NC CHILD TREATMENT PROGRAM | CENTER FOR CHILD & FAMILY HEALTH

# North Carolina Child Treatment Program (NC CTP)
# Evidence-Based Treatment (EBT) Service Delivery Time Model Series

## Clinical Service Delivery Time Model for Child-Parent Psychotherapy (CPP)

Case-level Time Estimate

### CPP Time Model Template

The *NC CTP Clinical Service Delivery Time Model (CPP)* template was developed to support service utilization data collection, aggregation, and analysis at the level of the client, caseload, and agency. NC CTP populated this template with case-level utilization *estimates* in order to provide guidance regarding the development and sustainment of an outpatient CPP program. *

CPP service utilization estimates and data should be interpreted with caution, under the guidance of a CPP clinical expert, when applied to: clinical network development and contracting, establishment of service delivery payment rates, utilization management, and clinical performance monitoring. This template should not be used to facilitate training, treatment, fidelity monitoring, and/or clinical supervision, as these standards are established by the CPP model developers (www.childparentpsychotherapy.com).

The *NC CTP Clinical Service Delivery Time Model (CPP)* defines a "typical" case as one in which CPP is delivered to a client and caregiver presenting with moderate clinical complexity, in the primary language of both participants. Service delivery is described in terms of: **a)** total number of clinical encounters (in-session treatment); **b)** total clinical encounter time (hours); and **c)** total out-of-session clinical support activity time (hours). Case-level service utilization is impacted by case complexity and other implementation-related factors; therefore, case-level service utilization may fall outside the "typical" range of encounters or time spent in- or out-of-session, yet remain acceptable clinically.

* Estimates are based on the peer-reviewed literature, CPP trainer experience, and service utilization data from a cohort of CPP clients associated with NC CTP trainees and graduates.

## CPP Service Delivery

- CPP is a dyadic, trauma treatment model that includes three phases: Foundational Phase (Assessment and Engagement), Core Intervention Phase, and Recapitulation and Termination Phase.
- CPP delivery typically includes a child-client and at least one primary caregiver. In select circumstances, a primary caregiver may be identified as the client, or target of intervention.
- Clinical encounter participation varies based on treatment phase, whereby the majority of clinical encounters are conducted individually with the caregiver during the Foundational Phase, and the majority of clinical encounters are conducted with client-caregiver dyad during Core Intervention Phase and Recapitulation and Termination Phase.
- Clinical encounters (treatment sessions) are conducted on a weekly basis over the course of a year; less frequent sessions may adversely impact the achievement of targeted clinical outcomes. In select circumstances, a client and/or caregiver may participate in more than one clinical encounter during a single week.
- A clinical encounter is typically scheduled for 60 minutes; treatment sessions frequently exceed 60 minutes, yet remain clinically appropriate.
- A typical course of CPP includes an estimated: **a)** 34 clinical encounters and **b)** 78 minutes of clinical support activity time (out-of-session) for every 60-minute clinical encounter.
- Case-level service utilization (clinical encounter number and time, and out-of-session clinical support time) may fall outside the "typical" range, yet remain clinically acceptable, due to case complexity and implementation-related factors.
- Treatment content and intensity, clinician fidelity, and clinical outcomes vary across a CPP caseload due to child-, caregiver-, family-, clinician-, agency-, and systems-level factors.

### Table One: CPP Total Treatment Time Estimate Summary
(Case-level)

| **Clinical Activities** (Case-level) | | **Treatment Time** | |
|---|---|---|---|
| | | Typical Case [a] (Hours) | Typical Range [b] (Hours) |
| **Total In-Session Activities** | | 34.0 | 21.0 - 56.0 |
| CPP-specific activities [c] | (Table Two) | 33.0 | 21.0 – 55.0 |
| General clinical activities [d] | (Table Two) | 1.0 | 0.0 – 1.0 |
| **Total Out-of-Session Activities** [e] | (Table Three) | 43.5 | 23.0 – 77.0 |
| **Total Treatment Time** | (In-Session + Out-of-Session) | 77.5 | 44.0 – 133.0 |
| **Ratio** [f] | (In-Session) : (Out-of-Session) | (1 : 1.3) | (1 : 1) – (1 : 1.4) |

[a] "Typical case" includes CPP delivery in a community-based setting, to a client presenting with moderate clinical complexity, in the primary language of both client and caregiver.

