NCTSN The National Child Traumatic Stress Network

CARE: Child-Adult Relationship Enhancement

GENERAL INFORMATION

Treatment Description

Acronym *(abbreviation)* **for intervention:** CARE

Average length/number of sessions: Single training session with potential for brief consultation

Aspects of culture or group experiences that are addressed *(e.g., faith/spiritual component, transportation barriers)***:** CARE can be delievered in any setting, thus reducing any transportation variables. It is a group training that incorporates culture and ethnicity issues

Trauma type *(primary)*: Any

Additional descriptors *(not included above)***:** CARE is a trauma-informed set of skills that can be used by any adult in any setting who interacts with children and teens who have experienced trauma. It is based on several evidence-based parenting programs, including PCIT, Incredible Years, Helping the Non-compliant Child, and PMTO. It may complement mental health treatments, but is not a therapy program. It has been used in a wide-variety of settings with varied audiences, including health, mental health, and allied health professionals, family members, and lay professionals. CARE has a building evidence-based including in medical settings and with foster parents.

Target Population

Age range: 2 **to** 18

Gender: ❒ **Males** ❒ **Females** ☒ **Both**

Ethnic/Racial Group *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** All

Other cultural characteristics *(e.g., SES, religion)***:** All

Language*(s)***:** English and Spanish

Region *(e.g., rural, urban)***:** Both

Other characteristics *(not included above)***:** CARE can be generalized to a wide variety of settings. With a growing evidence-base of its effectiveness, CARE training is applicable to a wide range of provider populations that can include but are not limited to:

- Parents/Foster/Adoptive parents
- Medical, Mental Health, and Allied Health professionals
- Child Life Specialists
- Child victim advocates
- Day care settings
- School settings
- Treatment centers/Residential living facilities
- Homeless/Emergency care shelter staff

Target Population cont'd	• Disaster Crisis Counselors • Home Visitors/In home services • Medical facilities • Law enforcement agencies • Child Welfare agencies • Drug and Family Court • Domestic Violence services • Military families and support personnel • Primary Care settings • Clergy • Scout Leaders/Coaches
Essential Components	**Theoretical basis:** Evidence-based CBT parenting programs (PCIT, IY, HNC, PMTO) **Key components:** Two components: Skills for improving attachment and/or strengthening relationships while reducing mild to moderate behavior concerns. Skills for increasing compliance. All components are grounded in an understanding of the impact of trauma on relationships and behaviors.
Clinical & Anecdotal Evidence	**Are you aware of any suggestion/evidence that this treatment may be harmful?** **❒ Yes ☒ No ❒ Uncertain** **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time)***.** 2, although writings related to the EBTs upon which CARE was developed have continually addressed these issues. **This intervention is being used on the basis of anecdotes and personal communications only** *(no writings)* **that suggest its value with this group.** **❒ Yes ☒ No** **Are there any anecdotes describing satisfaction with treatment, drop-out rates** *(e.g., quarterly/annual reports)***? ☒ Yes ❒ No** **If YES, please include citation:** Gurwitch, R.H. (Chair), Messer, E.P., Warner-Metzger, C.M., Masse, J., & Abner, J.P. (Discussant) (September, 2017). Child Adult Relationship Enhancement (CARE): Expanding capacity of PCIT principles. Symposium presented at the PCIT International Convention, Travers City, MI Gurwitch, R.H. & Masse, J. (March, 2018). Child-Adult Relationship Enhancement (CARE): Building stronger communities through stronger relationships. Keynote presentation at the Annual Washington State PCIT Conference, Seattle, WA

Clinical & Anecdotal Evidence cont'd

Has this intervention been presented at scientific meetings? ☒ Yes ❒ No

If YES, please include citation*(s)* **from last five presentations:**

Gurwitch, R.H., Kelley, A., & Berkowitz, S. (April, 2017) Child-Adult Relationship Enhancement (CARE): A New Program for Adults Making a Difference in the Lives of Children. Pre-Meeting Institute presented at the National Child Traumatic Stress Network Meeting, Washington, DC

Gurwitch, R.H., Abner, J.P., Warner-Metzger, C., Masse, J., & Kamo, T. (June, 2018). CARE: Building new bridges. Presented at the 2018 PCIT World Congress, Schweinfurt, Germany.

Messer, E., Gurwitch, R.H., Scott, R., & Wood, J. (August, 2019). PriCARE and IntegratedCARE: Enhancing ease of access to families. In J. Masse, Chair, Cultivating a culture for PCIT: Child-Adult Relationship Enhancement (CARE) in medical settings. Presented at the 2019 PCIT International Biennial Convention, Chicago, IL

Murphy, K.G., Warner-Metzger, C.M., & Moreland, A.D. (April 2019). Child-Adult Relationship Enhancement (CARE): Expanding evidence-based child behavior management skills to an academic medical center. *Behavior Therapist,* 42 (4), 118-121.

