TST Treatment Fidelity Form

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Date:	***Sources of Information (check all that apply)***
Participant ID#:	Clinician self-report:
Participant Name (if appropriate):	Clinician Interview:
Initials of Rater:	Supervisor report:
Initials of Co-Rater(s):	Team meeting:
Initials of Primary Clinician:	Chart Review:
Initials of Team Leader:	Other (specify):

Instructions

The following items assess how closely activities within TST interventions correspond to the 10 TST Treatment Principles as detailed in chapter 6 of the TST manual entitled Collaborative Treatment for Traumatized Children and Teens (Guilford Press, 2006). The rater should be familiar with the TST manual (and particularly with chapter 6) when making these ratings. Each of the following items describes a different TST principle and the core construct addressed by the principle. The rater should look for evidence from the variety of sources (team meeting, chart review, clinical supervision sessions, etc.) to determine if there was fidelity to the respective treatment principle. This form should be used to note whether this evidence was 'present', 'absent', or 'insufficient'.

Principle 1: Fix a Broken System

CORE CONSTRUCT: The clinician (or clinical team) assesses the stability of the child's social environment, the capacity of the child to regulate his or her emotions and behavior, and the interaction between them (the Trauma System). The clinician integrates this information into a concise list of 1-4 treatment goals ("TST Priority Problems"), and all interventions are devoted to addressing these TST Priority Problems. Evidence for fidelity to this principle includes:

Evidence	***Present***	***Absent***	***Insufficient***
1. Assessment activities explicitly reference the degree of emotional/behavioral dysregulation, the degree of environmental instability, and the link between them (e.g. use of TST Assessment Grid, identification of TST Priority Problems).			
2. Intervention activities explicitly reference the degree of emotional/behavioral dysregulation, the degree of environmental instability and the link between them (e.g. TST Priority Solutions are clearly linked to TST Priority Problems).			
3. Team discussion references the degree of emotional/behavioral dysregulation, the degree of environmental instability and the link between them			

Principle 2: Put Safety First

CORE CONSTRUCT: The clinician (or clinical team) is attuned to the signs of a threatening social environment and proactively adjusts the TST treatment plan based on an ongoing safety assessment that occurs throughout treatment.

Evidence	***Present***	***Absent***	***Insufficient***
1. Information about safety is explicitly assessed.			
2. This information is explicitly used for treatment planning.			
3. Safety concerns are reassessed throughout treatment and treatment plans adjusted based on new information.			

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Principle 3: Focused Plans that are based on facts			
CORE CONSTRUCT: The clinician (or clinical team) bases all clinical decisions on objective evidence gathered from clinical interviews, collateral contacts, and structured clinical assessments (e.g., self-report questionnaires). Clinical decision-making targets the Trauma System, as defined in chapters 7 and 8, and is summarized in the TST Treatment Plan. Evidence for fidelity to this principle includes:			
Evidence	***Present***	***Absent***	***Insufficient***
1. Moment-by-moment analysis is used to gather information regarding the child's emotional/behavioral dysregulation.			
2. The social environment is surveyed to identify possible stressful stimuli that may elicit this dysregulation.			
3. The TST Assessment Grid is completed using the clinical information gathered under steps #1 and #2.			
4. TST Priority Problems are identified by the clear links between stressful stimuli and dysregulated responses.			
5. TST Priority Solutions are drafted to intervene between these identified stimulus/response links.			
6. Problems and solutions are prioritized according to the format noted in chapter 8.			
7. Information related to treatment planning is supplemented by relevant instruments and tools (e.g. Legal Services Screener, Emotional Regulation Guide, Weekly TST Check-in).			
8. Information related to treatment planning is supplemented by relevant collateral contacts (e.g. teachers, social service workers, youth service workers, extended-family members).			

Principle 4: Don't "Go" Before You Are "Ready"			
CORE CONSTRUCT: The clinician (or clinical team) enters the process of engaging the family in the TST Treatment Plan before providing focused interventions. Evidence of fidelity to this principle includes:			
Evidence	***Present***	***Absent***	***Insufficient***
1. Prior to the initiation of treatment, the initial TST Assessment and treatment planning process are completed.			
2. This process includes the family members' perspectives on problems ('sources of pain') and solutions that they have considered.			
3. A treatment alliance is built around how the TST Priority Problems and Solutions may plausibly offer family members relief from this 'source of pain'. The treatment alliance should include a shared understanding about child traumatic stress and what will be required of the family should they choose to engage in treatment.			
4. Prior to the initiation of treatment a Family Collaborative Meeting is held where initial ideas regarding TST Priority Problems and Solutions are shared and discussed with the family. The final treatment plan is based on the agreement between the team and the family about how problems will be addressed in treatment.			
5. Prior to the initiation of treatment, the clinician, team members, and family work to surmount practical barriers to treatment engagement.			

