

Trauma-Informed Interventions:

EP: Early Pathways

<p>Treatment Description</p>	<ul style="list-style-type: none"> • Acronym (abbreviation) for intervention: EP • Average length/number of sessions: 8-16+ sessions (60-90 minutes with primary caregiver and child present) • Aspects of culture or group experiences that are addressed (e.g., faith/spiritual component, transportation barriers): Culturally sensitive nurturing practices; barriers to participation in treatment; emphasis on advocacy to address family needs (e.g., enrolling the child in school, referring parent to therapy, ensuring basic needs such as food and safe housing; helping family connect with available community resources – church, school, ethnic-based centers and programs). • Trauma type (primary): Child abuse and neglect, sexual abuse, intimate partner abuse, community violence, and multiple and prolonged traumatic events. • Trauma type (secondary): Complex Trauma • Additional descriptors (not included above): Following a referral, EP begins with a comprehensive intake evaluation and intake report that conceptualizes referral concerns, includes psychiatric diagnoses when relevant, and summarizes all intake data in a report. Initially, EP focuses on helping caregivers better understand and manage their child’s behavior and emotional problems by strengthening the parent-child relationship through child led play. While learning child-led play, caregivers are taught cognitive strategies to help them provide calm and thoughtful responses to their very young children. Next, proven strategies to strengthen the child’s prosocial behaviors and set limits on challenging behaviors are covered, all within a trauma-informed lens. Once these initial issues have improved, we focus more directly on trauma-informed strategies, depending on the child’s age, to include the broad categories of safety, trigger recognition, calming strategies, narratives of child’s trauma exposure, and recovery. EP includes measures at every session to monitor progress and essentially repeats the intake measures at post-treatment to measure overall progress.
<p>Target Population</p>	<ul style="list-style-type: none"> • Age range: (lower limit) 1 to (upper limit) 6 • Gender: <input type="checkbox"/> Males <input type="checkbox"/> Females <input checked="" type="checkbox"/> Both • Ethnic/Racial Group (include acculturation level/ immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans): African Americans, Caucasians, Latina/o, Asians, Native Americans • Other cultural characteristics (e.g., SES, religion): Over 85% of families served through EP to date have met the federal definition of poverty. All caregiver handouts are written at a 3rd to 4th grade reading level to accommodate the lower academic skills of caregivers. Many children also have developmental delays

	<ul style="list-style-type: none"> • Language(s): English; Spanish • Region (e.g., rural, urban): Primarily urban and suburban but has also been used in other regions including rural. • Other characteristics (not included above): In-Home Program helps reduce family barriers to treatment and ensures treatment strategies are implemented correctly by caregivers.
<p>Essential Components</p>	<ul style="list-style-type: none"> • Theoretical basis: EP Draws on: <ul style="list-style-type: none"> ○ Developmental theory to address developmental changes in cognition/language, social-emotional, motor, and adaptive areas; ○ Attachment and attunement research to strengthen parent-child relationships; ○ Cognitive-behavior theory to help caregivers manage their own thoughts/feelings; ○ Social learning theory and related strategies for managing young children’s behavior; ○ Trauma-informed theory and strategies for addressing children’s trauma symptoms. • Key components: <ul style="list-style-type: none"> ○ Strengthening the primary caregiver-child’s relationship through child-led play; ○ Cognitive strategies to teach parents to be more thoughtful about their own feelings, thoughts, and expectations before responding to their child’s challenging behaviors and emotional difficulties; ○ Nurturing strategies to strengthen the child’s prosocial behaviors (listening); ○ Discipline strategies to provide effective consequences for challenging behaviors (aggression, self-injury); ○ Trauma-informed safety, trigger recognition, calming, narratives, and recovery strategies to address the child’s trauma symptoms (nightmares; emotional tantrums, dissociation); and ○ Advocacy services to assist family in meeting child and family’s needs (e.g., refer child to pediatrician; help support a parent seeking a school IEP for their child; food stamps; etc.).
<p>Clinical & Anecdotal Evidence</p>	<ul style="list-style-type: none"> • Are you aware of any suggestion/evidence that this treatment may be harmful? <input type="checkbox"/>Yes <input checked="" type="checkbox"/>No <input type="checkbox"/>Uncertain • Extent to which cultural issues have been described in writings about this intervention (<i>scale of 1-5 where 1=not at all to 5=all the time</i>). 3 • This intervention is being used on the basis of anecdotes and personal communications only (no writings) that suggest its value with this group. <input type="checkbox"/>Yes <input checked="" type="checkbox"/>No • Are there any anecdotes describing satisfaction with treatment, drop-out rates (e.g., quarterly/annual reports)? <input checked="" type="checkbox"/>Yes <input type="checkbox"/>No If YES, please include citation: All our treatment outcomes studies listed below include a measure of family satisfaction and attrition information. We also routinely address these issues in the numerous grant reports we have written. • Has this intervention been presented at scientific meetings? <input checked="" type="checkbox"/>Yes <input type="checkbox"/>No If YES, please include citation(s) from last five presentations: Please see list of references at the end of this fact sheet. • Are there any general writings that describe the components of the

