Colorado Evaluation & Action Lab
UNIVERSITY OF DENVER
Using data to drive action

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Study

Final Report

REPORT HIGHLIGHTS:

- **This report documents lessons learned** regarding the school-based delivery of TF-CBT, the value of TF-CBT for Colorado's Family First service array, and recommendations for future evaluation work on TF-CBT.
- **Therapists should initiate positive contact with caregivers** to explain the importance of TF-CBT and their engagement.
- **School leadership should invest in mental health services** and the administration of TF-CBT.
- **Therapists felt more supported and capable** of implementing TF-CBT in settings where there was a mental health team with multiple providers working together.

AUTHORS:

Rachel Wildfeuer, PhD
Research Analyst, Center for Policy Research

CPR
center *for* policy research

For inquiries contact: Courtney Everson | courtney@coloradolab.org | www.ColoradoLab.org

Report Number: 21-10G. Date: June 30, 2024

Table of Contents

Background

Introduction

The Center for Policy Research (CPR) was contracted by the Colorado Evaluation and Action Lab (Colorado Lab) to design and conduct a rigorous study of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). This quasi-experimental study compared the treatment effects of youth aged 7–17 who received TF-CBT in a school-based setting (the intervention group) to the treatment effects of youth aged 7–17 who received treatment as usual (TAU) therapy in a school-based setting (the comparison group). Therapists employed by Denver Public Schools (DPS) were trained in TF-CBT and provided TF-CBT to students enrolled in the intervention group. Therapists employed by two DPS external partner organizations, Jewish Family Service (JFS) and Centus Counseling, Consulting, & Education (Centus), provided TAU therapy to students enrolled in the comparison group. A pre-analysis evaluation plan was completed in October 2022. The study officially began in January 2023 following Institutional Review Board approval.

TF-CBT is a widely practiced trauma intervention for youth ages 3–18, with evidence supporting its effectiveness.[1] It has received a "promising" evidence designation by the Title IV-E Prevention Services Clearinghouse. TF-CBT has demonstrated a statistically significant positive effect on target outcomes in the child and adult well-being domains, including the child well-being sub-domains of behavioral and emotional functioning and social functioning.[2] TF-CBT was identified by stakeholders as a mental health service positioned to drive well-being outcomes for Colorado's children and youth. The Colorado Lab recommended the inclusion of TF-CBT as a service for Colorado's mental health service array, mental health of children and youth track in its "Strategy for the Evidence-Based Aspects of the Family First Service Continuum"[3] delivered to the Colorado Department of Human Services (CDHS) to inform development of Colorado's Family First Prevention Services Plan.[4] The Family First Prevention Services Act incentivizes state systems and local agencies to move intentionally toward child welfare approaches that prioritize keeping kids safe and families together. This legislation authorizes federal reimbursement to states for the delivery of evidence-based services aimed at preventing the need for foster care.[5]

The purpose of this evaluation was to continue to build evidence for TF-CBT and assess its capacity to be included in Colorado's Family First Prevention Services Plan. Additionally, this evaluation sought to address the gap in research relative to TF-CBT's delivery within a school-based setting. Following two years of study implementation, CPR and the Colorado Lab recommended discontinuation of the study to CDHS due to persistent feasibility challenges. The challenges identified were driven by the difficult external setting of school-based mental health. Specifically, the workforce essential to the study's success (school-based therapists) were overwhelmed with daily stressors and experienced increasingly limited capacity. This resulted in chronic low enrollment in the study and inability to effectively meet sampling and design goals. CDHS agreed with the recommendation to pause the study and consider re-lifting it at a later date when the external environment of school-based mental health could be better leveraged for evidence building.

After pausing the study, CPR's evaluation focus shifted to documenting lessons learned related to delivering TF-CBT in a school-based setting and the value of TF-CBT for Colorado's Family First service array. Additionally, CPR has documented recommendations for future evaluation work on TF-CBT. In addition to their study involvement the last two years, including attendance at TF-CBT clinical consultations, CPR's documentation of lessons learned draws on two focus groups that were conducted with intervention group therapists, three short surveys that were administered to intervention group therapists during the study period to better understand implementation and enrollment challenges, and relevant literature. A synthesis of recommendations from these lessons learned was submitted to the Colorado Lab in March 2024.

