|  |
| --- |
| CHILD FIRST FIDELITY  FOUNDATIONAL PHASE: ASSESSMENT AND ENGAGEMENT  ADAPTED FROM CHILD-PARENT PSYCHOTHERAPY |

**Client Registration**

Clinical Team Names: \_\_Bella Lemacks and GabrielGuyton \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Initials: \_\_OF\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child First Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RHA AVL\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_07/09/2025\_\_\_\_\_\_\_ Completed by Clinical Team CareLogic ID: 22033

|  |
| --- |
| * Completed by the Clinical Team and reviewed with Clinical Director/Supervisor during reflective supervision. * **When Completed:**    + For all Child First sites, to ensure fidelity to trauma-informed CPP and Child First (2 Fidelity cases need to be maintained at all times): Procedures can be tracked as they are completed. The Contact Log should be completed after each session. The full packet should be completed at the end of the Foundational Phase. |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| TREATMENT INFORMATION | | | | | | | |
| Date CPP Treatment Started  Click or tap here to enter text. | | Language Treatment Conducted in (indicate all)  English | | | | Will a Translator be Used?  No  Sometimes  Yes | |
| TARGET CHILD INFORMATION | | | | | | | |
| Age in months  5 yr 5 months | Gender  male  female  other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Ethnicity (check all that apply)  African American  Asian\*  Caucasian  Latino/a\*  Native American  Other\*  \*Specify(Asian, Latino, Other) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Language(s) spoken  Spanish  English  Other (specify)  Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| SIBLING INFORMATION | | | | | | | |
| Age in Years | Gender (M/F/O) | | Relation to Child (e.g. full sibling, half sibling) | | Where Resides (e.g. w/ child, w/dad) | | In treatment with Child? |
| 2 yr | m | | Full sibling | | With client at both mom and dad house | | No  Sometimes  Yes |
| 10 | f | | Half sibling | | With mom | | No  Sometimes  Yes |
| Type here | Type here | | Type here | | Type here | | No  Sometimes  Yes |
| Type here | Type here | | Type here | | Type here | | No  Sometimes  Yes |
| Type here | Type here | | Type here | | Type here | | No  Sometimes  Yes |
| Type here | Type here | | Type here | | Type here | | No  Sometimes  Yes |
| Type here | Type here | | Type here | | Type here | | No  Sometimes  Yes |
| Type here | Type here | | Type here | | Type here | | No  Sometimes  Yes |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CAREGIVER #1 INFORMATION | | | | | | | | | |
| Age in Years  Click or tap here to enter text. | Years of Education (1st grade=1, Graduated High school=12; Graduated college=16)  High school, not graduated | | Ethnicity (check all that apply)  African American  Asian\*  Caucasian  Latino/a\*  Native American  Other\*  \*Specify(Asian, Latino, Other) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Language(s) spoken  Spanish  English  Other (specify)  Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Involved in child’s treatment?  Yes  Partially  No  UNK | | | Relationship to Child (select one)  Biological mother  Biological father  Adoptive mother  Adoptive father  Step-mother  Step-father  Foster mother  Foster father | Caregiver’s female partner (girlfriend)  Caregiver’s male partner (boyfriend)  Grandmother  Grandfather  Great grandmother  Great grandfather  Aunt | | | | Uncle  Great aunt  Great uncle  Other relative, please specify  Other non-relative, please specify  Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Not applicable – no other caregiver** | | | CAREGIVER #2 INFORMATION | | | | | | |
| Age in Years  Click or tap here to enter text. | | Years of Education (1st grade=1, Graduated High school=12; Graduated college=16)  Click or tap here to enter text. | Ethnicity (check all that apply)  African American  Asian\*  Caucasian  Latino/a\*  Native American  Other\*  \*Specify(Asian, Latino, Other) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Language(s) spoken  Spanish  English  Other (specify)  Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Involved in child’s treatment?  Yes  Partially  No  UNK | | | Relationship to Child (select one)  Biological mother  Biological father  Adoptive mother  Adoptive father  Step-mother  Step-father  Foster mother  Foster father | | Caregiver’s female partner (girlfriend)  Caregiver’s male partner (boyfriend)  Grandmother  Grandfather  Great grandmother  Great grandfather  Aunt | | | | Uncle  Great aunt  Great uncle  Other relative, please specify  Other non-relative, please specify  Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Not applicable – no other caregiver** | | | CAREGIVER #3 INFORMATION | | | | | | |
| Age in Years  Click or tap here to enter text. | | Years of Education (1st grade=1, Graduated High school=12; Graduated college=16)  Click or tap here to enter text. | Ethnicity (check all that apply)  African American  Asian\*  Caucasian  Latino/a\*  Native American  Other\*  \*Specify(Asian, Latino, Other) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | Language(s) spoken  Spanish  English  Other (specify)  Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Involved in child’s treatment?  Yes  Partially  No  UNK | | | Relationship to Child (select one)  Biological mother  Biological father  Adoptive mother  Adoptive father  Step-mother  Step-father  Foster mother  Foster father | | Caregiver’s female partner (girlfriend)  Caregiver’s male partner (boyfriend)  Grandmother  Grandfather  Great grandmother  Great grandfather  Aunt | | | | Uncle  Great aunt  Great uncle  Other relative, please specify  Other non-relative, please specify  Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**FOR THE NEXT FIVE FIDELITY STRANDS, CLINICIAN SHOULD MARK HIS/HER ANSWERS WITH A CHECK (1st column), AND CARE COORDINATOR SHOULD MARK HIS/HER ANSWERS WITH AN X (2nd column), IN ORDER TO HELP DIFFERENTIATE BETWEEN RESPONSES.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **REFLECTIVE PRACTICE FIDELITY** | | | | | | | | | | | | | | | | | | | |
| POTENTIAL SOURCES OF CHALLENGE | | Level (select one) | | | | | | | | | | | | | | | | | |
| No | | | | | Low | | | | | | | Moderate | | | | Significant | |
| Family is difficult to engage or work with | |  | | |  | |  | | |  | | | |  | | |  |  |  |
| Family trauma history is likely to provoke negative reactions in any Clinician/Care Coordinator | |  | | |  | |  | | |  | | | |  | | |  |  |  |
| Systems are involved in complicated and/or conflictual ways with family/treatment | |  | | |  | |  | | |  | | | |  | | |  |  |  |
| Clinician/Care Coordinator and caregiver have significantly different perspectives or cultural beliefs | |  | | |  | |  | | |  | | | |  | | |  |  |  |
| Clinician/Care Coordinator knowledge and skill level (e.g. new Clinician/Care Coordinator, new to the model or trauma work) | |  | | |  | |  | | |  | | | |  | | |  |  |  |
| Limited access to safe reflective supervision or reflective consultation | |  | | |  | |  | | |  | | | |  | | |  |  |  |
| \* Clinician and Care Coordinator have significantly different perspectives or cultural beliefs (Child First item) | |  | | |  | |  | | |  | | | |  | | |  |  |  |
| CLINICIAN/CARE COORDINATOR REFLECTIVE PRACTICE CAPACITY | | Clinician/Care Coordinator Capacity (select one) | | | | | | | | | | | | | | | | | |