	<p>intervention or how to administer it? <input checked="" type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>If YES, please include citation(s) from last five presentations: Fox, R. A. (2017). <i>Early Pathways: Home-Based Mental Health Services for Very Young Children in Poverty</i>. Unpublished Program Manual, Marquette University. Available at www.marquette.edu/education/early-pathways. Free on-line training course for professionals at same web address above.</p> <ul style="list-style-type: none"> • Has the intervention been replicated anywhere? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Other countries? <i>Mexico</i> • Other clinical and/or anecdotal evidence Three published randomized controlled studies with diverse samples in poverty and several large, published community based effectiveness studies. 	
Research Evidence	Sample Size (N) and Breakdown (by gender, ethnicity, other cultural factors)	Citation
<p>Pilot Trials/Feasibility Trials (w/o control groups)</p>	<p>238 total children; Gender: females=43; males=59 Race %: AA=43; C=21; L-21; Multi-15 Developmental Delay – 70% Poverty – 85% Child Mean Age – 2.66 years (SD=.74) This was a community-based study of the effectiveness of EP without control groups or random assignment.</p> <p>66 total children; Children in the three comparison groups did not differ significantly on the demographic variables shown below. Gender: females=16; males=50 Race %: AA=33; C=33, L-33 Developmental Delay ≥ 50% Poverty ≥ 82% Child Mean Age – 2.9 years (SD=1.1) This was a community-based, comparison study of the effectiveness of EP between three groups based on the child’s race and did not include control groups or random assignment.</p>	<p>Fox, R.A., & Holtz, C.A. (2009). Treatment outcomes for toddlers with behavior problems from families in poverty. <i>Child and Adolescent Mental Health, 14</i>, 183-189.</p> <p>Gresl, B.L., Fox, R.A. & Fleischmann, A. (2014). Home-based parent-child therapy in low-income African American, Caucasian, and Latino Families: A comparative examination of treatment outcomes, <i>Child & Family Behavior Therapy, 36</i> (1), 33-50,</p>
<p>Clinical Trials (w/control groups)</p>		
<p>Randomized Controlled Trials</p>	<p>199 total children with 102 randomly assigned to an immediate treatment group and 97 to a wait-list control group. Children in the immediate treatment and wait-list control groups did not differ significantly on the demographic variables shown below.</p>	<p>Harris, S. E., Fox, R.A., & Love, J.R. (2015). Early Pathways therapy for young children in poverty: A randomized controlled trial. <i>Counseling Outcome Research and Evaluation, 6</i>, 3-17.</p>

