INSTRUCTIONS AND CODEBOOK:
TREATMENT TARGETS, PROGRESS RATINGS & PRACTICE ELEMENTS

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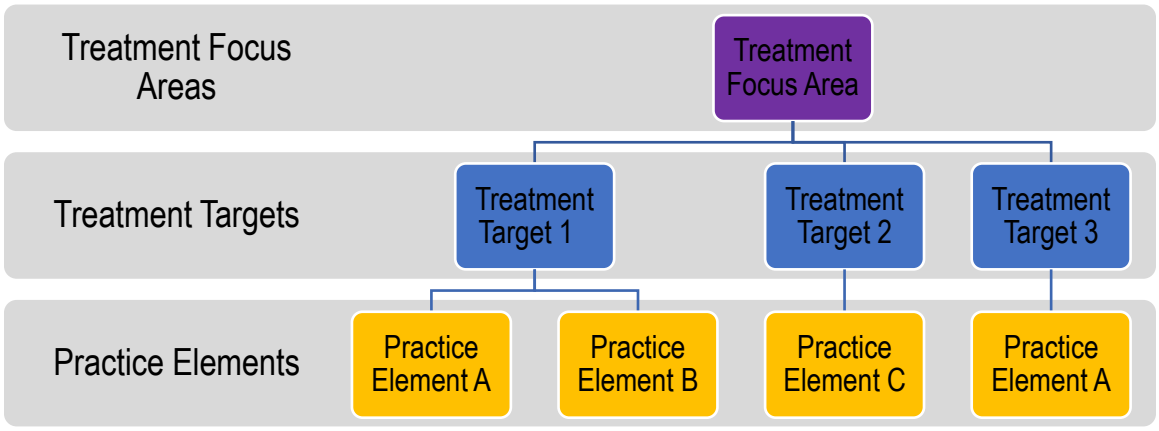
Introduction

This document is to be used in conjunction with the relevant CAMHD treatment forms, reports, and dashboards. This codebook defines the terms and possible responses necessary to accurately complete the treatment target, progress rating, and practice element fields throughout the CAMHD MAX system. A brief summary of the reliability and validity of these metrics is provided in the Appendix. For questions regarding these definitions or the use of these variables, please contact the Clinical Services Office at 808-733-9349. For questions regarding the psychometric properties, research and citation of these variables, please contact the Program Improvement and Communications Office/Research and Evaluation Team at 808-733-9255.

The Relationship Between Treatment Focus Areas, Treatment Targets & Practice Elements

Treatment focus areas, treatment targets, and practice elements are the common metrics by which CAMHD and CAMHD service providers describe and track treatment services (see Figure 1). Based on the treatment focus area, one or more treatment targets are selected as targets for treatment. From those targets, providers select (in consultation with the client and family) and apply practice elements (i.e., specific intervention strategies) within treatment sessions. It should be noted that the same treatment target can (if relevant) be assigned to more than one treatment focus area, just as the same practice element might be applied for more than one treatment target.

Figure 1. Relationship between treatment focus areas, treatment targets and practice elements.



Treatment Focus Areas

Definition of Treatment Focus Areas

Treatment focus areas are open text fields describing the three most important problem areas indicated by the youth and family. These treatment focus areas are deemed to be the primary foci of treatment. It is important to note that details on how to complete treatment focus areas is outside the scope of this document and can be found in instructions for the Initial Mental Health Evaluation and the Clinical Management Plan.

Treatment Targets

Definition of Treatment Targets

Targets are the strengths and needs being addressed as part of the mental health services for youth and family clients.

Purpose of Treatment Targets

Team- and client-identified treatment targets support clinical practice both by identifying concerns that might not arise in standardized measures, and prioritizing client concerns amidst an array of problems. In addition, provider agencies and system evaluators can examine target patterns, with the goal of improving services for clients. The initial list of treatment targets was developed in the early 2000s by the Hawai'i Evidence-Based Services Committee in collaboration with several panels of local practitioners, intervention developers, and other domain experts.