| Requires  Development | | | | | Emerging | | | | | | | | | | | Acquired | |
| Awareness of own emotional reactions | | | | | | | | | | | | | | | | | | | |
| In the moment (in session) | |  | | |  | |  | | | | | |  | | | | |  |  |
| Upon self-reflection (outside session) | |  | | |  | |  | | | | | |  | | | | |  |  |
| In supervision/consultation | |  | | |  | |  | | | | | |  | | | | |  |  |
| Awareness of own personal and/or cultural biases | | | | | | | | | | | | | | | | | | | |
| In the moment (in session) | |  | | |  | |  | | | | | |  | | | | |  |  |
| Upon self-reflection (outside session) | |  | | |  | |  | | | | | |  | | | | |  |  |
| In supervision/consultation | |  | | |  | |  | | | | | |  | | | | |  |  |
| Ability to consider multiple perspectives (caregiver’s, child’s, own) | | | | | | | | | | | | | | | | | | | |
| In the moment (in session) | |  | | |  | |  | | | | | |  | | | | |  |  |
| Upon self-reflection (outside session) | |  | | |  | |  | | | | | |  | | | | |  |  |
| In supervision/consultation | |  | | |  | |  | | | | | |  | | | | |  |  |
| Ability to recognize and regulate strong emotions prior to intervening (in the moment) | |  | | |  | |  | | | | | |  | | | | |  |  |
| Use of self-care practices to enhance ability to regulate | |  | | |  | |  | | | | | |  | | | | |  |  |
| USE OF EXTERNAL SUPPORTS  Appropriately uses supervision and/or consultation with colleagues to: | | | | | | | | | | | | | | | | | | | |
| Process emotional reactions | |  | | |  | |  | | | | | |  | | | | |  |  |
| Consider alternative perspectives | |  | | |  | |  | | | | | |  | | | | |  |  |
| Seek new knowledge & new skills | |  | | |  | |  | | | | | |  | | | | |  |  |
| **EMOTIONAL PROCESS FIDELITY** | | | | | | | | | | | | | | | | | | | |
| POTENTIAL SOURCES OF CHALLENGE  Degree to which in sessions. . . | | Level (select one) | | | | | | | | | | | | | | | | | |
| No | | | | | Low | | | | Moderate | | | | | | | Significant | |
| Caregiver is dysregulated or triggered | |  | | |  | |  |  | | |  | | | |  | | |  |  |
| Caregiver is avoidant or shut down | |  | | |  | |  |  | | |  | | | |  | | |  |  |
| Child is dysregulated or triggered | |  | | |  | |  |  | | |  | | | |  | | |  |  |
| Child is avoidant or shut down | |  | | |  | |  |  | | |  | | | |  | | |  |  |
| CAPACITY TO HANDLE EMOTIONAL CHALLENGES  Clinician/Care Coordinator is able to . . . | | Clinician/Care Coordinator Capacity (select one) | | | | | | | | | | | | | | | | | |
| Requires  Development | | | | | Emerging | | | | | | | | | | | Acquired | |
| Identify when caregiver is not regulated | |  | | |  | |  | | | | | |  | | | | |  |  |
| Tolerate caregiver’s strong emotional reactions | |  | | |  | |  | | | | | |  | | | | |  |  |
| Intervene in ways to help caregiver become regulated | |  | | |  | |  | | | | | |  | | | | |  |  |
| Identify when child is not regulated | |  | | |  | |  | | | | | |  | | | | |  |  |
| Tolerate child’s strong emotional reactions | |  | | |  | |  | | | | | |  | | | | |  |  |
| Create a context where child’s emotional response is understood | |  | | |  | |  | | | | | |  | | | | |  |  |
| Create a context where child is helped to regulate | |  | | |  | |  | | | | | |  | | | | |  |  |
| \*Identify when Clinician/Care Coordinator’s personal history, culture, or beliefs are impacting emotional process fidelity (Child First item) | |  | | |  | |  | | | | | |  | | | | |  |  |
| **DYADIC-RELATIONAL FIDELITY** | | | | | | | | | | | | | | | | | | | |
| POTENTIAL SOURCES OF CHALLENGE  Degree to which in the sessions. . . | Level (select one) | | | | | | | | | | | | | | | | | | |
| No | | | | | Low | | | | | | Moderate | | | | | | Significant | |
| Caregiver and child have conflictual, competing agendas |  | | |  | |  | | |  | | |  | | | |  | |  |  |
| Caregiver has difficulty understanding or tolerating child’s behavior or temperament |  | | |  | |  | | |  | | |  | | | |  | |  |  |
| Caregiver and/or child serve as trauma reminders to the other |  | | |  | |  | | |  | | |  | | | |  | |  |  |
| Caregiver has unrealistic expectations of the child |  | | |  | |  | | |  | | |  | | | |  | |  |  |
| Child has sensorimotor or affect regulation challenges |  | | |  | |  | | |  | | |  | | | |  | |  |  |
| CAPACITY TO ADDRESS THE NEEDS OF CAREGIVER AND CHILD  Clinician/Care Coordinator is able to . . . | Clinician/Care Coordinator Capacity (select one) | | | | | | | | | | | | | | | | | | |
| Requires  Development | | | | | Emerging | | | | | | | | | | | | Acquired | |
| Balance attention between caregiver and child (tracking both) |  | | |  | |  | | | | | | |  | | | | |  |  |
| Hold/support child and caregiver perspectives |  | | |  | |  | | | | | | |  | | | | |  |  |
| Bridge/translate between caregiver & child (help them understand each other) |  | | |  | |  | | | | | | |  | | | | |  |  |
| Intervene in ways that strengthen the caregiver-child relationship |  | | |  | |  | | | | | | |  | | | | |  |  |
| Think about and support child’s relationship with other important caregivers (e.g. father) |  | |  | | |  | | | | |  | | | | | | |  |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **TRAUMA FRAMEWORK FIDELITY** | | | | | | | | | |
| POTENTIAL SOURCES OF CHALLENGE  Challenges related to. . . | Level (select one) | | | | | | | | |
| No | | Low | | Moderate | | | Significant | |
| Child’s history being unknown |  |  |  |  |  | |  |  |  |
| Caregiver’s history being unknown |  |  |  |  |  | |  |  |  |
| Caregiver not fully acknowledging child’s history or not agreeing to talk about it |  |  |  |  |  | |  |  |  |
| Caregiver not having a trauma framework (does not view child behavior in light of history) |  |  |  |  |  | |  |  |  |
| Caregiver being triggered and having difficulty thinking about child’s past experience |  |  |  |  |  | |  |  |  |
| CAPACITY TO INTERVENE WITHIN A TRAUMA FRAMEWORK  Clinician/Care Coordinator is able to . . . | Clinician/Care Coordinator Capacity (select one) | | | | | | | | |
| Requires  Development | | Emerging | | | | | Acquired | |
| Keep child’s and caregiver’s trauma history in mind |  |  |  | | |  | |  |  |
| Think about how the child’s and caregiver’s history may be affecting interactions with each other and with the Clinician/Care Coordinator |  |  |  | | |  | |  |  |
| Frame interventions (e.g. affect regulation, improving relationships) within the broader context of the family’s traumatic experiences (in addition to other contributing factors) |  |  |  | | |  | |  |  |
| Directly talk about and bring up the family’s trauma history when relevant |  |  |  | | |  | |  |  |
| **PROCEDURAL FIDELITY** | | | | | | | | | |
| POTENTIAL SOURCES OF CHALLENGE | Level (select one) | | | | | | | | |
| No | | Low | | Moderate | | | Significant | |
| Scheduling challenges due to family illness, work, competing needs, or irregular visitation schedule make it difficult for family to attend weekly sessions |  |  |  |  |  | |  |  |  |
| Scheduling challenges due to Clinician/Care Coordinator illness, work schedule or competing needs make it difficult for Clinician/Care Coordinator to hold weekly sessions |  |  |  |  |  | |  |  |  |
| Family structure (e.g. multiple children) makes it difficult for Clinician and caregiver to hold sessions focusing on the needs of individual children when clinically indicated |  |  |  |  |  | |  |  |  |
| Home visiting environment often chaotic |  |  |  |  |  | |  |  |  |
