SPRING 2015 • Volume 21/Number 2

FOCUS

Newsletter of the Foster Family-based Treatment Association

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A *FOCUS* on Trauma-Informed Care*

*Articles will become available to non-members on a biweekly basis

Implementing the Neurosequential Model of Therapeutics™

by Kathleen Ayala, MSW and Tim Grove, MSW

SaintA has been committed to implementing the Neurosequential Model of Therapeutics™ (NMT™) since 2008, working closely with Dr. Bruce Perry and the ChildTrauma Academy staff, as well as its NMT™ partners and colleagues. Our journey has been demanding and yet remarkably rewarding, teaching all of us about children, their families and the communities in which they grow up. We have learned a few lessons along the way:

- Trauma is important but not all-inclusive. Neglect, relational interactions, neurobiological capability and other developmental opportunities are also very salient
- Resilience is primarily fostered by the strength of a child's connection to his core groups (family, community, system)
- The capability of parents/caregivers is the most significant variable in child well-being
- The children and families we serve are our best teachers and resources for their own healing
- Hope is indeed possible

H's story below illustrates the unique perspective that the NMT™ process offers. It is a story of hurt and hope, and how dedication and compassion created opportunities to heal and grow.

H came to his current SaintA treatment foster home after multiple placements and disruptions. This home was H's fourth foster home, following removal from his birth parent's custody for the second time. At only seven years old, H had spent the majority of his life in foster care. Throughout his life, H experienced significant adverse events without the buffering of a stable, healthy adult. His parents struggled with mental health disorders diagnosed as schizophrenia and depression, ADOA and their own chaotic/neglectful childhood experiences, all of which impeded their ability to respond to H's needs and provide an optimal environment for development. In addition, H witnessed domestic violence, experienced the loss of his father's involvement in his life, homelessness, medical trauma, and several transitions, such as the removal from his family of origin. With this lack of consistency and predictability in his life, H displayed many challenging behaviors when placed with SaintA. These behaviors created

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EDITOR'S COLUMN

—by Gretchen Test, MSW

On behalf of the Foster Family-based Treatment Association (FFTA) board of directors, we are excited to release *FOCUS*, our quarterly newsletter, to all stakeholders in the field of child welfare. For years, the FFTA Editorial Committee has sought out advanced-level articles from its broad membership. Until now, these articles have been available only to member agencies of the FFTA. In making *FOCUS* available to all, we hope to reach a wider audience and involve even more dedicated professionals in the vital work that we support every day. Our hope is that these articles inspire a renewed dedication to the field and generate new ideas. We encourage you to share and discuss these articles widely amongst your colleagues.

Each issue of *FOCUS* is dedicated to a specific relevant theme. In the latest issue, we explore trauma-informed care. Just a few years ago, this theme seemed like a "hot topic" and has now become integrated into our everyday lexicon and incorporated into the fabric of our organizations. According to the National Child Traumatic Stress Network, "child traumatic stress occurs when children and adolescents are exposed to traumatic events or traumatic situations, and when this exposure overwhelms their ability to cope with what they have experienced." [1]It can be the results of acute traumatic events (such as sudden loss of a loved one or physical assault) or due to chronic traumatic situations (such as longstanding sexual abuse). Children can react differently to trauma depending on many factors, and healing approaches that are tailored to a child's age, experience, culture, gender, etc. are critical. Thanks to a growing body of brain science

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Implementing the Neurosequential Model of Therapeutics™

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significant difficulty in stabilizing and maintaining him safely in the home and community. His diagnoses included ADHD, reactive attachment disorder (RAD) and post-traumatic stress disorder (PTSD). He was having multiple explosive tantrums each week that involved property destruction as well as verbal and physical aggression. In addition, H had put himself at significant risk for harm, which required the foster parent to provide line-of-sight supervision. If she needed to be away from the home, alternate programming had to be arranged for H, because he was not able to be safely maintained with another adult for periods of more than 30 minutes. H's biggest triggers appeared to be transitions and intimacy. It was very difficult to prevent H's tantrums; however, the foster parent had set up the home in a way that allowed H to be safe during the tantrums. He destroyed property with his tantrums, but he had become accustomed to using his bedroom as a more appropriate place to release his physical aggression. The foster mother had developed a process within her home that, to ensure safety, required all other children to leave the area when H started to escalate. H's explosive behavior also continued to be dangerous when he was in the community. The combination of his intense behaviors (themselves the result of a very sensitized stress response system) and a poorly matched medication regiment from his pediatrician resulted in a hospitalization stay. He had lost 30% of his body weight and was officially labeled with failure to thrive. The team had run the traditional course: individual therapy, medication management, day treatment services, etc. H was very much at risk for a residential stay. The silver lining of H's hospitalization was that it brought the opportunity for H's team to re-group and consider a different approach.