Trauma-Focused Cognitive Behavioral Therapy

First created as a treatment for sexual abuse trauma specifically, TF-CBT has since demonstrated effectiveness in treating diverse, multiple, and complex trauma experiences, in treating youth at different developmental levels, and in treating youth across different cultures.[6] The TF-CBT model is designed to be a short-term course of treatment that typically spans 12-16 one-hour sessions and includes both individual and combined therapy sessions with the child and the nonoffending adult caregiver. TF-CBT is intended for implementation in clinical settings, as well as in residential treatment facilities, schools, and homes.[7,8]

TF-CBT is implemented by licensed mental health professionals in three phases: 1) stabilization and skill building, 2) trauma narrative and processing, and 3) integration and consolidation. The intervention itself is comprised of nine therapy components that are typically completed in chronological order. These components are summarized by the acronym **PRACTICE**: **P**sychoeducation, **P**arenting skills, **R**elaxation skills, **A**ffective modulation skills, **C**ognitive coping skills, **T**rauma narrative and cognitive processing of the traumatic event(s), **I**n vivo mastery of trauma reminders, **C**onjoint child-parent services, and **E**nhanced safety and future developmental trajectory.[9]

School-Based Therapy

A meta-analysis of youth mental health service utilization found that schools were the most common setting to receive mental health care for both the general population of youth and for youth with elevated symptoms compared to outpatient, primary care, child welfare, juvenile justice, and inpatient settings. As the authors note, youth spend a lot of their waking time at school and recent legislation has focused on schools as a space for mental health support.[10] School-based mental health services are accessible and affordable and can be particularly effective in meeting the mental health needs of youth in rural areas, youth of color, LGBTQIA+ youth, youth with disabilities, and youth who are systems-connected (for example, those impacted by the foster care system or the criminal legal system).[11]

The literature on TF-CBT delivered in a school-based setting is limited but promising. A case study of a 16-year-old student who received TF-CBT in school found a significant reduction in post-traumatic stress disorder (PTSD) symptoms and impairments in daily living.[12] TF-CBT led to significant reduction of PTSD symptoms amongst students who were exposed to Hurricane Katrina

and had other trauma experiences.[13] Similarly, a quasi-experimental study of Latino immigrant students who were exposed to community violence found that students in the intervention group, who received group-based cognitive-behavioral therapy (CBT), had significantly greater improvements in PTSD and depressive symptoms compared to those on the waitlist at a three-month follow-up.[14] Orengo-Aguayo et al. (2020)[15] implemented TF-CBT in three separate low-resourced settings, including school-based TF-CBT in rural South Carolina and in Puerto Rico post-Hurricane Maria, and found a reduction in PTSD symptoms.

Literature also suggests that the use of telehealth to deliver TF-CBT in a school-based setting, in combination with cultural adaptations, helps to break down barriers to therapeutic treatment that are disproportionately experienced by African American youth.[16] In rural South Carolina, school-based TF-CBT provided to students via telehealth helped reach youth in underserved areas.[17]

The developers of TF-CBT have supported the use of TF-CBT in schools. A treatment applications guide[18], created to supplement the implementation manual[19,20], has a chapter specific to school-based implementation[21]. School psychologists have been identified as uniquely positioned to provide TF-CBT in a school-based setting, to ensure a team approach at the school, and to facilitate collaborative communication with parents, teachers, and other professionals during the treatment process[22]. The TF-CBT National Therapist Certification Program website, maintained by the developers of TF-CBT, provides resources on implementing TF-CBT in a telehealth setting.[23]

Study Overview

Design

As previously mentioned, the study was designed to compare the treatment effects of youth aged 7-17 who received TF-CBT in a school-based setting (the intervention group) to the treatment effects of youth aged 7-17 who received TAU therapy in a school-based setting (the comparison group). Depending on the school that they attended, enrolled students received either TF-CBT or TAU therapy. In other words, the students were in the intervention group or the comparison group via a non-random process based on where they attended school. TAU therapy refers to the usual or typical therapy services available in the school-based setting for students who have experienced trauma and have resultant post-traumatic stress (PTS) symptoms.

Three assessments were administered by therapists at three points in time: before study treatment (baseline), at the end of study treatment, and six months after the end of study treatment. The end of study treatment was operationalized as 12 therapy sessions, or for the intervention group, the end of TF-CBT if that came first. CPR created an online data collection form that corresponded to each assessment where the therapists were to enter information from the completed assessment. Before study treatment, the therapists also completed a basic information online data collection form to capture demographic information on the enrolled student (e.g., grade, age, sex/gender, race/ethnicity, and language of services). If analyses of the assessments administered six months after the end of study treatment demonstrated favorable effects, the assessments were going to be administered again 12 months after the end of study treatment.

