BILD workshop Bristol 2019

NOVALIS TRUST

Jake Lukas RSW Chief Executive

"From Trauma Informed to Trauma Organised & Back Again"

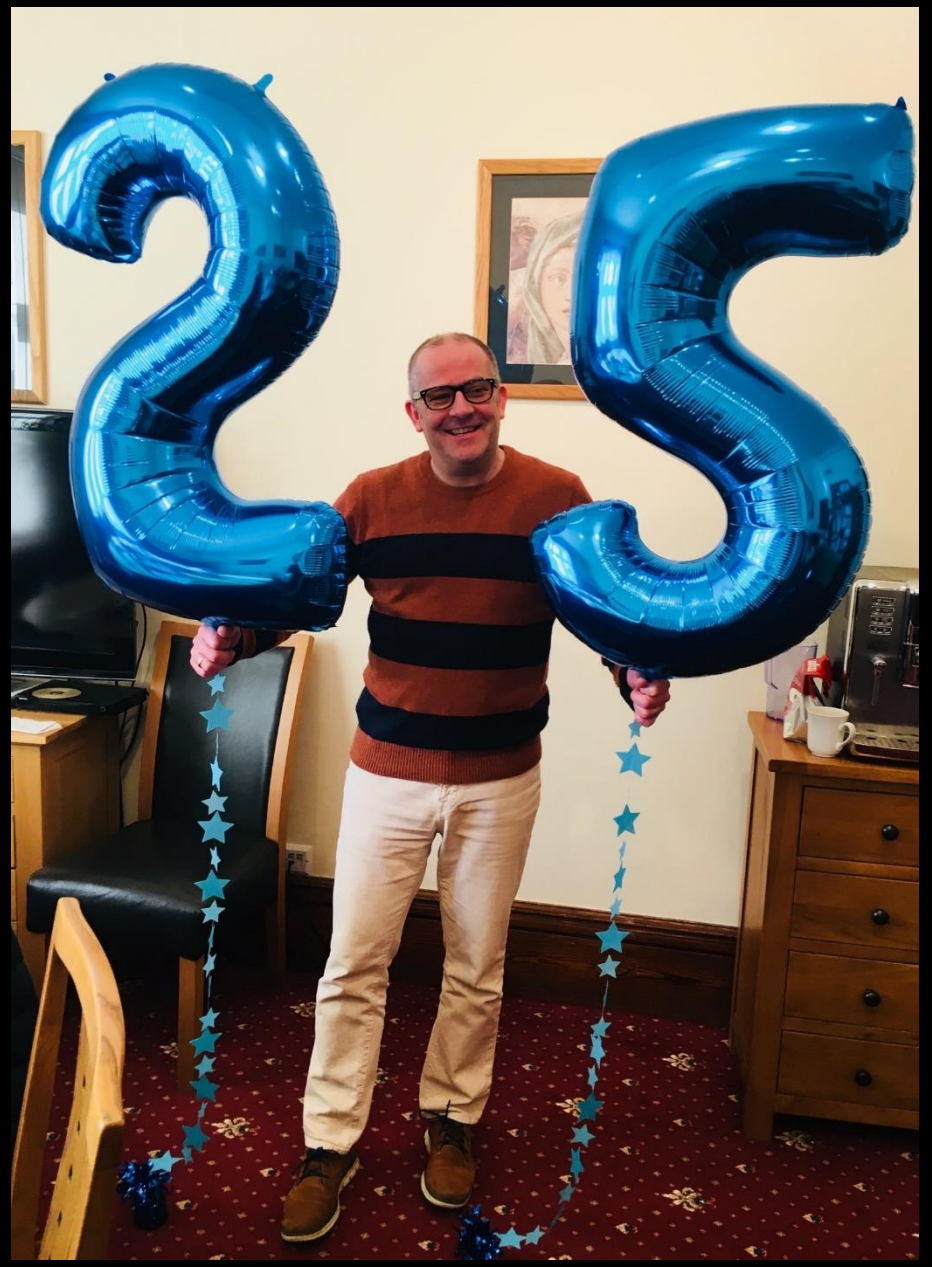
Jake Lukas RSW
MBASW

Registered Social Worker
Chief Executive

Joined in 1993
Live in House parent

"If your decisions are always in the best interests of the people in your care, they cant be wrong"

1993 -2017
Live in House parent
Senior House Parent
Day Care & Activities Manager
Training Manager
Head of Care
Head of Care Services
Executive Manager
Chief Executive RSW MBASW



1963-Students Cycling
2016-Students Reunion

Developmental or Complex Trauma

- The majority of children referred to Cotswold Chine School will have been exposed to multiple traumatic events impacting on immediate and long-term outcomes
- (complex trauma, see Briere & Scott, 2006).

