

# Ten Treatment Principles

## *The principles that guide TST*

---

### LEARNING OBJECTIVES

---

- 1) To introduce the ten treatment principles of TST
  - 2) To describe how these ten principles guide treatment
- 

---

### Icons Used in this Chapter

---

Essential Point



Academic Point



Quotation



Case Discussion



---

**T**rauma Systems Therapy is guided by ten treatment principles. These principles are based on some of the foundations described in the previous chapters and their implementation is described in the chapters that follow. Table 1 shows the ten principles. The rest of this chapter describes them.

- |  |
|--|
| 1. Fix a broken system                             |
| 2. Safety first                                    |
| 3. Plans are clear, focused, and based on facts    |
| 4. Don't "Go" before you are "Ready"               |
| 5. Put scarce resources where they'll work         |
| 6. Insist on accountability, particularly your own |
| 7. Align with reality                              |
| 8. Take care of yourself, and your team            |
| 9. Build from strength                             |
| 10. Leave a better system                          |

Table One: Ten Treatment Principles

## Principle One: Fix a Broken System

As we have described in chapter 1, it all starts from a Trauma System. The Trauma System is defined by:

- A traumatized child who is not able to regulate emotional states;
- A social environment/system of care that is not sufficiently able to help the child to regulate these emotional states.

What is different about TST is its relentless focus on fixing the trauma system and the interventions assembled in a clear, integrated, and organized way towards this focus



This is the Trauma System. The Trauma System is a broken system. Trauma Systems Therapy is devoted to fixing this broken system. Many people have asked us how TST is different from other models of treatment. We always say: TST uses a lot of elements from other types of treatment. What is different about TST is its relentless focus on fixing the trauma system. TST assembles interventions in a clear, integrated, and organized way towards this focus. A corollary to Principle One is:

If it is not about the Trauma System;

It is not Trauma Systems Therapy.

Treatment within TST always boils down to fixing a broken system. If a clinician or team cannot clearly see how an intervention is about helping a child to regulate emotional states, about helping the social environment and/or system of care to help the child to regulate these states and, ultimately, about the interaction between these two then the intervention is not part of TST.

The nine other principles are all about what it takes to fix a broken system.

## Principle Two: Safety First

When clinicians enter the Trauma System, there are all kinds of risks involved. The child can be at risk to hurt him or herself or

other people. The child can be at risk to be hurt by family members or others in the social environment. Sometimes, even the clinician can be at risk to be hurt. This is most important for the Surviving and Stabilizing phases of treatment (to be introduced in chapter 8) but risk occurs at any of the phases. The Surviving phase is, in fact, defined by this risk. The important part of Principle Two is that clinicians and teams must be vigilant about assessing risk and proactive about reorganizing treatment based on the results of this assessment. A clinician, for example, may be prepared to have a session focused on emotional regulation skills but gets information from the child about suicidal ideation or about child abuse. Accordingly, all plans stop in order to address safety. This principle is, of course, simply good clinical care, but in the messiness of treatment can sometimes be missed. This principle is similar to that contained in another treatment model called Multisystemic Therapy (MST), mentioned in chapter one. According to MST:

*If the social environment is dangerous, treatments that target anything else are unlikely to be effective (Henggeler, 1998).*

In other words, when a safety concern is raised, all treatment resources are devoted to helping with the safety concern. The treatment plan is not changed back until the safety concern is over.

### Principle Three: Plans are clear, focused and based on facts

TST is about focus. It requires the specific gathering of clinical evidence to decide about the child's level of emotional dysregulation and the level of instability in the child's environment and system of care. Chapters 7 and 8 describe the framework that must be used to assess and develop a treatment plan for a child and family within TST. This framework can only be used if facts are gathered methodically and clearly. A disorganized assessment will lead to an unfocused treatment plan, which will lead to ineffective treatment.

A disorganized assessment will lead to an unfocussed treatment plan, which will lead to ineffective treatment.

Once the team develops a clear notion about the treatment plan, this must be communicated to the family as part of the Ready-Set-Go module described in chapter 10. This forms the foundation for building a treatment alliance and troubleshooting practical barriers to care. It also contributes to what we call transparency—an openness and honesty with ourselves and the families about what the treatment is about. The construct of transparency is very important within TST. Unless everything is clear to all stakeholders (not the least of which is the clinician and the TST team), treatment will not work.