	<p>Gender %: females=30; males=70 Race %: AA=39; L-41; C/Other=20 Child Mean Age - 2.9 years (SD=1.1)</p> <p>81 total children with 44 randomly assigned to an immediate treatment group and 37 to a wait-list control group. Children in the immediate treatment and wait-list control groups did not differ significantly on the demographic variables shown below. Gender: females=32; males=68 Race %: AA=42; C=10; L-18; Multi-30 Child Mean Age - 3.2 years (SD=1.1)</p> <p>Children in the immediate treatment condition did have significantly more traumatic events endorsed ($M = 5.06$; $SD = 2.72$) than children in the wait-list control group ($M = 3.78$; $SD = 1.84$)</p>	<p>Love, J. R., & Fox, R.A. (in press). Home-based parent child therapy for young traumatized children living in poverty: A randomized controlled trial. <i>Journal of Child and Adolescent Trauma</i>.</p>
<p>Studies Describing Modifications</p>	<p>137 total children with 80 randomly assigned to an immediate treatment group and 57 to a wait-list control group. Children in the immediate treatment and wait-list control groups did not differ significantly on the demographic variables shown below. Gender: females=37; males=100 Race %: Latino-137 Child Mean Age - 2.89 years (SD=1.1)</p>	<p>Fung, M.P., & Fox, R.A. (2014). The culturally-adapted early pathways program for young Latino children in poverty: A randomized controlled trial. <i>Journal of Latina/o Psychology</i>, 2, 131-145.</p>
<p>Other Research Evidence</p>		
<p>Outcomes</p>	<p>What assessments or measures are used as part of the intervention or for research purposes, if any?</p> <ul style="list-style-type: none"> • Early Childhood Behavior Screen (Holtz & Fox, 2012; Harris et al., 2016) • Parent Behavior Checklist (Fox, 1994) • Traumatic Events Screening Inventory – Parent Report Revised (Ghosh-Ippen, et al., 2002) • Pediatric Emotional Distress Scale (Saylor, Swenson, Reynolds, & Taylor, 1999) • Preschool Traumatic Stress Screener (Harris, 2016) • Parent-Child Play Interaction (Fox, 2017; unpublished program manual) • Parent-Child Relationship Scale Interaction (Fox, 2017; unpublished program manual) • Treatment Barrier Scale (Gresl, Fox, & Besasie, 2016) • Eyberg Child Behavior Inventory (Eyberg & Pincus, 1999) • Family Satisfaction Scale Interaction (Fox, 2017; unpublished program manual) 	

	<ul style="list-style-type: none"> • If research studies have been conducted, what were the outcomes? EP when compared to wait-list control is linked to improvements in children’s prosocial behaviors and parental confidence, and to reductions in challenging behaviors, parental reliance on corporal and verbal punishment as discipline, and children’s posttraumatic stress symptoms. Also, large scale community-based studies showed similar evidence of effectiveness.
<p>Implementation Requirements & Readiness</p>	<ul style="list-style-type: none"> • Space, materials or equipment requirements? Home setting with minimal distractions; EP also can be implemented in a clinic office setting. Materials includes developmentally appropriate toys, safety supplies (e.g., cabinet locks), and a variety of rewards (stickers, games, etc.). • Supervision requirements (e.g., review of taped sessions)? A free online training program and program manual are available for professionals; the latter includes all parent handouts used in EP in English and Spanish. Normally attendance at a two-day live EP training workshop; participation in a learning community led by competent EP professional, twice monthly for 3-6 months with two successful cases using core EP measures. • To ensure successful implementation, support should be obtained from: An approved EP professional.
<p>Training Materials & Requirements</p>	<p>List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained. On-Line Training Program and EP Program Manual www.marquette.edu/education/early-pathways</p> <ul style="list-style-type: none"> • How/where is training obtained? Marquette University, Penfield Children’s Center (both in Milwaukee, WI) or on-site. • What is the cost of training? Initial two-day training is \$200/day with minimum of 10 participants and includes a EP Program Manual for free that normally costs \$50 (does not include travel costs for on-site training). Participation in a follow-up learning community is required to obtain EP Certification; costs for becoming a Certified EP Provider will vary depending on the number of meetings and contacts required. Certification requires demonstration of competence with EP through taped sessions and successful completion of two cases based on expected pre-post changes on assessment instruments. • Are intervention materials (handouts) available in other languages? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If YES, what languages? Spanish • Other training materials &/or requirements (not included above): Availability of an EP Certification Program will be available in early 2018.
<p>Pros & Cons/ Qualitative Impressions</p>	<ul style="list-style-type: none"> • What are the pros of this intervention over others for this specific group (e.g., addresses stigma re. treatment, addresses transportation barriers)? EP was the result of over 25 years of research on parenting young children including several descriptive studies as well as treatment effectiveness and efficacy studies. EP is practical and relatively easy for all caregivers to understand, regardless of their educational levels. A fidelity checklist is included in the manual, but therapists are encouraged to tailor the intervention to the immediate needs of the child and family. • What are the cons of this intervention over others for this specific group (e.g., length of treatment, difficult to get reimbursement)? Although EP is practical and easy to understand, the therapeutic art involves tailoring the program to the unique situation presented by each family. Attrition remains an ongoing

	<p>challenge, particularly when working with families in poverty.</p> <ul style="list-style-type: none"> • Other qualitative impressions: EP has been used across the spectrum of families from different SES, racial, ethnic and education levels. It also has been used in clinic-settings, although in-home is recommended especially for families in poverty with lower educational attainment
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