ChildParent Psychotherapy

Readiness to Implement CPP Agency Self Study

Agency: _____

Introduction

We hope this questionnaire is helpful to agencies and participants in helping you to determine your readiness to implement CPP.

This is phase 1 of the application process to help you determine if your agency is ready to successfully implement/sustain CPP. It is expected to take an hour to complete and should be completed as a self-study.

The full application for a CPP training includes:

Part I: Agency Readiness to Implement CPP Self Study

Part II: CPP Clinician Application and Registration Form (completed by each person in training)

Note:
CPP training typically involves agency teams because reflective supervision and ongoing consultation with colleagues is a core part of the model. We have also found that learning to do a trauma treatment requires the support of a team. For this reason, we typically do not accept private practitioners to training. Some trainers offer exceptions if all of the following conditions are met: 1) practitioners reside in a rural area or an area where there are limited services for young children; 2) practitioners provide services to low-income families who have experienced trauma, 3) practitioners are licensed, and 4) practitioners agree to form reflective supervision consultation groups at least for the duration of the 18-month learning collaborative.

AGENCY PROCEDURAL FIDELITY

Please share information about your agency's prospective CPP team, current client population, resources, practices, and policies, so we can think about how to support the adoption of CPP within your agency.

1. Learning Collaborative (LC) Team

Please check the appropriate box to indicate that you are aware of the criteria for participating in a CPP LC.

- ❑ Participants seeking to be eligible for the CPP roster are master's or doctoral-level clinicians with a degree in a mental health discipline.

OR

- ❑ Some clinical team members are not yet licensed. In which case, please read options below and check the boxes to indicate you are aware of these conditions.
  - ❑ Unlicensed team members must be supervised by a licensed team member who also participates in the LC.
  - ❑ Should that supervisor end participation in the LC, arrangements must be made to have non-licensed staff supervised by a licensed supervisor who has been or is being trained in CPP.
  - ❑ If there are no licensed CPP supervisors within the agency, there are two options for continuing.
    - ❑ Option 1: A licensed supervisor not yet trained in CPP may serve as clinical & legal supervisor. At a minimum, this supervisor needs to participate in consult calls to become aware of how CPP may influence their supervisee's clinical work. This person would not be eligible for the CPP roster unless s/he completes a full CPP Implementation Level course. Participation in consult calls is not counted towards an Implementation Level Course until after the participant attends the Initial CPP didactic training.
    - ❑ Option 2: The agency could contract separately with a licensed clinical supervisor who is trained in CPP, willing to provide clinical supervision, and able to serve as the supervisor of record.
  - ❑ Clinical trainees (those who have not yet completed their clinical internship) may participate in a CPP training but are not eligible for the CPP roster. Trainees typically require more intensive training. Exceptions are if the CPP training is provided through an endorsed CPP internship program.

Please fill in the number in each category below (enter each person only once in the chart). Most teams will typically only have staff entered in column A, but we include columns B&C in case other agency staff have prior CPP experience.
Note: A senior leader is someone who has the ability to support agency-level change. If supervisors function as senior leaders, list them under #3.

	COLUMN A	COLUMN B	COLUMN C

	# in Current CPP LC	# currently participating in another CPP LC	# who completed prior Implementation Level CPP training (Only count those still with your agency)
1) Therapists			
2) Supervisors			
3) Supervisors/senior leaders			
4) Senior leaders			
5) Other staff, specify			

2. Learning Collaborative Training Time

Learning any model requires time and either an adjustment to productivity expectations or an agreement by participants that they will do some of the learning on their own time. Indicate below how your clinic will allot time for CPP training activities.

Please make sure you understand these activities by reviewing the minimum requirements agreement: http://childparentpsychotherapy.com/wp-content/uploads/2018/03/CPP-Training-Agreement-2018.pdf

	Training time paid fully by grant or agency	Training time paid partially by grant or agency	Productivity requirements adjusted to account for training time	Participants expected to do on own time	Other: please specify below
Initial core CPP didactic training (3-day)					
Read CPP manual					
Reflective CPP supervision in agency					
Ongoing consult calls (hourly 2x month)					
Preparation time to present twice on consult calls					

Two competency building workshops (Learning Session 2 & 3; 2-days each)					
Specific calls for supervisors (if held)					
Specific calls for senior leaders (if held)					

3. Adequate Referrals

Approximately how many families does your agency serve in a year?

