TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a conjoint child and parent psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles.

TF-CBT is a model used within the service "Outpatient Therapy by Licensed Practitioners," so it 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 TF-CBT model has been conducted by national registries.

TF-CBT has received a CEBC Scientific Rating of 1-Well Supported by Research Evidence by the California Evidence Based Clearinghouse: https://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy/

TF-CBT has been independently and systematically reviewed by the Title IV-E Prevention Services Clearinghouse, and has received a rating of "Promising" in the Mental Health Programs and Services category:
https://preventionservices.abtsites.com/programs/119/show

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

Target Population Characteristics

TF–CBT was created for young people who have developed significant emotional or behavioral difficulties following exposure to a traumatic event (e.g., loss of a loved one, physical abuse, sexual abuse, domestic or community violence, motor vehicle accidents, fires, tornadoes, hurricanes, industrial accidents, terrorist attacks).

TF-CBT may benefit children with a known trauma history who are experiencing significant posttraumatic stress disorder (PTSD) symptoms, whether or not they meet full diagnostic criteria. In addition, TF-CBT may benefit children with depression, anxiety, and/or shame related to their

traumatic exposure. Children experiencing childhood traumatic grief can also benefit from the treatment.

TF-CBT may be delivered to children ages 3-18 and their parents.

TF-CBT may not be appropriate for the following:

1. Acutely suicidal youths;

2. Adolescents with current parasuicidal behaviors (self-cutting or non-fatal self-harm);

3. Youth with extensive inappropriate/illicit substance use;

4. Youth with a history of significant behavioral problems present prior to the trauma exposure; or

5. Youth with significant conduct problems (aggressive, destructive).

Philosophy and Treatment Approach

Trauma-Focused Cognitive Behavioral Therapy (TF–CBT) is designed to help those 3 to 18-year-olds and their parents overcome the negative effects of traumatic life events, such as child sexual or physical abuse. TF–CBT aims to treat serious emotional problems such as posttraumatic stress, fear, anxiety, and depression by teaching children and parents' new skills to process thoughts and feelings resulting from traumatic events.

TF–CBT is a treatment intervention that integrates cognitive and behavioral interventions with traditional child-abuse therapies. Its focus is to help children talk directly about their traumatic experiences in a supportive environment. TF-CBT components are described by the acronym PPRACTICE as follows:

1. **Psychoeducation.** The therapist works with the child and caregiver (typically, separately) to explain and normalize trauma-related symptoms and avoidance, describe the TF-CBT treatment, and build hope;

2. **Parenting.** With the goal of enhancing the parent/child relationship, the therapist teaches and reinforces positive parenting skills. If the child's behavior problems are significant and are of primary concern to the parent, this component should be a priority, and the therapist may consider meeting with the parent first during

sessions. The therapist will work to link the behaviors to the trauma, during work with the parent;

3. **Relaxation.** The therapist teaches specific skills for calming and reducing distress in the moment;

4. **Affective modulation.** The therapist works to help the child increase the capacity to identify a range of feelings, having a feelings vocabulary, and link feelings to appropriate expression. The child identifies/learns strategies to improve and calm affect, and identify feelings associated with the traumatic event;

5. **Cognitive coping.** The therapist teaches the CBT triangle; the relationship between thoughts, feelings, and behavior. The therapist teaches the child to identify automatic thoughts that cause distress, helps the child understand that thoughts drive feelings and feelings can be changed, and helps the child generate coping self-statements;

6. **Trauma narrative.** Through exposure and cognitive processing, the child is able to think and talk about the trauma, identify trauma-related unhelpful cognitions, and identify more helpful/accurate ways to think about the trauma. The goal is for the child to develop a helpful understanding of what happened, that acknowledges the trauma but does not define the child;

7. **In-vivo exposure.** The therapist helps the child separate harmless situations that trigger fear, from real danger. The therapist helps the child reduce avoidance that interferes with daily functioning;

8. **Conjoint trauma narrative.** The therapeutic session(s) provide the opportunity for the child to share the trauma narrative with key trusted adult(s) and receive validation, praise, and support; and

9. **Enhancing safety.** The therapist helps the child and caregiver create a safety plan to reduce risk of ongoing dangers, and teaches safety skills for use in risky situations.

The program largely operates by seeing the child and the caregiver separately. For example, the first part of the session is with the child, and then the later part of the session is with the parent. This allows for the child to begin talking about thoughts and feelings, without worrying about their caregivers' reactions. The parent component teaches parents parenting skills to provide optimal support for their children. Then, conjoint parent–child session(s) encourage the child to

discuss the traumatic events directly with the parent, and allows both the parent and child to communicate questions, concerns, and feelings more openly.

