**TF-CBT Training Application**

**Trauma Treatment and Supportive Services**

Below is the application for the Trauma-focused Cognitive Behavioral Therapy (TF-CBT) Learning Collaborative (LC) Program offered by the CARES Institute. The TF-CBT LC is not a typical one-time training. Rather, it is a process of learning, practice, and networking activities over the course of 8-9 months designed to enable clinicians to:

* Build evidence-based knowledge and practice skills concerning TF-CBT,
* Implement, use, and practice those skills on a daily basis with clients,
* Receive expert consultation two to three times per month concerning the cases they are seeing,
* Measure their progress over time with standardized measures,
* Sustain the use of TF-CBT in their organization and community long after the training has been completed,
* Provide clinicians with an opportunity to identify and overcome barriers to families receiving TF-CBT, and
* Engage in activities to enhance therapy skills and self-care

Agency senior leaders will also be included in portions of the training program. This training will allow therapists to provide a specific, evidence-based trauma-focused intervention to children who are living with the effects of a traumatic event.

***Applicants should serve youth who have experienced a traumatic event. Traumatic events include but are not limited to sexual abuse, physical abuse, exposure to domestic violence, exposure to community violence, medical traumas, bullying, foster placement, traumatic death of a loved one, and natural disasters. Therapists should be licensed or license-eligible (LAC, LPC, LSW, LCSW, LMFT, PhD, PsyD, etc.) and able to provide direct treatment to the child and their non-offending caregivers, preferably in an outpatient setting. At least one supervisor from each chosen location should be trained and complete cases***.

In keeping with our mission to strengthen families and individuals by providing comprehensive, personalized behavioral health and social services with a priority on serving those most vulnerable, **the CARES Institute will commit to the participating agencies in the following ways:**

* Provide extensive expert training in a scientifically supported, evidence-based practice, TF-CBT, by one of the creators of the model
* Provide ongoing support and consultation to clinicians and supervisors participating in the training
* Provide materials (books, games, etc.) for clinicians to utilize during treatment
* Provide, collect, and score pre- and post-treatment assessment measures for TF-CBT training cases
* Provide and collect pre, mid, and post-training surveys
* Provide consultation on matters relating to TF-CBT, as needed

There is a substantial and continued commitment on the part of both the agency and the supervisors/therapists. Expectations of participating agencies include, but are not limited to, the following:

**Organizational expectations:**

* This organization has **licensed or license eligible** Master’s and/or Doctoral level clinicians participating in the training program and providing therapy.
* This organization is able to commit a **team of people with at least one agency leader, one supervisor, and at least two-three clinicians** but the participation of more supervisors and clinicians is encouraged. **The participating supervisor should be the clinical supervisor specifically for the participating clinicians.**
* This organization will allow participating staff members sufficient time to dedicate to the training sessions, consultation calls, and the additional preparation required to implement TF-CBT.
* This organization has the capacity to provide therapy to parents/caregivers **separate** from and in conjunction with the child(ren) (e.g., **oversight of children in waiting area** and/or a team of two therapists working with parents/caregivers and children separately and together).
* This organization will have the involvement of agency leadership (e.g., director).
* Agency leader(s) need to be amenable to possible revision to/addition of intake/screening forms to include trauma screening questions.
* Agency leader(s) will participate in, at minimum, the first day of the Introductory Training and a two-hour meeting at the Advanced Training.