Once the plan is set up, it is very important for the team to have a high degree of focus on the specific treatment goals. A TST clinician needs to be tenacious. As we write in chapter 7, the TST clinician must stick to the plan like a dog to a bone! But while the clinician's focus on the plan must not waver, the plan itself needs to be flexible in response to new information or new circumstances. TST requires the continual gathering of clinical evidence and changing the plan based on new evidence. This was outlined in Principle Two regarding changing the plan when there is new evidence of safety concerns, but is relevant to any type of new evidence. The TST clinician and team are always proactive about gathering clinical evidence and redoing the plan based on new evidence. What remains constant is a dedication to focusing the plan on the most critical elements for fixing the trauma system.

The need to be proactive about redoing the plan is especially important when treatment is not working. The clinician and team must always be asking themselves when things are not going as planned: What am I missing? What are we missing?

If the team is not saying "What are we missing?" at least twice per meeting than the team is surely missing something!!!

If the team is not saying "What are we missing?" at least twice per meeting than the team is surely missing something!!!

## Principle Four: Don't "Go" before you are "Ready"!

As we detail in Chapter 10, the Ready-set-Go Module, before treatment can really begin three things must be in place:

- There must be the beginnings of an alliance with the family about a specific treatment plan,
- There must be troubleshooting of practical barriers to treatment (e.g. transportation, childcare, appointment times),
- There must be some psychoeducation regarding traumatic stress responses and what involvement with TST will entail.

It is a common mistake in almost any type of psychotherapy to dive into treatment without a clear treatment alliance with the family. In



our consultations with many clinicians who are doing TST, the most common reason for treatment failure is that Ready-set-Go is not properly completed. Frequently when a clinician thinks they have a good alliance with a family it is based on their idea that the family likes them and they like the family. Under TST, liking each other is not enough!

The treatment alliance is very specific. **It means that the family and the clinician agree to work on a problem that addresses something that the family is motivated to change and that the family and the clinician agree that the TST treatment plan can help to change that problem.** In chapter 10 we outline the ways in which Ready-set-Go can be completed and the parameters by which the clinician and the team should know that the child and family are "ready". Of course, building a solid alliance takes time (particularly with families that do not easily trust strangers [you!]). Accordingly, we do not believe that a treatment alliance must be absolutely and completely in place before anything else is done. It is a question of

how much alliance is enough to "GO".



We ask a lot of families in TST. For a family to be motivated to do what we ask them to do in TST they must have clarity on 2 things:

- That the treatment plan addresses an important source of their pain;
- That the treatment plan can, to some degree, alleviate their pain.

If the family does not have clarity on these two things, why in the world would they want to work with us?


## Principle Five: Put scarce resources where they'll work

Treatment will only work if the team is strategic about its resources.

TST addresses difficult and complex problems within the child, the social environment, and the system-of-care. Frequently these problems have existed for years before the TST team is put in place. Accordingly, it is presumptuous to even suggest that a treatment can change everything. Even if a treatment team was given endless resources, they couldn't change everything. And nobody has endless resources. In reality, mental health resources are very limited. So how can we begin to help?

Within TST, we have suggested a series of intervention modalities that we believe can help (e.g. home-based care, emotional regulation skills training, psychopharmacology, advocacy) and put them into a framework where they can fit together and strengthen each other. We believe that this is a great advance from previous interventions for child traumatic stress-- **but this is still not sufficient**. We can't, and shouldn't, give every service to every person. We need to be strategic about the way we use our resources.

Mental health interventions are expensive. Mental health clinics and agencies struggle to make ends meet. Accordingly with the limited (scarce) resources contained within a clinic or agency and placed on

a TST team, these resources must be allocated with a high degree of strategy. Milton Erickson, the founder of Strategic Therapy said that psychotherapy is like helping with a log-jam. The question is finding the right log to kick. The TST clinician, like the good  strategic therapist, is always searching for the right log to kick that will get the logs flowing down river. The TST clinician is also a good economist and knows that there are not unlimited resources that can be used to find and kick the right log. Therefore the TST clinician and team are always asking "How can we get the best bang for our buck (or the best flow for our kick)?"

As we describe in chapter 9 regarding the treatment team, the team is the holder of these scarce resources and is entrusted to use them strategically and effectively. This is true for a given child and family, where the team must make decisions about the use of its home-based, psychotherapy, psychopharmacology, and advocacy resources. It is also true at a macro level where a team must decide given its limited resources how many children will be able to get the various service elements at a given time. These types of decisions are not easy but will set the stage for effective (and efficient) interventions.