Additional Instructions for Identifying Treatment Targets

For a treatment focus area, please select the relevant treatment targets. The list of treatment targets is intended to provide a summary of strengths and needs that are commonly targeted for change during mental health service provision. These treatment targets are NOT diagnostic descriptions and the primary targets for treatment may change over time for a youth. For example, when treating a youth with an eating disorder, treatment may target eating/feeding behavior at one point but target medical regimen adherence or positive family functioning on other occasions. These treatment targets are for progress summary purposes and should NOT replace the detailed specification of goals and objectives (i.e., treatment focus areas within the Clinical Management Plan or corresponding measurable goals within the Mental Health Treatment Plan) as part of the treatment planning process. If a target is addressed for which there is absolutely no option, please select the "other" option and write in the target. The treatment targets have been developed in an extensive process, mirroring the extant treatment services literature and *every effort* should be made to utilize the list of preexisting treatment targets. It should also be noted that the same treatment target might be relevant for more than one treatment focus area. As an example, if a client has a treatment focus area of "increase mood" and a treatment focus area of "increase school attendance," it is possible that the treatment target depressed mood, might be relevant for both treatment focus areas. In cases like this, it is appropriate to indicate the treatment target twice (i.e., once for each treatment focus area).

TREATMENT TARGET OPTIONS			
Externalizing Behaviors	**Internalizing Behaviors**	**Positive Behaviors**	**Other Targets**
Aggression	Anxiety	Academic Achievement	Adjustment to Life Transition
Anger	Avoidance	Activity Involvement	Attending to Basic Needs
Attention Problems	Depressed Mood	Assertiveness	Cognitive/Intellectual Functioning
Fire Setting	Grief	Community Involvement	Eating/Feeding Problems
Hyperactivity	Phobia/ Fears	Contentment/Enjoyment/Happiness	Enuresis/Encopresis
Oppositional/Non-Compliant Bx	School Refusal/Truancy	Empathy	Gender Identity
Peer/Sibling Conflict	Self-Esteem	Peer Involvement	Health Mngmt/Medical Reg Adhere
Runaway/Elopement	Self-Injurious Behavior	Positive Family Functioning	Impulsivity
Substance Use	Suicidality	Positive Peer Interaction	Independent Living Skills
Willful Misconduct/Delinquency	Traumatic Stress	Positive Thinking/Attitude	LD/Underachievement
		School Involvement	Mania
		Self-Management/Control	Medical Regimen Adherence
		Social Skills	Occupational Functioning/Stress
			Personal Hygiene
			Psychosis
			Sexual Misconduct
			Sleep Disturbance/Sleep Hygiene
			Treatment Engagement

Academic Achievement – issues related to general level or quality of achievement in an educational or academic context. This commonly includes performance in coursework and excludes cognitive-intellectual ability/capacity issues and specific challenges in learning or achievement.

Activity Involvement – issues related to general engagement and participation in activities. Only code here those activities that are not better described by the particular activity classes of school involvement, peer involvement, or community involvement.

Adjustment to Life Transition – issues related to a youth's global response to a life transition or specific challenge (e.g., change of school, change of living situation, treatment transition or discharge, etc.).

Aggression – verbal and/or physical aggression, or threat thereof, that results in intimidation, physical harm, or property destruction.

Anger – emotional experience or expression of agitation or destructiveness directed at a particular object or individual. Common physical feelings include accelerated heartbeat, muscle tension, quicker breathing, and feeling hot.

Anxiety – a general uneasiness that can be characterized by irrational fears, panic, tension, physical symptoms (e.g., stomach aches, difficulty breathing, accelerated heartbeat, muscle tension, sweatiness, dizziness), and/or excessive anxiety, worry, or fear.

Assertiveness – the skills or effectiveness of clearly communicating one's wishes. For example, the effectiveness with which a child refuses unreasonable requests from others, expresses his/her/their rights in a non-aggressive manner, and/or negotiates to get what he/she/they wants in relationships with others.

Attending to Basic Needs – issues related to finding or stabilizing an appropriate living situation for a youth and/or establishing a safe and secure environment for the youth's development (formerly housing/living situation and safe environment).

Attention Problems – described by short attention span, difficulty sustaining attention on a consistent basis, and susceptibility to distraction by extraneous stimuli.

Avoidance – behaviors aimed at escaping or preventing exposure to a particular situation or stimulus.

