WHAT IS TAKE TWO, WHERE DID WE COME FROM AND WHO DO WE WORK FOR?

Aboriginal children are 14.3 times more likely to be in care

When Care is Not Enough

“...there are a number of children and adolescents in care, who have suffered traumatic early environments, for whom care is not enough to effectively address the aftermath. It is argued that these young people need consistent and high quality care, which offers continuity of positive relationships. However, they also need systematic therapeutic interventions, to assist them to rebuild their lives and address post-traumatic states and developmental disturbance associated with the severe abuse and neglect they have suffered.”


“I like the little girl in centre of group, but if taken by anyone else, any of the others would do, as long as they are strong” (Bird, 1998: 1).
“Promise me you’ll never forget me because if I thought you would, I’d never leave.” — A.A. Milne

When Therapy is Not Enough

“It is paramount that we provide environments which are relationally enriched, safe, predictable, and nurturing. Failing this, our conventional therapies are doomed to be ineffective.” (Perry, 2005, 3)

Take Two is a Berry Street program (www.berrystreet.org.au) in partnership with

– La Trobe University (Department of Social Work and Social Policy)
– Mindful – Centre for Training and Research in Developmental Health
– Victorian Aboriginal Child Care Agency (VACCA)

Take Two is required to . . .

To provide clinical services throughout Victoria
[our clinical teams]
To build and gather knowledge
[our Research & Information Management team]
To share and disseminate knowledge
[our Practice Development and Training team]

What is Take Two?

Take Two is a Victorian mental health service for infants, children and young people who have suffered trauma and disrupted attachment due to abuse and neglect and who are child protection clients.

Its mandate is to provide high quality clinical services and to contribute to service system improvement.

Accredited in relation to Australian health care standards and a NMT flagship
A Berry Street Initiative

Scoresby Bendigo Wangaratta Mildura Ballarat Geelong Flemington Eaglemont Morwell

Take Two Locations in Victoria, Australia 2013

Take Two staff
As of June 2013, Take Two has **110 staff** including (began with 43 in 2004)

- 35 regional clinical staff (no change)
- 5 in Aboriginal team (began as 1) (mostly funded by Berry Street)
- 4 Aboriginal Therapeutic Home-based Care (new in 2013)
- 2 Secure Welfare (began as 1)
- 4 Circle (therapeutic foster care) (since 2007, growth ahead)
- 11 TRC and variations (began as 6, growth ahead)
- 6 Stronger Families (began as 3 in 2010)
- 1 Youth Justice intensive therapeutic role (new in 2013)
- 15 Tune-In bushfire role (will finish in 2014)
- 6 Clinical managers, including deputy director (began as 4)
- 6 Research and information management team (began as 2)
- 9 Practice Development and Training Team (began as 1)
- 1 Director and 2 internal consultants (neuropsychologist and infant mental health)

Take Two Locations in Victoria, Australia 2013

Staff qualifications
- Social workers
- Psychologists
- Occupational therapists
- Psychotherapists
- Family therapists
- Psychiatric (mental health) nurses
- Access to child psychiatrist for secondary consultation

Clinical services provided by Take Two
- Clinical teams in each region throughout Victoria
- Clinical Aboriginal team (Statewide)
- Embedded within Secure Welfare
- Therapeutic specialist roles (mostly located within clinical teams) for:
  - Therapeutic Residential Care
  - Circle (Therapeutic foster care)
  - Stronger Families (family preservation)
  - Youth Justice Custodial Service (pilot)
  - Tune-In Youth Counselling Service (bushfire service)

Staff experience
- Mental health
- Child protection
- Other therapeutic or counselling services
- Case management services
- Disability services
- Aboriginal services
- Research and training
Who are we talking about?

Children of any age who:
- Have suffered multiple and unpredictable experiences of trauma and/or the deprivation of neglect of their core developmental needs
- Experience various types of affect and physiological dysregulation as a result of their developmental experiences
- Have usually had multiple placements and consecutive adults in their life saying ‘trust me’
- Do not have a safe, nurturing consistent adult in their life now who they know will be there in the future
- OR
  - Who have a safe, nurturing consistent adult in their life but who need additional assistance to redress the harms of the past

Who is eligible for Take Two services

Substantiated Child Protection clients, e.g.
- Infants, children/young people
- Not on a court order or on interim or long term court orders;
- any placement type including living at home,
- may be contracted to CSOs or case managed by DHS

Experienced severe abuse or neglect
At risk of or already demonstrating behavioural or emotional disturbance.
Take Two’s Research Functions

