NCTSN The National Child Traumatic Stress Network

Community Outreach Program-Esperanza (COPE)

Treatment Description	• **Acronym (abbreviation) for intervention:** COPE • **Average length/number of sessions:** Generally there are 12-20 therapeutic sessions, though there is wide variation depending on clinical need. The model offers 1-2 sessions a week, with sessions lasting from 45-90 minutes. Children can come back for booster sessions. • **Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, or addresses transportation barriers):* • **Trauma type** *(primary):* • **Trauma type** *(secondary):* • **Additional descriptors** *(not included above):* This is a home- and school-based trauma-focused treatment. The emphasis is on case management to enable clinicians to offer evidence-based trauma treatments in community settings. Primary treatment modality is trauma-focused cognitive-behavioral therapy (TF-CBT) and culturally-modified trauma focused treatment (CM-TFT). On an as-needed basis, parents may be offered parent-child interactive therapy (PCIT) to help improve interactions with their children and to teach the discipline strategies of PCIT. Case management can include helping other family members access services to care for the child more effectively (e.g., helping a substance-abusing parent find treatment) or to address the family's basic needs (e.g., receiving clothing or food donations, applying for Medicaid or Crime Victims Compensation, or accessing legal assistance).
Target Population	• **Age range:** *(lower limit)* 4 to *(upper limit)* 18 • **Gender:** ☐ Males ☐ Females X Both • **Ethnic/Racial Group** *(include acculturation level/ immigration/refugee history--e.g., multinational sample of Latinos, recent immigrant Cambodians, multigenerational African Americans):* This treatment generally includes ethnic minorities. A number of families have been recent immigrants and/or involved in migrant agricultural work. It has been offered to developmentally delayed children. • **Other cultural characteristics** *(e.g., SES, religion)*: Treatment generally includes children of low socioeconomic status and families. • **Language(s):** Spanish and English. • **Region** (.e.g., rural, urban)**:** Urban and rural. • **Other characteristics** (not included above): The target population is traumatized children who are presenting with behavior or social-emotional problems. There is no limitation as to trauma type, although to date the intervention has not been provided to children with medical trauma.
Essential Components	• **Theoretical basis:** Trauma-focused cognitive behavioral therapy (CBT) • **Key components:** Primary treatment includes psychoeducation, coping skills training, affective identification and processing, trauma narrative, and risk reduction. Basic case management needs and cultural issues are assessed

	and addressed depending on the needs and characteristics of individual family. Program includes child sessions, parent sessions, and joint sessions. Outreach and case management are essential components. Clinicians offering this practice also do extensive training in the community as part of their outreach efforts. Trainings help build trusting relationships with referral sources and parents.
Clinical & Anecdotal Evidence	• **Are you aware of any suggestion/evidence that this treatment may be harmful?** ☐Yes ☒No ☐ Uncertain • **Extent to which cultural issues have been described in writings about this intervention** *(scale of 1-5 where 1=not at all to 5=all the time).* 5 • **This intervention is being used on the basis of anecdotes and personal communications only (no writings) that suggest its value with this group.** ☐Yes ☒No • **Are there any anecdotes describing satisfaction with treatment, drop-out rates (e.g., quarterly/annual reports)?** ☐Yes ☒No **If YES, please include citation:** • **Has this intervention been presented at scientific meetings?** ☒Yes ☐No **If YES, please include citation:** **de Arellano, M.A.**, Danielson, C.K. (June, 2005). *Home-Based Delivery of Trauma Treatment.* Workshop presented at the National Child Traumatic Stress Network Special Institute at the 13th Annual Colloquium of the American Professional Society on the Abuse of Children, New Orleans, LA. **de Arellano, M.A.**, Danielson, C.K. (March, 2005). *Home-Based Trauma-Focused Cognitive-Behavioral Therapy.* Workshop presented at the National Child Traumatic Stress Network All Network Meeting, Alexandria, VA. **de Arellano, M.A.**, Danielson, C.K.& Doss, A.J. (August 2004). *Reaching traditionally underserved child trauma victims: The Community Outreach Program – Esperanza (COPE).* Presentation given at the 12th Annual Colloquium of the American professional Society on the Abuse of Children, Hollywood, CA. **de Arellano, M.A.**, (October 2003). *Reaching traditionally underserved child maltreatment victims.* Invited workshop presented at the Midwest Conference on Child Sexual Abuse, Madison WI. **de Arellano, M.A.**, (March 2003). *Improving access and use of*

mental health services among Hispanics: Making house calls. Invited paper presented at the annual meeting of the National Hispanic Medical Association, Washington D.C.

de Arellano, M. A. (March 2002). *Addressing the impact of socio-cultural factors on access and use of mental health services in rural populations.* Invited presentation for the NIH Office of Rural Mental Health meeting on Socio-cultural issues and mental health, Washington DC.

de Arellano, M.A. (November 1999). Community-based treatment for Hispanic child victims of maltreatment. In Michael A. de Arellano (Chair), *Trauma-related research and treatment issues in Hispanic populations.* Workshop conducted at the 15th Annual Meeting of the International Society for Traumatic Stress Studies, Miami, Florida.