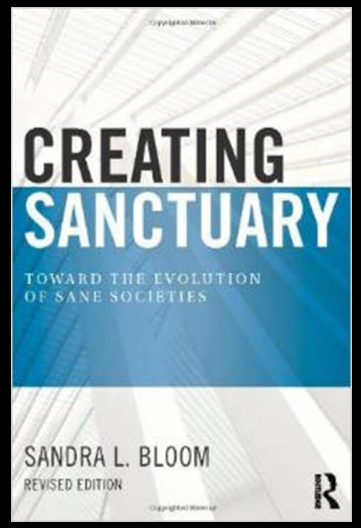
- This is also described as developmental trauma, defined as exposure to multiple or chronic interpersonal trauma, with early onset, impacting upon development. If this occurs within the family it can affect and undermine attachment with key safety figures.
- (See Cook et al, 2005; van der Kolk, 2005).

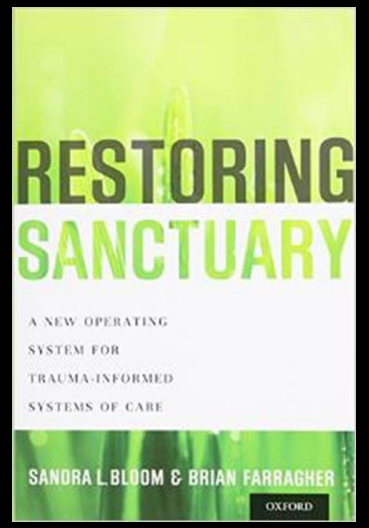
Sandra Bloom, M.D. is a Board-Certified psychiatrist

From 1980-2001, Dr Bloom served as Founder and Executive Director of the Sanctuary programs, inpatient psychiatric programs for the treatment of trauma.

Dr Bloom is a Past-President of the International Society for Traumatic Stress Studies and presently co-chairs the ACEs Task Force for Philadelphia as well as the Campaign for Trauma-Informed Policy and Practice, based in Washington, D.C.

Establish Safety





- **Physical safety**
- **Social safety**
- **Psychological safety**
- **Moral safety**

We cannot function when we feel unsafe. Brain responses are impaired, thinking becomes primarily focused upon establishing safety, fight , flight, freeze, or even submit responses.

In addition to safety itself we need to help children develop the ability to gain a sense of safety. Once a sense of safety is established the child is free to explore and develop fully, based on his / her own interests and capacities.

The Sanctuary Model

The Sanctuary® Model is a blueprint for clinical and organisational change which, at its core, promotes safety and recovery from adversity through the active creation of a trauma-informed community. A recognition that trauma is pervasive in the experience of human beings forms the basis for the Sanctuary Model's focus not only on the people who seek treatment, but equally on the people and systems who provide that treatment.

Traumatic Events

Examples of traumatic events could be but are not limited to:

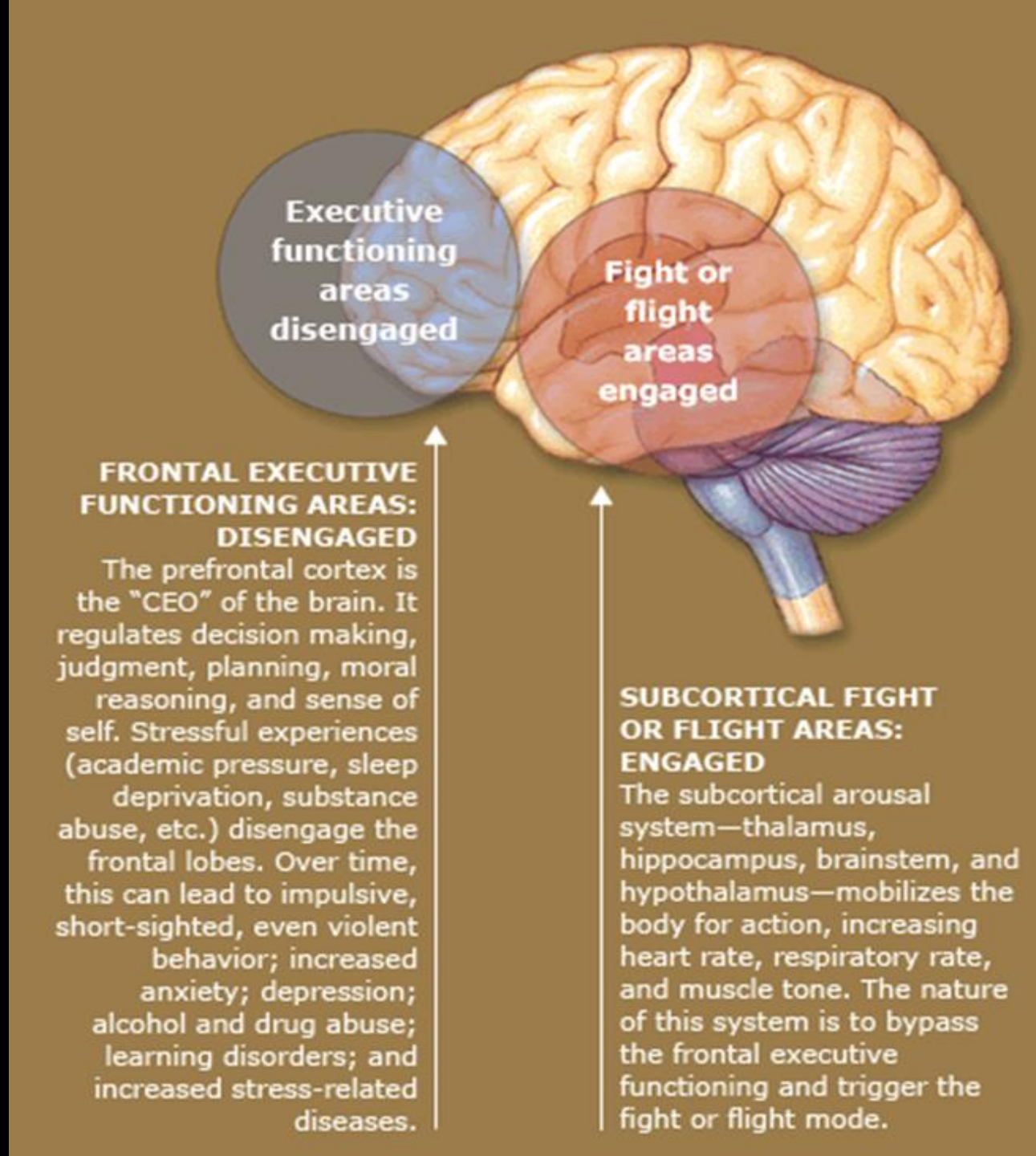
Violent personal assaults, sexual assaults, physical attack, neglect, witnessing domestic abuse, community violence, school violence, traumatic loss, medical trauma, natural disasters, and war.

Many people believe that serious threats to ones safety or the safety of others, sexual harassment and various manifestations of psychological abuse is also traumatic. Similarly being taken into care, or living in care could also be viewed in some cases as a traumatic events particularly through the eyes of children.