- Take Two undertakes research and evaluation in partnership with La Trobe University Department of Social Work and Social Policy.
- Examples of research and publications include:
  - Ongoing evaluation of Take Two (www.berrystreet.org.au)
  - Articles in peer reviewed journals
  - Report on child neglect (Office of Child Safety Commissioner)
  - Report on Assessment of Aboriginal children’s social and emotional wellbeing (Not One Size Fits All)
  - Report on child maltreatment and speech and language (Small Talk)
  - Completing project on family reunification

Four areas of exploration through Take Two’s research strategy

1. To explore what is known and not yet known about the target population
2. To explore what is known and not yet known about the system issues surrounding the population
3. To explore the interactions between the client population and the system
4. To explore research-based practice and interventions

Other losses and difficulties

- 18% of children had one or two deceased parents.
- 30% had one or more parents in gaol during Take Two involvement.
- 58% had at least one parent with own child protection history.

SDQ – results over time - Take Two

Reductions in those children reported in the clinical range

- in each scale and total difficulties scores
- according to all respondent types.

Significant reductions reported included:

- Child/YP – all four difficulties scales
- Parents – conduct; hyperactivity/ inattention
- Carers – Peer relationships
Evidence-based practice

The Institute of Medicine (IOM) defines ‘evidence based practice’ as a combination of the following three factors:

- best research evidence;
- best clinical experience; and
- consistent with patient values (2001)

Take Two’s approach to therapeutic intervention

- Guided by a research-informed theoretical and practice framework;
- Informed by a comprehensive assessment of the history and current situation;
- Attempts to bring about directed change in a child and/or in those who have a major influence on the wellbeing of the child;
- Through individualised and collective therapeutic relational attention (Frederico, Jackson, & Black, 2010).

Our therapeutic approach

- No single existing evidence-based intervention that sufficiently responds to depth and breadth of issues confronting Take Two client group.
- Take Two client group:
  - vary in age from infancy to adulthood;
  - have multiple and compounding experiences of abuse and neglect throughout their life;
  - show diverse combinations of emotional, behavioural and developmental difficulties; and for many,
  - are often in temporary or uncertain placements.

Take Two – Who are we and what do we do?

- Characteristics of children and others in their life
- Child’s experience that impact on vulnerability and resilience
- Targets for therapeutic intervention: - what are we wanting to change?
- Therapeutic approaches tailored to contribute to those changes
- Specific therapeutic interventions

“Research attention should be paid not simply to specific psychological procedures, but also to the ‘nonspecific’ factors such as engagement, empathy, therapeutic alliance, belief and hope.” (Jensen, et al, 2005, 70)

Take Two’s multiple layers of impact

- Carers: Child and parent therapy, Working with carers about child Care teams, Training
- Family: Child and parent therapy, Working with parents about child Family therapy
- Community & Systems: Consultations, Group training, Child in the Community
Therapeutic or trauma-informed reforms in Victoria – pre 2003

Prior to 2003 in Victoria there were:
- Child and Adolescent Mental Health Services
- Sexual assault services
- Small number of therapeutic roles within a couple of services

Therapeutic or trauma-informed reforms in Victoria – since 2003

- Take Two
- Principal Practitioner (Child Protection)
- Therapeutic Foster Care & Hurstbridge Farm
- Calmer Classrooms
- Therapeutic Residential Care
- Yarning Up On Trauma
- Grad Cert and Grad Dip in Child and Family Practice
- Third Evaluation report on Take Two
- Stronger Families
- Youth Justice
- Expansion of Therapeutic Residential Care and Therapeutic Foster Care

Conceptual map of the Berry Street TRC model

Therapeutic Residential Care

AN EXAMPLE OF A THERAPEUTIC REFORM

Therapeutic residential care

- In addition to providing high quality care...
- Therapeutic residential care:...
- Responds to complex consequences of abuse and neglect and the impact of separation from family through positive healing relationships in a trauma-attachment-informed and developmentally focused framework.
- Supports residential care to provide informed care and guidance beyond what is commonly expected by a parent or carer, to assist in addressing the young person’s everyday and exceptional needs and/or developmental delays that impede healthy functioning.
- Provides the young person with restorative experiences through safe, nurturing relationships in an emotionally regulated and consistent environment, promoting their capacity to experience and recognize safety in relationships with others.
- Focuses on hearing the young person’s voice, responding to their unique presence and understanding their experience and the multiple possible meanings behind their behaviours.
- Aims to strengthen the young person’s positive connections with their family, community and culture.” (McKenzie, Jackson & Bristow, 2009)
Sanctuary model: Commitments

• Commitment to non-violence (safety)
• Commitment to emotional intelligence
• Commitment to social learning
• Commitment to open communication
• Commitment to social responsibility
• Commitment to democracy (shared governance)
• Commitment to growth and change.