| CAPACITY TO CARRY OUT PROCEDURES  Clinician/Care Coordinator is able to . . . | Response (check one) | | | | | | | | |
| No | | Yes, But They Did  Not Attend Regularly | | | | | Yes, Attended | |
| Schedule sessions on a regular basis (2x per week during Foundational Phase, 1x per week after Foundational Phase, or as needed by family) |  |  |  | | |  | |  |  |
| Give appropriate notice for vacation |  |  |  | | |  | |  |  |
| Propose caregiver collateral sessions when . . .  Caregiver is triggered by child or child’s play or in need of psychoeducation   * Caregiver does not understand trauma as a potential cause of child’s behaviors * Caregiver needs to share information with Clinician/Care Coordinator (e.g. new traumatic events, new service needs) | Not needed | Not needed |  | | |  | |  |  |
| \* Identify when visits are made individually or as a Team, based on treatment goals being addressed (Child First item) |  |  |  | | |  | |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PROCEDURAL FIDELITY: CPP CONTACT LOG | | | | | | | | |
| COMPLETE FOR ANY CONTACT | | |  | COMPLETE FOR SCHEDULED SESSIONS (NOT PHONE CONTACTS) | | | | |
| Date | Contact Type  Assessment  Care Coordination  Feedback  Dyadic Treatment\*  Individual caregiver\*  Individual child\*  Caregiver phone – conversation  Caregiver phone – message  Collateral – meeting  Collateral – phone  Collateral – other  Team meeting  Other | Minutes |  | Session  Status  Show  Cancel  No Show | Reason for Not  Attending  Childcare problem  Conflicting appointment  Forgot  Illness  Team member cancelled  Transportation  Weather  Other | Who Attended  (check all that apply)  Target child  Caregiver 1 Sibling 1  Caregiver 2 Sibling 2  Caregiver 3 Sibling 3  Caregiver 4 Sibling 4  Collateral: specify  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Where Held  Home  Clinic  Community  Other | Session  Counter  (#) |
| 06/25 | assessment | 60 |  | text | Type here | Caregiver 1, child, sibling,grandma | home | text |
| 07/02 | assessment | 60 |  | text | Type here | Caregiver 1, child, sibling,grandma | home | text |
| 07/09 | assessment | 60 |  | text | Type here | Caregiver 1, child, sibling,grandma | home | text |
| 07/17 | assessment | 60 |  | text | Type here | Caregiver 1, child, sibling,grandma | home | text |
| 07/22 | assessment | 60 |  | text | Type here | Type here | home | text |
| Type here | Type here | Click or tap here to enter text. |  | text | Type here | Type here | Type here | text |
| Type here | Type here | text |  | text | Type here | Type here | Type here | text |
| Type here | Type here | text |  | text | Type here | Type here | Type here | text |
| Type here | Type here | text |  | text | Type here | Type here | Type here | text |
| Type here | Type here | text |  | text | Type here | Type here | Type here | text |
| Type here | Type here | text |  | text | Type here | Type here | Type here | text |
| Type here | Type here | text |  | text | Type here | Type here | Type here | text |
| Type here | Type here | text |  | text | Type here | Type here | Type here | text |
| Type here | Type here | text |  | text | Type here | Type here | Type here | text |

\*Typically during the Foundational Phase, most sessions are coded as assessment, case management, or feedback

MAKE ADDITIONAL COPIES OF PAGE AS NEEDED

|  |  |  |  |
| --- | --- | --- | --- |
| PROCEDURAL FIDELITY: ASSESSMENT AND ENGAGEMENT  This is a suggested order; items do not need to be done in this order but do need to be done before the CPP core intervention phase begins. This checklist should be completed for each caregiver involved in treatment, with attempts made to engage all primary caregivers. Trauma and symptom screening should occur without the child present unless the child is a young infant (e.g. < 6 months) and the caregiver has no source of childcare. | | | |
| # | ITEM – Item numbers with a preceding “CF” notation are items that are necessary for fidelity to the Child First model | Caregiver  Response | Done |
| CF1 | Initiated engagement process (Point of Entry Process in CareLogic)   1. Contacted family within 48 hours of case assignment 2. First visit was held within 2 weeks of assignment, if possible 3. If initial contact was unsuccessful, Team made multiple phone calls, sent letters, contacted referrer if Release of Information was provided at time of referral, and showed ingenuity in attempting initial contact |  | a  b  c |
| CF2 | Completed first visit procedures   1. Explained Child First model (frequency of visits, Team structure, independence from referral source, collaboration with agencies involved with family, and provision of services and support for all family members) 2. Answered caregiver questions and concerns 3. Provided rational for dyadic treatment 4. Provided rationale for inclusion of other important caregivers in child’s life 5. Provided rationale for play and caregiver-child interaction as an intrinsic component of intervention 6. Provided rationale for completing baseline, 6 month and termination assessments 7. Reviewed need for consistency in treatment and notification of cancellations 8. Reviewed limits to confidentiality and reporting requirements – e.g., mandated reporter 9. Reviewed and requested signature for the following forms: Consent for Child First Services and Authorization to Use and Disclose Health Information, Privacy Policies, Release of Information, Consent to Use Photograph and Video |  | a  b  c  d  e  f  g  h  i |
| 1 | Elicited caregiver perception of need for treatment  Discussed with caregiver the reason for referral, referral source, and how caregiver feels about treatment |  |  |
| 2 | Elicited caregiver description of family circumstances, challenges, and strengths  Discussed caregiver’s concerns about child, self, and other family members |  |  |
| CF3 | Used Intake Part 1: Guide to Child and Family Clinical History to ensure comprehensive assessment |  |  |
| CF4 | Used Intake Part 2: Service Needs Inventory for Families to determine services and supports needed |  |  |
| CF5 | Provided instrumental support promptly to assist with family stabilization   1. Assessed for any urgent needs and discussed possible steps with caregiver 2. Developed preliminary plan for family stabilization, if necessary |  | a  b |
| 3 | Provided a sense of positive expectations about improvement  Noticed protective actions, conveyed realistic hope, provided emotional support, and acknowledged that coming to treatment is an important first step |  |  |
| CF6 | Was mindful of not being a “better parent” than the caregiver |  |  |
| 4 | Shared with caregiver rationale for screening for child trauma (for this specific child or in general) |  |  |
| # | ITEM | Caregiver  Response | Done |
| 5 | Asked caregiver to jointly complete a child trauma screening instrument |  |  |
|  | 5a. Is caregiver aware of child’s history? | No  In part  Yes |  |
|  | 5b. Select one to describe how you and caregiver discussed child’s experience of trauma   1. Child has no known history of trauma (e.g. newborn baby) 2. Clinician met alone with caregiver and screened for child’s trauma history using the TESI to discuss what the caregiver knows and what is known from other sources (e.g. court reports, past therapists) 3. Caregiver is not aware of child’s trauma history. Clinician met alone with caregiver and used the TESI to talk to caregiver about child’s history (facts and hypotheses) gathered from other sources (e.g. social worker, prior caregivers & therapists, court reports)   Note: get appropriate releases prior to sharing information   1. Caregiver refused to complete the TESI, but did provide details regarding child’s trauma history 2. Caregiver refused to complete the TESI, and refused to talk about child’s trauma history | a (NA)  b  c  d  e |  |