- **Are there any general writings which describe the components of the intervention or how to administer it?** ☒Yes ☐No

If YES, please include citation: de Arellano, M.A., Waldrop, A.E., Deblinger, E., Cohen, J.A., & Danielson, C.K., Mannarino, A.P. (2005). Evidence-based treatment for victims of child maltreatment: A community-based demonstration. *Behavior Modification, 29,* 130-155.

- **Has the intervention been replicated anywhere?** ☐Yes X No

Other countries? *(please list)*

- **Other clinical and/or anecdotal evidence** (not included above)**:** This treatment started with a small grant, was invited to reapply to offer the treatment to a broader group of children. Now program is self-sustaining via Medicaid reimbursement and Crime Victims Compensation funds.

Research Evidence

		Number of Participants	Sample Breakdown	Citation
Published Case Studies	☐Yes ☒No	N =	By gender: By ethnicity: By other cultural factors:	
Pilot Trials/ Feasibility Trials (w/o control groups)	☐Yes ☒No	N =	By gender: By ethnicity: By other cultural factors:	
Clinical Trials (w/ control groups)	☐Yes ☒No	N =	By gender: By ethnicity: By other cultural	

				factors:	
	Randomized Control Trials	Yes ☒No	N =	By gender: By ethnicity: By other cultural factors:	
	Studies describing modifications	☐Yes ☒No	N =	By gender: By ethnicity: By other cultural factors:	
	Other research evidence	☐Yes ☒No	N =	By gender: By ethnicity: By other cultural factors:	
Outcomes	• **What assessments or measures are used as part of the intervention or for research purposes, if any?** TF-CBT and PCIT are evidence-based treatments that have been evaluated with other populations. The combination of these treatments with intensive case management has not been directly evaluated in this setting. Data collection for pre- and post-evaluation is currently underway. Data include self-report measures and chart review. • **If research studies have been conducted, what were the outcomes?**				
Implementation Requirements and Readiness	• **Space, materials or equipment requirements?** Treatment sessions are held in home, schools, or other community sites that parents or children find convenient (e.g., churches or the parent's workplace). • **Supervision requirements (e.g., review of taped sessions)? While beginning implementation of the intervention, regular supervision (e.g., weekly) is necessary, especially focused on issues more likely to be encountered in community-based than office-based treatment (e.g., safety, privacy, condition of home environment). Ideally, supervision should be provided by someone trained and experienced in community-based implementation of evidence-based treatment. Audio and/or video tapes can facilitate the supervision process.** • **In order for successful implementation, support should be obtained from: Supervision/consultation should be obtained from clinicians trained and experienced in community-based –implementation of evidence-based treatments.**				
Training Materials & Requirements	• **List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** • **How/where is training obtained?** Training is through reading (e.g., Treating Sexually Abused Children and Their Nonoffending Parents [Deblinger and Heflin, 1996], Parent-Child Interaction Therapy [Hembre-Kigin & McNeil, 1995]; treatment manuals; journal articles on theory, epidemiology, assessment, and treatment) and through supervision (2-3+ hours of group and/or individual supervision each week for 6-10 cases). • **What is the cost of training?** Determined on a case-by-case basis. • **Are intervention materials (handouts) available in other languages?**				

	☒Yes ☐No **If YES, what languages?** Spanish • **Other training materials &/or requirement** (not included above):
Pros & Cons/ Qualitative Impressions	• **What are the pros of this intervention over others for this specific group (e.g., addresses stigma re. treatment, addresses transportation barriers)?** Treatment approach reduces logistical barriers to treatment (e.g., transportation, scheduling) and facilitates addressing cultural issues in treatment because treatment is provided in the families home-environment and community. • **What are the cons of this intervention over others for this specific group (e.g., length of treatment, difficult to get reimbursement)?:** The treatment is more time intensive and can be cost prohibitive if ancillary services (e.g., drive time) are not reimbursable. • **Other qualitative impressions:**
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