A key principle in residential care being therapeutic is congruence (Anglin, 2002)

• Congruence is when what is happening across different roles makes sense and is either similar or linked.
• Some attitudes, behaviour and ways of relating are not only looked for in the young person, but in residential staff, supervisors, other workers, managers and the external world.
• For example, if we want young people to show respect to others • they need to see what this looks like in others; and • workers (all roles) are more likely to show respect if they feel respected by the organisation and system within which they work.
  » This is congruence (related concept to parallel process)

A Shared Language: S.E.L.F.

• S – Safety (physical, psychological, social and moral, cultural)
• E – Emotion management (not just for kids!) (ability to handle distressing and other feelings without becoming destructive)
• L – Loss (abuse, neglect, separation, getting stuck) – Placing loss in context, preparing for change.
• F – Future (how can things be better? – re-establishing capacity for choice and imagining a better future – hope!)

Anglin’s model of residential care

Basic psychosocial processes:

– Creating an extra-familial living environment ‘specially crafted to meet the needs of the children/young people living there’
– Responding to pain and pain-based behaviour (i.e. trauma related behaviour)
– Developing a sense of normality.

What are the S.E.L.F. steps to recovery?

• No one gets better or works well without having Safety; physical, emotional, social, moral and CULTURAL safety. Safety is always the start and end
• Managing Emotions is the step that helps to identify feelings and to handle feelings in a way that doesn’t hurt others or ourselves
• Loss is the step that helps acknowledge and grieve the painful things that have happened in a safe way and move to a healthy future
• Future is the step where choices are looked at in order to create a better personal future and to make the world a better place.

Balance between empowerment and limit setting

Taking responsibility for one’s own choices and behaviours

In developmentally appropriate balance
What children need . . .

“. . . if children are to reach their potential as adults they need a predictable, dependable, nurturing, safe environment in which to grow and which will be a resource to them as adults. . . . A safe, consistent, nurturing environment permits the development of attachments between children and parent-figures, attachments which represent affective bonds that can endure over time. Even when our parents are no longer available to us, there remains with us a sense of roots; this ensures a modicum of security and enables us to face the inestimable number of losses and acquisitions we experience throughout our lives” (Kagan & Schlosberg, 1989, 15)

Attachment – secure base

How can a residential care worker provide the consistent, safe, reliable base upon which I can . . .

Be ‘out of my comfort zone’ so that I can . . .
- Explore the world
- Take risks
- Make mistakes
- Try new things
- Learn new things
- Cope with change/transition.

Attachment – safe haven

How do I know I can go to a residential care worker when the going gets tough – when things are rough, unsafe, scary, uncertain: so that I can . . .

Return to ‘my comfort zone’ and
- Feel safe
- Recover, catch my breath
- Reflect and make sense of what has happened.
- Organise my thinking and feeling
- Regain energy and motivation

Needs of children in care
(adapted by Jackson, 2010 from Thoburn, 1994)

Permanence/ Stability
- Security
- Belonging
- Safety
- Family life
- Consistency
- Being loved
- Loving

Identity
- Knowing about birth family
- Knowing about past relationships
- Fitting present with past
- Knowing & valuing own culture
- Pride, honour and respect
- Appropriate contact with important people from now and past
- Being valued as person you are

The Therapeutic Attitude

“The powerful healing nature of the therapeutic attitude which underpins all interactions - it is the attitude that makes the strategies employed therapeutic.” (Dan Hughes, 1998)
The Therapeutic Attitude: PLACE

The attitude includes the following basic elements:
Staff / carers need to be able to remain:
- Playful
- Loving
- Accepting of children
- Curious
- Empathic (Hughes, DDP model)

What happens when we focus on behaviour?

Behaviour
Pattern of behaviour
Function of behaviour

Toxic Shame

“People who live with toxic shame feel fundamentally disgraced, intrinsically worthless, and profoundly humiliated in their own skin, just for being themselves... toxic shame arises when an individual's inner core is tormented through rejection.”
(Garbarino, 1999, 58)

The Concept of ‘Time In’

When children who have experienced ‘shame’ from trauma are having trouble with feelings, ‘time out’ is not helpful. Because they can’t understand cause and effect, can’t self-soothe and feel shamed easily, time out is experienced as a further abuse and produces more shame and rage.
How does “Time In” work?