Typically, TF–CBT is implemented through 12 to 18 weekly sessions. These aim to provide the parents and children with the skills to better manage and resolve distressing thoughts, emotions, and reactions related to traumatic life events. The sessions also aim to improve the safety, comfort, trust, and growth in the child and develop parenting skills and family communication.

Goals

1. Reduced symptoms of child trauma, PTSD, depression, anxiety;

2. Reduced child externalizing behaviors (including age-inappropriate sexual problem behaviors, if related to the primary trauma); and

3. Improved child adaptive functioning, caregiver parenting skills, caregiver-child communication, and attachment.

Specific Design of the Service

Treatment consists of the following:

1. 60-90 minute sessions weekly:

    a. Initially, sessions consist of 30-45 minutes of psychoeducation and intervention with the parent, and separately 30-45 minutes of psychoeducation and intervention with the child; and

    b. Later in treatment, the child and parent may participate together, conjointly, in the full length of the session.

2. TF-CBT therapists assign a homework component, to be completed together (child and caregiver), as well as assignments to be completed separately.

Recommended Intensity

The recommended intensity is one 60-90 minute session per week.

Recommended Duration

The recommended duration is 12-25 sessions.

A course of TF-CBT treatment is typically completed in 12-18 sessions; the duration of treatment will vary based on the extent and complexity of the youth's trauma history.

For youth experiencing complex trauma, research suggests that "the duration of TF-CBT treatment also often needs to be extended to 25 sessions and occasionally up to 28-30 sessions." (Research by: Cohen, J. A., Mannarino, A. P., Kliethermes, M., & Murray, L. A. (2012). Trauma-focused CBT for youth with complex trauma. *Child abuse & neglect*, *36*(6), 528–541. https://doi.org/10.1016/j.chiabu.2012.03.007).

If MCO policy requires prior authorization for Outpatient Therapy by Licensed Providers, including treatment episodes of TF-CBT, the following steps must be followed:

1. The provider requesting prior authorization should note that the evidence-based model TF-CBT is being used. An initial authorization of 25 sessions is recommended so that the provider may complete the medically necessary treatment episode and provide evidence-based care to the youth and family; and

2. If additional sessions beyond the initial authorization are needed to complete a treatment episode of TF-CBT, the re-authorization request should indicate that the specialty model TF-CBT is being utilized, and should note the reason for a need for additional sessions to complete the treatment episode of evidence-based care.

Delivery Setting

TF-CBT may be provided in a clinic, home-based, or residential setting.

Cultural Considerations

TF-CBT has been tested in U.S. white, African American and Latino populations as well as in European, Australian and African youth with positive outcomes in multiple domains. TF-CBT has been used with families of diverse SES and religions.TF-CBT includes engagement strategies which specifically ask about the child's and parents cultural practices.

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

Provider Qualifications and Responsibilities

Practitioners must meet qualifications and requirements established in the Outpatient Therapy by Licensed Practitioners section of this manual and requires training in the treatment model as minimum requirements.

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:
    a. 73 Licensed Clinical Social Worker (LCSW); and
    b. LL Lower Level – Licensed Master Social Worker (LMSW).
3. PT AK Licensed Professional Counselor (LPC) PS:
    a. 8E CSoC/Behavioral Health – LPC; and
    b. LL Lower Level – Provisionally Licensed Professional Counselor (PLPC).
4. PT AH Licensed Marriage & Family Therapists (LMFT) PS:
    a. 8E CSoC/Behavioral Health – LMFT; and

b. LL Lower Level – Provisionally Licensed Marriage and Family Therapist (PLMFT).

5. PT AJ Licensed Addiction Counselor PS 8E CSoC/Behavioral Health;

6. PT 20 Psychiatrist PS:

   a. 26 Psychiatry; and

   b. 2W Addiction Specialist.

7. PT 78 Registered Nurse (APRN) PS 26;

8. PT 93 Clinical Nurse Specialist (APRN) PS 26; and

9. PT 94 Physician Assistant PS 26.

Training

The TF-CBT National Certification Program establishes the following training requirements leading to TF-CBT certification, in the following order:

1. Completion of the online training course through TF-CBT Web 2.0;
2. Participation in a live, 2-day TF-CBT training conducted by a TF-CBT developer or a nationally-approved TF-CBT trainer;
3. Participation in at least 12 follow-up consultation calls with a TF-CBT developer/approved trainer; and
4. Completion of three separate TF-CBT treatment cases with three children or adolescents with at least two of the cases including the active participation of caretakers or another designated third party (e.g., direct care staff member in a residential treatment facility), and use of at least one standardized instrument to assess TF-CBT treatment progress with each of the above cases.

