CHILD PARENT PSYCHOTHERAPY

Child Parent Psychotherapy (CPP) is an intervention for children age 0-6 and their parents who have experienced at least one form of trauma including but not limited to maltreatment, sudden traumatic death of someone close, a serious accident, sexual abuse, or exposure to domestic violence. The primary goal of the treatment is to support and strengthen the relationship between a child and their parent (or caregiver) in order to repair the child's sense of safety, attachment, and appropriate affect to ultimately improve the child's cognitive, behavioral, and social functioning.

Child Parent Psychotherapy is a model used within the service Outpatient Therapy by Licensed Practitioners, so follows the requirements set out in the "Outpatient Therapy by Licensed Practitioners" section of this manual.

Evaluation of the Evidence Base for the EBP Model

Evaluation of the evidence-base for the CPP model has been conducted by a national registry.

CPP has received a CEBC Scientific Rating of 2-Supported by Research Evidence by the California Evidence Based Clearinghouse:
http://www.cebc4cw.org/program/child-parent-psychotherapy/detailed

The model and research evidence for CPP are also described in a fact sheet from The National Child Traumatic Stress Network (NCTSN):
https://www.nctsn.org/sites/default/files/interventions/cpp_fact_sheet.pdf

Target Population Characteristics

Children: Birth–6 years old that have:

1. Experienced at least one traumatic event; and

2. Are experiencing behavior, attachment, and/or mental health problems, including posttraumatic stress disorder (PTSD) because of experienced trauma.

Parent(s)/Caretaker(s) of traumatized child.

CPP may help when:

1. Children have been through scary or painful events such as:

a. Loss of a loved person;

b. Separation;

c. Serious medical procedures; and

d. Abuse or violence at home or in the community.

2. Children show difficult behaviors;

3. Children have a change in placement or caregivers;

4. Family members have physical health or mental health difficulties; or

5. Caregivers would like help with parenting and improving parent-child relationships.

Philosophy and Treatment Approach

CPP is a dyadic treatment with both the parent/caregiver and child, because caregivers are the most important people in their children's lives. Parents/caregivers know their children best and are central to their development. Stressful experiences affect the parent-child relationship, and young children rely on their parents/caregivers to feel safe. When difficult things happen, young children need parents and caregivers to help them with the following:

1. Make sense of what their family went through;

2. Know what they can expect in the future; and

3. Learn to cope with challenging negative emotions.

Goals

1. Reduction in child PTSD symptoms;

2. Reduction in child behavior problems;

3. Increased child/parent attachment security; and

4. Reduction in parent PTSD and other mental health symptoms.

Specific Design of the Service

Recommended Intensity:

Weekly 1 to 1.5-hour sessions.

Recommended Duration:

52 weeks (one year).

Delivery Settings

In order to follow the child, this program is typically conducted in a(n):

1. Adoptive Home;
2. Birth Family Home;
3. Community Agency;
4. Foster/Kinship Care;
5. Outpatient Clinic; and/or
6. School.

The type of trauma and the child's age/developmental status determine the structure of CPP sessions. For example, if the child is an infant, the focus is on helping the parent(s) understand the trauma's potential impact on development and or functionality of the infant. Older children often take an active role in the treatment, which often involves play to facilitate communication between child and parent.

Cultural Considerations

According to a review by The National Child Traumatic Stress Network (NCTSN), the model is broadly tailored and the basic theoretical principles and core goals of CPP are thought to apply across diverse groups. The treatment has been used extensively with a wide range of minority groups: Latino (Mexican, Central, and South American), African-American, and Asian (Chinese). Clinical and research data, including four randomized trials conducted with predominantly ethnic minority samples, document the efficacy of this approach with culturally diverse groups.

Additional culture-specific information on CPP can be found in a NCTSN fact sheet at: https://www.nctsn.org/sites/default/files/interventions/cpp_culture_specific_fact_sheet.pdf

Provider Qualifications and Responsibilities

EBP Model Requirements

Therapists must achieve satisfactory completion of the full 18 month CPP training, upon which the clinician will be eligible to join the roster of nationally trained CPP therapists. This list is held by the Child Parent Psychotherapy Learning Collaborative in Louisiana. Providers must submit verification of inclusion on the roster of nationally trained CPP therapists to each MCO with whom it contracts to demonstrate eligibility for CPP therapist status. Verification must be maintained in the therapist's personnel folder.

All clinicians seeking to complete training and be eligible for the CPP roster must be masters or doctoral-level licensed psychotherapists with a degree in a mental health discipline.

Certification should be maintained by engaging in periodic fidelity review activities, including completion of a CPP Case Presentation (template) and case consultation calls with a CPP Trainer, at the frequency described below in the description of fidelity monitoring.

Other Qualifications and Requirements

Practitioners must meet qualifications and requirements established in the Outpatient Therapy by Licensed Practitioners section of this manual.