Are there any general writings which describe the components of the intervention or how to administer it? ☒ Yes ❒ No

If YES, please include citation:
Gurwitch, R.H., Messer, E., Masse, J., Olafson, E., Boat, B.W., & Putnam, F.W. (2016). Child-Adult Relationship Enhancement (CARE): An evidence-informed program for children with a history of trauma and other behavioral challenges. *Child Abuse & Neglect*, 53, 138-145.

Has the intervention been replicated anywhere? ☒ Yes ❒ No

Other countries? Japan

Other clinical and/or anecdotal evidence *(not included above)***:** CARE is now being incorporated in several large-scale projects, including in school systems (Chicago and SE Ohio), in integrated and primary care settings, and in foster care clinics. Several grants in progress now include CARE

CARE has the following adapations: Primary Care settings (PriCARE), Integrated care settings (I-CARE), School Settings (CARE in the Classroom, versions for pre-K-elementary and middle/high school), Military (CARE for Families who Serve), and Autism (CARE Connections).

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Research Evidence	Sample Size (N) and Breakdown *(by gender, ethnicity, other cultural factors)*	Citation
Pilot Trials/Feasibility Trials *(w/o control groups)*		Wood, J., Dougherty, S. L., Long, J., Messer, E. P., & Rubin, D. M. (2017). A pilot investigation of a novel intervention to improve behavioral well-being for children in foster care. *Journal of Emotional and Behavioral Disorders*. https://dx.doi.org/10.1177/1063426617733715
Randomized Controlled Trials		1. Messer, E.P., Greiner, M., Beal, S., Cassedy, A., Eismann, E., Gurwitch, R.H., Boat, B., Bensman, H., Bemerer, J., Greenwell, S., Eiler-Sims, P. (2018). Child Adult Relationship Enhancement (CARE): A brief, skills-building training for foster caregivers to increase positive parenting practices. *Children and Youth Services Review*, 90, 74-82. 2. Schilling, S., French, B., Berkowitz, S. J., Dougherty, S. L., Scribano, P. V., & Wood, J. N. (2017). Child-Adult Relationship Enhancement in Primary Care (PriCARE): A randomized trial of a parent training for child behavior problems. *Academic Pediatrics, 17*, 53–60. http://dx.doi.org/10.1016/j.acap.2016.06.009

Outcomes	**If research studies have been conducted, what were the outcomes?** Overall improvement in positive parenting skills, decreased endorsement of corporal punishment, improved parent-child relationships, improved behaviors
Implementation Requirements & Readiness	**Space, materials or equipment requirements?** None **Supervision requirements** *(e.g., review of taped sessions)***?** None **To ensure successful implementation, support should be obtained from:** None
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** N/A Handouts for implementation are available at trainings **How/where is training obtained?** Trainings can be obtained through CARE trainers and/or CARE facilitators. Information for available trainers can be obtained in the contact information below **What is the cost of training?** Varies. In general, it is approximately $100/person with a trainer:participant ratio of 1:15-20. **Are intervention materials** *(handouts)* **available in other languages?** ☒ **Yes** ❒ **No**

Training Materials & Requirements cont'd	**If YES, what languages?** Spanish, Japanese **Other training materials &/or requirements** *(not included above)*: • CARE trainings are delivered in 3-6 hour trainings. This depends on the needs of the agency/setting/population. • Once participants complete their CARE training, they can teach CARE 1:1 • CARE offers a Facilitator training to allow these individuals to provide CARE training in a group setting with consultation from their CARE trainer. Requirements to become a CARE facilitator includes training in at least one of the EBTs on which CARE is based. • CARE Coach training can be provided to individuals who may work with a CARE Facilitator to help extend group numbers (e.g., 1 Trainer + 1 CARE Coach: 30-35 participants) • CARE is an extremely interactive training with live practice of skills.
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** CARE skills can be implemented by both professionals and non-professionals in almost any setting. CARE skills are appropriate for use with children and teens (2-18) who have experienced trauma. **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** CARE is not therapy; therefore, children/teens with significant behavior concerns should be enrolled in an evidence-based treatment. CARE may serve to complement this treatment. **Other qualitative impressions:** CARE was initially developed at the Trauma Treatment Training Center of Cincinnati Children's Hospital Medical Center. Since then, it has been manualized, further enhanced and expanded, with numerous adaptations and a growing evidence base. CARE training is manualized. To date, more than 10,000 adults have participated in CARE training in the US and abroad.
Contact Information	**Name:** Robin H. Gurwitch, Ph.D. and Erica Messer, Psy.D. **Phone number:** Gurwitch: 919-385-0707. Messer: 513-636-1734 **Email:** robin.gurwitch@duke.edu or erica.messer@cchmc.org