[b] Service utilization data may fall outside the "typical" range, yet remain clinically acceptable, due to case complexity and implementation-related factors.

[c] CPP-specific activities are defined per the CPP manuals[1,2] and Fidelity Toolkit[3]

[d] General clinical activities are conducted in-session and include clinical intake and other agency-specific clinical activities.

[e] Clinical support activities are conducted out-of-session by a treating clinician and include: clinical intake, clinical assessment, treatment and discharge planning, crisis response, clinical care coordination; case-level fidelity monitoring; and clinician travel. These services are critical to successful CPP implementation and to the achievement of targeted clinical outcomes.

[f] A typical course of treatment includes an estimated 78 minutes of clinical support activity time (out-of-session) for every 60-minute encounter.

**Table Two: CPP Clinical Activities Estimate**
(In-Session Activities)

| **In-Session Activities** [a] (Case-level) | Clinical Encounters **(# Sessions)** | | | Total Treatment Time **(Hours)** [b] | | |
|---|---|---|---|---|---|---|
| | Typical Case | Typical Range | | Typical Case | Typical Range | |
| | | Minimum | Maximum | | Minimum | Maximum |
| **CPP-specific Activities** [c] | | | | | | |
| Foundational Phase: Assessment and Engagement | 7 | 4 | 14 | 7.0 | 4.0 | 14.0 |
| Foundational Phase: Feedback | 1 | 1 | 2 | 1.0 | 1.0 | 2.0 |
| Core Intervention Phase: Introducing the Child to CPP | 1 | 1 | 1 | 1.0 | 1.0 | 1.0 |
| Core Intervention Phase | 16 | 10 | 24 | 16.0 | 10.0 | 24.0 |
| CPP interval assessment during Core Intervention Phase[d] | 2 | 0 | 4 | 2.0 | 0.0 | 4.0 |
| Recapitulation and Termination Phase | 6 | 5 | 10 | 6.0 | 5.0 | 10.0 |
| ***Subtotal*** | **33** | **21** | **55** | **33.0** | **21.0** | **55.0** |
| **General Clinical Activities** | | | | | | |
| General intake [e] | 1 | 0 | 1 | 1.0 | 0.0 | 1.0 |
| Other | - | - | - | - | - | - |
| **TOTAL** | **34** | **21** | **56** | **34.0** | **21.0** | **56.0** |

[a] Includes general and CPP-specific clinical activities delivered during a clinical encounter (treatment session); multiple activities may be delivered during a single clinical encounter.
[b] Assumes each clinical encounter is 60 minutes in duration; duration may vary based on clinical considerations.
[c] Defined by the CPP manuals[1,2] and Fidelity Toolkit[3]
[d] Standardized assessment measures are typically re-administered at the twelfth (12) Core Intervention session, and every 12 sessions thereafter. Timing of interval assessment administration may vary based on clinical need.
[e] Includes consent and other agency-specific documentation and activities.

