TRAUMA INFORMED MILIEU TREATMENT FOR YOUTH WITH ADVERSE EXPERIENCES

Association of Children’s Residential Centers Annual Conference
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Dr. Adam Brown Psy.D
Kari Smith, LCSW
Laura Manley, LCSW
INTRODUCTIONS

- Activity
- Ice Breaker
OBJECTIVES OF PRESENTATION

- Participants will become familiar with the concept of a trauma system, which looks at the interaction between the child’s social environment and how the environment can trigger a youth into “survival states”

- Participants will learn the basics of the Trauma Systems Therapy approach

- Participants will learn about the unique implementation strategy embedded in the TST model, which is a collaboratively developed approach to ensuring a treatment model is embedded in an organization to ensure successful implementation that addresses the organizations highest priorities while adhering to model fidelity

- Participants will learn about the unique strategy for engaging youth and families that is embedded in the approach
CAYUGA CENTERS

- Who we are?
- What we do?
- Why we were looking for a trauma model?

http://cayugacenters.org/about/our-history/
RESIDENTIAL TREATMENT
The Residential Treatment Center campus in Auburn, NY offers cottage residences, an on-premises school, recreation facilities, computer lab, and a health office for youth who are placed.

http://cayugacenters.org/programs/residential-treatment/

TREATMENT FAMILY FOSTER CARE
Treatment Family Foster Care is a research-informed program that combines Trauma System Therapy with behavior management techniques that help youth become successful living in the community. This program places only one youth at a time in a home with highly trained and supported treatment foster care parents.

COMMUNITY-BASED INTERVENTIONS
These diverse family therapy and resiliency programs support families and youth in crisis within the home. The goal is to keep families together, an alternative to out-of-home placement.

SERVICES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES
These programs, developed for those of any age with a developmental disability, are designed to assist consumers in making choices for a productive life, either in or out of the home setting. They are also developed to provide support to the caregiver.

IMMIGRANT FOSTER CARE
Our mission is to serve children, families and individuals, within a safe and therapeutic environment, so that they may grow as independent, healthy human beings. Within this mission, we believe all children deserve to feel safe.
WHY CAYUGA CENTERS NEEDED A TRAUMA MODEL...

• We were relying on a behavior driven treatment model.
  
  o We were responding to crisis without getting to the bottom of what was causing youth to dysregulate and enter survival states.

  o Direct Care staff and school staff were not trained on the impact of trauma and how they could create a trauma sensitive environment for youth.
WHY CAYUGA CENTERS NEEDED A TRAUMA MODEL CONTINUED…

- We were approaching trauma symptoms with a behavioral approach, focusing more on the presenting issues and less on how past traumas were affecting the youth presently.

- Treatment plans were not individualized and did not focus on reducing trauma symptoms.

- The families and youth we served were not informed or educated on trauma and the benefits of trauma treatment.
Why Cayuga Centers Needed a Trauma Model continued…

- We were looking to bring in a treatment model that could be used across multiple agency programs and levels of care (e.g. residential, community based, treatment foster care).

- We were looking for a cutting edge evidenced informed treatment model that our stakeholders would be more likely to refer too.
TRAUMA INFORMED CARE/TRAUMA MODELS

- Are people seeing a prevalence in trauma symptoms in the population you work with?
- How are you treating youth that have experience trauma?
IMPLEMENTATION OF TST AT CAYUGA CENTERS

- Started Organizational Planning with Adam Brown, PsyD, in 2010-2011.
- Established a TST Leadership Team, received training, and set up consultation calls to begin programmatic planning for TST for each department (Residential, TFFC, CBI).
- Piloted in one Residential Cottage Fall 2011.
- Treatment team received weekly consultation calls with Adam Brown with the focus on treatment planning, implementation, and troubleshooting any issues that arose.
- Systems were created to integrate TST specific paperwork (e.g. treatment plans, trauma assessments, milieu check-in).
IMPLEMENTATION CONTINUED