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Principle 5: Put Scarce Resources Where They'll Work			
CORE CONSTRUCT: The TST Treatment Team strategically focuses on a limited set of highly specific priority problems and allocates their limited intervention resources toward the highest priority problems. Evidence of adherence to this principle includes:			
Evidence	***Present***	***Absent***	***Insufficient***
1. Team discussion includes the reality of the team's limited intervention resources for the population they are serving as a whole.			
2. Team discussion includes allocation of these scarce resources for the highest priority problems of the families served by the team.			

Principle 6: Insist on Accountability, Particularly your Own			
CORE CONSTRUCT: The clinician (or clinical team) ensures that all members of the treatment team are held fully accountable for agreements made within TST treatment. Evidence of fidelity to this treatment principle includes:			
Evidence	***Present***	***Absent***	***Insufficient***
1. Treatment agreements are recorded and 'signed off' by the responsible party on the TST Treatment Planning Form.			
2. The TST Treatment Planning Form is used in each treatment session to 'check in' about whether agreements were kept.			
3. In cases where treatment agreements are not kept, this is addressed proactively. Reasons for not keeping agreements are discussed. Barriers are addressed. Renegotiation of the TST Treatment Plan is considered based on the reality of agreements not kept.			
4. Circumstances where a member of the TST Treatment Team did not keep an agreement are addressed in the same way as when a child or family member did not keep an agreement. The TST Treatment Team member is expected to apologize when appropriate.			

Principle 7: Align With Reality			
CORE CONSTRUCT: The clinician (or clinical team) continually engages in the process of understanding the clinical realities of a case (e.g., a compromised caregiver; a child's being unable to achieve sufficient regulation to participate in desired activities) and makes every effort to distinguish the child's, caregivers', and their own wishes from this clinical reality. Evidence of fidelity to this principle includes:			
Evidence	***Present***	***Absent***	***Insufficient***
1. Team meetings and clinical supervision sessions include critical review of such questions as "what is true?" "what is real?", "do we have all the facts?", "do we have the most accurate information?"			
2. Difficult decisions regarding a case are explicitly weighed against the wish to 'preserve the alliance" with the family. Clinicians and team members openly discuss the tension between "alliance-preserving" wishes and clinical realities so that care is not compromised.			

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Principle 8: Take Care of Yourself and Your Team			
CORE CONSTRUCT: The clinician (or clinical team) deliver care mindful of the difficulties of the work and appropriately include self-care and social-support in clinical decision making. Evidence of fidelity to this principle includes:			
Evidence	***Present***	***Absent***	***Insufficient***
1. Team discussion includes opportunities to address team members' reactions to their work.			
2. Team discussion includes levity, humor, and efforts to boost morale.			
3. Team leaders regularly underscore that team members should 'never worry alone'.			

Principle 9: Build From Strength			
CORE CONSTRUCT: The clinician (or clinical team) assesses the strengths within the child, family, and social environment and organizes treatment plans around these pre-existing strengths. Evidence of fidelity to this principle includes:			
Evidence	***Present***	***Absent***	***Insufficient***
1. The assessment includes documentation of strengths within the child and the social environment.			
2. Emotional regulation interventions include strategies that build from the way the child has successfully managed emotion in the past.			
3. Social environmental stability strategies identify and engage any member of the child's environment who can help him or her manage emotion (e.g. immediate or extended family members, neighbors, or professionals).			
4. Social environmental interventions integrate understandings of the family's specific way of managing emotion (e.g. cultural or religious rituals).			

Principle 10: Leave a Better System			
CORE CONSTRUCT: The clinician (or clinical team) prepare the family for the end of treatment and build skills or systems that can help the child and family after treatment ends. The team is also aware that their work can inform public policy regarding improved service systems for traumatized children. Evidence of fidelity to this principle includes:			
Evidence	***Present***	***Absent***	***Insufficient***
1. The notion of the end of treatment is raised during the *Ready-Set-Go* process and continues to be raised throughout treatment, as clinically appropriate.			
2. Skill building for emotional regulation, cognitive processing, or meaning making includes strategies for continuing to build these skills after treatment ends.			
3. Efforts to stabilize the social environment and/or system of care integrate how these changes can continue after treatment ends.			
4. Team discussion includes possible public policy implications of the work and, perhaps, strategies for using the clinical experience to inform public policy.			

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