Sites

Using school-level data provided by DPS and from the Colorado Department of Education, CPR selected intervention and comparison site schools that were comparable in terms of grade levels served and school demographics (percentage of low-income students and percentage of racial/ethnic minority students).

The school sites that were included in this study have established processes for identifying and referring students for therapy. Typically, a school mental health team, composed of the resident school social worker/psychologist(s) and therapists from external mental health providers meet regularly to determine the needs of students with social-emotional related issues. Students in need of therapy are referred to the therapy provider, as services are available. This process varies somewhat, however, depending on the school and the resources and staff that are available.

Prior to the start of the study, intervention group therapists received TF-CBT training from Dr. Monica Fitzgerald, a nationally recognized TF-CBT trainer. Dr. Fitzgerald served as the study's clinical consultant. Both intervention and comparison group therapists received training from Dr. Fitzgerald on administering the three reliable and valid assessments used in the study: the Child and Adolescent Trauma Screen (CATS), the Mood and Feelings Questionnaire (MFQ), and the Strengths and Difficulties Questionnaire (SDQ).

Sample

Students were eligible to be enrolled in the study if they were between the ages of 7-17; they had experienced at least one traumatic event and had a total score on the CATS of 15 or higher; and they were able to communicate with the therapist in English and/or Spanish (if the therapist provided services in Spanish). Prior to study enrollment, the therapist was required to receive both informed assent from the student and informed consent from their caregiver. Students were ineligible to be enrolled in the study if the school-based mental health team determined that they needed services beyond what could be provided in a school setting. A power analysis determined that the appropriate sample size for the study to detect statistically significant effects was 75 students in each group.

Therapists first began enrolling students in the study, and providing study treatment, in January 2023 and continued through May 2023, the end of that academic year. These students, referred to as Cohort 1, were administered baseline, end of study treatment, and six months after the end of study treatment assessments before the study was paused in January 2024.

In September 2023, at the start of the next academic year, therapists again began enrolling students and providing study treatment. Students were enrolled until the study was paused in January 2024. These students, referred to as Cohort 2, were administered baseline and, in some cases, end of study treatment assessments.

As previously mentioned, both cohorts experienced chronic low enrollment for the intervention group and the comparison group. CPR made efforts to boost enrollment, including facilitating a one-hour training for intervention group therapists on strategies to effectively provide school-based therapy, and extending the originally anticipated enrollment period.

Fidelity

Fidelity to the TF-CBT model was defined as completion of the nine TF-CBT PRACTICE components and therapy delivered by a fully trained therapist who participated in routine clinical consultation sessions. Routine clinical consultation sessions, defined as sessions twice a month, were facilitated by Dr. Fitzgerald. Fidelity was measured with the TF-CBT Brief Practice Checklist, which is an ongoing record of the content and sequence of the PRACTICE components of TF-CBT.[24] Therapists providing TF-CBT maintained a Brief Practice Checklist for each enrolled student to record activities for each therapy session, including if there was caregiver participation.

In terms of fidelity to the study, as previously mentioned, all participating therapists received the same training on the three assessments. CPR created shared Google Drives, one for intervention group therapists and one for comparison group therapists, which housed all the study materials including the informed assent and consent documents, copies of the three assessments and links to the online data collection forms, and the study protocol. To maintain student confidentiality, therapists assigned a de-identified study ID number to enrolled students that was used on the online data collection forms and for the intervention group therapists, the Brief Practice Checklists.

Preliminary Findings

Study consultant Dr. Fitzgerald participated in a panel discussion at the International Society for Traumatic Stress Studies annual conference in November 2023. In preparation for this presentation, CPR analyzed preliminary data from Cohort 1 students with complete baseline and end of study treatment data (n = 23). Dr. Fitzgerald noted in her presentation that these were unofficial and preliminary results from a small sample.

In the intervention group (n = 14), the median grade was 7th, the median age was 13 years old, 86% of students were female, 50% were Hispanic, and 93% of the therapy was provided in English. In the comparison group (n = 9), the median grade was 6th, the median age 12 years old, 56% of students were female, 100% were Hispanic, and 56% of the therapy was provided in both English and Spanish (33% was provided in English only).