- Started using TST treatment meeting structure
- Shifted language and provided visual examples within the milieu, school, administration building, health office, etc. (e.g. cat hair, treatment principles, phase grids)

The Principles that Guide Trauma Systems Therapy:

1. Fix a broken system.
2. Put safety first.
3. Create clear, focused plans that are 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.
10. Leave a better system.
IMPLEMENTATION CONTINUED

- Training and group supervisions for clinical staff focused on enhancing understanding of the TST model and treatment interventions. (e.g. book clubs, sharing of resources/activities, progress and updates of trauma narratives)

- Created tools to help our clients, and stakeholders understand TST and why we chose this model to treat trauma symptoms.
Adam Brown, Psy.D.
NYU Child Study Center
## Disclosure/Conflict of Interest

<table>
<thead>
<tr>
<th>Institution Name</th>
<th>Grant Support</th>
<th>Book Royalties</th>
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<tbody>
<tr>
<td>The Substance Abuse and Mental Health Services</td>
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<td>Administration for Children and Families</td>
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<td>Guilford Press</td>
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The TST Manual

http://www.amazon.com/Trauma-Systems-Therapy-Children
Whatever It Takes

There are no half measures or tentative choices that are appropriate. It’s “all in” or it’s not; it’s “whatever it takes” or it’s not; it’s about looking at the reality, or it’s about averting our eyes.

Ultimately, the issue of addressing Gerald’s needs—in all their complexity—boils down to the answer to a simple question: Do we look away, or not? Trauma is such a deep assault on the soul of a child—and on whom he or she might become—that our choice about how to help is not unlike what we must do when we walk along a riverbank and see a person drowning. There are no half measures or tentative choices that are appropriate. It’s “all in” or it’s not; it’s “whatever it takes” or it’s not; it’s about looking at the reality, or it’s about averting our eyes.
NEVER LOOK AWAY
GROUP DISCUSSION – WHY IS IT SO HARD TO LOOK?
Why is this important?

One billion children were exposed to violence last year

Global Prevalence of Past-year Violence Against Children: A Systematic Review and Minimum Estimates

Susan Hillis, PhD, MSN,a James Mercy, PhD,b Adaugo Amobi, MD, MPH,c Howard Kress, PhDd

abstract

CONTEXT: Evidence confirms associations between childhood violence and major causes of mortality in adulthood. A synthesis of data on past-year prevalence of violence against children will help advance the United Nations’ call to end all violence against children.

OBJECTIVES: Investigators systematically reviewed population-based surveys on the prevalence of past-year violence against children and synthesized the best available evidence to generate minimum regional and global estimates.


STUDY SELECTION: Two investigators independently assessed surveys against inclusion criteria and rated those included on indicators of quality.

DATA EXTRACTION: Investigators extracted data on past-year prevalences of violent victimization by country, age group, and type (physical, sexual, emotional, or multiple types). We used a triangulation approach which synthesized data to generate minimum regional prevalences, derived from population-weighted averages of the country-specific prevalences.

RESULTS: Thirty-eight reports provided quality data for 96 countries on past-year prevalences of violence against children. Base case estimates showed a minimum of 50% or more of children in Asia, Africa, and Northern America experienced past-year violence, and that globally over half of all children—1 billion children, ages 2–17 years—experienced such violence.

LIMITATIONS: Due to variations in timing and types of violence reported, triangulation could only be used to generate minimum prevalence estimates.

CONCLUSIONS: Expanded population-based surveillance of violence against children is essential to target prevention and drive the urgent investment in action endorsed in the United Nations 2030 Sustainable Development Agenda.

In 2015, according to the U.S. Department of Health and Human Services, 4.5% of the U.S. child population were the subjects of child abuse investigations.

Let’s do a little math.

In 2015, the child population of the U.S. was 74,382,502. So, how many children were the subjects of abuse and neglect investigations?

3,358,347

Children

This is up from 3,047,706 in 2011, with a steady increase each year.
REFINING TRAUMA

An Event Is Traumatic when it...

threatens physical survival (of self or someone close) or one’s core sense-of-self.