Cognitive/Intellectual Functioning – issues related to cognitive-intellectual ability/capacity and use of those abilities for positive adaptation to the environment. This includes efforts to increase intelligence quotient, memory capacity, or abstract problem-solving ability.

Community Involvement – detailed description of amount of involvement in specific community activities within the child's day.

Contentment/Enjoyment/Happiness – refers to issues involving the experience and expression of satisfaction, joy, pleasure, and optimism for the future.

Depressed Mood – behaviors that can be described as persistent sadness, anxiety, or "empty" mood, feelings of hopelessness, guilt, worthlessness, helplessness, decreased energy, fatigue, etc.

Eating/Feeding Problems – knowledge or behaviors involved with the ingestion or consumption of food. May include nutritional awareness, food choice, feeding mechanics (e.g., swallowing, gagging, etc.), and social factors relating to eating situations.

Empathy – identification with and understanding of another person's situation, feelings, and motives.

Enuresis/Encopresis – enuresis refers to the repeated pattern of voluntarily or involuntarily passing urine into inappropriate places (e.g., bed, clothes) during the day or at night. Encopresis refers to a repeated pattern of voluntarily or involuntarily passing feces into inappropriate places (e.g., bed, clothes) during the day or at night.

Fire Setting – intentionally igniting fires.

Gender Identity– issues related to a youth's self-concept or self-understanding involving sex roles and social behaviors in relation to his/her/their biological sex. This does not address self-concept issues involving sexual orientation, which would be coded as "other."

Grief – feelings associated with a loss of contact with a significant person in the youth's environment (e.g., parent, guardian, friend, etc.).

Health Management/Medical Regimen Adherence – issues related to the improvement or management of one's health, inclusive of both physical illness and fitness. In addition to dealing with the general development of health-oriented behavior and management of health conditions, this target can also focus on exercise or lack of exercise. This includes knowledge, attitudes or behaviors related to regular implementation procedures prescribed by a health care professional, covered under medical regimen adherence. This also includes lifestyle behaviors (e.g., exercise, nutrition), taking medication, or self-administration of routine assessments (e.g., taking blood samples in a diabetic regimen).

Hyperactivity – can be described by fidgeting, squirming in seat, inability to remain seated, talking excessively, difficulty engaging in leisure activities quietly, etc.

Impulsivity – behavior characterized by little or no forethought, reflection, or consideration of the consequences of an action that impairs functioning. This can include behaviors that put a youth at risk,

including emotional dysregulation. Behaviors that are purely physical or motoric (e.g., shaking legs) should be coded as hyperactivity. Impulsivity related to self-injurious behavior and mania should be coded under those behaviors respectively.

Independent Living Skills – issues related to the development of independent living, social functioning, financial management, and self-sufficiency skills that are not better captured under other codes such as personal hygiene, self-management, social skills, housing/living situation, or occupational functioning/stress (formerly adaptive behavior/living skills).

Learning Disorder/Underachievement – refers to specific challenges with learning or educational performance that are not better accounted for by cognitive/intellectual functioning or general academic achievement.

Mania – an inflated self-perception that can be manifested by a loud, overly friendly social style that oversteps social boundaries, high energy and restlessness, and a reduced need for sleep.

Occupational Functioning/Stress – issues related to career interests, seeking employment, obtaining work permits, job performance, or managing job stress or strain that are not better characterized under other targets (e.g., anxiety, independent living, social functioning, financial management, self-sufficiency, personal hygiene, self-management/self-control, social skills, or housing/living situation).

Oppositional/Non-Compliant Behavior – behaviors that can be described as refusal to follow adult requests or demands or established rules and procedures (e.g., classroom rules, school rules, etc.).

Peer Involvement – a greater involvement in activities with peers. Activities could range from academic tasks to recreational activities while involvement could range from working next to a peer to initiating an activity with a peer. This differs from positive peer interaction in that peer involvement targets actual engagement in activities with peers regardless of interactional processes, while positive peer interaction focuses on interactional behavior, styles, and intentions.

Peer/Sibling Conflict – peer and/or sibling relationships that are characterized by fighting, bullying, defiance, revenge, taunting, incessant teasing and other inappropriate behaviors.

Phobia/Fears – irrational dread, fear, and avoidance of an object, situation, or activity.

Personal Hygiene – challenges related to self-care and grooming.