Percentage in each age group that your agency serves
____% 0-5 ____% 6-12 ____% 13-18 ____%19+

How many children aged birth through 5 is your agency currently serving?

For how many years has your agency provided services to children aged birth through 5?

What services do you provide to children aged birth through 5 (if you use any specific, well-defined treatment models, including any evidence-based models please list and/or describe them here). *Please feel free to include any website links or to upload documents and attach them to this application.*

If your agency is already providing CPP, how many children a year?

Of the children aged birth through 5 that your agency currently serves, what percentage do you think have experienced trauma?

How did you arrive at this number? (please check the one that fits best)

- ❑ Estimate given what is known about the population agency serves
- ❑ Data obtained from screening families treated at the agency

Does agency have adequate referrals of children aged birth through 5 who have likely experienced at least one traumatic event so as to enable your staff to meet the meet the minimum requirements for the CPP training?

Minimum requirements for 18-month training: Clinicians treat at least 4 CPP clients. Supervisors who want to be rostered - at least 2 CPP clients. Children are aged 0-5 and experienced at least one traumatic event.

- ❑ Yes, established early childhood program and/or established early childhood referral source
- ❑ Yes, adequate to do training, but interested in enhancing the number of early childhood referrals we receive
- ❑ No, but we have a plan for cultivating additional referrals as part of engaging in this training
- ❑ No, and we need help to develop a plan to cultivate referrals

If your agency does not have adequate referrals, describe any plans you have for cultivating referrals.

4. Special Populations with Whom you Work

Please let us know if agency staff participating in CPP training provide a majority of their services to any of the following populations. We we will take this into account when selecting agencies who will participate in training even if the agency is not able to send a large team

- ❑ Rural populations (describe):
- ❑ Geographic/service region with few mental health providers (describe):
- ❑ Children with developmental disabilities (describe):
- ❑ Children and families involved with child welfare (describe):
- ❑ Children from military families (describe):

Ethnicity (approximate percentage)

___% African American ___% Caucasian ___% Asian ___% Native American ___% Latino ___% Mixed
___% Other:_____

Socioeconomic Status (approximate percentage)

____%Low(poverty level) _____% Middle _____%High

Specific Language Groups (check all groups served in their native language)

- ❑ Spanish
- ❑ Mandarin
- ❑ Cantonese

❑ Other, specify _____

5. CPP Training Resources
These are resources typically needed for training or for conducting CPP. Please let us know the plan for allowing staff to access these resources.

CPP Manuals
Described on Training Agreement form

Describe plan for providing participants with access
- ❑ Agency will purchase for each participant
- ❑ Agency will purchase a copy & participants will share
- ❑ Participants are aware they need to purchase own books
- ❑ No plan for how participants will access these materials

Video-Enabled Technology
Smartphones, tablets, video-enabled computers
- ❑ Yes - agency provides
- ❑ Staff have to use their own
- ❑ No

Access to Specific Platforms:
- ❑ GOOGLE (e.g. drive)
- ❑ Dropbox,
- ❑ Video Conferencing Software (e.g., WebEx, Zoom)
- ❑ Adobe
- ❑ Other (CPP Trainers specify any specific platforms)

Do you foresee any difficulties allowing staff to videotape sessions and share them with the CPP trainer?
- ❑ No difficulties
- ❑ Moderate difficulties but can likely be overcome
- ❑ Little chance of doing this but will explore

❑ Not possible under current agency policies

What capacity does your organization have for entering data (e.g. fidelity data) into the CPP data system? (check all that apply)

- ❑ Existing research or data management team that can do this
- ❑ Can designate administrative support for these activities
- ❑ Clinicians will do this and are allotted time for data entry
- ❑ Clinicians will do this but no provisions have been made for the additional time this may take
- ❑ Not sure how this will be done
- ❑ Other (CPP Trainers specify any specific platforms)

Toys and Art Supplies

Play and art are key CPP modalities. The toys a CPP clinician uses may vary depending on the age of the child, the goals of treatment, and the trauma the child has experienced. Please see CPP Recommended Toy List.