A threat to physical survival is not hard to see.

A threat to one’s core sense-of-self means that an individual feels that the answer to the question: ‘Who am I?’ may change forever.

Not all individuals who are abused go on to develop PTSD
TRAUMA DOES NOT MEAN TRAUMATIC STRESS

- 15-40% of traumatized individuals (depending on how one counts) will get a traumatic stress response.

- **Good news:** People are resilient

- **Bad news:** Trauma exposure is so common that 15-40% means an awful lot of people.

- What is 15-40% of 1 Billion children/year????
WHAT IS TRAUMATIC STRESS?

“Traumatic stress occurs when a child is unable to regulate emotional states and in certain moments experiences his or her current environment as extremely threatening even when it is relatively safe”

Saxe, Ellis, Brown, 2016
Within TST this becomes defined as a Survival State (or a Survival-in-the-Moment State)

“an individual’s subjective experience of the present environment as threatening to his or her survival with corresponding thoughts, emotions, behaviors, and neurochemical and neurophysiological responses”

Saxe, Ellis, Brown 2015
Healthy brain development requires a stimulating, nurturing environment.
TST is two things

A clinical model that specifies how to help a child and family.

An organizational model that specifies how agencies should organize, integrate, and manage their services to support the TST clinical model.
The Trauma System

A traumatized child who shifts to *Survival States* in specific definable moments

A social environment and/or system of care that is not able to help the child regulate these *Survival States*
Primary Aim of Treatment

To address the traumatized child’s tendency to have dramatic shifts to survival states when confronted by a stressor or traumatic reminder…

by intervening on both sides of the trauma system:

- **Social interventions** enhance the capacity of members of the child’s social environment to protect child from reminders and support child’s regulation

- **Psychotherapy** enhances a child’s capacity to stay regulated when confronted by a stressor/reminder

- **Psychopharmacology** supports this capacity
The 4 Service Elements

- Psychiatry/Psychopharmacology
- Home and Community-Based Services/Milieu-based services
- Legal Advocacy
- Skill-Based Psychotherapy
The 3 phases of TST treatment

Safety-Focused Treatment

Regulation-Focused Treatment

Beyond Trauma
Becoming a TST Detective
What is unique about TST?

TST offers the **specific**, and **actionable**, information you need, to help a traumatized child: no matter how complex and severe her/his problems.
The Specific, and Actionable, Information You Need…
To Help this child:
Jeffrey

A 17 year old boy with a trauma history who is in residential treatment related to his history of aggressive behavior. He is currently in seclusion for assaulting a direct care staff member. He has assaulted two other staff members in the two weeks since his arrival to the program. He has been admitted to psychiatric hospital twice in the last 12 months for assaulting others.

Where do we start?
What more do we need to know to help Jeffrey?
What do we need to know how to help him?

How much will knowing his diagnoses help?

How much will knowing his trauma history help?

How much will knowing his family and social history help?

How much will knowing his psychiatric and medical history help?
We need to go from speculating about what it might be... To knowing what it is.

It's all about moments
Count the Moments

Problematic Moments
All Moments = Very Small
When the lunch period was ending, Jeffrey asked for more food. He said he was still hungry. He reached for the food tray to get more spaghetti. One of the direct care staff grabbed the food tray and pulled it out of Jeffrey’s hands saying – in a harsh voice – lunch period is over, you have to follow our rules. In an instant, Jeffrey stood up and punched the staff member in the face, as hard as he could.
What do we know, now?

It’s all about **patterns** of survival-in-the-moment.
What is Jeffrey’s Pattern?

• **Event #1**: When the lunch period was ending, Jeffrey asked for more food ... In an instant, Jeffrey stood up and punched the staff member in the face, as hard as he could.

• **Event #2**: When a staff member declined to give Jeffrey a snack, Jeffrey assaulted him.

• **Event: #3**: When another teen in the residential program abruptly changed the TV channel when Jeffrey was watching his favorite cooking show, Jeffrey assaulted him.
What do we know, now?
How many problems might be addressed in Jeffrey’s treatment?