**Trainee expectations:**

* Complete the free of charge **TF-CBT 10-hour web-based training** (TF-*CBTWeb,* [*www.musc.edu/tfcbt*](http://www.musc.edu/tfcbt) *)* prior to the first day of the Introductory Training.
* Participate in **additional training activities** including one 90-minute webinar that provides training on the use of relevant assessment measures.
* Complete pre, mid, and post-training surveys that include questions about therapy skills and confidence, as well as personal and professional well-being. The surveys are done online and take approximately 25-30 minutes to complete.
* Participate in both of the in-person TF-CBT trainings. Attendance at all days of the learning sessions is required for clinicians and supervisors.
* The Introductory Training is a 2 ½-day training at a location to be determined by CARES.
* The Advanced Training is a 2-day training that will take place approximately 4-6 months after the Introductory Training at a location to be determined by CARES.
* Participate (including case presentations) in two to three consultation calls per month with the CARES consultants with attendance on **at least 80% of the 16-18 required calls**. Each call is 60 minutes.
* **Sign a consultation call waiver form** prior to the initial consultation call with CARES.
* **Screen/assess** 2 to 3 clients for appropriateness for TF-CBT **prior** to the first day of the Introductory Training and **initiate weekly therapy** sessions with at least 2 to 3 TF-CBT clients **prior** to the start of the consultation calls. **For the purposes of this training, supervisors will be required to see therapy cases themselves.**
* **Administer and submit the required assessment measures** with their TF-CBT clients. These assessment measures include standardized measures to assess trauma history, children’s trauma symptoms and behavior problems, and/or caregivers’ parenting skills. All client measures submitted to CARES will be de-identified.

To successfully complete the TF-CBT learning collaborative, in addition to fulfilling all of the above requirements, trainees are expected to successfully graduate at least one TF-CBT client based on the standardized assessments during the course of the collaborative. We therefore highly recommend that participants actively work with more than one TF-CBT client during the training period.

**If your agency is awarded a DCF contract to provide TF-CBT through the Trauma Treatment and Support Services Program, your agency’s TF-CBT Training Application will be sent to CARES for processing. Beth Cooper, LC Administrative Coordinator, at** [**cooperbe@rowan.edu**](mailto:cooperbe@rowan.edu)**, will reach out to your organizational contact to provide additional information.**

Thank you very much for your interest,

Esther Deblinger, Ph.D.

Co-Director, CARES Institute

Professor of Psychiatry

Rowan University

Elisabeth Pollio, Ph.D.

Trainer/Training Coordinator

Assistant Professor of Psychiatry

Rowan University

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**Organization Application**

**Organization Name:** Click here to enter text.

**Organizational Contact:** Click here to enter text.

Name: Click here to enter text.

Phone: Click here to enter text. E-mail: Click here to enter text.

Address: Click here to enter text.

**Clinical Director Name:** Click here to enter text.

**Executive Director Name:** Click here to enter text.

**Please list names of current referral sources:** Click here to enter text.

**What is the percentage of clients currently being seen who would report a traumatic event and could use this form of therapy?** Click here to enter text.

**How many clients are served by your organization annually?** Click here to enter text.

**Can you commit to the agency / therapist obligation list?** Choose an item.

**Can you commit to the supervisor(s) participation and case completion obligations?** Choose an item.

**Can you commit to the participation of the agency leader(s)?**  Choose an item.

**Has anyone at your agency previously participated in a LC with CARES?** Choose an item.

**If yes, who?** Click here to enter text.

**How many therapists / supervisors would be interested in training *(1 supervisor + 3 clinicians minimum)*?** Click here to enter text.

**How many child-serving therapists/supervisors does your agency employ?** Click here to enter text.

**How would you sustain the TF-CBT model practice post-training program?** Click here to enter text.

**Is your organization able to bill Medicaid for outpatient mental health services?** Choose an item.

**Organization Application (cont’d)**

What is the name of the **supervisor** you would like to participate in the learning collaborative (LC)? Click here to enter text.

What is the title of supervisor? Click here to enter text.

Why was this person chosen to participate in the LC? Click here to enter text.

What is the name of the **first clinician** you would like to participate in the LC? Click here to enter text.

What is the title of this clinician? Click here to enter text.

Why was this person chosen to participate in the LC? Click here to enter text.

What is the name of the **second clinician** you would like to participate in the LC? Click here to enter text.

What is the title of this clinician? Click here to enter text.

Why was this person chosen to participate in the LC? Click here to enter text.

What is the name of the **third clinician** you would like to participate in the LC? Click here to enter text.

What is the title of this clinician? Click here to enter text.

Why was this person chosen to participate in the LC? Click here to enter text.

Are there any other individuals you would like to participate in the LC?Choose an item.

*(If yes, please provide the information listed above for each individual you would like to include in the LC.)* Click here to enter text.