Adapted from Bloom 2011,

Impact of Trauma on the Brain

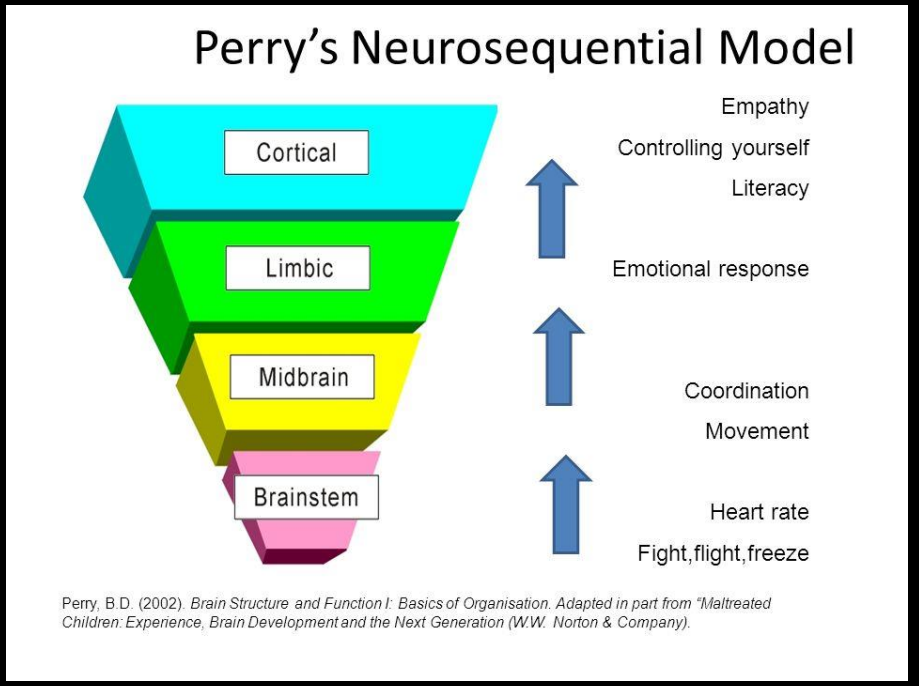
- If there is danger, the "thinking" brain shuts down, allowing the "doing" brain to act
- Traumatised children experience changes in brain structures, neuro-chemistry & genetic expression

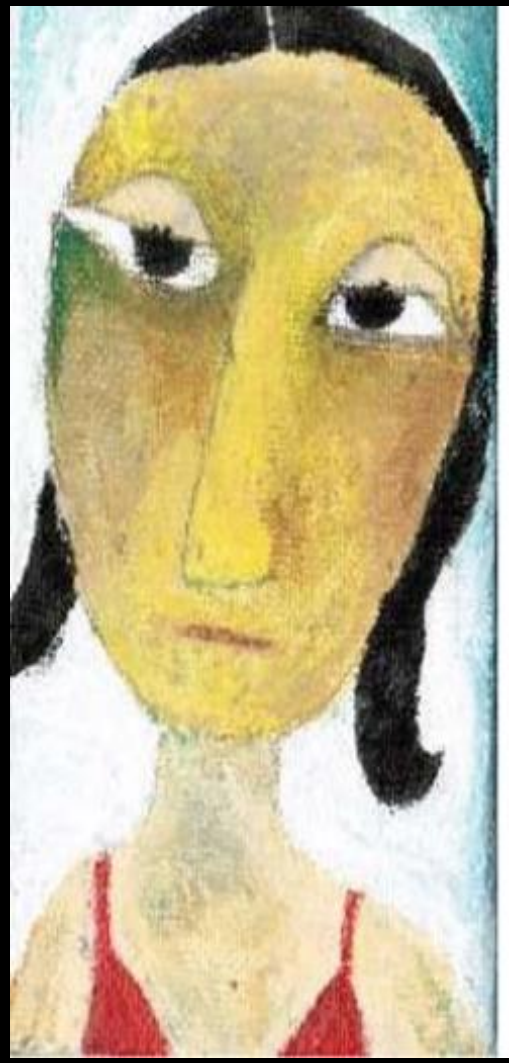


- Top down when you feel fearful, under threat, brainstem kicks in, managing information, and tries to solve problems, very differently

- You move to lower part of the brain as you feel more threatened, residing in the brain stem when you feel particularly terrified.

- This is **helpful** if your trying to avoid being hit by a car, or immediately need to remove your hand from a hot radiator with no time to process.





"long after the danger is past, traumatized people relive the event as though it were continually recurring in the present."