Allowed Provider Types and Specialties

1. PT 31 Psychologist PS:
    a. 6A Psychologist – Clinical;
    b. 6B Psychologist – Counseling;
    c. 6C Psychologist – School;
    d. 6D Psychologist – Developmental;
    e. 6E Psychologist - Non-declared;
    f. 6F Psychologist – Other; and
    g. 6G Psychologist – Medical.
2. PT 73 Social Worker (Licensed/Clinical) PS 73 Social Worker;
3. PT AK Licensed Professional Counselor (LPC)) PS 8E LPC;
4. PT AH Licensed Marriage & Family Therapists (LMFT) PS 8E;
5. PT AJ Licensed Addiction Counselor PS 8E CSoC/Behavioral Health;
6. PT 19 Doctor of Osteopathic Medicine PS:
    a. 26 Psychiatry;
    b. 27 Psychiatry; Neurology; and
    c. 2W Addiction Specialist.
7. PT 20 Psychiatrist PS;
    a. 26 Psychiatry; and

b. 2W Addiction Specialist.

8. PT 78 Advanced Practice Registered Nurse PS 26;

9. PT 93 Clinical Nurse Specialist PS 26; and

10. PT 94 Physician Assistant PS 26.

Training

The intensive 18-month training structure includes:

1. 3 day - initial core didactics is ≥ 18 hours face to face classroom time;

2. 6 months- twice-monthly consultation calls for treatment collaboration;

3. 2 day – face-to-face participant driven case based collaboration between training clinicians and trainer;

4. 6 months –twice-monthly consultation calls to strengthen and support development;

5. 2 days – face-to-face competence building with case based participant driven collaboration lead by the trainer; and

6. 6 months – continued consultation and supportive twice-monthly calls.

Minimum requirements include:

1. Therapist must attend all face-to-face sessions and a minimum of 70% of the consultation calls during the 18-month period; and

2. Therapists must work with at least four (4) qualifying parent-child dyads in the 18-month period.

Quality Assurance

Outcomes

Outcomes to be measured in the delivery of CPP include:

1. Effectiveness of CPP on reducing behavioral symptoms among CPP members as evidenced by the (ECSA) Brief Early Childhood Screening Assessment once before treatment, at the 6 month interval, and again post treatment as reported by the guardian; and

2. Effectiveness of CPP on improving caregiver/child relationship as measured using The Relationship Scale at pre- and post- treatment.

Model-Specific Documentation Requirements

Case Consultation form. While not completed on every case as required practice, the Case Consultation form is a tool that should be completed on specific cases that will be submitted for fidelity review.

Fidelity

Therapist fidelity to the CPP model is monitored via therapist submission of a Case Consultation form for one case, at two different time points during the case (early in treatment, as well as 2-3 months into treatment).

These Case Consultation forms are submitted to the CPP Trainer, who will review and follow up with the therapist on a 30-60 minute case consultation phone call.

To maintain CPP fidelity, CPP therapists should submit Case Consultation forms and complete a case consultation call with a CPP trainer at the following frequency:

1. For the first 2 years post-certification: Every 6 months; and

2. Beyond 2 years post-certification: Annually.

Limitations/Exclusions

CPP, as a service offered under Outpatient Therapy by Licensed Practitioners, has an initial authorization level of benefit, and services which exceed the limitation of the initial authorization may require approval for re-authorization prior to service delivery. The recommended duration of the CPP model is 52 weeks; therefore re-authorization should be requested indicating that the specialty model CPP is being utilized and therefore appropriately may exceed the initial authorization and should be authorized for continuing services to complete the medically necessary treatment episode and provide evidence-based care to the youth and family.

Billing

1. Only direct staff face-to-face time with the child or family may be billed. CPP is a face-to-face intervention with the individual and caregiver present; however, the child receiving treatment does not need to be present for all contacts. If the child is not present, the appropriate procedure code must be billed, e.g. 90846 - Family Psychotherapy without Patient Present;

2. Collateral contacts billable to Medicaid should involve contacts with parents, guardians using the appropriate procedure code as stated above. All contacts must be based on goals from the child's/youth's plan of care. Phone contacts are not billable;

   NOTE: The exception to the allowance of collateral contacts while providing evidence-based practices is coordination with other child-serving systems such as parole and probation programs, public guardianship programs, special education programs, child welfare/child protective services and foster care programs. Coordination with these child-serving systems is considered collateral contact and may be necessary to meet their goals of the individual, but is not billable through Medicaid. Services may be provided by these child-serving systems, however, the services provided must be funded through the agency providing the service.

3. Therapists bill standard CPT individual and family therapy codes for sessions providing CPP. The EB tracking code "EB02" should be indicated on claims to note that the therapy session utilized CPP as an evidence-based model of therapeutic intervention; and

4. To use the CPP EB tracking code of "EB02" on claims, the therapist must first provide documentation (stating that the clinician has fulfilled the requirements of an implementation level course in Child-Parent Psychotherapy from a trainer

endorsed by the University of California, San Francisco) to the MCO(s) the provider is contracted with as part of the therapist's credentialing.