## Principle Six: Insist on accountability, particularly your own

Why should they trust you?

Why should a family trust you? This is not personal. We are sure you are very nice, but you are a stranger. Why should they trust you? Family members may have been violated by those in authority and may have long histories of adversarial relationships with authorities such as teachers, social service workers, court officers, police, or previous mental health clinicians. Why should they trust you? You are usually of a different race, class, or ethnic group. If they do trust you on your first meeting, sometimes that's even a 'red flag'.



We discuss the issue of trust in detail in chapter 5, the Therapeutic Relationship. What is most important regarding the building of trust is accountability; doing what you say

you will do. This is very important. We all know that *action speaks louder than words*. When we enter the therapeutic relationship with an individual who has been traumatized, frequently there is the unspoken scanning of the clinician for evidence that he or she will be "just like everyone else". The failure to keep one's word, no matter how unavoidable the circumstances, is a sure sign from the families' perspective that their fears are real.

The root of the word "accountability" is "count". This is about the indispensable question that clinicians and families ask (to themselves) of each other: *Can I count on you?*

Here is the rub: **You are like everyone else!** The TST clinician is (believe it or not) human and will, accordingly, fail. The importance of this principle is the understanding that accountability is extremely important and our communication, via our behavior more than our words, is critical. When we fail, addressing our failure up front and with authenticity will help a great deal. We are building trust in people who have no implicit reason to trust us and we are modeling something very important for the building of relationships and for good parenting. Accordingly, some of the ideas mentioned earlier about transparency and alliance building are very important for communicating to families the value of accountability. The root of the word "accountability" is "count". This is about the indispensable question that clinicians and families ask (to themselves) of each other: *Can I count on you?*

The other part of insisting on accountability is insisting on the child and family member's accountability, as well as others in the child's social environment and system of care (including professionals). An important reason for our development of TST Treatment Planning Form that will be introduced in chapter 8 is to facilitate accountability from everyone that is involved in implementing the treatment plan, including family members. The treatment planning form outlines the treatment plan and specifies who is responsible for what, including a space for signatures. The only way that a TST clinician can be in a position to insist on the family's accountability is by being meticulous about our own.

This principle is extremely important, as family members may never have had the experience before of expectations communicated in such a clear way. What are these expectations? Family members are

expected to do their specified part in the treatment plan. This can include activities that are very difficult to complete but, if the Ready-set-Go part of treatment is properly instituted, family members will know what they have to do, why they have to do it, and how it can benefit them and their child. Additionally, they will have agreed to do the specified activity beforehand. These agreements can include such challenges as:

- Stopping the use of drugs and starting drug abuse treatment,
- Asking a partner to leave and completing a restraining order,
- Calling the police to help with a violent child or partner,
- Taking psychiatric medications regularly,
- Participating in a department of social services investigation,
- Allowing a home-based team into the home.

Every session of TST includes a check-in on what was agreed to the previous session. When agreements are kept, family members are given a lot of credit. When agreements are not kept, this is discussed explicitly, including going back to the original treatment agreement and discussing whether the family members will be able to keep that agreement. This discussion may include re-negotiating the treatment alliance, re-troubleshooting practical barriers, re-examining the treatment plan in light of new information, or providing further psychoeducation. The important principle is that agreements are attended to and accountability is expected. TST clinicians must be vigilant about this or else all their hard work creating a treatment plan and building an alliance will not pay off.

## Principle Seven: Align with Reality



Align with reality? What does this mean? Whose reality? Clinicians and families must work within the bounds of reality, and must also stand for what's real—no matter how strong the pull is to enter a fiction of a simpler, happier world.

Without getting too far into metaphysics, it is important to note that TST takes certain stances about reality. These include:

1. Decisions that conform to the practical realities (that align with reality) are more likely to succeed. A decision to place a child in a supportive classroom with 2:1 supervision and an emphasis on teaching Latin may be just what the child needs, but if that classroom doesn't exist—if it isn't real—the plan will fail. Similarly, while it might be easier to believe the parent when she says 'oh, Jinny is lying about my hitting her!' we can't believe her just because it's easier. If we don't make our decisions based on what's real, we won't succeed.
- 2) The high level of emotion contained within the trauma system can interfere with making decisions that conform to the practical realities. These mistakes can be made by everyone inside this system (including the TST clinician),
- 3) The TST clinician has an important role to play helping children and families to conform to the practical realities of their situation and to build skills toward making these types of decisions,
- 4) The TST Treatment Plan is built within the bounds of practical realities, and is a map of the best decisions possible—given reality.