Please describe your agency's capacity to provide therapists with this resource:

- ❑ Our agency already has or is able to purchase/obtain toys and other materials
- ❑ Clinicians are expected to be responsible for the materials they need to conduct CPP
- ❑ We do not have funding or capacity to purchase these toys
  **We can be creative in thinking about how to do this work when you do not have the capacity to purchase toys.*

Childcare as needed: (check all that apply)

In CPP, the therapist need to meet alone with the caregiver (e.g. to talk about the child's experience of trauma, the caregiver's experience of trauma, and critical safety concerns the child should not hear about). In families with multiple children, given the needs of one particular child, it may be critical to work alone with the dyad. For example, if a child has been abused and the sibling has not, it might not be good for the sibling to be exposed to what happened. The child who experienced the abuse may need all of their caregiver's attention to process what happened.

- ❑ Agency offers childcare
- ❑ Can arrange for childcare as needed (e.g. other agency staff can watch children)
- ❑ Able to schedule with caregivers to hold sessions alone
- ❑ Can reimburse parents for some childcare
- ❑ No, and this may represent a challenge to doing CPP

Transportation: Does your clinic have transportation resources for families?

Many low-income families may have great difficulty coming to a clinic, and conducting treatment in their homes or communities may present challenges to treatment due to safety issues or lack of privacy.

- ❑ Yes, (e.g. vouchers, rides, or tokens)
- ❑ Not currently but can make this possible
- ❑ Not possible

6. Agency Policies and Procedures and CPP Policies and Procedures

Weekly CPP sessions

Agency caseload allows CPP therapists to see CPP clients on at least a weekly basis

- ❑ Yes, currently
- ❑ Not currently but can make this possible
- ❑ Does not fit with agency policies

Longer Term Psychotherapy if Needed

How many sessions do you typically provide to the children/families you serve?

Any limit to the number of sessions you can provide? If yes, specify approximate number of sessions.

Any time limits related to how long you can work with a family (e.g. 6 months, 1 year). If yes, specify time limit.

Flexibility in Treatment Setting

CPP is a flexible treatment with sessions held in the home, the clinic, or the community as determined by safety considerations, the needs of the family, and treatment goals. Indicate whether it is feasible to conduct treatment in the following settings:

	Yes, can do	Not currently but can make this possible	Does not fit with agency policies
Office visits			
Home visits			
Community setting (e.g., childcare or community center with adequate private space)			

Foundational Phase Procedures

Can CPP therapist conduct the CPP assessment?

In some agencies or systems, the assessment is done by a separate team or individual.

- ❑ Yes, therapists can conduct the assessment with the family
- ❑ Not currently but can make this possible
- ❑ Can at least arrange for therapists to be able to conduct the trauma screenings
- ❑ Does not fit with agency policies

Specifically, the therapist is able to meet **alone** with the caregiver to assess for:	Yes, currently	Not currently but can make this possible	Does not fit with agency policies
Child trauma history using a comprehensive child trauma screening instrument			
Child symptoms and general areas of concern (can be done with an instrument or clinical interview)			
Child trauma symptoms (can be done with an instrument or clinical interview)			
Caregiver trauma history using a comprehensive trauma screening instrument			
Caregiver symptoms (can be done with an instrument or clinical interview)			
The therapist meets with the child and caregiver to assess for:	Yes, currently	Not currently but can make this possible	Does not fit with agency policies
Child's developmental functioning (using structured assessment or clinical observation)			
Quality of the caregiver-child relationship (using clinical observation or other observational methods)			
Determination of the Appropriateness of CPP	Yes, good fit	Not currently but can make	Does not fit with agency

		this possible	policies
Agency allows therapists to use the foundational phase and the assessments conducted during this phase to determine whether it is safe and appropriate to involve the child in CPP and if not consider alternate modalities (e.g. CPP without the child, dyadic therapy that does not include a direct focus on the child's trauma history, referral to other treatment, referral to other clinic).			
CPP Termination Process	Yes, good fit	Not currently but can make this possible	Does not fit with agency policies
Agency understands that in trauma treatment, termination is a phase of treatment and, when clinically indicated, enables a therapist to spend 2 months or more, as needed, on this phase of treatment.			