There was a statistically significant improvement for the intervention group for the CATS total score and for each of the four subscale scores (re-experiencing; avoidance; negative alterations in cognitions/mood; hyperarousal). For the comparison group, there was a statistically significant improvement for just one of the CATS subscale scores (re-experiencing). There was a statistically significant improvement on the MFQ total score for the intervention group but not for the comparison group. For the SDQ, the intervention group had a statistically significant improvement for the total difficulties score and the emotional problems scale score while there were no statistically significant changes for the comparison group. **Overall, these preliminary results**

suggested a decrease in PTS symptoms, depressive symptoms, and general mental health symptoms for the intervention group compared to the comparison group.

Lessons Learned

CPR has documented the following lessons learned regarding the school-based delivery of TF-CBT, the value of TF-CBT for Colorado's Family First service array, and recommendations for future evaluation work on TF-CBT. This information has relevance for practitioners, evaluators, and stakeholders.

Delivering TF-CBT in a School-Based Setting

School Schedule, Student Attendance, and Caregiver Engagement

Intervention group therapists experienced and identified barriers inherent to providing TF-CBT in a school-based setting. The school schedule, including summer break and testing days, disrupted the delivery of therapeutic services. Inconsistent student attendance was also an issue that impacted delivery for multiple therapists. Caregiver engagement, an integral part of TF-CBT, was challenging in the school-based setting. As one therapist explained, "The kids that I have, parents are not necessarily available…It would be like way after [school] hours that I would be able to connect with them." In the TF-CBT treatment applications guide, Rivera (2012)[25] acknowledges these barriers that are specific to implementing TF-CBT in a school-based setting and provides strategies to overcome them. **For example, it is recommended that therapists initiate positive contact with caregivers to explain the importance of TF-CBT and their engagement**. While these strategies were reinforced to therapists in the study during their clinical consultations, they were often still challenging to implement. Ongoing research is exploring the benefit of augmenting TF-CBT training and consultation with the Beliefs and Attitudes for Successful Implementation in Schools (BASIS) strategy to improve the delivery of TF-CBT in school-based settings.[26]

Competing Responsibilities on Therapist Time

Intervention group therapists, who were employed by DPS, often reported feeling overwhelmed and had competing responsibilities and demands that impacted their capacity and time to implement TF-CBT. In addition to their workload providing mental health services, they often had to "do duty" at their schools and handle tasks such as lunch duty, recess duty, door duty, and proctoring exams. Implementation of an intervention like TF-CBT was also frequently impacted by students' crises, where it is "all hands-on deck" for the therapists. As one intervention group therapist explained, "I wish I had more time to implement it outside of my other duties." Connors et al. (2021),[27] in their description of the barriers and facilitators to the implementation of TF-CBT in thirteen schools in an urban public school district, similarly note concerns about lack of time for therapists. **They recommend that therapists have protected time just for providing TF-CBT and/or that there is a therapist who only provides TF-CBT.** Additionally, a school-based therapist from an external partner organization, such as JFS or Centus, may have more capacity for providing TF-CBT as they do not have the responsibilities that often come with being an employee at the school.

Built Environment

The physical space that a therapist is working in also impacts school-based delivery. One intervention group therapist's office was right next to the dean's office which got very loud. She explained, "I think to ask someone to write a narrative about the worst things in their life, when there's banging on the wall and yelling and screaming…I don't think that's appropriate." Another therapist mentioned that her original office was too small to have space for caregivers to join sessions. While she was able to move to a larger office, it was next to the cafeteria and noisy. Concern about physical office environment was also identified as a barrier to implementation by Connor et al. (2021).[28]

Team Approaches

Some intervention group therapists were at schools where there was a mental health team with multiple providers working together (for example, a psychologist, multiple therapists, and a social worker). **These therapists felt more supported and capable of implementing TF-CBT than therapists who were the only therapist at their school and/or did not have that sense of community at their school.** As one therapist noted, "There are so many benefits if you have a team." These benefits include having more people to help with the crises that arise, having a better delegation system for who will provide what to students, and increased visibility of mental health services at the school. Being part of a team also meant improved ability to participate in the study, and for these therapists, enrollment tended to be higher.