(Herman, 1992, 37)

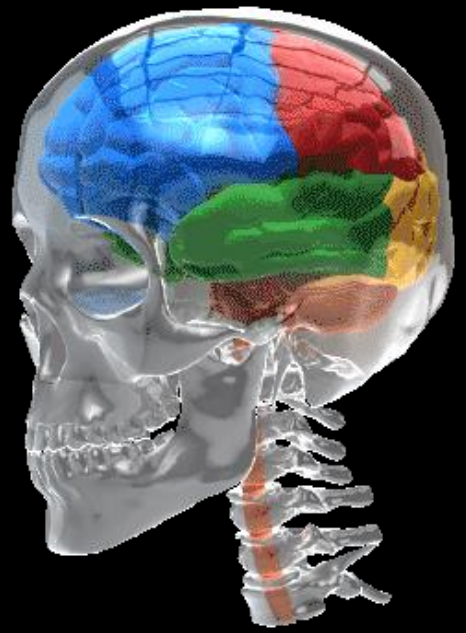
traumatic reactions

Fight!
Flight!
Freeze!
Submit!

Traumatised individuals will often seem frozen in time, unable to move past the trauma and destined to relive it.

Trauma Effects the Whole Person

- “The Brain is organised in a hierarchical fashion, such that all incoming sensory input first enters the lower parts of the brain” Perry 1999
- The brain has 3 main parts, which operate bottom up, brain stem, reptilian brain, basic bodily functions, then limbic system or emotional brain, pre frontal cortex, rational thought and analysis. During trauma your brains rational thought and analysis capabilities are disabled.



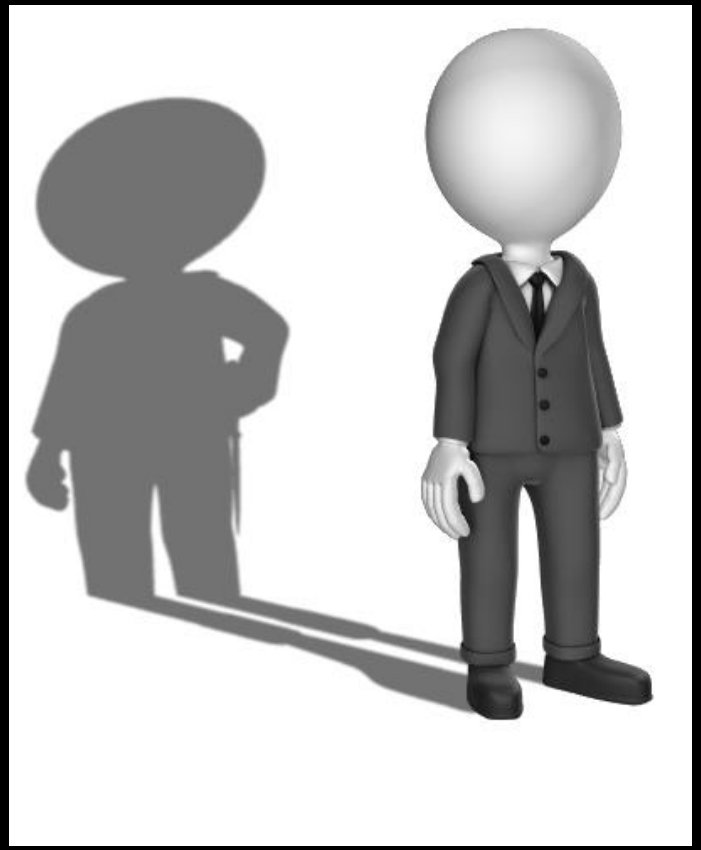
Survival is more important than reasoning

- Everything about us our minds our brains and our bodies leads to collaboration, social systems, this is our most powerful survival strategy.

- Problem solving in the **neocortex** is philosophical and well thought through

- Problem solving in the limbic and **diencephalon** is emotional and ultimately reactive

- Problem solving in the **brainstem** is reacting and you're essentially not thinking.



Risk Taking

- If your fight flight freeze response is upset during an event it permanently increases your stress and anxiety levels, which can lead to harmful adrenalin type behaviours, many traumatised people seem to seek out risk taking experiences.

- Traumatised people often return to the source of their trauma, this is particular prevalent in people returning to the place and people who abused them,

  - "if I cant be safe anywhere I had just as well be unsafe where its feels familiar"

  - "sometimes we prefer to certainty of misery then the misery of uncertainty" Perry 2002

Trauma Theory-Deals with the results of trauma experiences on behaviour. It also asserts that organisations act like people. When placed under stress by challenging behaviour (the trauma) the organisation starts to act like a person with the emergence of dysfunctional thinking and responses.