7. Capacity to Bill for CPP Activities

Agency billing practices allow therapists to have the following types of sessions and/or activities	Yes, currently	Not currently but can make this possible	Does not fit with agency policies
Dyadic caregiver-child sessions			
Separate treatments with different caregivers if clinically indicated (e.g. child & mom and child & dad seen separately in cases with domestic violence, or child & bio parent and child & foster parent if indicated for families in the foster care mental health system)			
Family sessions			
Collateral sessions alone with caregiver(s) to conduct initial and subsequent assessments			
Collateral sessions alone with the caregiver (e.g. to focus on safety issues, to help the caregiver better understand and support treatment)			

Collateral sessions with other care providers (e.g. childcare)			
Individual sessions with child (if clinically indicated)			
Case management			

AGENCY REFLECTIVE PRACTICE FIDELITY

CPP uptake is more efficient and more sustainable when team members have regular time within the agency to reflect on the model and their work.

During training, all CPP participants meet at least twice a month for CPP supervision/consultation within their own agency (this is separate from the consultation they receive with the CPP trainer). We strongly recommend that those who can, conduct weekly reflective supervision meetings.

*Please note:

- Participants who are not in an agency (e.g. private practice clinicians) should form CPP peer supervision teams.
- Agency and peer supervision/consultation groups are often conducted on the weeks when a CPP consultation session is not held with the CPP trainer.

Experience in Reflective Supervision
What type of training/experience have your staff had in reflective supervision? (please describe below)

Current Reflective Supervision
Currently, how many hours a week on average do team members receive supervision?
Estimated percentage of supervision spent on administration/billing?
Estimated percentage of supervision spent on clinical issues?

- administration/billing:
- clinical issues:

Current Case Consultations
How many hours a week do team members spend in case conferences/presentations, not including reflective supervision?

Agency Plan for Reflective Supervision in Agency During Training
(check one)

- ❑ Minimum once a week
- ❑ Minimum twice a month (this is the training minimum)
- ❑ Minimum once a month
- ❑ No plan for supervision/consultation within the agency

Briefly describe what supervision looks like in your agency.
(type description here)

Agency Plan for Reflective Supervision in Agency After Training

Unlicensed staff (check all that apply)

- ❑ Regular reflective supervision, at least once a week one hour
- ❑ Regular reflective supervision, twice a month
- ❑ Regular reflective supervision, at least once a month
- ❑ Reflective supervision as needed
- ❑ Case-based team meetings
- ❑ No plan for supervision/consultation within the agency

Licensed staff

- ❑ Regular reflective supervision/consultation, at least once a week one hour
- ❑ Regular reflective supervision/consultation, twice a month
- ❑ Regular reflective supervision/consultation, at least once a month
- ❑ Reflective supervision/consultation as needed
- ❑ Case-based team meetings
- ❑ No plan for supervision/consultation within the agency

Addressing Potential Vicarious Trauma
Hearing about and directly addressing the trauma experienced by young children and their families may impact the provider. Please describe how agency currently addresses vicarious trauma and any plans you may have to address it as your agency begins implementing a trauma treatment.

Support for Gaining Foundational Knowledge
How will staff gain expertise in areas fundamental to CPP.?

Foundational Knowledge Areas	Agency staff have expertise & will serve as a resource to staff in need of additional learning	Agency will seek additional trainings with CPP training team or other trainers	Agency enables staff to participate in outside trainings	Staff will seek training on their own (please describe)
Early Childhood Development (normative development, attachment, temperament)				
Diagnostic Frameworks for Young Children (DC: 0-5)				
Understanding Adult Development (Becoming a parent as a key transition)				
Working with Adults with Severe Mental Illness (Depression, PTSD, Other Serious Mental Illness, Substance Use)				
Understanding Trauma and Its Impact on Development, Functioning, and Relationships				
Integrating a Focus on Culture, Diversity, and Context				

AGENCY EMOTIONAL PROCESS FIDELITY

Supporting Caregivers with Strong Emotional Reactions
If clinically called for, agency policies enable therapists to meet alone with caregivers who are having strong emotional reactions that interfere with their capacity to help their child process his/her experience.

- ❑ Yes, good fit with agency policies
- ❑ Not currently but can make this possible
- ❑ Does not fit with agency policies

Agency staff can connect caregivers to therapy services as needed (check all that apply).

- ❑ Yes, adult services provided on site
- ❑ Yes, can link to services outside of agency
- ❑ Not currently but can make this possible
- ❑ Does not fit with agency policies

Supporting Children's Emotional Needs
Agency policies enable therapist to configure treatment (e.g. have family sessions that include siblings or hold separate sessions for different siblings) based on the emotional needs of different family members.