|  | 5c. Indicate method used to screen for child trauma history  TESI-PRR Other, specify: Click here to enter text. |  |  |
| 6 | Considered caregiver’s response to child’s trauma history  Considered the quality of the way the caregiver thinks about the child’s traumatic experiences (NA child has no trauma hx) |  | NA |
|  | 6a. Factual response: Select one to describe caregiver’s factual response to child’s trauma history   1. N/A - Child has no known history of trauma 2. Acknowledged traumatic event(s) and impact on child 3. Acknowledged traumatic event(s) but may be unsure of impact on child 4. Acknowledged event but denied impact 5. Denied child’s experience of documented traumatic events | a (NA)  b  c  d  e |  |
|  | 6b. Emotional response: Select one to describe caregiver’s emotional response to child’s trauma history   1. N/A Child has no known history of trauma 2. Integrated: Emotionally integrated, able to talk about experience without being overwhelmed 3. Triggered: Overwhelmed or flooded by thinking about child’s experience 4. Avoidant: Avoids thinking about child’s experience, blocks or pushes away experience 5. Mixed Avoidant & Triggered: Overwhelmed by child's experience and actively avoids thinking about it | a (NA)  b  c  d  e |  |
|  | Note: Caregivers can refuse to answer any questions that make them feel uncomfortable. However, if a caregiver completely refuses to talk about a child’s potential history of trauma, or if a caregiver denies the child’s experience of trauma, and the child has a known history of trauma, a fundamental goal of the Foundational Phase is to determine if the caregiver can talk about and acknowledge the child’s history once s/he forms a relationship with you and feels safer. If not, CPP with a focus on enhancing the parent-child relationship may begin, with the goal of creating enough safety that trauma may be addressed later in treatment. | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| # | ITEM | Caregiver  Response | | Done |
| 7 | Assessed child symptoms (May be done prior to screening for trauma)  Met with caregiver and obtained caregiver report of child’s symptoms and areas of concern |  |  | |
|  | 7a. Method for assessing child’s symptoms (select one)  a) Clinical interview  b) Standardized questionnaire (check all used)  (Below are optional instruments. It is recommended that you use one of them, but none are required)  CBCL ASQ:SE BITSEA ITSEA PKBS-2 SDQ Other: Click here to enter text. |  |  | |
| 8 | Assessed child trauma symptoms (Ideally done after screening for trauma)  Clinician met alone with caregiver and obtained caregiver report of child’s trauma symptoms using a standardized instrument or clinical interview (check NA if child has no history of trauma exposure) |  | NA | |
|  | 8a. Method for assessing child’s trauma symptoms (check all that apply)  TSCYC DIPA PAPA P.I.E. Interview None Other, specify: |  |  | |
| 9 | Assessed child developmental functioning  Assessed child’s developmental functioning (regulatory capacity, achievement of age appropriate skills) |  |  | |
|  | 9a. Method for assessing child’s developmental functioning (check all that apply)  ASQ - Developmental Clinical observation Clinical Interview M-CHAT-R/F Sensory screen Other: |  |  | |
| 10 | Discussed connection between child’s symptoms and child’s trauma history  Talked to caregiver about how child's symptoms or functioning may be related to the child's trauma history (including any history of separations). Note: This may be repeated at different times in the treatment but needs to happen in the beginning as part of setting the trauma frame (check NA if child has no history of trauma exposure) |  | NA | |
| 11 | Discussed trauma reminders  Helped the caregiver understand the concept of a trauma reminder and begin to identify possible trauma reminders for the child and caregiver (check NA if child and caregiver have no history of trauma exposure) |  | NA | |
| 12 | Assessed for child safety risks to engaging in trauma-informed treatment  (check NA if child and caregiver have no history of trauma exposure) |  | NA | |
|  | 12a. Code any safety risks (check one)  No risks, it seems safe to talk about the child’s experience of trauma with the child  Yes, there are potential safety risks  (check all potential risks)  Child has contact with violent caregiver who is unaware that child is participating in trauma treatment  Child has contact with violent caregiver who denies the child’s experience of trauma  Other safety risk, specify Click here to enter text. |  |  | |
|  | Note: If there are safety risks that cannot be resolved, conducting trauma-informed CPP with the child may be contraindicated. You can help the caregiver think about how to support the child and ensure safety, and/or engage in CPP to strengthen the parent-child relationship, but it would not be safe to involve the child in trauma treatment at this time. | | | |
| # | ITEM | Caregiver  Response | | Done |
| 13 | Observed child and caregiver interaction  Observed child and caregiver together to obtain information regarding quality of their relationship, the way child and caregiver typically play and interact |  |  | |
| CF7 | Conducted play assessment  Conducted play assessment with child to explore relatedness, developmental level, and presence of symbolic play |  |  | |
| 14 | Discussed impact of child trauma treatment on caregivers  Met alone with caregiver and discussed how talking about/processing a child’s traumatic experiences can affect caregivers, highlighting both risks and benefits (check NA if child has no history of trauma exposure) |  | NA | |
| 15 | Shared rationale for asking about caregiver trauma history  Examples:   * It may be helpful to know caregiver’s trauma history, so you can support him/her with any reactions that may arise as you both talk about and process child’s trauma history with child * When caregivers have experienced trauma, especially as children, this can affect the way they raise their children in positive and negative ways. It may be good to talk about this in treatment to break the cycle of trauma and violence |  |  | |
| 16 | Asked caregiver to jointly complete a caregiver trauma screening instrument  Clinician met alone with caregiver and discussed using a trauma screening instrument to think about caregiver history |  |  | |
|  | 16a. Caregiver response (select one)   1. Reports s/he has not experienced any traumatic events 2. Agreed to complete screening instrument 3. Did not agree to screening instrument but did describe his/her history 4. Did not want to talk about own trauma history now but is open to talking about it later 5. Did not want to talk about own trauma history | a  b  c  d  e |  | |
|  | 16b. Indicate instrument used to screen for caregiver trauma history  LSC-R Other, specify: Click here to enter text. |  |  | |