Leadership Support

Finally, some intervention group therapists noted that the administration and staff at their schools did not buy into or understand school-based mental health services, including TF-CBT. As one therapist explained, "I think there's honestly a disconnect and they don't know what we do and what we can't do." This disconnect can result in a resistance to therapists pulling students from class for sessions and a prioritization of therapists assisting with special education and student safety (for example, the suicide risk review assessment) over providing mental health services. Connors et al. (2021)[29] similarly emphasize **the importance of having school leadership be invested in mental health services and the administration of TF-CBT.**

The Value of Trauma-Focused Cognitive Behavioral Therapy

Perceived Value

Therapists were positive about the benefits of TF-CBT as an intervention for children and youth who have experienced trauma. As one intervention group therapist noted, "I think it's a great modality, and I think it really does support and move kids through their trauma and give them a new experience and understanding of what they've been through and how to understand it." Another therapist reported, "This is an effective way to intervene with families and children with trauma and I have seen incredible impacts using it." Some therapists mentioned that they found school to be an ideal setting for implementing the skills learned during TF-CBT. Therapists also emphasized that many of these children and youth would not have access to TF-CBT if it wasn't

provided at their school. As one therapist explained, “Our community doesn’t have access to TF-CBT any other place.” Additionally, for some students, their parents would not be able or willing to get them to therapy appointments outside of school.

Improving Reach

While therapists were enthusiastic about TF-CBT, there were concerns about how many students it could reach compared to a group-based intervention. As one intention group therapist explained, “I would rather serve more kids in groups and things like that than spend that much time weekly with one student. And how do you pick? It just seems inequitable to me because so many students could benefit from TF-CBT. It’s a good intervention, but how do you equitably pick?” One suggestion from the therapists was **to incorporate TF-CBT into a continuum of care alongside a group-based intervention** such Cognitive Behavioral Intervention for Trauma in Schools (CBITS) where students are first provided the group-based intervention and then students who could best benefit from TF-CBT are identified. Another option is to **provide TF-CBT itself in group, rather than individual, settings**. In the TF-CBT treatment applications guide, Rivera (2012)[30] explains that most components of TF-CBT can be delivered in group sessions with individual sessions conducted if a student needs more individualized attention, misses a group session, or expresses discomfort with participating in a group session. Additionally, the trauma narrative sessions, where students share details of their trauma, are conducted individually. As Rivera (2012)[31] notes, “By delivering school-based services and using a group format, more children can be reached and can reap the benefits of TF-CBT” (p. 48). Two recent meta-analyses find support for group-based TF-CBT amongst children and adolescents with PTSD.[32,33] As previously mentioned, Kataoka et al. (2003) found that group CBT delivered by school social workers improved student’s PTSD and depressive symptoms. Li et al., (2023)[34] similarly found that group-based TF-CBT delivered in a school setting by trained lay counselors, college students supervised by experts, alleviated PTSD, depression, and generalized anxiety in Chinese children who had experienced trauma.

Future Evaluation Work on TF-CBT

During the study, four aspects of the study design were both essential and particularly challenging to the evaluation: 1) fidelity, 2) caregiver engagement, 3) consent, and 4) communication. While grounded in the use case of TF-CBT, these evidence-building insights are transferable to multiple evaluations within the Family First strategy. Overall, CPR recommends that evaluators gain feedback from providers on study design, ensure providers can access and are aware of study resources, and provide study-specific training.

Fidelity

Therapists often had questions about the enrollment processes and the data collection processes. At the start of the study, CPR had developed a study protocol document that was available on the shared Google Drives. Providing each provider with a hard copy of the study protocol document would potentially help increase familiarity with the information and reduce confusion. Additionally, although CPR briefly went over the document during the training provided by Dr. Fitzgerald, evaluators should instead coordinate an additional, separate training to review these processes.

Evaluators should also prioritize getting input from providers on the study design to help reduce burden and ensure feasibility. Feedback is important both when planning the study and throughout. For example, prior to the study being paused, CPR was exploring whether therapists could scan de-identified paper versions of the completed assessments to the research team to enter the data after hearing from some therapists that they struggled with using the online data collection forms.

It is important to acknowledge the time and effort that enrollment and data collection take. Before the study was paused, CPR was exploring providing compensation to therapists for their work at each time point in the study. As mentioned above, therapists had very busy schedules and competing responsibilities outside of the study.

Caregiver Engagement

As previously mentioned, caregiver engagement was often difficult in the school-based setting. At the start of the study, CPR had developed a one-page information sheet caregivers document and a brief recruitment script to help facilitate therapist outreach to caregivers about the study. These documents were available on the shared Google Drives and briefly introduced to therapists.