- ❑ Yes, good fit with agency policies
- ❑ Not currently but can make this possible
- ❑ Does not fit with agency policies

Pacing of Treatment
Agency policies are responsive to the fact that the pacing of treatment (e.g. how many sessions are needed) is determined in part on the emotional needs of family members rather than on just the specific goals the therapist and family have set.

- ❑ Yes, good fit with agency policies
- ❑ Not currently but can make this possible
- ❑ Does not fit with agency policies

AGENCY DYADIC RELATIONAL FIDELITY

Dyadic Therapy: Does your agency currently use any dyadic models?
Model where a caregiver and child are seen jointly together

- ❑ Yes, agency has a history (> 2 years) of providing dyadic treatment
- ❑ Yes, agency has been providing dyadic treatment for 2 years or less

- ❑ No, but there is a clear commitment across clinical staff, supervisors, and managers to do dyadic treatment
- ❑ No, and it is unclear whether the agency has a clear commitment across staff to do dyadic treatment

If yes, describe the dyadic models your agency currently uses.
If you have described this before in this application, just name the model here.

Family Therapy: Does your agency currently use any family therapy models?
Models where multiple caregivers and/or children are seen jointly together

- ❑ Yes, agency has a history (> 2 years) of providing family therapy
- ❑ Yes, agency has been providing family therapy for 2 years or less
- ❑ No, but there is a clear commitment across clinical staff, supervisors, and managers to do family therapy
- ❑ No, and it is unclear whether the agency has a clear commitment across staff to do family therapy

If yes, describe the family therapy models your agency currently uses.
If you have described this before in this application, please just name the model here.

AGENCY TRAUMA FRAMEWORK FIDELITY

Trauma Responsive Case Assignments and Caseloads
As an agency begins to provide trauma treatments, it is critical that agency staff (senior leaders, supervisors, and therapists) think jointly about how trauma may affect the therapist when they assign a caseload. Here are key factors to think about:

- Therapist history and whether the therapist wants to become a trauma therapist and do trauma treatment
- Therapist history and how this affects the types of cases this therapist may perceive as challenging. Please note, we should not assume that a therapist with a specific trauma history (e.g. sexual abuse or witnessing domestic violence) would be challenged in working with families with similar experiences but rather would hope that the agency climate might allow a therapist to discuss this to determine how to best support therapist (e.g. additional reflective supervision or consultation around these cases or possibly not taking on referrals that are identified as having these presenting concerns)
- Caseload
    - It is important to think about the way an agency counts cases (e.g. one family is one case or by clinical hours to account for high intensity families)
    - Some cases are more straightforward requiring one clinical hour per week. Others are more complex and may require additional time for the following reasons:
        - More intense case coordination needs (e.g. a family who does not have basic needs, a family with immigration status challenges, a family living in a violent area)

- Ongoing safety issues that need to be addressed
- Multiple caregivers in treatment with child (sometimes together and sometimes requiring separate sessions)
- Multiple children in the family (sometimes may be seen together but at other times this limits the efficiency or effectiveness of the treatment

- Many therapists have shared that it is challenging to be in the Foundational Phase with numerous clients at the same time as you are hearing and integrating their trauma histories. They prefer to begin with a few cases, see them intensively and then as their treatments progress add additional cases. Would this be possible in your agency if this is something that therapists preferred?
- Many therapists have shared that it is hard to carry a full load of high risk cases, and that the work is especially challenging with families where safety is not yet established and/or the caregivers do not acknowledge the child's experience of trauma and its impact on development. It is helpful to include cases within each therapist's caseload that have a higher likelihood of treatment success because the caregiver acknowledges and wants to address the child's trauma history.
- Factors that may affect a therapist's capacity to carry a higher trauma caseload
  - Whether a therapist is learning the model or has established some competence in the model
  - Amount of agency support
  - Capacity to receive reflective supervision
  - Variability in terms of caseload
    - e.g. not all sexual abuse or traumatic bereavement cases
    - e.g. not all cases with significant systems issues
    - e.g. not all cases with significant safety issues
  - Complexity of cases (e.g. systems involvement, multiple caregivers)
- In some places there is additional burden placed on clinicians who provide services in other language due to the agency's limited capacity to otherwise serve families with specific linguistic needs. These clinicians may have a higher number of cases, more complex cases (e.g. with immigration and housing issues), and specific challenges related to providing services in another language.