In order to illustrate what we mean by 'staying within the bounds of practical realities', we offer the following case illustration:



Nicole, a 14 year-old girl recently was discharged from a hospital after a serious suicide attempt. You see her for a first visit after the discharge. She cut herself on the arms the evening before your visit after having a fight with her mother. Just prior to the hospitalization she had disclosed to her mother that her mother's boyfriend had sexually abused her. The department of social services investigation is ongoing but her mother has said that this abuse is "impossible". The night before this visit Nicole and her mother had a big fight about the allegation. Nicole's mother called her a "liar". Nicole called her mother a "bitch". Nicole then went to her bedroom and cut her arms. At this visit, Nicole and her mother are both agitated and angry. You raise the possibility of having Nicole go back to the hospital. Nicole becomes more upset, saying that she hated the hospital and could never be "locked up again". She says that she learned her lesson and will never hurt herself again. She begs you not to send her to the hospital and says she will call you if she has new thoughts of hurting herself. Nicole's mother, in frustration and anger, states "I don't care what you do with her". There are no other friends or relatives that can be identified to help.

**Comment:**

This case brings up a number of "reality" concerns. What decisions best conform to the practical realities of this clinical situation? Nicole's understanding of reality is that she has "learned her lesson" and does not need to go to the hospital. Further, she "contracts for safety" by promising to call you. What is the practical reality?

This is an adolescent who had recently been hospitalized following a serious suicide attempt in the wake of disclosure of sexual abuse. She impulsively cut her arms after a fight with her mother over the reality of the abuse. She is currently quite agitated and her mother is not displaying evidence of being able to help minimize risk. There are no other members of the social environment that can be engaged to help. The clinician's appraisal of the reality of risk,

based on this clinical data and knowledge of the literature on suicide risk, is very high. Thus by aligning with reality, the clinician initiates another hospitalization. This is a prudent decision. What does this mean for the treatment alliance? It all depends how this alliance was initially constructed. Presumably, with Nicole, this alliance would include working together to minimize the risk to hurt herself. According to Nicole's understanding of her current reality she is not at risk. On the contrary, your understanding of the practical realities suggests very high risk. An important corollary of principle seven is:

**The alliance with the patient is always constrained by the alliance with reality.**

The TST clinician must always be asking him or herself about the practical realities of the clinical situation despite huge pressures to ignore them (as illustrated in this case). The TST clinician must never deviate from this understanding. In this way, TST is a treatment model that is strongly grounded in reality.

After Nicole is hospitalized, you have a session with her mother reviewing the suicide attempts and her allegation of abuse from her boyfriend. Nicole's mother becomes angry at you for bringing this up. She says, "You're not going to believe her are you?" You ask why she believes the abuse is "impossible". She says that she knows how to "read people" and she can tell that her boyfriend is not an abuser. She also says that Nicole "lies about everything". She has complied with the department of social services request that her boyfriend not come to her apartment but she admits that she has met him 2 to 3 times since this request was made. When asked about their relationship she says he is "the perfect gentleman". When asked, she admits that he hit her "once or twice when he was using...but he's clean now". You raise the concern about what it means for Nicole that her mother believes the abuse is "impossible" even before the DSS investigation is completed. Her immediate response is "I can't believe a word that kid says".

**Comment:**

One of the main factors that interfere with good decision-making within the trauma system (and elsewhere) is the difficulty distinguishing a wish from reality. From the details presented, Nicole's mother so strongly wishes that her boyfriend has not abused her child that she is not even willing to consider the possibility that it might be true. This wish can be motivated by many things such as her guilt for letting a dangerous man into her home or by her own urgency for companionship. Her decision to not consider the possibility that her daughter might be telling the truth is not prudent as it raises the real risk that she will not protect her child from a man who might be dangerous and it does not include the reality of what her blanket denial can mean for her daughter's mental health and for her future relationship with her daughter. The TST clinician aligns with reality by keeping these facts on the table. Aligning with reality is not unlike the psychoanalytic notions of the "ego" as having a main function of helping individuals understand reality in the face of their wishes, emotions, and impulses.