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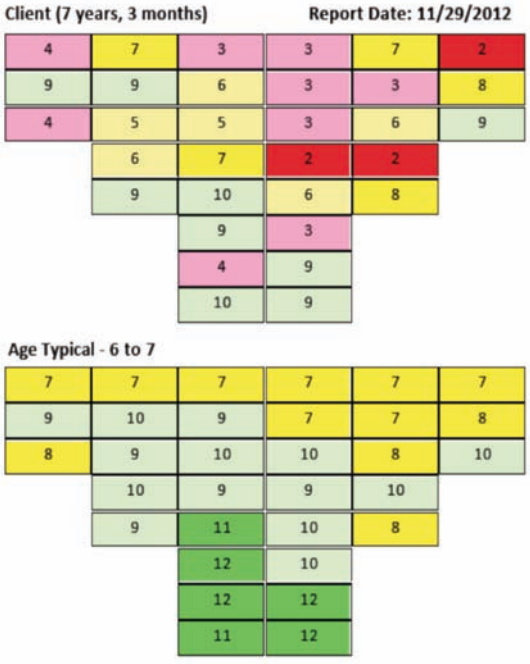

Table 1 (left) represents H's (Client) brain "map" at the beginning of services. The "map" is a part of the NMT process that approximates developmental capability across 32 functional items like cardiovascular/ANS, temperature regulation/metabolism, attention/tracking, sleep-sensory integration, attunement/empathy, speech/articulation, reading/verbal, etc. A numerical score is given by the clinician in collaboration with the team for each of the 32 items with 1 being the lowest score and up to 12 being the highest score. When you compare H's "map" to an age typical map, the effect of H's developmental experiences is evident.

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and child development research, as well as emergence of more evidence based programs, we know much more about how to help kids who've experience trauma to heal, grow and thrive.

In this *FOCUS* you'll learn just what trauma-informed care looks like for an organization, its staff, families and youth. We begin with a wonderful and hopeful story by Kathleen Ayala and Tim Grove of SaintA in Wisconsin about "H", a young boy who had experienced many traumas. Using an approach called Neurosequential Model of Therapeutics™ (NMT™) "H" improved significantly and, well, you have to read the article for the happy ending!

In Kasserian Ingera we learn about FFTA member PATH's trauma-informed care for a young child who has experienced multiple and severe traumas including witnessing domestic violence and experiencing sexual abuse. This story highlights the role of expert consultant Dr. Bruce Perry in working with the team of clinicians and foster parents to help Cheyenne build a set of six core strengths in her path to wellness.

J. Kellie Evans and Ronnie Gehring of The Up Center in Virginia describe a deliberate process of organizational transformation, with a specific focus on what changed for resource parents, from recruitment and assessment, to the home study and training, to improved foster family supports and services and involvement in quality improvement.

Kimberley Bradley of Seneca Falls Family of Agencies in California discusses practice approaches and principles for supporting caregivers and birth parents, including parenting unconditionally, understanding and acknowledgement of their own emotional or traumatic experiences. By better understanding themselves, Bradley argues, parents can better help the children they care for.

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Implementing the Neurosequential Model of Therapeutics™ | continued from pg. 2

Using the NMT™ core principles and H's NMT™ metric as a guide for understanding the challenges H faced, the team began to create their sequential priorities. The first priority was to figure out how to engage H's foster parent, recognizing that she was going to be the difference-maker. She committed to a 30-day plan that involved working with an occupational therapist and treatment foster care specialist to enhance H's regulatory capacity through exposure to a variety of somatosensory activities. Such activities included whole-body activities (riding bikes, playing basketball, swimming); oral activities (chewing gum, blowing bubbles, using a vibrating toothbrush); cognitive and fine motor activities (doing crossword puzzles, building Legos, playing chess). This process also involved the larger Wraparound Milwaukee team, which included seven formal supports and one informal support — H's mom. All of these team members agreed to learn all of the regulatory activities and used them during their time with H. Ongoing psycho-education happened with the foster parent, as she started to make the connection between H's adverse history and the importance of regulation.