Providing hard copies of these documents and study-specific training to therapists on outreach techniques may have helped increase and improve caregiver engagement.
Additionally, based on therapist feedback, CPR was looking into making study materials available in Arabic to reach additional caregivers. Evaluators should be prepared to check in with providers once the study is underway to get feedback and consider potential adjustments to the study design, including regarding caregiver engagement.

Consent

Relatedly, multiple therapists found it challenging to gain informed consent from students' caregivers. CPR had developed an informed consent script at the start of the study and was considering updating that script to better facilitate the process when the study was paused. Once again, hard copies of the informed consent script and training may have helped therapists with this part of the study.

CPR received feedback from therapists that it would be helpful to have caregivers be able to provide consent via DocuSign rather than return the form. In terms of less paperwork, evaluators can also explore whether the informed consent for the study can be combined with or happen at the same time as the informed consent for therapy.

When the study was paused, CPR was exploring providing compensation to therapists that went through the consent process but did not ultimately receive consent to acknowledge their time and effort. Evaluators should be thoughtful about how to reduce provider discouragement and frustration amidst the often lengthy consent process.

Communication

Finally, issues arose about how to best communicate about the study, and TF-CBT, to therapists, students, caregivers, and other stakeholders. Prior to the study being paused, CPR was considering drafting a one-pager for participating therapists and a one-pager for principals and other school personnel. Developing these documents before the study began may have helped reduce confusion.

Relationships between the research team, therapists, liaisons at each therapy provider organization, and clinical consultant were imperative in working through these communication challenges. Future evaluation work requires strong intermediary support to ensure the foundation and continued connection between the clinical implementation and the evaluation research.

Conclusion

CPR's evaluation, while initially intended to build evidence for TF-CBT and assess its capacity to be included in Colorado's Family First Prevention Services Plan, shifted to document lessons learned regarding delivering TF-CBT in a school-based setting and the value of TF-CBT for Colorado's' Family First service array. CPR has also documented recommendations for future evaluation work on TF-CBT that are transferable to other evaluations within the Family First strategy.

When implementing school-based TF-CBT, it is important to consider the certain barriers inherent to that setting; the often-competing responsibilities on therapist time, especially for therapists employed by the school; the impact of the built environment and therapist's physical space; the benefits of a team approach; and the importance of leadership support. Therapists involved in the study were enthusiastic about TF-CBT in the school-based setting but suggested either incorporating it into a continuum of care alongside a group-based intervention or providing TF-CBT in a group setting to help improve its reach. In terms of future evaluation work, CPR recommends gaining feedback from providers on study design, ensuring that providers can access and are aware of study resources, and providing study-specific training,

This study provides important insight into the implementation of and evaluation of school-based TF-CBT. As Lyons et al. (2021)[35] explain, the limited research on TF-CBT in the school-based setting hinders attempts to "scale-out" TF-CBT into the educational sector. The lessons learned from this study will inform future evaluations of TF-CBT as well as other Family First services.

Endnotes

[1] Children's Bureau. (2021). Title IV-E prevention program. U.S. Department of Health and Human Services, Administration for Children and Families. https://www.acf.hhs.gov/cb/title-iv-e-prevention-program

[2] Title IV-E Prevention Services Clearinghouse. (2019). Trauma-Focused Cognitive Behavioral Therapy. Prevention Services Clearinghouse. https://preventionservices.acf.hhs.gov/programs/224/show

[3] Clemens, E., V., Everson, C. L., Henninger, J., & Moses, S. (2021). Strategy for the evidence-based aspects of the Family First service continuum (Report No. 20-07A). Colorado Evaluation and Action Lab at the University of Denver. https://coloradolab.org/wp-content/uploads/2021/07/Strategy-for-the-Evidence-based-Aspects-of-the-Family-First-Service-Continuum.pdf

[4] Colorado Department of Human Services [CDHS]. (2022). Colorado Five-Year Family First Prevention Services Plan. Retrieved from https://co4kids.org/prevention-services/

[5] Title IV-E prevention program. U.S. Department of Health and Human Services, Administration for Children and Families. https://www.acf.hhs.gov/cb/title-iv-e-prevention-program

[6] Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. Guilford Press.

[7] Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2017). *Treating trauma and traumatic grief in children and adolescents* (2nd ed.). Guilford Press.