| 17 | Shared rationale for asking about caregiver symptoms  Examples:   * It is common for caregivers to be strongly affected when their children experience trauma, especially if they experienced the same event * Caregiver’s mood and functioning can affect the child * In CPP, the Clinician supports the caregiver and family in addition to the child |  |  | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| # | ITEM | Caregiver  Response | | Done |
| 18 | Introduced caregiver symptom measures  Discussed using questionnaires or interviews to better understand the caregiver’s symptoms |  |  | |
|  | 18a. Caregiver response (select one)   1. Agreed to complete questionnaires regarding his/her symptoms 2. Did not agree to questionnaire but did describe symptoms 3. Did not want to talk about own symptoms now but is open to maybe talking about it later 4. Did not want to talk about own symptoms | a  b  c  d |  | |
|  | 18b. Indicate method used to assess caregiver PTSD  NA No Trauma Hx  None  PCL-C/PCL-5  PSSI  Clinical Interview Other, specify: |  |  | |
|  | 18c. Indicate method used to assess caregiver depression  None  CES-D  Clinical Interview Other, specify: Click here to enter text. |  |  | |
|  | 18d. Indicate other instruments used to assess caregiver mood or functioning  None  PSI-4-SF Other |  |  | |
| CF8 | Collected other required assessments in Child First Assessment Protocol  PQ  SNIFF  CCIS HOPE |  |  | |
| CF9 | Obtained collateral information   1. Sent signed Release of Information to other providers 2. Obtained information from health provider 3. Obtained information for early care and education setting, as needed 4. Obtained collateral information from other service providers and child stakeholders, including early intervention, adult mental health and substance abuse, child welfare, etc., as appropriate |  | a  b  c  d | |
| CF10 | Observed child in early care and education/child care setting or classroom |  |  | |
| CF11 | Identified child and caregiver strengths and vulnerabilities |  |  | |
| CF12 | Noted areas of contradiction or in need of further clarification |  |  | |
| CF13 | Completed the Child First Baseline Assessment Checklist *(refer to Child First Toolkit)* |  |  | |
| 19 | Processed information gathered during assessment/engagement with supervisor/colleague   * For supervisees: reviewed the checklist and discussed the assessment results and treatment conceptualization with a Clinical Director/Supervisor * For Clinical Directors/Supervisors: As needed, processed assessment with State/Regional Clinical Director or other colleague to conceptualize treatment and reflect on emotions brought up by the dyad. Check done if reflected alone and no additional support was needed. |  |  | |
| CF14 | Clinical Team developed case formulation  Clinical Team developed/updated case formulation taking into account child social-emotional development and behavior, child developmental capacities, trauma history, important relationships, caregiver challenges, culture, and other |  |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| PROCEDURAL FIDELITY: TRAUMA-INFORMED CPP FEEDBACK SESSION  After completing the assessment, and if one or more traumatic events have been endorsed on the TESI, Clinician and caregiver meet alone to discuss what they have learned, plan treatment, and talk about how to introduce the child to treatment, including how to bring up the child’s trauma history. Other caregivers may be present, but the child should not be present unless the child is an infant. | | | |
| # | ITEM | Caregiver  Response | Done |
| 4 | Reviewed rationale for dyadic treatment again  Examples   * We work with caregivers to think about how trauma may affect the child’s development and relationships and how caregivers can help them heal from this experience * For older toddlers and preschoolers: We help very young children talk/play about and process experiences with their caregivers * If a caregiver’s trauma history is affecting perceptions of or interactions with the child, treatment can help the caregiver consciously think about how his or her history affects parenting and develop ways to change intergenerational patterns |  |  |
| 5 | Processed cultural beliefs about talking about trauma  Discussed with caregiver how CPP’s view of talking about and processing trauma may be different from the way they were raised or from typical cultural beliefs. Elicited caregiver’s view on this.  (check NA if child and caregiver have no history of trauma exposure) |  | NA |
| 6 | Discussed play again, specifically its role within CPP  Spoke with caregiver about how we use play in CPP (e.g. to process experience and build relationships) and how this may differ from how people typically interact with young children in the caregiver’s family/culture or in the broader culture |  |  |
| 7 | Requested permission to introduce trauma-related toys (for children old enough to use play to process experience)  Discussed with caregiver the toys you might bring to help the child process his/her experience. Obtained permission to introduce trauma-related toys (e.g. dolls especially for boys, police cars, knives). Highlighted that young children often benefit from having “props” to tell their “story” (check NA if child is too young or has no history of trauma exposure) |  | NA |
| 8 | Discussed child’s need for emotion regulation while processing trauma (for children old enough to process trauma)  Helped caregiver understand that child may need “emotion regulation breaks” when processing traumatic experiences. Helped caregiver think about the way this child may do this and how the caregiver will support the child in doing this. |  | NA |
| 9 | Reviewed with caregiver the need for regular weekly sessions again |  |  |
| 10 | Asked about caregiver’s perspective of trauma-informed CPP |  |  |
|  | 10a. Is caregiver in agreement about the need to address child’s trauma history (either directly or at least if the child brings it up)? *Code in part if there are aspects of the child’s trauma history the caregiver is willing to bring up, and there are aspects that the caregiver prefers not be discussed.* | No  In part  Yes |  |
|  | 10b. Does caregiver understand why CPP is conducted jointly with child and caregiver? | No  In part  Yes |  |
|  | If the caregiver does not agree with the treatment model or has serious concerns, it will be important to explore this further. Trauma-informed CPP may be contraindicated at this time, but family can continue receiving relationship-based CPP through Child First. | | |
| # | ITEM | Caregiver  Response | Done |
| 11 | Thought about the appropriateness of beginning trauma-informed CPP with child  Considered items assessing: Caregiver’s Response to Child’s Trauma History, Safety Risks to Engaging in Trauma-Informed Treatment, and Caregiver’s Perspective of CPP and decided whether to include child in CPP. |  |  |
|  | 11a. Clinician assessment of appropriateness of CPP (select one)  a) It seems safe/appropriate to include child in CPP even if treatment includes a focus on child’s trauma history  b) It is not safe and/or appropriate to begin trauma-informed CPP with the child at this time  Given concerns, the treatment plan will focus on the following (check all that apply)  1. Work with caregiver alone during collateral sessions to enhance safety and provide care coordination  2. Work with caregiver alone during collateral sessions to help caregiver begin to acknowledge child’s history  3. Work with caregiver alone during collateral sessions to help enhance caregiver’s emotional regulation  4. Conduct CPP with caregiver and child to strengthen the relationship and enhance caregiver/child emotional regulation, but not address the trauma  5. Develop alternate CPP plan, (describe) Click here to enter text. |  |  |