**Table Three: CPP Clinical Support Activities Estimate**
(Out-of-Session Activities)

| **Out-of-Session Activities** [a] (Case-level) | | **Time per Activity** | | |
|---|---|---|---|---|
| | | Typical Case (Hours) | Typical Range (Hours) | |
| | | | Minimum | Maximum |
| Case Support Activities | General intake [b] | 0.5 | 0.0 | 1.0 |
| | Clinical assessment [c] | 3.0 | 1.0 | 5.0 |
| | Treatment planning | 0.5 | 0.5 | 1.0 |
| | Clinical encounter (session) preparation [d] | 2.8 | 1.8 | 4.7 |
| | Clinical encounter (session) documentation [e] | 5.7 | 3.5 | 9.3 |
| | Discharge planning | 0.5 | 0.0 | 1.0 |
| | Clinical care coordination [f] | 17.0 | 10.5 | 28.0 |
| | Crisis response [g] | 4.0 | 0 | 10.0 |
| | Other | - | - | - |
| CPP Fidelity Support Activities | Clinician fidelity self-monitoring [e,h] | 5.7 | 3.5 | 9.3 |
| | CPP reflective supervision [i] | 2.8 | 1.8 | 4.7 |
| | Other | 0 | 0 | - |
| General Support Activities [g] | Additional documentation | - | - | - |
| | Insurance + billing support | 1.0 | 0 | 3.0 |
| | Clinician Travel | - | - | - |
| | Court preparation + testimony | - | - | - |
| | Other | - | - | - |
| **TOTAL** | | 43.5 | 22.6 | 77.0 |

[a] Conducted out-of-session by a treating clinician; critical to successful CPP implementation and achievement of targeted clinical outcomes.

[b] Includes consent and other agency-specific documentation and activities.

[c] Includes out-of-session: scoring and interpretation of clinical assessment measures; collateral contact; record review; case conceptualization; and documentation of assessment process, findings, and conclusions.

[d] Assumes five (5) minutes per clinical encounter; includes preparation of case-specific clinical materials.

[e] Assumes ten (10) minutes per clinical encounter.

[f] Assumes thirty (30) minutes per clinical encounter. Includes case-specific: treatment/multidisciplinary team participation; collateral contact; service coordination and monitoring; provision of consultation to professionals; and direct caregiver support.

[g] Highly variable across clients.

[h] Fidelity is monitored by a treating clinician at the clinical encounter level, and at regular intervals, as defined by the CPP Fidelity Toolkit[3]

[i] Assumes five (5) minutes per clinical encounter, averaged over the course of treatment. A treating clinician should participate in case-specific CPP reflective supervision with a trained supervisor or peer; frequency depends upon caseload size, case complexity, supervision structure, agency requirements, and other factors.

## Agency-level CPP Program: Additional Resource Requirements

The following should be considered when determining the resource allocation necessary to develop and sustain an outpatient CPP treatment program:

### Clinician Training and National Rostering

To become nationally rostered, a clinician must complete all training and rostering requirements, as outlined by the CPP National Therapist Rostering Program (www.childparentpsychotherapy.com).

The cost associated with participation in a CPP training program is variable and depends upon: curriculum content and format; costs incurred by trainer and trainee participants; and direct and indirect funding sources.

### Post-Training Reflective Supervision

While maintaining an active caseload, a CPP clinician should participate in a minimum of two hours per month of CPP reflective supervision provided by a trained supervisor or peer. CPP reflective supervision may be conducted in a group or individual format, using the CPP fidelity toolkit. Additionally, the clinician should self-monitor fidelity across their caseload throughout treatment delivery.

When allocating resources to support supervision, consider: caseload size and complexity; CPP fidelity requirements; supervision structure; agency requirements; and other factors. Case-specific reflective supervision is estimated to be five (5) minutes for every clinical encounter, or 2.8 hours, for a typical course of treatment.

### Clinical Assessment Measures

CPP requires the administration of standardized clinical tools to assess multiple client and caregiver domains including: trauma history, trauma symptoms, mental health symptoms and functioning, child development, physical safety, child-caregiver interaction, parenting, and family ecology.

The cost associated with purchase or licensing of standardized clinical assessment measures should be considered when allocating resources to support an agency-level CPP program.

### Clinical Materials

CPP delivery utilizes a clinical toy kit and other clinical materials during each clinical encounter; cost is variable.

### Clinician Travel

A CPP clinician may participate in activities that require travel, including home-based treatment delivery and clinical support activities (out-of-session).

When allocating resources to support an agency-level CPP program, consideration should be given to clinician travel time, as well as direct travel expenses.