The carer responds firmly and clearly in a way that acknowledges that the child is doing the best they can but that they need to help them manage their feelings more effectively. This does not mean accepting unacceptable behaviour, but it does mean drawing the child closer and talking through what is happening in a calm way.
Hurstbridge Farm
A SEMI-RURAL THERAPEUTIC RESIDENTIAL CENTRE (TRC)

The Site......

The views......

The animals......
A Berry Street Initiative

The animals...

A Berry Street Initiative

Completion...

A Berry Street Initiative

Trauma and Stress Response Systems in the Brain

Take Two – Who are we and what do we do?

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What is Neurosequential Model of Therapeutics (NMT)?

- The NMT is a developmentally-informed, biologically respectful approach to working with at-risk children.
- The NMT is not a specific therapeutic technique or intervention, rather it is a way to organise a child’s history and current functioning to inform the therapeutic process.
- The approach integrates several principles of neurodevelopment and traumatology.
- It is a systematised way of thinking about therapeutic intervention.
- The NMT was developed by Dr Bruce Perry and the Child Trauma Academy.
Association

- The brain makes associations between sensory signals co-occurring in any given moment in time.
- This capacity allows humans to learn, create images of the future and survive.
- This capacity can also make humans vulnerable to false associations - creating fears of non-threatening objects.

Risk-Taking and adolescence

- Highest age for taking risks especially 14-17 yrs
- They use the same cognitive strategies as adults to solve problems and assess risk similarly BUT
- They weigh risk and reward differently and more actively seek reward, especially when with peers (Steinberg)

Strange but true

We are geared up to be threatened by what is strange and unfamiliar (at the same time as being driven to explore our world, be curious and excited)

We are more likely to seek what is familiar than what is good for us?

What can influence our state

- Co-regulation with another
- Familiar group ‘belonging and recognition’
- Another’s internal state (mirror)
- Feeling under threat
- Feeling pleasure and reward
- Intimacy barrier
- Our physical state (e.g. sleep, diet, exercise)
- Power differential (height, surprises, control and unfamiliarity)

Implications for Intervention

“It is important to understand that the brain altered in destructive ways by trauma and neglect can also be altered in reparative, healing ways. Exposing the child, over and over again, to developmentally appropriate experiences is the key. With adequate repetition, this therapeutic healing process will influence those parts of the brain altered by developmental trauma.” (Perry, 2005, 3)

Therapeutic Interventions

“If interventions with these children are going to work, the number of repetitions required cannot be provided in weekly therapy. Effective therapeutic and enrichment interventions must recruit other adults in a child’s life – caregivers, teachers, parents – to be involved in learning and delivering elements of these interventions, in addition to the specific therapy hours dedicated to them during the week.” (Perry, 2005, 38)
Core elements of positive developmental, educational and therapeutic experiences

- Relational (safe)
- Relevant (developmentally-matched)
- Repetitive (patterned)
- Rewarding (pleasurable)
- Rhythmic (resonant with neural patterns)
- Respectful (child, family, culture)

Sensory integration

- Sensory integration provides the ‘just right’ challenge via controlled sensory input (mainly vestibular, proprioceptive and tactile).
- It helps to organise the body and create the right level of arousal to enable the person to be, feel and explore safely.

MARCHING TO THE BEAT OF HIS OWN DRUM

Different senses

- Touch
- Hearing
- Smell
- Sight
- Taste
- Balance

Plus:
- (6) Balance (vestibular)
- (7) Body awareness through muscles and joints (proprioception)
- (8) Ability to consciously perceive signals from the body (interoception)

Sensory detective

- We can observe how she responds to different sensations (it may be a small reaction) – be a sensory detective – notice her response to activity, the person and the environment.
- Establish her likes and dislikes for different types of activities
- Assess her sensory diet and sensory seeking and sensory avoiding behaviours
- Provide sensory-rich opportunities relevant to her likes and level of understanding when in a calm state (to test it out)

(Gay, 2012)
**Sensory diet**

- Provide planned, regulated sensory activities throughout the day (dose)
- An individualised activity schedule using sensory input throughout the routine
- Helps regulate amount of sensory input to help them calm and yet alert
- Developmentally informed yet age-respectful

**AROUSAL**

Arousal needs to change throughout the day and be at an optimal level for successful engagement with activities and people

Arousal is important for
- Sleep and wake cycles
- Learning
- Self calming
- Attention

We can break down tasks into small steps making each step a stimulating (to the senses) experience