- history of sexual abuse by Uncle
- withholding of food
- extreme neglect
- not enough food often hungry
- mother is in critical condition
- He was arrested for defending his mother
- exposed to domestic violence
- failing at school
- is often truant
- hates social studies
- doesn’t clean his room
- mother has trouble enforcing limits
- swears too much
- teachers say he seems tired at school
- family doesn’t have money for new clothes he wants
- family doesn’t have money for summer camp for him
- brother is involved in gang
- doesn’t have contact with his bio father

Let’s get this number to a manageable size…

...by spotting patterns between the moments.
What about Jeffrey?

- **Event #1**: When the lunch period was ending, Jeffrey asked for more food ... In an instant, Jeffrey stood up and punched the staff member in the face, as hard as he could.

- **Event #2**: When a staff member declined to give Jeffrey a snack, Jeffery assaulted him.

- **Event: #3**: When another teen in the residential program abruptly changed the TV channel when Jeffrey was watching his favorite cooking show, Jeffrey assaulted him.
What problems does TST seek to address?

All clinical problems addressed in TST are defined in only one way:

**TST Priority Problems:**

*Patterns of links between a traumatized child’s experience of threat in the present environment, and the child’s transition to a Survival-in-the-Moment state.*
Sexual abuse from uncle that was associated with the withholding of food

Asked for seconds, told no

Hit staff member in the face

Not given a snack

Attacked staff member

Peer changed channel while Jeffrey was watching a cooking show

Dissociation, physical aggression

Signals of being deprived of food
Jeffrey’s Priority Problem

When Jeffrey is exposed to withholding behavior concerning food, Child’s name Description of threat signals (cat hair)

She/he responds by feeling panicked, and then enraged and assaults others. Description of Survival-in-the-Moment state (3A’s in Re-experiencing)

This pattern can be understood through his past experience(s) of: sexual abuse from uncle associated with threats to withhold food. Information about Environment-Past that informs understanding of Survival-in-the-Moment response in present
The 3 phases of TST treatment

Safety-Focused Treatment

Regulation-Focused Treatment

Beyond Trauma
# Treatment Phase

## TST Treatment Planning Grid

<table>
<thead>
<tr>
<th>The Child's Survival States</th>
<th>The Environment's Help and Protection</th>
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<tbody>
<tr>
<td>No Survival States</td>
<td>Beyond trauma</td>
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<tr>
<td></td>
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<tr>
<td></td>
<td>Safety-focused</td>
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<td>Survival States</td>
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<td></td>
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<td>Dangerous Survival States</td>
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What did we do?

When Jeffrey is exposed to withholding behavior concerning food, Description of threat signals (cat hair)

She/he responds by feeling panicked, and then enraged and assaults others. Description of Survival-in-the-Moment state (3A's in Re-experiencing)

This pattern can be understood through his past experience(s) of: Sexual abuse from uncle that was associated with the withholding of food.

Information about Environment-Past that informs understanding of Survival-in-the-Moment response in present

Interventions:
• More flexible rules re food on unit and empathic attitude towards Jeffery.
• Build emotional regulation skills re food.
• Psychopharmacology to help while skills are built.
• Communications with next providers re Jeffrey’s vulnerabilities and the interventions that will address them.
PROBLEMS TO SOLVE WITH TST

- Effective assessment and treatment of trauma symptoms.
- Reduce restraints and move away from a predominately behavioral approach.
- Agency wide treatment model that could be utilized across systems and programs.
- Trauma informed staff and environments
IMPLEMENTATION APPROACH

- TST Leadership Team became certified as trainers for the agency.
- All clinicians received the TST book and training
- Clinical team formed a book club to process and discuss the TST intervention and treatment phases.
- Direct Care Staff received TST training
- School Staff received TST Training
IMPLEMENTATION APPROACH CONTINUED…

- TST “Theme of week” discussed in weekly staff meeting.