[8] Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. Guilford Press.

[9] Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2017). *Treating trauma and traumatic grief in children and adolescents* (2nd ed.). Guilford Press.

[10] Duong, M. T., Bruns, E. J., Lee, K., Cox, S., Coifman, J., Mayworm, A., & Lyon, A. R. (2021). Rates of mental health service utilization by children and adolescents in schools and other common service settings: A systematic review and meta-analysis. *Administration and Policy in Mental Health and Mental Health Services Research*, *48*, 420–439. https://doi.org/10.1007/s10488-020-01080-9.

[11] Tawa, K. (2022). *Addressing the youth mental health crisis through equitable school-based services*. The Center for Law and Social Policy. https://www.clasp.org/publications/report/brief/addressing-the-youth-mental-health-crisis-through-equitable-school-based-services/

[12] Stevens, A. E., & Michael, K. D. (2014). Trauma-Focused Cognitive Behavioral Therapy applied to childhood traumatic grief in the aftermath of a motor-vehicle accident: A school-based case study. *Clinical Case Studies, 13*(5), 405-422. https://doi.org/10.1177/1534650113517932

[13] Jaycox, L. H., Cohen, J. A., Mannarino, A. P., Walker, D. W., Langley, A. K., Gegenheimer, K. L., Scott, M., & Schonlau, M. (2010). Children's mental health care following Hurricane Katrina: A field trial of trauma-focused psychotherapies. *Journal of Traumatic Stress, 23*(2), 223–231. https://doi.org/10.1002/jts.20518

[14] Kataoka, S. H., Stein, B. D., Jaycox, L. H., Wong, M., Escudero, P., Tu, W., Zaragoza, C., & Fink, A. (2003). A school-based mental health program for traumatized Latino immigrant children. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*(3), 311–318. https://doi.org/10.1097/00004583-200303000-00011

[15] Orengo-Aguayo, R., Stewart, R. W., Villalobos, B. T., Hernandez Rodriguez, J., Dueweke, A. R., de Arellano, M. A. & Young, J. (2020). Listen, don't tell: Partnership and adaptation to implement Trauma-Focused Cognitive Behavioral Therapy in low-resourced settings. *American Psychologist, 75*(8), 1158–1174. https://psycnet.apa.org/doi/10.1037/amp0000691

[16] Stewart, R. W., Orengo-Aguayo, R., Wallace, M., Metzger, I. W., & Rheingold, A. A. (2021). Leveraging technology and cultural adaptions to increase access and engagement among trauma-exposed African American youth: Exploratory study of school-based telehealth delivery of Trauma-Focused Cognitive Behavioral Therapy. *Journal of Interpersonal Violence, 36*(15-16), 7090–7109. https://doi.org/10.1177/0886260519831380

[17] Orengo-Aguayo, R., Stewart, R. W., Villalobos, B. T., Hernandez Rodriguez, J., Dueweke, A. R., de Arellano, M. A. & Young, J. (2020). Listen, don't tell: Partnership and adaptation to implement Trauma-Focused Cognitive Behavioral Therapy in low-resourced settings. *American Psychologist, 75*(8), 1158–1174. https://psycnet.apa.org/doi/10.1037/amp0000691

[18] Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2012). *Trauma-focused CBT for children and adolescents: Treatment applications*. Guilford Press.

[19] Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. Guilford Press.

[20] Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2017). *Treating trauma and traumatic grief in children and adolescents* (2nd ed.). Guilford Press.

[21] Rivera, S. (2012). Application of TF-CBT in Schools. In J. A. Cohen, A. P. Mannarino, & E. Deblinger (Eds.), Trauma-focused CBT for children and adolescents: Treatment applications (pp. 29–48). Guilford Press.

[22] Fitzgerald, M. M., & Cohen, J. A. (2012). Trauma-focused cognitive behavior therapy for school psychologists. Journal of Applied School Psychology, 28, 294-315. https://doi.org/10.1080/15377903.2012.696037

[23]Cohen, J. A., Deblinger, E., & Mannarino, A. P. (2024). TF-CBT telehealth resources. Trauma-Focused Cognitive Behavioral Therapy: National Therapist Certification Program. Retrieved from https://tfcbt.org/telehealth-resources/

[24] Deblinger, E., Cohen, J. A., Mannarino, A. P., Murray, L., & Epstein, C. (2008). Brief Practice Checklist. Retrieved from https://tfcbt.org/tf-cbt-brief-practice-checklist/

[25] Rivera, S. (2012). Application of TF-CBT in Schools. In J. A. Cohen, A. P. Mannarino, & E. Deblinger (Eds.), *Trauma-focused CBT for children and adolescents: Treatment applications* (pp. 29–48). Guilford Press.