| 12 | Clinician developed CPP Triangle of Explanations with caregiver |  |  |
|  | 12a. Describe the components of the CPP triangle  Experience:  Click or tap here to enter text.  Feelings/Behavior:  Click or tap here to enter text.  How Treatment will Help:  Click or tap here to enter text.  Protective and Growth Promoting Factors:  Click or tap here to enter text.  Modality: Way this will be shared with the child (e.g. discussion, using toys)  Click or tap here to enter text. |  |  |
| CF15 | Scheduled treatment planning session |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| PROCEDURAL FIDELITY: FORMULATION AND TREATMENT PLANNING SESSION  After completing the CPP Feedback Session, if needed Clinical Team meets alone with the caregiver to discuss treatment planning goals. Other caregivers may be present, but the child should not be present unless the child is an infant. | | | | |
| # | ITEM | | Yes | No |
| 1 | Clinical Team elicited caregiver perception about assessment process and Foundational Phase  Engaged caregiver in a conversation about what s/he learned, positive experiences, concerns, ideas for future steps | |  |  |
| 2 | Described Clinical Team’s current formulation to caregiver | |  |  |
| CF16 | | Clinical Team checked with caregiver that formulation is consistent with caregiver’s understanding |  |  |
| CF17 | | Clinical Team elicited caregiver’s priorities in the work moving forward |  |  |
| CF18 | | Clinical Team shared recommendations, possible next steps, and solicits feedback from caregiver |  |  |
| CF19 | | Preliminary Child and Family Plan of Care was presented  Preliminary Child and Family Plan of Care was presented and caregiver’s goals for treatment and priorities were further discussed; planned with caregiver steps involved in meeting objective, measurable goals, including how to evaluate goal achievement. Treatment Plan is revised, if necessary, to incorporate caregiver perspective and any new treatment goals. |  |  |
| 3 | | Care Coordinator provided other referrals as needed for child, caregiver, or other family members |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| PROCEDURAL FIDELITY: CHILD AND FAMILY PLAN OF CARE | | | | |
| # | ITEM | | Yes | No |
| CF20 | | Revised Child and Family Plan of Care was provided to caregiver |  |  |
| CF21 | | Child and Family Plan of Care was signed by caregivers/guardians and clinical team members |  |  |
| CF22 | | Child and Family Plan of Care was completed within 30 days of initial visit (sooner if state requires initial treatment plan) |  |  |
| CF23 | | Child and Family Plan of Care was signed by Clinical Director/Supervisor |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| PROCEDURAL FIDELITY: BEFORE EACH HOME VISIT | | | | |
| # | ITEM | | Yes | No |
| CF24 | | Clinical Team reviewed all assessments and planned for session  Clinical Team reviewed all assessments that were conducted to date, reviewed current hypotheses, and planned for the session |  |  |
| CF25 | | Clinical Team discussed and practiced any potentially challenging approaches |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| PROCEDURAL FIDELITY: DURING ALL HOME VISITS | | | | |
| # | ITEM | Yes | | No |
| CF26 | Clinical Team did not attempt to be the “better parent” by taking over for caregiver during sessions  Clinical Team did NOT try to teach the caregiver by “modeling” the correct way |  |  | |
| CF27 | Clinical Team made positive comments about child’s need for and attachment to caregiver to strengthen the relationship   * Clinical Team watched for positive approves made by child to caregiver, and highlighted the child’s need for, positive feelings for, and connection to the caregiver * Clinical Team watched for any positive approaches made by caregiver toward child, and made positive, supportive comments, especially highlighting any positive response by the child |  |  | |
| CF28 | Clinical Team selected interventions that honored family’s culture and norms |  |  | |
| CF29 | Clinical Team reflected with caregiver on impact of cultural/family roles/norms on dyadic relationships and expectations |  |  | |
| CF30 | Considered how Clinical Team is perceived by family and its impact on treatment |  |  | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| PROCEDURAL FIDELITY: AFTER EACH HOME VISIT | | | | |
| # | ITEM | Yes | | No |
| CF31 | Clinical Team debriefed together  Clinical Team debrief together and discussed what each observed and understood about the session, including their individual perceptions of the child, caregivers, and any others present |  |  | |
| CF32 | Reassessment of the formulation  Clinical Team reassessed their understanding and formulation of the case; discussed differences in perceptions or understanding of session events |  |  | |
| CF33 | Clinical Team planned for next intervention session |  |  | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **CPP CASE CONCEPTUALIZATION AND CONTENT FIDELITY** | | | | | | |
| * Clinical Focus: Throughout the phase, degree to which the Clinician/Care Coordinator’s interventions addressed the objective:   0=not at all a focus; 1=minor; 2=moderate; 3=significant   * Appropriateness: Under=Clinician/Care Coordinator should have focused more on this objective; Appropriate=Amount of therapeutic focus seems appropriate; Over=Clinician/Care Coordinator may have overly focused on this objective, to the detriment of other important objectives * Progress Towards Objective (Referral=Upon Referral; Current=At the end of the Foundational Phase)   3 = Established: Good enough to support development; 2 = Present but Unstable: Good under some conditions. Not fully consolidated. Lost in response to internal or external stress; 1 = Emerging: Early manifestations; 0 = Primary Target/Urgent Concern: Immediate risk to development, relationship and/or therapeutic alliance | | | | | | |
| CPP OBJECTIVES | Clinical Focus  (0-3) | Appropriateness  (check one) | | | Progress  Referral  (0-3) | Progress  Current  (0-3) |
| Under | Appropriate | Over |
| CONVEY HOPE | | | | | | |
| * Highlighted that change and growth are possible given positive steps the family has made * Provided realistic examples of potential pathways for healing, noting ways that caregiver efforts and treatment may lead to improved caregiver and child functioning * Helped caregiver identify “angels in the nursery” and reflect on times when he/she felt safe and loved * Helped the family connect to spiritual resources consistent with family traditions | \_\_\_\_\_ |  |  |  | \_\_\_\_\_ | \_\_\_\_\_ |
| DEVELOP EMPATHIC RELATIONSHIP WITH FAMILY MEMBERS | | | | | | |
| * Empathically listened to concerns:  caregiver  child’s * Understood difficult behavior given past history & current context: caregiver child * Made warm supportive comments or recognized accomplishments:  caregiver child * Understood caregivers’ mistrust of providers and reluctance to engage in treatment in light of their past history and current experiences with potentially punitive systems | \_\_\_\_\_ |  |  |  | \_\_\_\_\_ | \_\_\_\_\_ |
