Trauma-Focused Cognitive Behavioral Therapy

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based psychosocial therapeutic model that incorporates cognitive-behavioral and attachment theories in empathetic and empowering ways to help individuals and their families deal with trauma. Studies have shown that TF-CBT is extremely useful for work reducing trauma-related symptoms for children, adolescents, as well as their caregivers. Specifically, TF-CBT helps children understand and manage thoughts, feelings, and behaviors related to traumatic events, as well as enhance safety and improve parenting skills and family communication. Further, TF-CBT is used to help clients develop alternative ways to cope with day to day life and situations. The model can be applicable for children experiencing PTSD, sexual abuse, depression, domestic violence, and other traumatic events including multiple trauma.

The model is structured for short-term treatment for children and adolescents ranging in age 3-18 years. Treatment length is minimally 12-16 sessions but can last upwards to 25 sessions. This typically lasts 3 to 6 months. However, a client’s needs determine the appropriate length of treatment. An asset of this model is the flexibility and inclusiveness of the model. The model is effective with diverse populations and varying settings. Children that reside in foster care are also a fit for this model.

The model utilizes a component-based framework called PRACTICE. This acronym is as follows:

- Psychoeducation
- Parenting skills
- Relaxation and stress management skills
- Affective expression and modulation
- Cognitive coping and processing
- Trauma narration
- In vivo mastery of trauma
- Conjoint child-parent sessions
- Enhancing future safety and development

These skills are delivered to both the youth and caregivers as needed. The inclusion of the family in treatment helps to strengthen the youth’s ability to learn, practice and retain the skills learned in individual sessions.
Fulton County Juvenile Court TF-CBT Services Referral Form

**Referral Source**

Name of referring person: ___________________________ Date of Referral: ______

Cherokee  Cobb  Clayton  Dekalb  Douglas  Forsyth  Fulton  Gwinnett  Hall  Kennesaw  Rockdale

Agency: DFCS  School  BHL  PRTF  Family  Probation  DJJ  Other

Phone: ___________________________ Fax: _______________ Cell: _______________

Email: ___________________________ Preferred Contact Method: email  phone  cell

Supervisor: ___________________________ Phone: ___________________________

Is Client aware referral is being made  Yes  No

**Client Information**

Client Name: ___________________________ Case ID# (if applicable): _______________

DOB: _______ Gender: Male  Female  Ethnicity: _______ Language Spoken _______

Client’s School: ___________________________ Current Grade Level: _______________

Current Placement: Biological Parent  Foster Placement  Group Home

Legal Guardians Name: ___________________________

Current Address: ___________________________

Phone Number: ___________________________ Cell Phone: _______________________

Mental Health Diagnosis: ___________________________ Medications: __________________

Medicaid #: ___________________________ Social Security Number#: _______________

Type: Medicaid  Peachstate/Cenpatico  Amerigroup  WellCare  *Uninsured

*For uninsured, families must apply for Peachcare - www.peachcare.org

Has client had a **psychological evaluation in the past 12 months? Yes  No  Unknown

Has client had a **psychiatric evaluation in the past 12 months? Yes  No  Unknown

Behavior in last 6 months: Runaway  Physical Aggression  Suicidal Ideation / Attempt

Verbal Aggression  Defiance  ISS/OSS  Legal Involvement  Deprived

Sexual Acting Out  Self-Harming Behaviors  Other

**********Please attach psychological/psychiatric if available**********
Presenting Problems:

Legal:
Open/Pending Court Case _____ Yes _____ No Court Date: _______ Court Part ______
Name: ____________________ County: _______ Phone ______

DFCS Involvement: *Yes _____ No _____ DFCS approval for services Yes _____ No _____
*If child is in the custody of DFCS please complete consent form
Caseworker: ____________________ Telephone #: ____________________
I ____________________, the case worker for ____________________ as guardian of said
consumer, authorize the Foster Parent/FP Case Manager ____________________ For
________________________ the authority to sign the Family Ties, Inc. legal and consent
form’s authorizing CORE services.
Signature: _____________________________________________________________________________
Date: _________________________________________________________________________________

Status of Referral: (office only)
Accept Team: ______________ Case Number: __________ Date: ______________
Decline Reason: _________________________________________________________________________
Date: _________________________________________________________________________________