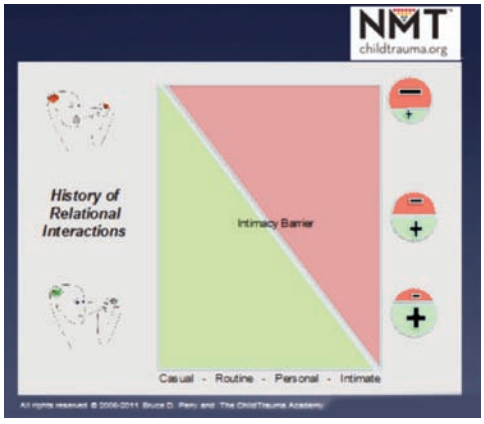

Table 2 (left) represents The Intimacy Barrier. The general premise is that children who have early experiences that are positive, safe & nurturing develop a broader capacity for engaging in interactions that range from casual to intimate and respond accordingly. Children with early experiences that are marked by fear, threat and insecurity often prioritize safety which restricts the risk they are willing to take in the same relational contexts. Like H, these children require patience, repetition and attuned caregiving so that their capacity for more intimate interactions can be gradually enhanced.

As H started to show small signs of progress, he also began to have moments where he would allow relational interactions to pass through the protective barrier he had erected. This was a remarkable NMT™-related discovery — that some kids have such a high degree of relational sensitivity that the focus must be on enhancing their regulation before attempts are made at relational connection. The foster parent was taught about H's "intimacy barrier" and learned ways to benefit from his regulatory capacity and interact with him to help him feel safe. These activities were completed the majority of the time in the context of a relationship. At first, the foster mom and other team members conducted the activities in parallel, with H slowly working to close the intimacy barrier. As time went on, the team remained committed to utilizing these activities as a way to reduce negative behaviors and increase H's ability to appropriately interact with others.

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Christine Bowlby of Right Turn of Nebraska stresses the importance of vicarious trauma and its impact on staff well-being, behavior and job performance, and offers practical tips for supervisors and agency leaders to recognize that "it's there" and create a supportive environment that will help staff and strengthen the agency.

These articles are just a sampling of the expertise of our members. Thanks to all of our authors for giving of their valuable time and writing skills. Do you want to learn more about trauma-informed care? We have also included some online resources for you to explore. Hope you enjoy…

[1] National Child Traumatic Stress Network, Defining Trauma and Child Traumatic Stress, http://www.nctsnet.org/content/defining-trauma-and-child-traumatic-stress

Gretchen Test, MSW, is a Senior Associate at the Annie E. Casey Foundation, located in Baltimore, MD. She serves on the FFTA Board of Directors and is the Chair of the Editorial Committee.

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H's progress now moved forward at a much quicker pace. H's stress response system began to experience some much-needed regulation. This resulted in a reduction of the intensity and frequency of his aggressive episodes, from several times a week to once or twice a month. H no longer destroyed property. H began to learn to trust adults and seek out affection. He made improvements with listening to rules both at home and in the community (i.e., previously he had tried to run into the streets or leave the adults he was with, but he was now no longer considered a flight risk). His school also accepted the recommended adaptations, and sensory activities were added to his functional behavioral plan. He was able to successfully discharge from day treatment, remain on a minimal amount of medications and be described as a model student. He stabilized and is now placed with a pre-adoptive family, where he will be able to achieve permanency in several months.

Client (8 years, 10 months) Report Date: 6/10/2014

5	7	6	5	8	4
9	9	8	6	5	8
7	6	6	7	6	10
	8	7	5	6	
	9	10	8	7	
		10	5		
		9	10		
		11	11		

Age Typical - 8 to 10

8	8	8	8	8	8
10	11	10	8	8	9
9	10	11	10	9	11
	10	10	10	11	
	10	11	11	9	
		12	11		
		12	12		
		12	12		

Table 3 (above) represents H's brain "map" as scored by his clinician and team 18 months later, again compared to an age typical child. Notice the absence of red items compared to his first "map" and also a significant reduction in pink items. These changes suggest that the collective efforts of H's team contributed to significant gains in developmental capacity, which usually translates to positive changes in behavioral outcomes.

H's story is one of many that are taking place in our community. A group of dedicated foster parents, professionals and teams are learning how to apply core developmental concepts to create hope and healing for the people we serve.

Kathleen Ayala, MSW, has been a social worker in the Treatment Foster Care Program with SaintA, Inc. for last 5 years.

Tim Grove, MSW, is the Chief Clinical Officer at SaintA. He spearheaded SaintA's trauma-informed care philosophy and practices, including implementing Dr. Bruce Perry's Neurosequential Model of Therapeutics™.

FOCUS

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The Foster Family-based Treatment Association strengthens agencies that support families caring for vulnerable children.

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FOCUS is the newsletter distributed to all Foster Family-based Treatment Association agency members. Articles of the newsletter are made available to the general public on a staggered basis.

To receive the full FOCUS, consider joining FFTA.

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