| ENHANCE SAFETY | | | | | | |
| Safety - Physical Safety (chart all safety risks separately)   * Helped caregiver reflect on his/her history of physical endangerment and how it shapes current expectations regarding danger and safety * In a supportive, non-confrontational manner, directly addressed safety issues with caregiver with the goal of increasing caregiver awareness and mobilizing protective action * Balanced respect for the caregiver’s psychological vulnerabilities with the need to address lapses in safety and destructive or self-destructive behavior * Encouraged the caregiver to develop an attitude that prioritizes safety as a core value for the caregiver, child, and family * Supported caregiver in engaging other family members in addressing risks to safety (including partners who may have been violent) * Focused on and addressed serious risks to physical safety, including risks within family relationships and permanency of placement * Engaged in safety planning * Assessed for and filed appropriate DCF reports for suspected abuse | \_\_\_\_\_ |  |  |  | \_\_\_\_\_ | \_\_\_\_\_ |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| CPP OBJECTIVES | Clinical Focus  (0-3) | Appropriateness  (check one) | | | Progress  Referral  (0-3) | Progress  Current  (0-3) |
| Under | Appropriate | Over |
| ENHANCE SAFETY (continued) | | | | | | |
| Safety - Environmental Context   * Discussed ways that contextual risks (e.g. poverty, community violence, immigration related-risks, inadequate or unsafe housing, and inadequate access to services) affect child and family functioning * Considered the impact of racism and historical trauma on child and family functioning | \_\_\_\_ |  |  |  | \_\_\_\_\_ | \_\_\_\_\_ |
| Safety – Stabilization   * Discussed provision/maintenance of basic needs * Provided care coordination to help family obtain basic needs * Helped caregiver develop the capacities to obtain services and needs independently (to overcome barriers, communicate about needs, and collaborate with service providers) * Helped caregiver identify and address root causes of recurrent crisis and ongoing instability | \_\_\_\_ |  |  |  | \_\_\_\_\_ | \_\_\_\_\_ |
| Safety & Consistency in Treatment   * Acknowledged safety risks to participating in treatment: mandated reporting, etc. * Encouraged consistent, on-time participation in treatment * Created a consistent environment for treatment | \_\_\_\_ |  |  |  | \_\_\_\_\_ | \_\_\_\_\_ |
| Perceived Safety   * Identified misperceptions of danger or safety: caregiver child * Fostered accurate perceptions of danger and safety | \_\_\_\_ |  |  |  | \_\_\_\_\_ | \_\_\_\_\_ |
| Safety within Caregiver-Child Relationships   * Acknowledged past history of risks to safety:  caregiver  child * Highlighted the need for safe behavior while legitimizing feelings   (e.g. child cannot hit others even though child is angry)   * Fostered caregiver’s ability to socialize child in ways that are consistent both with the caregiver’s cultural values and beliefs and the family’s context * Identified factors that may interfere with caregivers capacity to socialize child, including environmental circumstances, strong emotions (e.g. guilt, fear, feelings of worthlessness), and prior history * Supported caregiver’s development of routines to enhance safety * Helped establish caregiver as a protective, benevolent, legitimate authority figure | \_\_\_\_ |  |  |  | \_\_\_\_\_ | \_\_\_\_\_ |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CPP OBJECTIVES | | Clinical Focus  (0-3) | Appropriateness  (check one) | | | | Progress  Referral  (0-3) | Progress  Current  (0-3) |
| Under | Appropriate | | Over |
| STRENGTHEN FAMILY RELATIONSHIPS: PROMOTE EMOTIONAL RECIPROCITY | | | | | | | | |
| * Helped caregiver reflect on how current expectations about relationships (child’s or caregiver’s) are shaped by past experience * Helped caregiver identify and explore origins of negative views/representations of the child * Helped caregiver think about how perceptions may affect behavior or interactions with child * Helped caregiver and child notice and respond supportively to each other’s relational bids * Helped caregiver reflect and respond benevolently to the child’s challenging behavior * Helped identify negative perceptions child may have about caregiver * Helped child understand and appreciate caregiver’s efforts on the child and family’s behalf * Helped caregiver and child learn ways to repair and connect after conflict * Helped caregiver and child consciously explore new ways of relating that promote trust, continuity, reciprocity, and pleasure | | \_\_\_\_ |  |  | |  | \_\_\_\_\_ | \_\_\_\_\_ |
| Additional Child First Treatment Objectives   * Helped caregiver follow child’s lead; noticed and supported caregiver in accomplishment * Fostered caregiver’s understanding of the importance of engagement and mutual enjoyment in caregiver-child relationship and consequent reduction of behavioral problems * Helped caregiver reflect on spontaneous moments of engagement and enjoyment in session * Facilitated dyadic play, reciprocal interactions and normative developmental activities that are mutually enjoyable. Reflected with caregiver on how these may be used in session and as daily activities | | \_\_\_\_ |  |  | |  | \_\_\_\_\_ | \_\_\_\_\_ |
| COORDINATE CARE/ADDRESS FAMILY SERVICE NEEDS | | | | | | | | |
| * Engaged in systematic efforts to obtain all relevant information about child history (e.g. CPS reports related to placement history, child health history) * Helped family members obtain needed referrals to other services * Communicated and coordinated care as needed with other service providers * Reflected on the needs of the entire family and prioritized services according to immediacy of needs * Took steps to ensure that risks to the child’s safety were known and addressed effectively by the team of service providers involved with the family * Fostered a climate of transparency in communicating to caregiver the way that service providers are working together to ensure child safety | \_\_\_\_\_ | |  | |  |  | \_\_\_\_\_ | \_\_\_\_\_ |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| CPP OBJECTIVES | | Clinical Focus  (0-3) | Appropriateness  (check one) | | | Progress  Referral  (0-3) | Progress  Current  (0-3) |
| Under | Appropriate | Over |
| COORDINATE CARE/ADDRESS FAMILY SERVICE NEEDS (continued) | | | | | | | |
| Additional Child First Treatment Objectives   * Responded promptly and thoughtfully to concrete family needs in order to improve quality of life, enhance growth, and reduce stress * Helped caregiver develop effective and realistic problem-solving strategies that would meet the needs of the family * Provided hands-on assistance to connect children and caregivers with needed services and supports, both formal and informal * Supported self-reflection in the caregiver to avoid repetition of interpersonal problems, which have impacted her capacity to advocate effectively for herself and family * Supported caregiver in identifying potential obstacles when communicating with agencies and service providers. Helped caregiver reflect on how to overcome potential barriers in accessing community services * Reflected on possible psychological barriers which interfered with the caregiver’s success in accessing services | \_\_\_\_\_ | |  |  |  | \_\_\_\_\_ | \_\_\_\_\_ |