Sensory focussed activities are everyday experiences that stimulate the senses by alerting or relaxing them:
- By stimulating the senses (e.g. music, smells, food, drinks)
- By sensorimotor activities (e.g. exercise, movement, rocking, dance, sport)
- By environmental changes (e.g. heat, light, colour, furnishings) (Gay, 2012)

**PAIN Relief**

- P - Predict and Prepare
- A - Acknowledge
- I - Inform
- N - Nurture and Notice

These are four integrated steps. The first three are usually done in order. The fourth must be present throughout. (Dwyer, et al., 2010)

**Patterned Repetitive Somatosensory Activities**

- Managing Transitions
- Calming/Regulating
- Alerting/Awakening
Brainstem Enhancement Activities

- **Pacification**
  - Soothing activities in the child’s preferred sensory modality
  - Rocking, touching, massage (face, hands, feet, or body), painting nails, brushing hair, feeding, dressing, swinging, singing, telling stories

- **Sensory stimulation**
  - Activities that stimulate each sensory system
  - Touching with sand/clay, finger painting, shaving cream play, cooking (for touch, smell & taste), smelling for fun and identification with household smells, texture bags, sounds for fun and identification

- **Infant games**
  - Stimulation to attain mutual attention and attunement
  - Involve face-to-face & eye-to-eye contact and mutual enjoyment
  - Songs, nursery rhymes, touching games, family rituals, nurturing activities

Midbrain Enhancement Activities

- **Music:**
  - songs, chanting, rhyming, poems, nursery rhymes, rhythm bands, marching bands

- **Narrative:**
  - dramatic story telling, reading books/poems with rhyme and rhythm (e.g., Dr Seuss & nursery rhymes)

- **Movement:**
  - songs/chants with dance/movement, crawling activities, balance beams, swings, seesaws, slides, merry-go-rounds, playing with balls/hoops/ribbons

Limbic Enhancement Activities

- **Social skills games:**
  - Sharing games, cooperation games, taking turns, pets (to learn gentleness, empathy)

- **Nature discovery:**
  - Walk or trips to discover natural world with the senses (sticks, stones, water, clouds, animals, trees, wind)

- **Creative dance & movement** activities continue with more complex movements

- **Art:**
  - Drawing, painting, crafts, plays/dramas to act out

Cortical Enhancement Activities

- **Narrative Therapy**
- **Trauma Focused CBT or other types of CBT**
- **Insight Oriented Therapies** (psychotherapy)
- **Family therapy**
- **Education and Psychoeducation**

Every target of therapeutic intervention aims to change the brain

Targets for therapeutic intervention include:

- Regulation of child’s arousal, emotional and behavioural systems
- Compensate or heal developmental insults and gaps
- Key people in child’s life to be attuned, responsive, available and safe
- Child to have positive, trusting, lasting relationships with others
- Helping child make sense of past so it no longer intrudes on present
- Maximising a congruent response of key people in child’s network to hold the child in mind

(Frederico, Jackson & Black, 2010)
Therapeutic activities include:

- Therapeutic assessments that guide not only our own intervention but others
- Create – between clinician and child – rhythmic, in tune, co-regulated relational experiences
- Enable reparative, stimulating and calming experiences and for child to practice new skills
- Inform carers/teachers/others of meanings behind child’s difficulties and his or her own responses
- Help child to develop a coherent trauma narrative and bearing witness to the story
- Develop child’s social networks and their skills to further strengthen relationships with others
- Facilitate and educate care team responses and consult about community and system responses  
  (Frederico, Jackson & Black, 2010)

Our therapeutic approach

- It is about what happens in a therapy session (with child, child and parent/carer, parent or carer about child, or with family) AND
- It is what happens in the rest of the child’s world that purposefully contributes to the child’s recovery, i.e. ‘has therapeutic intent’  
  (Frederico, Jackson & Black, 2010)

Other things to consider

THE IMPACT ON WORKERS AND CARERS
A Berry Street Initiative

Resources for practice

Calmer Classrooms (Downey, 2007)

Yarning up on Trauma (Coade, Downey, & McClung, 2008)

Positive solutions in practice – using sensory focused activities to help reduce restraint and seclusion (Gay, 2012)

Resources on therapeutic care

Essential elements for TRC –

VERSOS Consulting evaluation of TRC (2011)

La Trobe University evaluation of Circle (2012) (Therapeutic Foster Care)

“Piglet sidled up to Pooh from behind. "Pooh?" he whispered. "Yes, Piglet?" "Nothing," said Piglet, taking Pooh’s hand. "I just wanted to be sure of you."

— A.A. Milne