North Carolina Child Treatment Program
Evidence-Based Treatment (EBT) Service Delivery Time Model Series

# Clinical Service Delivery Time Model for Child-Parent Psychotherapy (CPP)

Model Overview, Research Base, and Outcomes

## Section One: CPP Overview

### Model Developers

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### Treatment Protocols (manuals)

- Lieberman, A. F., Ghosh Ippen, C., & Van Horn, P. (2015). *Don't hit my mommy!: A manual for child-parent psychotherapy with young witnesses of family violence* (2nd ed.). Washington, DC: Zero to Three.[1]
- Lieberman, A. F., & Van, H. P. (2008). *Psychotherapy with infants and young children: Repairing the effects of stress and trauma on early attachment*. New York, NY: Guilford Press[2]

### Model Description

CPP is an evidence-based, dyadic mental health treatment for children who are experiencing symptoms following a wide range of traumatic experiences or exposures; additionally, the model may be used to address client-caregiver attachment difficulties. CPP incorporates multiple treatment strategies, including: family assessment and engagement; safety planning; care coordination; psychoeducation about child development and behavior; provision of reflective, non-directive developmental guidance; support of dyadic physiological and affective co-regulation; and trauma processing.

### Treatment Theory

CPP is based on attachment, psychoanalytic, and developmental psychopathology theories.

### Target Population

CPP is indicated for children birth through five years of age* who are symptomatic following traumatic experiences and exposures, or are experiencing significant difficulties in the child-parent relationship. CPP may also be indicated for caregivers exhibiting significant stress or dysfunction due to trauma, interpersonal violence, mental health disorders, substance use, or physical health challenges.

*Treatment delivery may be tailored based on the developmental age, rather than chronological age, of a client with intellectual and/or developmental disabilities.

**Targeted Clinical Outcomes**
CPP was developed to promote child and caregiver: physical and psychological safety and stabilization; attachment security; affective and physiological regulation; trauma processing and symptom reduction; and healthy development and functioning.

**Treatment Participants**
CPP delivery typically includes a child-client and at least one primary caregiver; however, in select circumstances, the primary caregiver may be identified as the client, or target of intervention.

Clinical encounter participation varies based on CPP treatment phase. During the Foundational Phase, the majority of clinical encounters are conducted individually with the caregiver. During the Core Intervention Phase and Recapitulation and Termination Phase, the majority of clinical encounters are conducted with the client-caregiver dyad. In rare clinical circumstances, a clinician may conduct client-only sessions.

**Treatment Delivery Professionals**
CPP is delivered by a licensed mental health clinician who is actively engaged in training with an endorsed trainer, or has successfully completed all CPP training requirements, as defined by the model developers (www.childparentpsychotherapy.com).

**Service Setting and Type**
CPP may be delivered in an outpatient clinic, home, residential, and/or in other community settings. Additionally, CPP may be offered through a variety of service delivery models, including: outpatient services, enhanced outpatient services, intensive in-home services, residential treatment services, and other service delivery models.

**Treatment Delivery and Intensity**
- CPP clinical encounters (treatment sessions) are conducted on a weekly basis over the course of a year; less frequent sessions may adversely impact the achievement of targeted clinical outcomes. In select circumstances, a client and/or caregiver may participate in more than one clinical encounter during a single week.
- A clinical encounter is typically scheduled for 60 minutes; treatment sessions may exceed 60 minutes, yet remain clinically appropriate.
- A typical course of CPP includes an estimated: **a)** 34 clinical encounters and **b)** 78 minutes of clinical support activity time (out-of-session) for every 60-minute clinical encounter.
- In select circumstances, two primary caregivers may be unable or unwilling to participate in CPP together, necessitating the initiation of two separate courses of treatment with a single client.
- Case-level service utilization (clinical encounter number and time, and out-of-session clinical support time) may fall outside the "typical" range, yet remain clinically acceptable, due to case complexity and implementation-related factors.

**Reflective Supervision**
While maintaining an active caseload, a CPP clinician should participate in a minimum of two hours per month of CPP reflective supervision provided by a trained supervisor or peer. CPP reflective supervision may be conducted in a group or individual format, using the CPP fidelity toolkit. Additionally, the clinician should self-monitor fidelity across their caseload throughout treatment delivery.

