatment (Family Kit)</u>. (Based on P. M. Barrett's (1995) <u>Group Koala Workbook</u>. Unpublished manuscript. Griffith University, Nathan, AU)</p> <p>Wignall, A. & Rapee, R. "Cool Kids" Parent and child workbooks. -Available through Macquarie University Anxiety Research Unit Sydney, NSW, 2109, Australia. http://www.psy.mq.edu.au/MUARU/order.pdf cheque payable to 'Macquarie Research Ltd.' Approx. cost (Sept 2006) group treatment manual \$59.95 AU, workbooks \$30.00 AU each, \$250.00 AU for 10 sets</p> <p>Rapee, R.M., Wignall, A., Hudson, J.L. and Schniering, C.A. (2000). <u>Treating Anxious Children and Adolescents: An Evidence-Based Approach</u>. New Harbinger Publications, Inc. -Available at Chapters.Indigo.ca (http://tinyurl.com/cudyk) Approx. cost (Sept 2006) \$50.00</p> <p>Rapee, R.M., Spence, S.H., Cobham, V. and Wignall, A. (2000). <u>Helping Your Anxious Child. A Step-by-Step Guide for Parents</u>. New Harbinger Publications, Inc. -Available at Chapters.Indigo.ca (http://tinyurl.com/b8mle) Approx. cost (Sept 2006) \$19.95</p>

Selected Outcome Studies & Hot Links	<p>Coping Koala: Barrett, P.M. (1998). Evaluation of cognitive-behavioural group treatments for childhood anxiety disorders. <u>Journal of Clinical Child Psychology</u>, <u>27</u>, 4, 459-468. http://tinyurl.com/zpa3f</p> <p>Barrett, P., Duffy, A., Dadds, M., Rapee, R. (2001). Cognitive-Behavioral treatment of anxiety disorders in children: long-term (6-year) follow-up. <u>Journal of Consulting and Clinical Psychology</u>, <u>69</u>, 1, 135-41. http://tinyurl.com/fm6xs</p> <p>Muris, P., Meesters, C., van Melick, M. 2002. Treatment of childhood anxiety disorders: a preliminary comparison between cognitive-behavioral group therapy and a psychological placebo intervention. <u>Journal of Behavior Therapy</u>, <u>33</u>, 143-158. http://tinyurl.com/kdzf5</p> <p>Cool Kids: Rapee, R.M. (2003). The influence of comorbidity on treatment outcome for children and adolescents with anxiety disorders. <u>Behaviour Research and Therapy</u>, <u>41</u>, 105-112. http://tinyurl.com/zsgds</p> <p>Rapee, R.M. (2000). Group treatment of children with anxiety disorders: Outcome and predictors of treatment response. <u>Australian Journal of Psychology</u>, <u>52</u>, (3), 125-129. http://tinyurl.com/gtpyx</p>
	Item ID#: 16

17 Managing Anxiety and Separation from Parents

NOTE: The following services are listed as examples of the types of manualized evidence-based nonpharmacological interventions that might be considered if the problems noted in the Brief Child and Family Phone Interview are confirmed on clinical assessment. This does not represent an individualized service plan. An individualized service plan must be composed by a clinician who has completed a comprehensive assessment. Note this is not a comprehensive listing of evidence-based interventions. There are often several closely related versions of evidence-based interventions that may yield similar outcomes. These interventions require training, manuals, and expertise in each area. They are not successful with all children, may not result in complete problem resolution, and must often be combined with other services.