Positive Family Functioning – issues related to healthy communication, problem-solving, shared pleasurable activities, physical and emotional support, etc. in the context of interactions among multiple persons in a family relation, broadly defined.

Positive Peer Interaction – social interaction and communication with peers that are pro-social and appropriate. This differs from peer involvement in that it focuses on interactional behavior, styles, and intentions, whereas peer involvement targets actual engagement in activities with peers regardless of interactional processes.

Positive Thinking/Attitude – this target involves clear, healthy, or optimistic thinking, and involves the absence of distortions or cognitive bias that might lead to maladaptive behavior.

Psychosis – issues related to bizarre thought content (e.g., delusions of grandeur, persecution, reference, influence, control, somatic sensations), and/or auditory or visual hallucinations.

Runaway/Elopement – running away from home or current residential placement for a day or more.

School Refusal/Truancy – reluctance or refusal to attend school without adult permission for the absence. May be associated with school phobia or fear manifested by frequent somatic complaints associated with attending school or in anticipation of school attendance, or willful avoidance of school in the interest of pursuing other activities.

School Involvement – detailed description of amount of involvement in specific school activities within the child's scheduled school day. Synonymous with school connectedness.

Self-Esteem – an inability to identify or accept his/her/their positive traits or talents and accept compliments. Verbalization of self-disparaging remarks and viewing oneself in a negative manner.

Self-Injurious Behavior – acts of harm, violence, or aggression directed at oneself.

Self-Management/Self-Control – issues related to management, regulation, and monitoring of one's own behavior.

Sexual Misconduct – issues related to sexual conduct that are defined as inappropriate by the youth's social environment or that include intrusion upon or violation of the rights of others.

Sleep Disturbance/ Sleep Hygiene – difficulty getting to or maintaining sleep.

Social Skills – skills for managing interpersonal interactions successfully. Can include body language, verbal tone, assertiveness, and listening skills, among other areas.

Substance Use – issues related to the use or misuse of a common, prescribed, or illicit substance(s) for altering mental or emotional experience or functioning.

Suicidality – issues related to recurrent thoughts, gestures, or attempts to end one's life.

Traumatic Stress – issues related to the experience or witnessing of life events involving actual or threatened death or serious injury to which the youth responded with intense fear, helplessness, or horror.

Treatment Engagement – issues related to targeting interest, motivation, or active participation in therapeutic activities. This includes targeting improved rapport.

Willful Misconduct/Delinquency – persistent failure to comply with rules or expectations in the home, school, or community. Excessive fighting, intimidation of others, cruelty or violence toward people or animals, and/or destruction of property.

Other – any written response to an open-ended question that could not be categorized into another treatment target sub-category and did not necessitate the addition of a new category.

Treatment Target Progress Ratings

Definition of Progress Ratings

Progress ratings are defined as the degree of progress achieved between a client's baseline level of functioning (i.e., the beginning of service) and the goal specified for the target. These progress ratings are provided on a 7-point scale with the anchors of *Deterioration (< 0%), No Significant changes (0 – 10%), Minimal Improvement (11 – 30%), Some Improvement (31 – 50%), Moderate Improvement (51 – 70%), Significant Improvement (71 – 90%),* and *Complete Improvement (91 – 100%)*.

Purpose of Progress Ratings

The use of team- and client-identified treatment targets allows the treatment team to track specific progress ratings over time. This approach is more precise and detailed in assessing outcomes of treatment services than standard measures of clinical diagnostic cut-offs or more general measures of functioning or adjustment. In addition, provider agencies and system evaluators can examine progress rating patterns, with the goal of improving services for clients.