| STRENGTHEN DYADIC AFFECT REGULATION CAPACITIES | | | | | | | |
| * Fostered caregiver’s ability to respond in soothing ways when child is upset * Fostered child’s ability to use caregiver as a secure base * Provided developmental guidance around typical early childhood fears/anxieties * Acknowledged and helped find words for emotional experiences: caregiver child * Provided developmental guidance around emotional reactions: caregiver child * Taught, developed, or fostered strategies for regulating affect: caregiver child * Explored with caregiver links between emotional responses to past experiences and current emotional responses to child’s behavior | \_\_\_\_\_ | |  |  |  | \_\_\_\_\_ | \_\_\_\_\_ |
| STRENGTHEN DYADIC BODY-BASED REGULATION | | | | | | | |
| * Fostered body-based awareness, including awareness of physiological responses, particularly as they relate to stress caregiver child * Fostered understanding and identification of body-based trauma reminders * Helped caregiver learn/engage in body-based regulation techniques to regulate affect * Helped caregiver & child learn or use body-based regulation techniques to soothe child * Helped caregiver and child exchange physical expressions of care * Enhanced understanding of safe body-based boundaries | \_\_\_\_\_ | |  |  |  | \_\_\_\_\_ | \_\_\_\_\_ |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| CPP OBJECTIVES | Clinical Focus  (0-3) | | Appropriateness  (check one) | | | Progress  Referral  (0-3) | Progress  Current  (0-3) |
| Under | Appropriate | Over |
| SUPPORT CHILD’S RELATIONSHIP WITH OTHER IMPORTANT CAREGIVERS | | | | | | | |
| * Helped caregivers understand the child’s perspective and need for positive representations of alternative caregivers (e.g., father, step-parent, foster parents) * Helped caregiver support the child in integrating the positive and negative aspects of other caregivers * Shared the concept of angel moments and the importance of helping the child hold on to positive memories involving alternative caregivers, even when relationships between caregivers are strained * Supported child in developing an age-appropriate understanding of the family history * Supported the child in understanding that different family members have different points of view and different ways of relating to each other and to the child | \_\_\_\_\_ | |  |  |  | \_\_\_\_\_ | \_\_\_\_\_ |
| ENHANCE UNDERSTANDING OF THE MEANING OF BEHAVIOR | | | | | | | |
| * Helped caregiver notice behavior (child’s, caregiver’s, or another caregiver’s) * Provided developmental guidance regarding age appropriate behavior and developmental meaning of behavior * Provided developmental guidance around how children learn and develop * Helped caregiver consider (reflect on) the meaning of child and/or caregiver behavior (thinking about developmental stage, past experiences, cultural beliefs) * Helped enhance reflective functioning in caregivers and child | \_\_\_\_\_ | |  |  |  | \_\_\_\_\_ | \_\_\_\_\_ |
| Additional Child First Treatment Objectives   * Helped caregiver notice antecedents to child’s behavior, responses of others to those behaviors, and contributing factors leading to escalation * Provided information to help caregiver understand their importance in the growth of his/her child’s healthy development * Provided information about unique sensori-motor or other neurologically-based processing needs and limitations, as needed * Introduced frequently used language and concepts to build a common vocabulary (e.g., emotional muscle, Circle of Security concepts and language, trauma reminders, etc.) | \_\_\_\_\_ | |  |  |  | \_\_\_\_\_ | \_\_\_\_\_ |
| ATTACHMENT-EXPLORATION BALANCE AND HEALING RELATIONSHIP DISRUPTIONS (Child First Treatment Objectives) | | | | | | | |
| * Noted and reflected on caregiver’s prompt, appropriate response to child’s attachment cues * Provided guidance regarding need of child for proximity to caregiver and for independent exploration. Referred to Circle of Security diagram * Provided guidance regarding the importance of being “bigger, stronger, wiser, and kind” in response to dangerous or inappropriate child behavior * Provided guidance regarding need for caregiving during disruptions and major separations * Reflected with caregiver on past caregiver-child experiences that may have led to “miscuing” * Reflected with caregiver on her emotional responses to child’s attachment/exploration cues and serving as a secure base | \_\_\_\_\_ | |  |  |  | \_\_\_\_\_ | \_\_\_\_\_ |
| CPP OBJECTIVES | | Clinical Focus  (0-3) | Appropriateness  (check one) | | | Progress  Referral  (0-3) | Progress  Current  (0-3) |
| Under | Appropriate | Over |
| SUPPORT CHILD IN RETURNING TO A NORMAL DEVELOPMENTAL TRAJECTORY | | | | | | | |
| * Supported adaptive behavior and normative developmental activities * Supported healthy non-trauma play * Supported positive identity development * Fostered caregiver’s efforts to engage in age appropriate activities * Provided care coordination to help engage child in age appropriate activities (e.g., pre-school) | | \_\_\_\_\_ |  |  |  | \_\_\_\_\_ | \_\_\_\_\_ |
| NORMALIZE THE TRAUMATIC RESPONSE | | | | | | | |
| * Acknowledged effects of child’s and caregivers’ experience of trauma and historical trauma * Provided psychoeducation: Impact of trauma, including common symptoms & PTSD, trauma reminders and how they affect child and caregiver * Helped caregiver anticipate developmental changes in child’s processing of the trauma | | \_\_\_\_\_ |  |  |  | \_\_\_\_\_ | \_\_\_\_\_ |
| SUPPORT DYAD IN ACKNOWLEDGING THE IMPACT OF TRAUMA | | | | | | | |
| * Promoted a deep emotional acknowledgement of the impact of trauma while attending and responding to dysregulated (over or under) affective states * Helped caregiver acknowledge what child has witnessed & remembers * Helped caregiver and child understand each other’s reality (with regards to the trauma) * Helped caregiver & child identify and cope with trauma reminders * Helped caregiver think about his/her own trauma history (ghosts in the nursery) and ways this history may affect her/him and the way s/he parents | | \_\_\_\_\_ |  |  |  | \_\_\_\_\_ | \_\_\_\_\_ |
| HELP DYAD DIFFERENTIATE BETWEEN THEN AND NOW | | | | | | | |
| * Highlighted difference between past and present circumstances * Helped dyad understand that they can make new choices * Helped child and caregiver become aware of the difference between reliving and remembering by helping them identify traumatic triggers and pointing out the different circumstances in the past and the present | | \_\_\_\_\_ |  |  |  | \_\_\_\_\_ | \_\_\_\_\_ |
| HELP DYAD PUT THE TRAUMATIC EXPERIENCE IN PERSPECTIVE | | | | | | | |
| * Supported caregiver and child in making meaning (e.g. creating a story, using ritual, connecting with spiritual beliefs) * Integrated historical trauma as part of the family and personal narrative * Worked with beliefs (existential challenges) around why the traumatic events happened * Helped caregiver/child see trauma as something that happened to them but that does not define them * Supported family’s advocacy work or work to help others * Fostered acceptance around how these experiences have shaped the caregiver and child’s sense of self * Helped the family find pathways to post trauma growth and joy * Encouraged appreciation of goodness, beauty, and hope | | \_\_\_\_\_ |  |  |  | \_\_\_\_\_ | \_\_\_\_\_ |