BCFPI Area of Concern	Managing Anxiety and Separation from Parents
Intervention Modality	Cognitive Behavioural Therapy (CBT): 'Coping Bear' Program group or individual treatment
Goal	Reduce anxious avoidant behavior by increasing child problem solving skills & contingency management; cognitive restructuring; improving family communication & problem solving skills; exposure to anxious situations
Description	The 'Coping Bear' program is a Canadian-developed group program adapted from Kendall's original 'Coping Cat' program. An individualized version of the 'Coping Bear' program was later developed. The group program runs for 12 90-minute sessions. 6 to 8 children are recommended per group and a minimum of 4 parents for the parent component. The individual program is also 12 sessions in length. Both the children's and parent groups use group problem solving, exercises, and homework assignments to help children understand physical reactions to anxiety, develop relaxation skills, use alternatives to anxious thoughts, and reward effective coping responses.
Age group	ages 8 to 12 years
Efficacy of Intervention	Probably Efficacious
Manual	<p>Manassis, K. (1996). <u>Keys to Parenting Your Anxious Child</u>. New York: Barron Educational Series. -Available at Chapters.Indigo.ca (http://tinyurl.com/9kcdm) Approx. cost (Sept 2006) \$11.50</p> <p>Manassis, K. A Psychoeducational group program for Parents of Anxious Children. Unpublished manuscript.</p> <p>Mendlowitz, S.L. & Scapillato, D. (1994). <u>The Coping Bear Workbook and Notebook</u>. Unpublished manuscript. (group program)</p> <p>Mendlowitz, S.L. (1998). <u>The Coping Bear Workbook</u> (Individual). Unpublished manuscript.</p> <p>-Order information: Certified cheque or money order payable to "Psychiatry Education Fund" c/o Donna Scapillato, Outpatient Psychiatry, Hospital for Sick Children, 1st Floor Elm Wing, 555 University Ave, Toronto, ON, M5G 1X8 416-813-7654x4410 Approx. cost (May 2004) \$35.00</p>
Selected Outcome Studies & Hot Links	<p>Manassis, K., Avery, D., Butalia, S. & Mendlowitz, S. (2004). Cognitive-behavioral therapy with childhood anxiety disorders: functioning in adolescence. <u>Depression and Anxiety</u>, 19, 209-216. http://tinyurl.com/hzl69</p> <p>Manassis, K., Mendlowitz, S., Scapillato, D., Avery, D., Fiksenbaum, L., Friere, M., Monga, S., & Owens, M. (2002). Group and individual cognitive-behavioral therapy for childhood anxiety disorders: a randomized trial. <u>Journal of the American Academy of Child and Adolescent Psychiatry</u>, 41,12, 1423-1430. http://tinyurl.com/k3hfg</p> <p>Mendlowitz, S., Manassis, K., Bradley, S., Scapillato, D., Mieztis, S. & Shaw, B. (1999). Cognitive-behavioural group treatments in childhood anxiety disorders: The role of parental involvement. <u>Journal of the American Academy of Child and Adolescent Psychiatry</u>, 38,10,1223-29. http://tinyurl.com/kar68</p>
	Item ID#: 17

18 Managing Anxiety and Separation from Parents

NOTE: The following services are listed as examples of the types of manualized evidence-based nonpharmacological interventions that might be considered if the problems noted in the Brief Child and Family Phone Interview are confirmed on clinical assessment. This does not represent an individualized service plan. An individualized service plan must be composed by a clinician who has completed a comprehensive assessment. Note this is not a comprehensive listing of evidence-based interventions. There are often several closely related versions of evidence-based interventions that may yield similar outcomes. These interventions require training, manuals, and expertise in each area. They are not successful with all children, may not result in complete problem resolution, and must often be combined with other services.

BCFPI Area of Concern	Managing Anxiety and Separation from Parents
Intervention Modality	Cognitive Behavioural Therapy (CBT): 'FRIENDS' Program Family-based group treatment
Goal	Reduce anxiety and help children master anxiety provoking situations by teaching children cognitive coping strategies and relaxation skills and improving parenting skills
Description	<p>2 parallel programs available: one for children 6-11, another for 12-16 year olds.</p> <p>'FRIENDS' includes 10 weekly sessions and 2 booster sessions 1 and 3 months after treatment. Parents & children meet together for first 10 minutes and again in the last 5 minutes of each child session.</p> <p>Child sessions: Child sessions are 50 to 60 minutes long with 5 to 13 children per group. Therapists use problem solving, modeling, role playing, homework exercises, contingent reinforcement, peer support & peer learning to help children develop cognitive coping strategies, develop relaxation skills, and gradually master anxiety provoking situations.</p> <p>Parent sessions: Parents attend 10 40-minute sessions that help them to support their child by using reinforcement, anxiety management strategies, communication, and problem solving skills.</p>
Age group	ages 6 to 10 years
Efficacy of Intervention	Probably Efficacious
Manual	<p>Barrett, P.M., Lowry-Webster, H., & Turner, C. (2000). <u>FRIENDS</u>, Brisbane: Australian Academic Press.</p> <p>-Order information: http://www.friendsinfo.net/orderingpdf.html Approx. cost (Sept 2006) \$52.00 manual and workbook</p>
Selected Outcome Studies & Hot Links	<p>Shortt, A., Barrett, P. & Fox, T. 2001. Evaluating the FRIENDS program: a cognitive-behavioral treatment for anxious children and their parents. <u>Journal of Clinical Child Psychology</u>, 30, 4, 525-535</p> <p>http://tinyurl.com/jxoe</p>
	Item ID#: 18