Additional Instructions for Completing Progress Ratings

For a single treatment target, select a progress rating based on the 7-point scale. *Importantly, anchors refer to changes from baseline or beginning of services for that target.* Thus, a youth who had reached 90% of an initial goal would receive a rating of "significant improvement." If that progress were to decline to 70% in the following session, the youth would then get a rating of "moderate improvement" for that target for that session (not "deterioration"). "Deterioration" refers to when a target gets worse from the time it was initially addressed (i.e., baseline). If there is a break in addressing a specific target (e.g., a target is addressed, then not addressed for a month, then addressed again in a later month), use the initial baseline from the first time as the point of comparison. Only when there is a break in the complete episode of care (i.e., discharge followed by later admission), should that reset the baseline for a given target. If a goal is reached (improvement is complete), you may choose to note the date within MAX. This implies that the target is no longer being addressed. Targets that are not complete should be rated again on the following session's progress note. When possible, your overall ratings should be informed by a review of objective measures such as any available and relevant questionnaires or behavioral observation data. For example, if a youth receives a T-score of 70 during an intake assessment and the treatment goal is to reduce this score to 60, then if a youth receives a T-score of 65 during a monthly assessment, then 50% progress may be reported [i.e., (70 – 65)/(70 – 60) = 5/10 = 50% - Some Improvement]. Or if a youth gets into 10 fights per week initially and the treatment goal is to reduce fighting to 0 fights per week, then during a week in which the youth was fighting only 3 times per week, that would reflect 70% progress [i.e., (10 – 3)/(10 – 0) = 7/10 = 70% - Moderate Improvement].

PROGRESS RATINGS
1 - Deterioration <0%
2 - No Significant Changes 0% - 10%
3 - Minimal Improvement 11% - 30%
4 - Some Improvement 31% - 50%
5 - Moderate Improvement 51% - 70%
6 - Significant Improvement 71% - 90%
7 - Complete Improvement 91% - 100%

Practice Elements

Definition of Practice Elements

Practice elements are the discrete clinical intervention strategies (e.g., "time out," "praise") applied by the therapist and/or treating provider within a treatment session.

Purpose of Practice Elements

The initial list of practice elements was developed in the early 2000s by the Hawai'i Evidence-Based Services Committee in collaboration with several panels of local practitioners, intervention developers, and other domain experts. The practice element reporting method offers important clinical information. For example, therapists and families can evaluate the relationship between outcomes and practice elements over time. In addition, provider agencies and system evaluators can examine practice patterns, with the goal of improving services for clients.

Additional Instructions for Completing Practice Elements

For a single treatment session, select the practice elements or intervention strategies applied to address a specific treatment target. If strategies were employed that are not in the following list of definitions, please select "other" and write in the practice element used. The practice elements have been developed in an extensive process, mirroring the extant treatment services literature and *every effort* should be made to utilize the preexisting practice elements, before utilizing the "other" option. It should also be noted that the same practice element might be relevant for more than one treatment target. As an example, if a client has both the depressed mood and anxiety treatment targets, it is possible that a therapist might apply the practice element self-monitoring for both treatment targets. In this case, it would be appropriate to indicate the same practice element for both targets.

PRACTICE ELEMENT OPTIONS

Behavior Management	**Coping/Self-Control**	**Core Practices**	**Other Practices**
Attending	Activity Scheduling	Accessibility Promotion	Anger Management
Behavioral Contracting	Assertiveness Training	Cognitive/Coping	Assessment
Commands/Limit Setting	Biofeedback/Neurofeedback	Family Engagement	Care Coordination
Discrete Trial Training	Communication Skills	Insight Building	Catharsis
Functional Analysis	Exposure	Motivational Interviewing	Crisis Management
Ignoring/DRO	Goal Setting	Psychoed w/ Child	Cultural Training
Line of Sight Supervision	Guided Imagery	Psychoed w/ Parent or Teacher	Educational Support
Modeling	Hypnosis	Relationship/Rapport Building	EMDR
Natural & Logical Consequences	Maintenance/Relapse Prevention	Supportive Listening	Family Therapy
Parent or Teacher Monitoring	Mindfulness		Free Association
Parent or Teacher Praise	Personal Safety Skills		Ind. Therapy for Caregiver
Response Cost	Physical Exercise		Interpretation
Stimulus/Antecedent Control	Problem Solving		Marital Therapy
Tangible Rewards	Relaxation		Medication/Pharmacotherapy
Therapist Praise / Rewards	Response Prevention		Mentoring
Time Out	Self-Monitoring		Milieu Therapy
	Self-Reward/ Self-Praise		Narrative
	Skill Building		Parent Coping
	Social Skills Training		Peer Pairing/ Peer Modeling
			Play Therapy
			Strengthening Informal Supports
			Twelve Step Programming

Accessibility Promotion - any efforts to make treatment services more convenient and accessible (e.g., on-site child care, taxi vouchers, bus tokens, rides).

