

# 2018-2019 Wisconsin Child Parent Psychotherapy Learning Community

# Application Form

# *Each individual applicant within an organization completes the CPP application*

|  |  |  |  |
| --- | --- | --- | --- |
| First Name: | | Last Name: | |
| Degree : | License Type: | | License #: |
| Institution where Degree Obtained: | | | Year Degree Obtained: |

Have you completed the University of Wisconsin Infant and Early Childhood Mental Health Certificate Program: If yes, date completed:

Have you completed infant and early childhood mental health program in another state? If yes, what was the name of your program and when did you complete it?

Job Title:

|  |  |  |  |
| --- | --- | --- | --- |
| Address: | | | Primary Phone: |
|  | | | Other Phone (if applicable): |
|  | | |
| City: | State: | Zip: | Fax Number: |

Applicant’s E -mail:

Primary Role: (Select one.)

Clinical Supervisor Clinician

Secondary Role, if applicable: (Select one.)

Senior Leader Clinical Supervisor Clinician Other, specify role:

## Organization Information:

|  |  |
| --- | --- |
| Agency Name: | Website: |
| Counties served by organization: |  |

Program Manager (Contact person regarding this proposal):

|  |  |  |  |
| --- | --- | --- | --- |
| Program Manager’s Address: | | | Program Manager’s Phone: |
|  | | |
| City: | State: | Zip: |

Program Manager’s E-mail:

Clinical Supervisor: Supervisor Phone: Supervisor E-mail (if different from program manager):

Executive Director: Executive Director Phone: Executive Director E-mail:

|  |  |  |  |
| --- | --- | --- | --- |
| Services Provided by Organization: | Outpatient | Rehabilitative | Day Treatment |
| Co-Located Services – Site: | | |
| Other- List | | |

Which services are provided by Applicant?

Wisconsin CPP Cohort 4 Training Application Packet

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|  |  |
| --- | --- |
| Diagnoses and/or presenting problems served by Organization: | Age-Range Served by Organization: |
| Diagnoses and/or presenting problems served by Applicant: | Age-Range Served by Applicant: |

Please identify your team from your agency that is applying for this training program. Note that each team member who intends to participate in the trainings must complete his/her own application. Agency managers/senior leaders who are not completing the full Implementation Level CPP Training, but plan to attend the first learning session to become informed on this practice do not need to complete an application.

# Team Member #1

Name: Title:

Credentials: (e.g., LCSW, Ph.D., LPC, etc.):

Discipline: (e.g., Social Work, Psychology, Psychiatry, Mental Health Counselor, Marriage and Family Counselor, etc.):

Telephone Number: Email Address: Mailing Address:

Primary Role: (Select one.)

Clinical Supervisor Clinician Senior Leader Other, specify role:

Secondary Role, if applicable: (Select one.)

Senior Leader Clinical Supervisor Clinician Other, specify role:

# Team Member #2

Name: Title:

Credentials: (e.g., LCSW, Ph.D., LPC, etc.):

Discipline: (e.g., Social Work, Psychology, Psychiatry, Mental Health Counselor, Marriage and Family Counselor, etc.):

Telephone Number: Email Address: Mailing Address:

Primary Role: (Select one.)

Clinical Supervisor Clinician Senior Leader Other, specify role:

Secondary Role, if applicable: (Select one.)

Senior Leader Clinical Supervisor Clinician Other, specify role:

# Team Member #3

Name: Title:

Credentials: (e.g., LCSW, Ph.D., LPC, etc.):

Discipline: (e.g., Social Work, Psychology, Psychiatry, Mental Health Counselor, Marriage and Family Counselor, etc.):

Telephone Number: Email Address: Mailing Address:

Primary Role: (Select one.)

Clinical Supervisor Clinician Senior Leader Other, specify role:

Secondary Role, if applicable: (Select one.)

Senior Leader Clinical Supervisor Clinician Other, specify role:

# QUESTIONS FOR CLINICIANS AND CLINICAL SUPERVISORS

1. CPP has been demonstrated to be efficacious with children under the age of six exposed to trauma and their primary caregivers. It is a flexible modality that can be delivered in the clinic or in the family’s home.
   1. What is the population with which you plan to implement CPP during this training?
   2. Please describe the setting(s) in which the practice will be implemented, age range of the children who will receive CPP, and types of trauma the families have experienced.
2. Describe your knowledge of early childhood development (both normal and clinical populations). What experience do you have working with infants and very young children and their caregivers? (Please indicate participation in the Infant, Early Childhood and Family Mental Health Capstone Certificate Program, equivalent training, and/or Endorsement.)
3. What experience do you have working with adults (parents/caregivers) and families with mental health concerns and/or exposure to trauma?
4. At present, what type of therapy does your site typically provide for families seeking treatment for their young children and/or to families seeking assistance with trauma- related symptoms or experiences?
5. Please describe your training and experience in using evidence-based practices in mental health treatment.
6. How do you plan to identify potential CPP clients and when will the process of identifying and screening clients for CPP begin?
7. For this training, each site should conduct an assessment (including for trauma exposure) with all children and caregivers receiving CPP at the start and end of treatment. Do you foresee any difficulties obtaining or scoring the measures? If so, how can you address these issues?
8. Clinicians will be asked to complete several fidelity forms to assess effective implementation of CPP. Do you foresee any difficulties with the completion and review of these forms?
9. Briefly describe the range of diversity in the children (0-6) and families you serve and how your work reflects an awareness of cultural differences. Each individual or family represents a unique constellation of experiences and culture. Diversity may encompass age, gender, sexual orientation, ethnicity, race class, country of origin, religious or spiritual beliefs, physical characteristics, motor or cognitive abilities, family constellation, or other differences for purposes of this application.
10. Please describe any other experiences, training, or factors that prepare you for this Child Parent Psychotherapy training.
11. Will your supervisor participate in this CPP training? Please describe the type of supervision you are currently receiving.
12. Please describe your interest in and need for financial assistance through the scholarships available.

# QUESTION FOR CLINICAL SUPERVISORS

1. Describe the model that is used for clinical supervision at your site.
2. Please describe your training to provide Reflective Supervision.

# QUESTIONS FOR SENIOR LEADERS

# (Please identify a Sr. Leader in your organization to complete the following questions)

# Name of Sr. Leader responding to questions bellow: ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

15**.** Has your team experienced any barriers to successfully treating young children with trauma-related symptoms and/or parent-child relationship issues? If so, please describe

1. How will you ensure agency buy-in to support the training and implementation of CPP during the training?
2. What do you anticipate will be challenges your organization may face in implementing and sustaining the practice of CPP at your site?
3. How may you address these challenges ?
4. How will you work to ensure that Child-Parent Psychotherapy takes hold and will be implemented with sufficient fidelity after the training ends?

# *Organization Executive Director (agency head) certifies that:*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Y** | **Initials** | **NO** | **Date** | **Statement** |
|  |  |  |  | **1**. The organization is enrolled to provide Mental Health Services through Medicaid? |
|  |  |  |  | **2. Assurance of Employee Full Participation.** The organization will allow time for trainee(s) to participate in three in-person training sessions (March 5-7, 2018; August 13-14, 2018 and March 4-5, 2019) and teleconference consultation calls (one-hour calls, 4x per month), which include fidelity calls with the trainer and small reflective consultation calls with a consultant trained in CPP, beginning in March, 2018 through August, 2019 (18 months). The trainee must present at least two cases of their CPP practice during the fidelity calls and more frequently in their reflective consultation groups. |
|  |  |  |  | **3. Assurance of Employee Access to Practice CPP**  The trainee must see 4 families using CPP and following CPP fidelity process regarding screening, assessment, treatment, termination and fidelity monitoring forms required by the trainer(s) during the course of training in order to complete the training requirements |
|  |  |  |  | **4. Assurance of Completion of Training.** The applicant or the organization will reimburse the amount of the scholarship provided if the applicant does not complete the requirements for rostering in CPP. |

## Applicant Agreement to Complete and Signature:

|  |  |
| --- | --- |
| I have read the requirements for training listed in the  (**Print Applicant’s Name)** CPP Training Announcement. If selected for the CPP Training, I agree to complete the listed requirements. | |
| **Signature:** | **Date:** |

**PROPOSAL AUTHORIZATION**

|  |  |
| --- | --- |
| **Name of Applicant’s Executive Director:** | |
| **Signature:** | **Date:** |
| **Name of Applicant’s Clinical Supervisor** | |
| **Signature:** | **Date:** |

**Please send your completed application to**: Sarah Strong, Associate Director by email attachment: [sstrong@wisc.edu](mailto:strong@wisc.edu). Fax: 608-263-0265; Address: WISPIC/Department of Psychiatry, 6001 Research Park Blvd, Madison, WI 53719

**CPP Scholarship Application: To be considered for a CPP scholarship to assist with registration fees, use the following link to complete the scholarship application:**

<https://uwmadison.co1.qualtrics.com/jfe/form/SV_29Jdhh4RhxjvCO9>