19 Separation from Parents and School Refusal

NOTE: The following services are listed as examples of the types of manualized evidence-based nonpharmacological interventions that might be considered if the problems noted in the Brief Child and Family Phone Interview are confirmed on clinical assessment. This does not represent an individualized service plan. An individualized service plan must be composed by a clinician who has completed a comprehensive assessment. Note this is not a comprehensive listing of evidence-based interventions. There are often several closely related versions of evidence-based interventions that may yield similar outcomes. These interventions require training, manuals, and expertise in each area. They are not successful with all children, may not result in complete problem resolution, and must often be combined with other services.

BCFPI Area of Concern	Separation from Parents and School Refusal	
Intervention Modality	Child Cognitive-Behavioral Therapy (CBT) and Parent/Teacher training	
Goal of Intervention	To return to school by coping with stressors associated with school attendance	
Description	<p>Child sessions consist of 8 50 minutes individual sessions that include relaxation training, social skills training, cognitive therapy & desensitization.</p> <p>Parent sessions consist of 8 50 minute clinical sessions that include strategies to reduce home-based reinforcement during school hours, planning for escorting the child to school, and positive reinforcement of coping behaviour and attendance.</p> <p>School consultations consist of a school visit, handouts and telephone contacts. The consultations include strategies to help the child settle into school, positive reinforcement and planned ignoring, and strategies to accommodate the child academically, socially and emotionally.</p>	
Age	5-15	
Efficacy of Intervention	Well Established	
Manual	<p>Heyne, D., Rollings, S., King, N., & Tonge, B. (2002). School Refusal (Parent, Adolescent and Child Training Skills). Blackwell Publishers: Oxford.</p> <p>-Available at Chapters.Indigo.ca http://tinyurl.com/lxcu8 Approx. cost (Sept 2006) \$21.50</p>	
Selected Outcome Studies & Hot Links	<p>Heyne, D., King, N., Tonge, B., Rollings, S., Young, D., Pritchard, M., & Ollendick, T. (2002). Evaluation of child therapy and caregiver training in the treatment of school refusal. Journal of the American Academy of Child And Adolescent Psychiatry, 41, 6, 687-695. http://tinyurl.com/euq3u</p> <p>King, N., Tonge, B., Heyne, D., Pritchard, M., Rollings, S., Young, D., Myerson, N., & Ollendick, T. (1998). Cognitive-Behavioral treatment of school-refusing children: a controlled evaluation. Journal of the American Academy of Child And Adolescent Psychiatry, 37, 4, 395-403. http://tinyurl.com/hcv47</p>	
		Item ID#: 19 new

20 Separation from Parents and School Refusal

NOTE: The following services are listed as examples of the types of manualized evidence-based nonpharmacological interventions that might be considered if the problems noted in the Brief Child and Family Phone Interview are confirmed on clinical assessment. This does not represent an individualized service plan. An individualized service plan must be composed by a clinician who has completed a comprehensive assessment. Note this is not a comprehensive listing of evidence-based interventions. There are often several closely related versions of evidence-based interventions that may yield similar outcomes. These interventions require training, manuals, and expertise in each area. They are not successful with all children, may not result in complete problem resolution, and must often be combined with other services.