Select the option that best captures your agency's current position regarding the above:

- ❑ My agency is aware of these issues and has been able to alter the referral process and caseloads accordingly
- ❑ My agency is aware of these issues but could use support in thinking about how possible ways to alter referral processes and caseloads
- ❑ My agency is not yet aware of these issues, but I believe the agency would welcome thinking about them
- ❑ My agency is not yet aware of these issues; I am unsure if my agency is able to alter referral processes and caseloads

Trauma-Informed Services

Does your agency currently provide trauma treatments or trauma-informed services? Please describe below (include the age-groups served):

Trauma and Engagement

Trauma can affect the way that families engage with treatment.

- They may fear systems involvement due to past history with systems or providers that have felt oppressive
- They may be mandated to treatment or feel that treatment is obligatory, so that they are not initially treatment seekers
- They may experience mental health challenges (e.g. depression and PTSD) that make it difficult to engage in services
- They may have had challenging interpersonal experiences that would naturally lead to lower levels of trust and more difficulty establishing rapport
- They may be experiencing numerous competing demands in addition to therapy (e.g. need to get stable housing, employment, other services)
- They may fear systems involvement due to ongoing risky behavior (e.g. substance abuse, domestic violence)
- Families with immigration status challenges may worry if treatment is safe or may jeopardize their ability to be in this country

Please feel free to see the Barriers to Engagement and Facilitators of Engagement tables (Ghosh Ippen, 2012) for a listing of additional factors to consider.

Below we ask about the agency engagement process. By this we mean, the following:

- Outreach: Whether there is community outreach and who provides outreach
- How referrals are handled
- Initial meeting with families: How the process and paperwork are explained to them
- Agency policies around initial attendance during an engagement phase

Select the option that best captures your agency's current position regarding the above:

- ❑ My agency is aware of these issues and has been able to alter the engagement process accordingly
- ❑ My agency is aware of these issues but could use support in thinking about ways to alter the engagement process
- ❑ My agency is not yet aware of these issues, but I believe the agency would welcome thinking about them.
- ❑ My agency is not yet aware of these issues; I am unsure if the agency is capable of altering the engagement process

Content Fidelity

Please review the CPP Fidelity form to understand common CPP intervention objectives. Below we highlight specific objectives that require agency support.

Safety

When we work with families who have experienced trauma, we often work with families who may be experiencing ongoing safety concerns (e.g. living in community violence, immigration status challenges, experiencing ongoing domestic violence).

Agency is aware that the course and focus of treatment may be affected by existing or emerging safety issues?

- ❑ Yes, fully
- ❑ Yes, in part
- ❑ Unsure
- ❑ Not something the agency currently considers

Agency understands how policies around reporting (e.g. domestic violence, child abuse, immigration issues) may affect engagement?

- ❑ Yes, fully
- ❑ Yes, in part
- ❑ Unsure
- ❑ Not something the agency currently considers

When there are significant safety concerns, do agency policies allow for additional support (e.g. supervision around how to handle safety issues, emotional support to prevent burnout)?

- ❑ Yes, fully
- ❑ Yes, in part
- ❑ Unsure
- ❑ Not something the agency currently considers

Care Coordination

When we work with families who have experienced trauma, they often have other needs and services (e.g. housing, adult mental health treatment, child welfare involvement)

Agency has links with child welfare, can obtain CPS reports related to placement history, and has the capacity to participate in team meetings to coordinate care.

- ❑ Yes, fully
- ❑ Yes, in part
- ❑ Unsure
- ❑ Not something the agency currently considers

Agency has ability to connect families to other services (e.g. adult mental health, substance use, housing, case management)

- ❑ Yes, fully (describe below)
- ❑ Yes, in part (describe below)

❑ Unsure ❑ Not something the agency currently considers
Agency has the capacity to provide case management within the agency (check all that apply) ❑ Therapist can provide case management ❑ Agency provides case management services ❑ Agency has close links to case management services in another agency ❑ Unsure ❑ Not something the agency currently provides

*Modified 12/23/2020 by A. Fultz to include specifics regarding Oklahoma LC