- Trauma assessments incorporated into pre-existing clinical paperwork (e.g. TSCC, CSDC, Biopsychosocial)

- TST Treatment Principals reviewed and focused on during team meetings.

- Two clinician model, and session frequency changed to intensify support and enhance the quality of work accomplished in therapy.
IMPLEMENTATION APPROACH CONTINUED…

- TST “Theme of week” discussed in weekly staff meeting.
- Trauma assessments incorporated into pre-existing clinical paperwork (e.g., TSCC, CSDC, Biopsychosocial).
- TST Treatment Principals reviewed and focused on during team meetings.
- Two clinician model, and session frequency changes to intensify support and enhance the quality of work accomplished in therapy.
- Aligning milieu practices and routines using an individualized trauma informed approach as opposed to assessing functioning from a behavioral lens.
**Trauma Systems Therapy**

**Barriers**
- Difficulty with turnover
- Resistance to change
- Uncertainty
- Overwhelming response to new paperwork/ additional demands

**Successes**
- Teams felt more accomplished in their work with youth and families.
- Creating systems for integrating TST paperwork with preexisting documents (e.g. maintaining compliance, frequency, avoiding duplication)
- Moving from the treatment happening only in therapy versus a more team based approach.
- Structured treatment model to help guide the process
TRAUMA SYSTEMS THERAPY

Take a minute and think about your organization

- Was there a time that a change had to be made or something new was rolled out?
  - What was that experience like?
  - Any barriers?
  - What made it successful?
TRAUMA SYSTEMS THERAPY

How has TST changed practice?
- Training that includes focus on self awareness and self care.
- Way in which we discuss cases and provide treatment.
- How we view behaviors, and engage families and other systems that interact with our youth and families.
I feel safe when I am far away from the problem. For example, thinking of Calvin and knowing he is around makes me feel not safe and uncomfortable. Sometimes when I am at Bill and Lorna's house's I get this tickle in my stomach and I feel uncomfortable and not safe.

- Jennifer
MEET HANNAH:

Hannah came to us with a history of familial sexual abuse. She was engaging in risky sexual behaviors, displaying active dissociation in response to triggers in her environment.

The team prioritized safety, by focusing on her risky sexual behaviors and active dissociation which led to increased restraints.

Safety focused treatment included increased therapy sessions, increased supervision in the cottage, supervised visitation with her family, and psychiatric medication management.

I have lived a tough life, but I can’t change the past.
I have learned that I am strong.
I am going to make it.

— Hannah, in Residential Treatment
Hannah then moved to regulation focused treatment where the focus in treatment was on learning coping skills that would help her manage her emotions and becoming more aware of which triggers prompted survival states. Hannah developed a ‘Managing Emotions Guide’ which was shared with cottage staff. Hannah’s passion was music which became an identified coping skill for her through listening to music and participating campus choir.

Hannah then moved to Beyond Trauma Treatment, which included completion of trauma narrative. She chose to complete her trauma narrative in the form of an altered book. She began making meaning of her trauma through mentoring peers who were struggling to engage in their treatment.
HOW DOES TST CREATE A TREATMENT FOCUSED MILIEU...

- Staff are trained as “TST detectives”, always looking for “cat hairs”, utilizing the Moment by Moment Assessment to breakdown and process through different events.

- Staff are aware of the various emotional regulation skills that the youth are learning in therapy or treatment groups and are trained to encourage youth to use these skills when escalated.

- TST encouraged environmental changes: increased staffing ratios, personalized rooms, recreation as part of treatment, drawing on the youths individual strengths.
What does a child need to succeed? To feel valued.

It is our responsibility to value the spirit of every child.

Cayuga Centers
Lives when children thrive.

—Constance Evelyn,
Superintendent Auburn Enlarged School District
Cayuga Centers Board of Trustees

We help youth in trouble and families in crisis. We provide guidance and relief to the support givers of those with disabilities. We listen, we act.

315-253-5383 CayugaCenters.org
QUESTIONS/DISCUSSION