BCFPI Area of Concern	Separation from Parents and School Refusal
Intervention Modality	Functionally based analysis - assessed relative strength of 4 school refusal functional conditions, treatment was designed for each condition
Goal of Intervention	To return to school, to reduce physical symptoms and anticipatory anxiety, reduce social anxiety, build social skills, improve parent skills
Description	From 3 to 10 weekly individual sessions determined by the time needed for successful outcome. Prescriptive treatment was based on the highest rated of 4 functional conditions from the School Refusal Assessment Scale (SRAS). Children with 'avoidance of stimuli provoking negative affectivity' received relaxation training, systematic desensitization, and gradual re-exposure to school setting. Those with 'escape from aversive social or evaluative situations' received modeling, shaping, role-play, and cognitive restructuring. Children with 'attention seeking' received parent contingency management consisting of differential reinforcement of other behaviour. Those with 'positive tangible reinforcement' received family contingency contracting consisting of increased rewards for attending and decreased rewards for not attending school.
Age	5-17
Efficacy of Intervention	Probably Efficacious
Manual	Kearney, C. A., & Albano, A. M. (2000). <i>When children refuse school: A cognitive-behavioral therapy approach/Therapist's guide</i> . San Antonio, TX: The Psychological Corporation. Available from Caversham Booksellers. Approx. cost (Sept. 2006) \$47.00 http://tinyurl.com/gthgp Kearney, C.A. (in press; expected 2006). The survival guide to getting your child back to school: A handbook for parents. <i>New York: Oxford University Press</i> .
Selected Outcome Studies & Hot Links	Kearney, C.A. & Silverman W.K. (1999). Functionally based prescriptive and non-prescriptive treatment for children and adolescents with school refusal behavior. <i>Behavior Therapy</i> , 30, 673-695 Kearney, C.A. & Silverman W.K. (1990). A preliminary analysis of a functional model of assessment and treatment for school refusal behavior. <i>Behavior Modification</i> , 14, 3, 340-366. http://tinyurl.com/l3465
	Item ID#: 20 new

21 Managing Mood

NOTE: The following services are listed as examples of the types of manualized evidence-based nonpharmacological interventions that might be considered if the problems noted in the Brief Child and Family Phone Interview are confirmed on clinical assessment. This does not represent an individualized service plan. An individualized service plan must be composed by a clinician who has completed a comprehensive assessment. Note this is not a comprehensive listing of evidence-based interventions. There are often several closely related versions of evidence-based interventions that may yield similar outcomes. These interventions require training, manuals, and expertise in each area. They are not successful with all children, may not result in complete problem resolution, and must often be combined with other services.

BCFPI Area of Concern	Mood
Intervention Modality	Multisystemic Therapy (MST)
Goal of Intervention	To reduce suicide morbidity while reducing need for hospitalization To increase quality of life by improving youth's affective state, building social support networks, managing psychiatric emergencies, improving family functioning, and increasing social and educational skills To intervene directly within systems and processes known to be related to antisocial behaviour (e.g., parental discipline, family affective relations, peer associations, and school performance).
Description	MST is an individualized home-based family treatment. The program provides comprehensive services, using a family preservation model (e.g. a commitment to maintaining children in their homes and a family systems perspective). Therapists conduct treatment using a range of strategies (e.g. cognitive-behavior therapy and structural family therapy) according to 9 MST principles. Goals are established by the family and treatment is tailored to the strengths of each family. Treatment contracts are time-limited, ranging from 3 to 6 months with individual sessions lasting up to 90 minutes. Therapists provide 24-hour coverage. The frequency of sessions varies (e.g. daily to once per week) with the stage of treatment. Sessions are conducted at convenient times in the family's home or community locations.
Age	10-17
Efficacy of Intervention	Probably Efficacious
Manual	Henggeler, S.W., Schoenwald, S.K., Rowland, M.D., & Cunningham, P.B. (2002). <u>Serious Emotional Disturbance in Children and Adolescents: Multisystemic Treatment</u> . New York: Guilford Press. -Available at Chapters.Indigo.ca http://tinyurl.com/hm2xu Approx.cost (Sept 2006) \$45.50
Selected Outcome Studies & Hot Links	Henggeler, S., Rowland, M., Halliday-Boykins, C., Sheidow, A., Ward, D., Randall, J., Pickrel, S., Cunningham, P., & Edwards, J. (2003). One-year follow-up of multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis. <u>Journal of the American Academy of Child and Adolescent Psychiatry</u> , 42, 5, 543-551. http://tinyurl.com/fgfvq Huey, S., Henggeler, S., Rowland, M., Halliday-Boykins, C., Cunningham, P., Pickrel, S. & Edwards, J. (2004). Multisystemic therapy effects on attempted suicide by youths presenting psychiatric emergencies. <u>Journal of the American Academy of Child and Adolescent Psychiatry</u> , 43, 2, 183-190. http://tinyurl.com/jje9a
	Item ID#: 21 new

22 Conduct and Cooperation

NOTE: The following services are listed as examples of the types of manualized evidence-based nonpharmacological interventions that might be considered if the problems noted in the Brief Child and Family Phone Interview are confirmed on clinical assessment. This does not represent an individualized service plan. An individualized service plan must be composed by a clinician who has completed a comprehensive assessment. Note this is not a comprehensive listing of evidence-based interventions. There are often several closely related versions of evidence-based interventions that may yield similar outcomes. These interventions require training, manuals, and expertise in each area. They are not successful with all children, may not result in complete problem resolution, and must often be combined with other services.