After meeting with Nicole's mother, you call the DSS worker to get information on the investigation. The DSS worker appears clearly stressed and rushed, and says the case is being "screened out". She says that she tried to interview Nicole during her first hospitalization and Nicole would not speak to her. Further, staff at the unit confirmed that she does "lie" and that they have difficulty trusting her. The DSS worker had interviewed the mother who, consistent with what she had told you, reported that her boyfriend could not possibly have abused Nicole and that Nicole was never alone with her boyfriend. The DSS worker also reported that the mother's boyfriend completely denied the abuse. When you bring up issues such as the boyfriend's past domestic violence and drug abuse, mother's possible motivations for believing the abuse is "impossible", Nicole's possible reasons for not wanting to be interviewed on one occasion, and the need to integrate a full psychological evaluation in this decision, the DSS worker replies, "It is too late, the decision has already been made".

**Comment:**

None of us are immune from factors that can interfere with aligning with reality. The DSS worker likely has a large case-load and is managing a lot of pressure to discharge her cases. She may not have fully had the time to conduct a reasonable evaluation. Nevertheless, the decision making of this worker does not conform to the practical realities of the current situation. Accordingly, you protest this decision and using advocacy skills that you learned reading Chapter 10 of this manual, write a letter to the director of the DSS area office outlining the realities.

When the TST clinician enters the Trauma System and is confronted with the many reality-bending emotions contained within this system, it can be difficult to “see” the practical reality of a given situation and to make prudent decisions.



Obviously, TST clinician's are only human and do not have the market cornered on access to reality. Further, when the TST clinician enters the Trauma System and is confronted with the many reality-bending emotions contained within this system, it can be difficult to “see” the practical reality of a given situation and to make good decisions. Accordingly, we have built certain “safe-guards” within TST. These include team discussions and decision-making (reviewed in chapter 9), supervision, and the clarity of a structured treatment model. Further, the Principle discussed next of *Take Care of Yourself and Your Team* is partly based on helping to manage emotion so that prudent decision making is enhanced.

In order to know whether team decision making is integrating Principle Six, team discussions should be peppered with such questions as “Is it practical?”, “What is the reality?”, and “Can it work?”.



It is, of course, important given the difficulty in discerning practical realities across language or culture to get consultation when indicated or, even better, to have diverse cultural groups represented on the team.

## Principle Eight: Take care of yourself and your team

When oxygen levels drop on an aircraft, there is always an announcement to parents to put on their *own* oxygen mask before



their child's. Why? Isn't a parent's main concern during an emergency the safety of their child? The airlines have wisely discerned that for parents to most effectively attend to their child's safety they must be strong enough to do it by ensuring they have enough oxygen.

The Trauma System is like an oxygen-poor environment. It is easy to get weakened, sick, disoriented, and hurt. In order for clinicians to manage what they must do to *Fix a Broken System*, they must take care of themselves, and be sufficiently cared for by their team,

The Trauma System is like an oxygen-poor environment. It is easy to get weakened, sick, disoriented, and hurt.

agency, and organization. We review some of these ideas in chapter 9 on the Treatment Team about how a team should be structured to take care of its members.

Trauma clinician's face some of the following challenges daily:

- Facing the cruelty of life by hearing stories of children assaulted, tortured, and murdered,
- Facing the randomness of life by hearing stories of children unexpectedly injured or ill,
- Trying to help children and families in great need, without a lot of resources to help,
- Experiencing the extreme emotions that trauma elicits and sometimes is directed at the clinician,
- Making decisions that will contribute to a parent losing custody of their child,
- Making decisions that will contribute to the child staying in the home when the clinician is unsure the home is really safe,
- Making decisions related to whether a child will hurt himself or someone else.

Such ubiquitous challenges can corrode the humanity in us if we are not careful. In particular, the repeated bearing of witness to the harm that one person can cause to another, and particularly to a child, can lead to withdrawal, burnout, and personal life stress. Clinicians with their own histories of trauma can be especially vulnerable.

The emotional toll that this work takes can affect clinical decisions. It is hard to make good decisions when one is burned out or fed up. Similarly, emotions related to this work can lead to the clinician withdrawing from the child or family or being overly punitive with them. Chapter 6, on the Therapeutic Relationship, describes ways in which this relationship can adversely affect clinicians and influence

clinical decision-making. Chapter 9 describes ways in which the team can be organized to take care of its members. All teams must be on top of how its members are responding emotionally and be helpful towards making this important work rewarding and fulfilling.