Following these training components, the application process for TF-CBT national certification has two steps:

1. Part 1 requires therapists to document completion of the above training components, upon which candidates then become eligible to take the TF-CBT Therapist Certification Program Knowledge-Based Test; and
2. Passing the knowledge-based test is Part 2 of the application for certification.

TF-CBT certification is good for five (5) years. At five (5)-years post-certification, TF-CBT therapists must complete three (3) modules of re-certification education, whereupon they can be re-certified for another five (5) years.

Certified TF-CBT therapists are listed on a national registry at https://tfcbt.org/members/

Quality Assurance

Outcomes

The primary outcome measured in TF-CBT treatment is the effect of treatment on trauma symptoms. TF-CBT providers should obtain child self-report of trauma symptoms at pre- and post-treatment:

1. The Child PTSD Symptoms Scale for the DSM-5 (CPSS-5) can be used as a self-report measure for children between the ages of 8 and 18; and
2. For younger children, TF-CBT providers should obtain parent report of youth trauma symptoms using the Young Child PTSD Checklist (YCPC).

For children where behavior problems are also a primary concern in treatment, child behavior outcomes may be measured at pre- and post-treatment as well. A standardized behavioral inventory, such as the CBCL (Child Behavior Checklist) or the SDQ (Strengths and Difficulties Questionnaire), may be used for this purpose.

Model-Specific Documentation Requirements

The TF-CBT Brief Practice Checklist is a self-report form that is available in Appendix 4 of the TF-CBT Implementation Manual. The Brief Practice Checklist should be completed by the therapist or supervisor after each session, to indicate which TF-CBT components were implemented during the session. For each TF-CBT component that are checked off on the Brief

Practice Checklist as having been used during the session, the progress note should then provide detail on how the component was implemented and the client's response. The Brief Practice Checklist should be kept in the client chart along with the progress notes for each session.

Fidelity

Fidelity to the TF-CBT model may be reviewed as needed by reviewing treatment records. Records should demonstrate that: the TF-CBT provider used the TF-CBT Brief Practice Checklist to specify which components were used in each session; the therapist detailed in progress notes how those components were implemented in each session; and over the course of a completed case that the therapist used the majority of the PPRACTICE components to treat the child or youth.

The TF-CBT National Certification Program does not require post-certification fidelity monitoring. The TF-CBT National Certification Program does require therapists to re-certify every five (5) years, by providing evidence of completion of three (3) modules of re-certification education.

Limitations/Exclusions

Limitations and exclusions noted in the "Outpatient Therapy by Licensed Practitioners" apply.

Billing

1. Only direct staff face-to-face time with the child or family may be billed. TF-CBT 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:

    a. Typical sessions during which there is both a child-delivered portion of the session, and a parent-delivered portion of the session, may be billed as 90832, 90834, or 90837 (or their successors) – Psychotherapy, with patient present, as long as:

        i. The client is present for all or the majority (greater than 50 percent) of the time billed; and

        ii. The entirety of the service is provided to, or directed exclusively toward the treatment of, the Medicaid-eligible child or youth.

b. If there is a parent-directed session for which the child is not present for the majority of the time, the appropriate procedure code must be billed, e.g. 90846 (or its successor)– Family Psychotherapy without Patient Present:

i. The parent-directed session must be directed exclusively toward the treatment of the Medicaid-eligible child or youth.

2. Collateral contacts billable to Medicaid should involve contacts with parents or 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 TF-CBT;

4. The EBP tracking code "EB07" should be indicated on claims to note that the therapy session utilized TF-CBT as an evidence-based model of therapeutic intervention;

5. To use the TF-CBT tracking code of "EB07" on claims, the therapist must first provide documentation of national certification in TF-CBT, as part of the therapist's credentialing package. Certified TF-CBT therapists are listed on a national registry at https://tfcbt.org/members/; and

6. LMSWs, PLPCs and PLMFTs may not directly bill for services provided to a Medicaid enrollee. LMSWs, PLPCs and PLMFTs may be the rendering provider on a claim when in accordance with Title 46 and their individual practice act.