**Factors Impacting Treatment Delivery and Outcomes**
Treatment content and intensity, clinician fidelity, and clinical outcomes vary across a CPP caseload due to child-, caregiver-, family-, clinician-, agency-, and systems-level barriers and supports.

## Section Two: CPP Clinical Inclusion and Exclusion Criteria

| | Inclusion Criteria | Exclusion Criteria |
|---|---|---|
| **Child (client)** | ○ Birth to six years of age<br>○ Clinical indication:<br>▪ Symptomatic due to a traumatic event or exposure [a]<br>▪ Concerns regarding attachment relationship with primary caregiver<br>○ Available to participate in treatment sessions, as clinically indicated | ○ Unable to participate in scheduled treatment sessions [b] |
| **Caregiver** [c] | ○ Concerns regarding attachment relationship with child<br>○ Available to participate in regularly scheduled treatment sessions [b] | ○ Perpetrator of sexual abuse<br>○ Actively psychotic or significantly thought-disordered<br>○ Unable to participate in regularly scheduled treatment sessions [b] |

[a] A traumatic experience or exposure is defined as a frightening, dangerous, and/or violent event that poses a threat to a child's life or bodily integrity *and/or* witnessing of a traumatic event that threatens the life or physical security of a loved one.

[b] Clinical encounters are typically conducted on a weekly basis; less frequent sessions may adversely impact the achievement of targeted clinical goals.

[c] In select circumstances, a primary caregiver may be identified as the client, or target of intervention.

## Section Three: CPP Assessment Strategy

Case-level CPP clinical assessment should be individualized and include: administration, scoring, and interpretation of standardized clinical assessment measures for both client and caregiver; clinical interview and observation; collateral contact; record review; case conceptualization; documentation of the assessment process, findings, and conclusions; and the provision of feedback.

Required clinical assessment is conducted during the Foundational Phase (Assessment and Engagement) and the Recapitulation and Termination Phase. Assessment may also be conducted during the Core Intervention Phase, generally upon completion of the twelfth (12) Core Intervention session, and every twelfth session thereafter.

| | | **CPP Treatment Phase** | | |
|---|---|---|---|---|
| | | Foundational (Assessment and Engagement) | Core Intervention | Recapitulation and Termination |
| **Assess Child** | Required | ○ Trauma history and symptoms<br>○ Child-caregiver relationship quality<br>○ Mental health symptoms<br>○ Developmental functioning<br>○ Physical health<br>○ Physical safety<br>○ Family ecology | ○ Trauma history and symptoms<br>○ Child-caregiver relationship quality<br>○ Mental health symptoms<br>○ Physical safety | ○ Trauma history and symptoms<br>○ Child-caregiver relationship quality<br>○ Mental health symptoms<br>○ Physical safety |
| | As clinically indicated | - | ○ Developmental functioning<br>○ Physical health<br>○ Family ecology | ○ Developmental functioning<br>○ Physical health<br>○ Family ecology |
| **Assess Caregiver** | Required | ○ Trauma history and symptoms<br>○ Child-caregiver relationship quality<br>○ Mental health symptoms<br>○ Cognitive and adaptive functioning<br>○ Parenting strategies and stress<br>○ Physical safety<br>○ Family ecology | ○ Trauma history and symptoms<br>○ Child-caregiver relationship quality<br>○ Mental health symptoms<br>○ Parenting strategies and stress<br>○ Physical safety | ○ Trauma history and symptoms<br>○ Child-caregiver relationship quality<br>○ Mental health symptoms<br>○ Parenting strategies and stress<br>○ Physical safety |
| | As clinically indicated | ○ Physical health<br>○ Substance use | ○ Adaptive functioning<br>○ Physical health<br>○ Substance use<br>○ Family ecology | ○ Adaptive functioning<br>○ Physical health<br>○ Substance use<br>○ Family ecology |

## Section Four: NC CTP CPP Service Delivery Checklist

The *NC CTP Clinical Service Delivery Checklist (CPP)* was developed to support the collection, aggregation, and analysis of service utilization data within an outpatient CPP program. The *Checklist* describes core clinical and fidelity requirements for the delivery of CPP, per standards established through the CPP manuals[1,2] and the CPP Fidelity Toolkit[3,4]. *Checklist* adaptation may be required to support service utilization analysis within other service delivery models or treatment environments.