Activity Scheduling – the assignment or request that a child participate in specific activities outside of therapy time, with the goal of promoting or maintaining involvement in satisfying and enriching experiences.

Anger Management – treatment in the family of anger management with no specific practices identified.

Assertiveness Training – exercises or techniques designed to promote the child's ability to be assertive with others, usually involving rehearsal of assertive interactions.

Assessment – a service provider learning more about the child and family through formal and codified evaluation, testing, or observation (that would not qualify as parent- or self-monitoring).

Attending – exercises involving the youth and caregiver playing together in a specific manner to facilitate their improved verbal communication and nonverbal interaction. This can involve the caregiver's imitation and participation in the youth's activity, as well as parent-directed activities (previously called directed play).

Behavioral Contracting – the development of a formal agreement to specify rules, consequences, and a commitment by the youth and relevant others to honor the content of the agreement. Includes contracting that is not better characterized by goal setting.

Biofeedback/Neurofeedback – strategies to provide information about physiological activity that is typically below the threshold of perception, often involving the use of specialized equipment.

Care Coordination – coordinating among the service providers to ensure effective communication, receipt of appropriate services, adequate housing, etc.

Catharsis – strategies designed to bring about the release of intense emotions, with the intent to develop mastery of affect and conflict.

Cognitive/Coping – any techniques designed to alter interpretation of events through examination of the child's reported thoughts, typically through the generation and rehearsal of alternative counter-statements. This can sometimes be accompanied by exercises designed to comparatively test the validity of the original thoughts and the alternative thoughts through the gathering or review of relevant information.

Commands/Limit Setting – training for caregivers in how to give directions and commands in such a manner as to increase the likelihood of child compliance.

Communication Skills – training for youth or caregivers in how to communicate more effectively with others to increase consistency and minimize stress. Can include a variety of specific communication strategies (e.g., active listening, "I" statements).

Crisis Management – immediate problem-solving approaches to handle urgent or dangerous events. This might involve defusing an escalating pattern of behavior and emotions either in person or by telephone and is typically accompanied by debriefing and follow-up planning.

Cultural Training – education or interaction with culturally important values, rituals, or sites with no specific practices identified.

Discrete Trial Training – a method of teaching involving breaking a task into many small steps and rehearsing these steps repeatedly with prompts and a high rate of reinforcement.

Educational Support – exercises designed to assist the child with specific academic problems, such as homework or study skills. This includes tutoring.

Exposure – techniques or exercises that involve direct or imagined experience with a target stimulus, whether performed gradually or suddenly, and with or without the therapist's elaboration or intensification of the meaning of the stimulus.

Eye Movement Desensitization and Reprocessing– a method in which the youth is guided through a procedure to access and resolve troubling experiences and emotions, while being exposed to a therapeutic visual or tactile stimulus designed to facilitate bilateral brain activity.

Family Engagement – the use of skills and strategies to facilitate family or child's positive interest in participation in an intervention. This is distinct from relationship/rapport building, which aims to increase the quality of the relationship between the youth and the therapist.

Family Therapy – a set of approaches designed to shift patterns of relationships and interactions within a family, typically involving interaction and exercises with the youth, the caregivers, and sometimes siblings.

Free Association – technique for probing the unconscious in which a person recites a running commentary of thoughts and feelings as they occur.

Functional Analysis – arrangement of antecedents and consequences based on a functional understanding of a youth's behavior. This goes beyond straightforward application of other behavioral techniques.

Goal Setting – the clarification of specific goals and developing commitment from youth or family to attempt to achieve those goals (e.g., academic, career, etc.), that is not better characterized by behavioral contracting.

Guided Imagery – visualization or guided imaginal techniques for the purpose of mental rehearsal of successful performance. Guided imagery for the purpose of physical relaxation (e.g., picturing calm scenery) is not coded here, but rather is coded under relaxation.

Hypnosis – the induction of a trance-like mental state achieved through suggestion.

Ignoring/ Differential Reinforcement of Other Behavior – the training of parents or others involved in the social ecology of the child to selectively ignore mild target behaviors and selectively attend to alternative behaviors.