BCFPI Area of Concern	Conduct & Cooperation	
Intervention Modality	Aggression Replacement Therapy	
Goal of Intervention	Improve social skill competence, anger control and moral reasoning	
Description	<p>3 1 hour sessions per week for 10 weeks using repetitive learning techniques and guided group discussion incorporating 3 specific interventions.</p> <p>Skill streaming uses modeling, role-playing, performance feedback & transfer training to teach prosocial skills.</p> <p>Anger control training includes strategies such as identifying triggers and cues, reminders (e.g. "chill out") and reducers (e.g. deep breathing) and self-evaluation.</p> <p>Moral reasoning includes group discussion of moral reasoning problem situations to raise the youths' level of fairness, justice and concern for the needs and rights of others.</p>	
Age	12-17	
Efficacy of Intervention	Promising	
Manual	<p>Goldstein, A., Glick, B., & Gibbs, J. (1998). Aggression Replacement Training: A Comprehensive Intervention for Aggressive Youth. Champaign, IL: Research Press. http://www.researchpress.com/product/item/5004/ Approx. cost (Sept 2006) \$25.95 U.S. http://www.aggressionreplacementtraining.org/publications.htm (International)</p>	
Selected Outcome Studies & Hot Links	<p>Goldstein A. & Glick, B. (1994). Aggression Replacement Training: Curriculum and Evaluation. Simulation and Gaming, 25, 1, http://www.uscart.org/ART-Cirriculum-Eval.pdf</p>	
		Item ID#: 22 new

23 Regulation of Attention, Impulsivity and Activity Level and Cooperation

NOTE: The following services are listed as examples of the types of manualized evidence-based nonpharmacological interventions that might be considered if the problems noted in the Brief Child and Family Phone Interview are confirmed on clinical assessment. This does not represent an individualized service plan. An individualized service plan must be composed by a clinician who has completed a comprehensive assessment. Note this is not a comprehensive listing of evidence-based interventions. There are often several closely related versions of evidence-based interventions that may yield similar outcomes. These interventions require training, manuals, and expertise in each area. They are not successful with all children, may not result in complete problem resolution, and must often be combined with other services.

BCFPI Area of Concern	Regulation of Attention, Impulsivity and Activity Level and Cooperation	
Intervention Modality	PSCT Problem-solving communication training alone or with BMT Behaviour management training	
Goal of Intervention	Reduce parent teen conflict	
Description	<p>18 60 minute sessions held approximately twice per week 18 sessions of PSCT or 9 sessions of BMT and 9 sessions of PSCT PSCT program trains both adolescents and parents in problem solving, communication training and cognitive restructuring using direct instruction, modeling, behaviour rehearsal, role playing, feedback and homework assignments. BMT program teaches parents contingency management skills to modify inappropriate teen behaviour. Skills include positive parental attention, point systems, use of grounding and loss of privileges, and anticipation and planning for impending situations.</p>	
Age	12-18	
Efficacy of Intervention	Probably Efficacious	
Manual	<p>Barkley, R., Robin, A., & Edwards, G. (1999). Defiant Teens: A Clinician's Manual for Assessment and Family Intervention. /New York: Guilford.</p> <p>-Available at Chapters.Indigo.ca http://tinyurl.com/ev85d Approx. cost (Sept 2006) \$46.50</p>	
Selected Outcome Studies & Hot Links	<p>Barkley, R., Edwards, G., Laneri, M., Fletcher, K., & Meteviw, L. (2001). The efficacy of problem-solving communication training alone, behaviour management training alone, and their combination for parent-adolescent conflict in teenagers with ADHD and ODD. Journal of Consulting and Clinical Psychology, 69, 6, 926-941. http://tinyurl.com/jw6ht</p> <p>Barkley, R., Guevremont, D., Anastopoulos, A., & Fletcher, K. (1992). A comparison of three family therapy programs for treating family conflicts in adolescents with attention-deficit hyperactivity disorder. Journal of Consulting and Clinical Psychology, 60, 3, 450-462. http://tinyurl.com/eb662</p>	
		Item ID#: 23 new