CPP service utilization data should be interpreted with caution, under the guidance of a CPP clinical expert, when applied to: clinical network development and contracting, establishment of service delivery payment rates, utilization management, and clinical performance monitoring.

The *Checklist* should not be used to facilitate training, treatment, fidelity monitoring, or clinical supervision. Rather, the CPP manuals[1,2] and the CPP Fidelity Toolkit[3,4] should be used for this purpose.

| **Foundational Phase (Assessment and Engagement)** | |
|---|---|
| **Clinical Activities** | **Fidelity Assessment** |
| 1. Conduct and document weekly sessions, individually or jointly, with each participating caregiver to:<br>a. Assess:<br>○ Referral issues and presenting concerns<br>○ Child trauma history and symptoms; general symptoms and functioning; developmental status; and safety<br>○ Caregiver trauma history and symptoms; general symptoms and functioning; and safety<br>○ Family biopsychosocial history<br>○ Client-caregiver relationship quality<br>b. Provide psychoeducation about trauma and its impact<br>c. Describe CPP rationale, treatment parameters, clinical assessment, and targeted clinical outcomes<br>d. Address CPP clinical objectives, including:<br>○ Establish therapeutic relationship<br>○ Promote physical safety, psychological safety, and ecological stabilization<br>○ Enhance dyadic emotional reciprocity<br>○ Enhance affective and physiological co-regulatory capacity<br>○ Normalize client and caregiver response regarding traumatic event<br>○ Promote client and caregiver ability to address trauma reminders<br>○ Facilitate client and caregiver ability to make meaning of traumatic experience (CPP trauma narration)<br>○ Promote normative client development<br><br>2. Conduct and document the client-caregiver Observation Session(s), individually, with each participating caregiver, to assess:<br>a. Child-caregiver relationship quality<br>b. Child developmental functioning<br>c. Parenting skills and strategies<br><br>3. Conduct and document the Assessment Feedback Session, individually or jointly, with each participating caregiver to:<br>a. Elicit caregiver perception regarding assessment process<br>b. Provide feedback regarding assessment findings and case conceptualization<br>c. Introduce the CPP Core Intervention Phase<br>d. Assess safety risks associated with child participation in treatment<br>e. Develop plan to introduce CPP to client<br><br>4. Provide recommendations and referrals for child, caregiver, and family members<br><br>5. Conduct out-of-session case support activities, as clinically indicated<br><br>6. For treatment termination prior to full CPP course, conduct and document clinically indicated activities | 1. Self-assess and document adherence to CPP fidelity standards following each clinical encounter per *Procedural Fidelity: Assessment and Engagement* metric<br><br>2. Self-assess and document adherence to CPP fidelity standards following the Feedback Session per:<br>a. *Procedural Fidelity: Feedback Session* metric<br>b. *CPP Core Intervention Fidelity: Case Conceptualization and Content for Foundational Phase)* metric<br><br>3. Self-assess and document adherence to CPP fidelity standards upon completion of Foundational Phase, per the *CPP Core Intervention Fidelity* metric, for Foundation Phase specifically addressing:<br>a. Reflective Practice fidelity<br>b. Emotional Process fidelity<br>c. Dyadic-Relational fidelity<br>d. Trauma Framework fidelity<br>e. Procedural fidelity<br>f. Case Conceptualization and Content (CPP objectives) fidelity<br><br>4. For treatment termination prior to full course of CPP, self-assess and document adherence to CPP fidelity standards following each clinical encounter per *Procedural Fidelity: Planned Termination* metric<br><br>5. Participate in routine, case-specific reflective supervision |