**Supervisor Application**

*(****To be completed by the trainee****. Each person listed above as an LC participant should complete the below application.)*

Applicant’s Name: Click here to enter text.

Name of Agency: Click here to enter text. Job Title: Click here to enter text.

Work Address: Click here to enter text.

Phone Number: Click here to enter text. E-mail address: Click here to enter text.

License Number and State of Licensure: Click here to enter text.

Professional Discipline: Click here to enter text.

Date of completion of TF-CBT*Web*. (If not yet completed, please provide the projected completion date.):Click here to enter text.

Describe any TF-CBT or CBT Training you have received, including participation in workshops, supervision, consultation calls, familiarity with TF-CBT manuals and books, etc.: Click here to enter text.

How many years have you been providing therapy to children and families? Click here to enter text.

What percent of your caseload do you believe could benefit from TF-CBT? Click here to enter text.

How often do you see most of your clients? (e.g., weekly, monthly, etc.)? Click here to enter text.

If you see your clients less than weekly, would you be able to schedule TF-CBT clients for weekly sessions? Choose an item.

Do you actively engage parents in treatment (i.e., participate in individual parent sessions and conjoint sessions with the child)? Choose an item.

Please check those settings in which you would implement TF-CBT after receiving training:

Outpatient clinic

Inpatient setting

School based

Home-based services

Other (describe): Click here to enter text.

Please describe your role at the agency (i.e., clinician, supervisor, etc.): Click here to enter text.

Please describe your goals for participating in the TF-CBT Learning Collaborative Program: Click here to enter text.

**Please attach current curriculum vitae or resume if available.**

**Clinician Application**

*(****To be completed by the trainee****. Each person listed above as an LC participant should complete the below application.)*

Applicant’s Name: Click here to enter text.

Name of Agency: Click here to enter text. Job Title: Click here to enter text.

Work Address: Click here to enter text.

Phone Number: Click here to enter text. E-mail address: Click here to enter text.

License Number and State of Licensure: Click here to enter text.

Professional Discipline: Click here to enter text.

Date of completion of TF-CBT*Web*. (If not yet completed, please provide the projected completion date.):Click here to enter text.

Describe any TF-CBT or CBT Training you have received, including participation in workshops, supervision, consultation calls, familiarity with TF-CBT manuals and books, etc.: Click here to enter text.

How many years have you been providing therapy to children and families? Click here to enter text.

What percent of your caseload do you believe could benefit from TF-CBT? Click here to enter text.

How often do you see most of your clients? (e.g., weekly, monthly, etc.)? Click here to enter text.

If you see your clients less than weekly, would you be able to schedule TF-CBT clients for weekly sessions? Choose an item.

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Other (describe): Click here to enter text.

Please describe your role at the agency (i.e., clinician, supervisor, etc.): Click here to enter text.

Please describe your goals for participating in the TF-CBT Learning Collaborative Program: Click here to enter text.

**Please attach current curriculum vitae or resume if available.**

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Please describe your role at the agency (i.e., clinician, supervisor, etc.): Click here to enter text.

Please describe your goals for participating in the TF-CBT Learning Collaborative Program: Click here to enter text.

**Please attach current curriculum vitae or resume if available.**

**Clinician Application**

*(****To be completed by the trainee****. Each person listed above as an LC participant should complete the below application.)*

Applicant’s Name: Click here to enter text.

Name of Agency: Click here to enter text. Job Title: Click here to enter text.

Work Address: Click here to enter text.

Phone Number: Click here to enter text. E-mail address: Click here to enter text.

License Number and State of Licensure: Click here to enter text.

Professional Discipline: Click here to enter text.

Date of completion of TF-CBT*Web*. (If not yet completed, please provide the projected completion date.):Click here to enter text.

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How many years have you been providing therapy to children and families? Click here to enter text.

What percent of your caseload do you believe could benefit from TF-CBT? Click here to enter text.

How often do you see most of your clients? (e.g., weekly, monthly, etc.)? Click here to enter text.

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Please describe your role at the agency (i.e., clinician, supervisor, etc.): Click here to enter text.

Please describe your goals for participating in the TF-CBT Learning Collaborative Program: Click here to enter text.

**Please attach current curriculum vitae or resume if available.**