Individual Therapy for Caregiver – any therapy designed directly to target individual (non-dyadic) psychopathology in one or more of the youth's caregivers. This is distinct from marital therapy and communication skills.

Strengthening Informal Supports – working with youth or families to make use of informal supports in their homes and communities (e.g., cultural or faith-based groups, neighbors and friends, etc.).

Insight Building – activity designed to help a youth achieve greater self-understanding.

Interpretation – reflective discussion or listening exercises with the child designed to yield therapeutic interpretations. This does not involve targeting specific thoughts and their alternatives, which would be coded as cognitive/coping.

Line of Sight Supervision – direct observation of a youth for the purpose of assuring safe and appropriate behavior.

Maintenance/Relapse Prevention – exercises and training designed to consolidate skills already developed and to anticipate future challenges, with the overall goal to minimize the chance that gains will be lost in the future.

Marital Therapy – techniques used to improve the quality of the relationship between caregivers.

Medication/Pharmacotherapy – any use of psychotropic medication to manage emotional, behavioral, or psychiatric symptoms.

Mentoring – pairing with a more senior and experienced individual who serves as a positive role model for the identified youth.

Milieu Therapy – a therapeutic approach in residential settings that involves making the environment itself part of the therapeutic program. Often involves a system of privileges and restrictions such as a token or point system.

Mindfulness – exercises designed to facilitate present-focused, non-evaluative observation of experiences as they occur, with a strong emphasis of being "in the moment." This can involve the youth's conscious observation of feelings, thoughts, or situations.

Modeling – demonstration of a desired behavior by a therapist, confederates, peers, or other actors to promote the imitation and subsequent performance of that behavior by the identified youth.

Motivational Interviewing – exercises designed to increase readiness to participate in additional therapeutic activity or programs. These can involve cost-benefit analysis, persuasion, or a variety of other approaches.

Natural and Logical Consequences – training for parents or teachers in (a) allowing youth to experience the negative consequences of poor decisions or unwanted behaviors, or (b) delivering consequences in a manner that is appropriate for the behavior performed by the youth.

Narrative - exercises designed to assist the child in developing and sharing a verbal, written, or artistic narrative or story about the child's life events (typically traumas) and the cognitive and affective processing of those events.

Parent Coping – exercises or strategies designed to enhance caregivers' ability to deal with stressful situations, inclusive of formal interventions targeting one or more caregiver.

Parent or Teacher Monitoring – the repeated measurement of some target index by the caregiver or teacher.

Parent or Teacher Praise – the training of parents, teachers, or others involved in the social ecology of the child in the administration of social rewards to promote desired behaviors. This can involve praise, encouragement, affection, or physical proximity.

Peer Pairing/Peer Modeling – pairing with another youth of same or similar age to allow for reciprocal learning or skills practice.

Personal Safety Skills – training for the youth in how to maintain personal safety of one's physical self. This can include education about attending to one's sense of danger, body ownership issues (e.g., "good touch-bad touch"), risks involved with keeping secrets, how to ask for help when feeling unsafe, and identification of other high-risk situations for abuse.

Physical Exercise – the engagement of the youth in energetic physical movements to promote strength or endurance or both. Examples can include running, swimming, weight-lifting, karate, soccer, etc. Note that when the focus of the physical exercise is also to produce talents or competence, skill building may also apply.

Play Therapy – the use of play as a primary strategy in therapeutic activities. This may include the use of play as a strategy for clinical interpretation. Different from attending, which involves a specific focus on modifying parent-child communication. This is also different from play designed specifically to build relationship quality.

Problem Solving – techniques, discussions, or activities designed to bring about solutions to targeted problems, usually with the intention of imparting a skill for how to approach and solve future problems in a similar manner.

Psychoeducation with Child– the formal review of information with the child about the development of a problem and its relation to a proposed intervention.

Psychoeducation with Parent or Teacher – the formal review of information with the caregiver(s) about the development of the child's problem and its relation to a proposed intervention. This often involves an emphasis on the caregiver's role in either or both.

Relationship/Rapport Building – strategies in which the immediate aim is to increase the quality of the relationship between the youth and the therapist. Can include play, talking, games, or other activities. This is distinct from family engagement, which focuses on the use of skills and strategies to facilitate family or child's positive interest in participation in an intervention.