[26] Lyon, A. R., Pullman, M. D., Dorsey, S., Levin, C., Gaias, L. M., Brewer, S. K., Larson, M., Corbin, C. M., Davis, C., Muse, I., Joshi, M., Reyes, R., Jungbluth, N. J., Barrett, R., Hong, D., Gomez, M. D., & Cook, C. R. (2021). Protocol for a hybrid type 2 cluster randomized trial of Trauma-Focused Cognitive Behavioral Therapy and a pragmatic individual-level implementation strategy. *Implementation Science, 16*(3), https://doi.org/10.1186/s13012-020-01064-1

[27] Connors, E. H., Prout, J., Vivrette, R., Padden, J., & Lever, N. (2021). Trauma-focused cognitive behavioral therapy in 13 urban public schools: Mixed methods results of barriers, facilitators, and implementation outcomes. *School Mental Health, 13*(4), 772-790. https://doi.org/10.1007/s12310-021-09445-7

[28] Connors, E. H., Prout, J., Vivrette, R., Padden, J., & Lever, N. (2021). Trauma-focused cognitive behavioral therapy in 13 urban public schools: Mixed methods results of barriers, facilitators, and implementation outcomes. *School Mental Health, 13*(4), 772-790. https://doi.org/10.1007/s12310-021-09445-7

[29] Connors, E. H., Prout, J., Vivrette, R., Padden, J., & Lever, N. (2021). Trauma-focused cognitive behavioral therapy in 13 urban public schools: Mixed methods results of barriers, facilitators, and implementation outcomes. *School Mental Health, 13*(4), 772-790. https://doi.org/10.1007/s12310-021-09445-7

[30] Rivera, S. (2012). Application of TF-CBT in Schools. In J. A. Cohen, A. P. Mannarino, & E. Deblinger (Eds.), *Trauma-focused CBT for children and adolescents: Treatment applications* (pp. 29–48). Guilford Press.

[31] Rivera, S. (2012). Application of TF-CBT in Schools. In J. A. Cohen, A. P. Mannarino, & E. Deblinger (Eds.), *Trauma-focused CBT for children and adolescents: Treatment applications* (pp. 29–48). Guilford Press.

[32] Davis, R. S., Meiser-Stedman, R., Afzal, N., Devaney, J., Halligan, S. L., Lofthouse, K., Smith, P., Stallard, P., Ye, S., & Hiller, R. M. (2023). Systematic review and meta-analysis: Group-based interventions for treating posttraumatic stress symptoms in children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry, 62*(11), 1217–1232. http://dx.doi.org/10.1016/j.jaac.2023.02.013

[33] Xie, S., Cheng, Q., Tan, S., Li, H., Huang, T., Xiang, Y., Zhou, X. (2024). The efficacy and acceptability of group trauma-focused cognitive behavior therapy for the treatment of post-traumatic stress disorder in children and adolescents: A systematic review and meta-analysis. *General Hospital Psychiatry, 86*, 137–134. https://doi.org/10.1016/j.genhosppsych.2023.11.012

[34] Li, J., Li, J., Zhang, W., Wang, G., & Qu, Z. (2023). Effectiveness of a school-based, lay counselor-delivered cognitive behavioral therapy for Chinese children with posttraumatic stress symptoms: A randomized controlled trial. *The Lancet Regional Health – Western Pacific, 33,* Article 100699. https://doi.org/10.1016/j.lanwpc.2023.100699

[35] Lyon, A. R., Pullman, M. D., Dorsey, S., Levin, C., Gaias, L. M., Brewer, S. K., Larson, M., Corbin, C. M., Davis, C., Muse, I., Joshi, M., Reyes, R., Jungbluth, N. J., Barrett, R., Hong, D., Gomez, M. D., & Cook, C. R. (2021). Protocol for a hybrid type 2 cluster randomized trial of Trauma-Focused Cognitive Behavioral Therapy and a pragmatic individual-level implementation strategy. *Implementation Science, 16*, Article 3, https://doi.org/10.1186/s13012-020-01064-1