*NC CTP CPP Service Delivery Checklist Continued*

| Core Intervention Phase | |
|---|---|
| **Clinical Activities** | **Fidelity Assessment** |
| 1. Conduct and document the *Introducing Client to CPP* Session with the client-caregiver dyad<br><br>2. Conduct and document weekly sessions with the client-caregiver dyad to address CPP clinical objectives, including:<br>a. Enhance therapeutic relationship<br>b. Promote physical safety, emotional safety, and ecological stabilization<br>c. Enhance dyadic emotional reciprocity<br>d. Enhance affective and physiological co-regulatory capacity<br>e. Enhance caregiver ability to respond to client behavioral cues<br>f. Normalize client and caregiver response regarding traumatic event<br>g. Promote client and caregiver ability to address trauma reminders<br>h. Facilitate client and caregiver ability to make meaning of traumatic experience (CPP trauma narration)<br>i. Promote client normative development<br><br>3. Provide recommendations and referrals for child, caregiver, and family members<br><br>4. Conduct out-of-session case support activities, as clinically indicated<br><br>5. Conduct and document assessment upon completion of the twelfth (12) Core Intervention session, and every twelfth session thereafter<br><br>6. For treatment termination prior to full CPP course, conduct and document clinically indicated activities | 1. Self-assess adherence to CPP fidelity standards following each clinical encounter per the *CPP Core Intervention Fidelity: Case Conceptualization and Content (CPP objectives)* metric, and document adherence every 12 sessions<br><br>2. Self-assess and document adherence to CPP fidelity standards following the session in which the child is introduced to CPP per the *Procedural Fidelity: Introducing the Child to CPP* metric<br><br>3. Self-assess and document adherence to CPP fidelity standards upon completion of approximately every twelve (12) Core Intervention sessions per the *CPP Core Intervention Fidelity* metric, specifically addressing:<br>a. Reflective Practice fidelity<br>b. Emotional Process fidelity<br>c. Dyadic-Relational fidelity<br>d. Trauma Framework fidelity<br>e. Procedural fidelity<br>f. Case Conceptualization and Content (CPP objectives) fidelity<br><br>4. For treatment termination prior to full course of CPP, self-assess and document adherence to CPP fidelity standards following each clinical encounter per *Procedural Fidelity: Planned Termination* metric<br><br>5. Participate in routine, case-specific reflective supervision |

*NC CTP CPP Service Delivery Checklist Continued*

*NC CTP CPP Service Delivery Checklist Continued*

| Recapitulation and Termination Phase | |
|---|---|
| **Clinical Activities** | **Fidelity Assessment** |
| 1. Conduct and document weekly sessions, individually or jointly, with each participating caregiver to:<br>a. Introduce the Recapitulation and Termination Phase<br>b. Assess:<br>o Progress towards achievement of targeted clinical outcomes<br>o Child trauma history and symptoms; general symptoms and functioning; and safety<br>o Caregiver trauma history and symptoms; general symptoms and functioning; and safety<br>o Family biopsychosocial status<br>o Client-caregiver relationship quality<br>c. Provide feedback regarding assessment findings and current case conceptualization<br><br>2. Conduct and document weekly sessions with the client-caregiver dyad to:<br>a. Prepare for treatment termination<br>b. Review the client-caregiver dyad Family Story (CPP trauma narration)<br>c. Address CPP clinical objectives, including:<br>o Sustain therapeutic relationship<br>o Promote physical safety, emotional safety, and ecological stabilization<br>o Enhance dyadic emotional reciprocity<br>o Enhance affective and physiological co-regulatory capacity<br>o Enhance caregiver ability to respond to client behavioral cues<br>o Normalize client and caregiver response regarding traumatic event<br>o Promote client and caregiver ability to address trauma reminders<br>o Facilitate client and caregiver ability to make meaning of traumatic experience (CPP trauma narration)<br>o Promote client normative development<br><br>3. Provide recommendations and referrals for child, caregiver, and family members<br><br>4. Conduct out-of-session case support activities, as clinically indicated<br><br>5. For treatment termination prior to full CPP course, conduct and document clinically indicated activities | 1. Self-assess and document adherence to CPP fidelity standards following each clinical encounter per:<br>a. *Procedural Fidelity: Planned Termination* metric<br>b. *CPP Core Intervention Fidelity: Case Conceptualization and Content (CPP objectives)* metric<br><br>2. Self-assess and document adherence to CPP fidelity standards upon completion of the Recapitulation and Termination Phase per the CPP Core Intervention Fidelity metric for Termination Phase specifically addressing:<br>a. Reflective Practice fidelity<br>b. Emotional Process fidelity<br>c. Dyadic-Relational fidelity<br>d. Trauma Framework fidelity<br>e. Procedural fidelity<br>f. Case Conceptualization and Content (CPP objectives) fidelity<br><br>3. Participate in routine, case-specific reflective supervision |