## Principle Nine: Build from strength

People are resilient. Our families are resilient. People have, over time, developed ways of coping with their situations that are adaptive, notwithstanding other ways of coping that may be highly maladaptive.

Cultures have developed rituals over the centuries to help its members manage adversity. These should never be ignored.

Given the degree of emotion and need expressed by some children and families, it is easy to see them as packages of pathology. The strengths and ways of coping that patient's have adapted over time are powerful means of managing emotion and should be explicitly integrated into care. This notion of strength-based care is often given lip-service in mental health systems but is, truly, an effective approach to treatment. Traumatized children can have many social, intellectual, artistic, or athletic skills that can help them a great deal to manage emotion. Further, it is not only individual strengths but community and cultural strengths that can be used. Cultures have developed rituals over the centuries to help its members manage adversity. These should never be ignored. In a way, this is consistent with Principle Three, *Put scarce resources where they will work*. As mental health treatment resources are scarce and expensive, it is highly strategic to integrate powerful individual, family, and cultural coping mechanisms into the treatment plan. Before these can be integrated the clinician must, of course, know what they are. In Chapter 7 and 8 on Assessment and Treatment Planning we discuss ways of assessing strengths and integrating them into the treatment plan. The chapters on Emotional Regulation Skills, Cognitive Processing Skills, and Meaning Making Skills also discuss the integration of strengths into care.

*Building from Strength* is also a principle that is important for alliance building. Why would anyone want to ally with us about anything if they believe we only see their problems? When children



and families see that we see their strengths as well as their vulnerabilities they are more apt to feel that we see them as people worthy of care and want to work with us towards this care.

## Principle Ten: Leave a better system

The operative word here is *leave*.

The operative word here is *leave*. Other similar words are "finish", "terminate", "so long", and "goodbye". Notwithstanding the considerably complex problems that TST is meant to address, it is not meant to be a long-term support for a child and family. There are significant downsides to long-term treatment, not the least of which is the development of dependence on the treatment team. A piece of wisdom transmitted across the ages is:

*If you give a man a fish you feed him for a day,*

*If you teach a man to fish you feed him for a lifetime.*

TST is about teaching people to fish. *Never do for a family what you believe they can do for themselves.* This does not mean that the TST clinician and team do not do things for children and families. Families are in great need, particularly early in treatment. TST clinician's, accordingly are very active. The guiding principle is that over time, children and families should be doing more and more for themselves. Our job is to enter the Trauma System, to assess the problem with focus, to construct a treatment plan that strategically allocates intervention resources, to conduct the plan mindful of the changes that need to be made for treatment to end, and to **leave** children and families with the skills necessary to do enough of this work on their own, and with services in place that maximize the chance of lasting change.

Principle One: *Fix a Broken System* is about intervening in the trauma system:

- A traumatized child who is not able to regulate emotional states;
- A social environment/system of care that is not sufficiently able to help the child to regulate these emotional states.



Principle Ten: *Leave a Better System* is about imagining from the start what needs to be in place in the child's emotional regulation capacities and the capacities of the social environment/system of care in order for treatment to end.



Will we leave a perfect system? None exists on earth. Our goal is to leave a system that is *good enough* to help the child to manage emotion when faced with a reasonable range of stressors and reminders.

- *Leaving a better system* means giving the child the right emotional regulation skills (chapter 16), cognitive processing skills (chapter 17), and some semblance of meaning and perspective towards the traumatic event or events (chapter 18).
- *Leaving a better system* means giving parents the right skills to help their child to manage emotion and to protect them from threat.
- *Leaving a better system* means giving parents the right skills to advocate for themselves and their children within the system-of-care.
- *Leaving a better system* means instituting processes within the system-of-care to help and protect the child after treatment ends. Such processes might include a more appropriate Individualized Education Plan (IEP) or Social Service Plan.



*Leaving a better system* can have important public policy implications. Although TST is not explicitly about changing public policy, the TST Clinical Team will come face-to-face with public policy issues every day. The specific focus on advocacy, systems-of-care, and the mental health needs of traumatized children, gives the TST Team unprecedented information that can be useful for improving public policy. Similarly, it is our hope that using an intervention model that is comprehensive, focused, integrated, and testable can influence other treatment providers and public policy makers in order to **build a better system** for traumatized children's needs.