Relaxation – techniques or exercises designed to induce physiological calming, including muscle relaxation, breathing exercises, meditation, and similar activities. Guided imagery exclusively for the purpose of physical relaxation is also coded here.

Response Cost – training parents or teachers how to use a point or token system in which negative behaviors result in the loss of points or tokens for the youth.

Response Prevention – explicit prevention of a maladaptive behavior that typically occur habitually or in response to emotional or physical discomfort.

Self-Monitoring – the repeated measurement of some target index/behavior by the child.

Self-Reward/Self-Praise – techniques designed to encourage the youth to self-administer positive consequences contingent on performance of target behaviors.

Skill Building – the practice or assignment to practice or participate in activities with the intention of building and promoting talents and competencies.

Social Skills Training – providing information and feedback to improve interpersonal verbal and non-verbal functioning, which may include direct rehearsal of the skills. If this is paired with peer pairing/peer modeling that should be coded as well.

Stimulus/Antecedent Control – strategies to identify specific triggers for problem behaviors and to alter or eliminate those triggers in order to reduce or eliminate the behavior.

Supportive Listening – reflective discussion with the child designed to demonstrate warmth, empathy, and positive regard, without suggesting solutions or alternative interpretations.

Tangible Rewards – the training of parents or others involved in the social ecology of the child in the administration of tangible rewards to promote desired behaviors. This can involve tokens, charts, or record keeping, in addition to first-order reinforcers.

Therapist Praise/Rewards – the administration of tangible (i.e., rewards) or social (e.g., praise) reinforcers by the therapist.

Time Out – the training of or the direct use of a technique involving removing the youth from all reinforcement for a specified period of time following the performance of an identified, unwanted behavior.

Twelve-Step Programming – any programs that involve the twelve-step model for gaining control over problem behavior, most typically in the context of alcohol and substance use but can be used to target other behaviors as well.

Other – any written response to an open-ended question that could not be categorized into another intervention strategy sub-category and did not necessitate the addition of a new category.

Appendix

Psychometric Studies of the Treatment Targets, Progress Ratings and Practice Elements

The psychometric properties of the treatment targets, progress ratings and practice elements have been studied extensively by the CAMHD since the early 2000s. Until recently, these metrics have been measured on a monthly basis via the Monthly Treatment and Progress Summary (MTPS). In February 2019, CAMHD providers began reporting treatment targets, progress ratings and practice elements on a session by session basis. It should be noted that the studies listed below are based on monthly reporting.

Treatment Targets

- On average, 6-8 TTs are endorsed per month[8]
- Most commonly endorsed TTs in intensive in-home: Academic Achievement, Activity Involvement, Aggression, Anger, Depressed Mood, Oppositional/Non-Compliant Behavior, Positive Family Functioning, and Treatment Engagement[3,8]
- Stability of TTs is average to good (k = .52 - .66) across one- and three-months[2]
- Stability of TTs across treatment planning documents is low (k = .32 – .47), with internalizing targets most frequently dropped[10]
- TTs have demonstrated convergent and discriminant validity via relations to diagnoses[6]
- Five-Factor Structure of TTs: Withdrawal, Conduct Problems, Disinhibition, Neurobiological Issues, and Negative Affect[6]

Progress Ratings

- There are significant negative correlations between MTPS and CAFAS at 3, 6, and 9 months (r = -.22, -.28, -.44, respectively) and the CALOCUS at 3 months (r = -.36)[8]
- Average rate of improvement on TTs: 81 days (SD = 17.4) [4,5]
- Disruptive behavior and depressed mood TTs improved by the largest amount[4,5,7]
- Anxiety TTs improved at the fastest rates[4,5,7]

Practice Elements

- Stability of PEs is average to good (k = .50 – .67) across one- and three- months[2]
- Stability of PEs across treatment planning documents is low (k = .26 – .38), with Peer Modeling/Pairing, Anger Management, and internalizing PEs commonly being dropped[10]
- Three-Factor Structure of PEs: Behavioral Management (n = 15, α= .81), Coping and Self-Control (n = 19, α= .82), and Family Interventions (n = 13, α= .78)[9]
- Clinicians more likely to over-report than under-report their use of PEs[1]

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