## Section Five: CPP Research Base

### Treatment Research

As of January 2017, five randomized control trials support the efficacy of CPP treatment for children with a history of trauma and symptoms of traumatic stress. CPP has been studied with the following populations:

- Pregnant women and infants exposed to intimate partner violence (IPV)[4]
- Anxiously attached infants of Latina immigrant moms[5]
- Infants exposed to maltreatment[6,16-18]
- Young children exposed to maltreatment[10]
- Young children of depressed mothers[7–9]
- Young children exposed to domestic violence[11,12]
- Young children exposed to interpersonal trauma[19]
- Young children who experienced at least four traumatic and stressful life events, including domestic violence[13]
- Young children in a wraparound foster care program[14,15]
- Diverse ethnic and racial populations, including African-American, Latinx, White, and/or Biracial children[5,15]

## Section Six: CPP Research Outcomes

| Client Outcomes | |
|---|---|
| **Immediate Post-Treatment Outcome** | **Outcome Sustained Following Treatment** |
| Decrease in child PTSD symptoms and PTSD diagnosis[11,14,15,19] | At 6 months (for children with ≥ 4 traumatic events)[13] |
| Decrease in child behavior problems[11,13–15] | At 6 months[12,13] |
| Decrease in depression symptoms and co-occurring diagnoses[13] | At 6 months[13] |
| Improvement in regulation of cortisol levels (biological regulatory processes)[18] | -- |
| Higher cognitive scores[8] | -- |
| Improvement in life domain functioning, behavioral emotional needs, and risk behaviors[14,15] | -- |
| Improvement in attachment security[6,7,9] | At 1 year[16] |
| Improvement in strengths[15] | -- |
| Decrease in avoidance, resistance, and anger towards mother[5] | -- |
| Decrease in negative self-representations[10] | -- |
| Decrease in maladaptive maternal attributions[10] | -- |
| Improvement in relationship expectations[10] | -- |
| Improvement in mother-toddler reciprocity during reunion following separation[5] | -- |

| Caregiver Outcomes | |
|---|---|
| **Immediate Post-Treatment Outcome** | **Outcome Sustained Following Treatment** |
| Decrease in maternal PTSD symptoms[4,11,13,19] | At 6 months[13] |
| Decrease in maternal general distress[12] | At 6 months[12] |
| Decrease in maternal child-related stress[17] | -- |
| Decrease in maternal depression symptoms[4,13] | At 6 months[13] |
| Improvement in empathy and engagement with children[5] | -- |
| Improvement in positive child-rearing attitudes[4] | -- |

| Systems Outcomes | |
|---|---|
| Education | Higher cognitive scores compared to no treatment comparison group[9] |

**North Carolina CPP Clinical Outcomes**

The NC Child Treatment Program provides intensive CPP training and clinical coaching to approximately 17-39 (average: 27) licensed clinicians each year. Since 2014, NC CTP has monitored clinical outcomes for a minimum of two clients per clinician-trainee; additionally, select caregiver outcomes are assessed. Per comparison of pre-and post-treatment assessment results:

- The majority of clients demonstrate a statistically significant reduction in PTSD symptoms, social/emotional problems, hyperactivity, and peer problems (per caregiver report).
- The majority of caregivers demonstrate a statistically significant reduction in PTSD symptoms, anxiety, and parental stress (per caregiver self-report).

**Section Seven: References**

# References under annual faculty review as of January 2020. Draft version not for dissemination.