What did Trauma Organised look like for our children and young people?

Risk Taking-Traumatised people often return to the source of their trauma
Dissociation (disconnect the consciousness from what is happening).
Becoming a coping strategy that is used whenever the survivor feels overwhelmed.

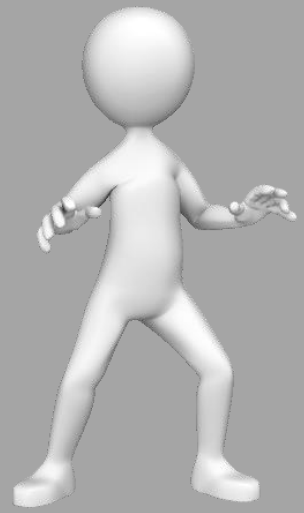
Feeling **isolated**
Body memories associated with the trauma that are difficult to put into words **Flashbacks**

Alexithymia (the inability to name a feeling, identify emotion or have a defined sense of self)
Intense emotions and difficulties managing these

Hyperarousal is a primary symptom of post-traumatic stress disorder (PTSD). It occurs when a person's body suddenly kicks into high alert as a result of thinking about their trauma

Hypo-arousal, or a freeze response, may cause feelings of emotional numbness, emptiness, or paralysis

Difficulty forming and maintaining relationships
Disrupted social functioning
Physical and emotional illness
Little sense of a **positive future**



Loss of safety: The world becomes a place where anything can happen.

Loss of danger cues: How do you know what is dangerous when someone you trust hurts you and this is then your 'normal?'

Loss of trust: This is especially true if the abuser is a family member or a close family friend.

Shame: Huge, overwhelming, debilitating shame. As a child, even getting something wrong can trigger the shame. The child may grow into an adult who cannot bear to be in the wrong because it is such a trigger.

Loss of intimacy: For survivors of sexual abuse, relationships can be something to avoid.

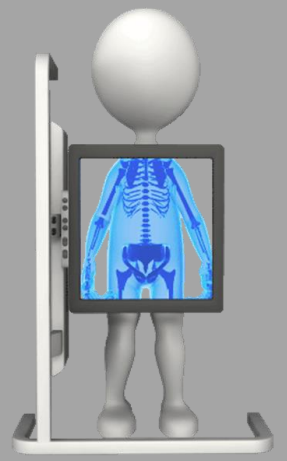
Loss of **self-worth:**

Multiple placements with multiple new and **broken care relationships**

High levels of restraint and incidents of **aggression and violence**

Medicalised models of care repeating trauma

Lack of person centred care that promotes identity and a positive future



What does Trauma Organised look like in ourselves and our environment?

- The chronically stressed organisation
- Fear of service users and management
- Chronic frustration and anger.
- Feelings can be vented towards services users as a safer target then management.
- Feelings of helplessness in the face of the complexity of service user
- problems and the dysfunction of the team/ service.
- Increasingly crisis orientated service leading to feelings of hyperarousal amongst staff and a climate of anxiety in the service.
- Increased emphasis on control measures leading to more conflict with service users
- Experienced staff leave taking with them the memory of previous approaches
- Communication breaks down between teams and between disciplines leading to increasing levels of frustration
- Interpersonal conflicts increase generating further hostility that is mirrored by relationships between service users
- Teams become fragmented and split leading to inconsistent management and more violence from service users
- Emotional exhaustion leads to burnout and a decrease in staff ability to emotionally engage decreasing clinical effectiveness. Staff feel deskilled, devalued and beleaguered continually fearful of when the next reorganisation will be announced

Everything about us our minds our brains and our bodies leads to collaboration, through social systems, this is our most powerful survival strategy.

"Dr Bruce Perry tells us that the bottom line is that the human brain is a remarkable organ, it mediates all of our thinking all of our functioning"

The way your brain allows you to have smooth motor control, think and solve problems, allows you to form and maintain relationships,

is ALL STATE DEPENDANT

We tend to solve routine problems by applying old problem solving paradigms, as you can become more emotional your thinking becomes less sophisticated.

There was an important job to be done and Everybody was sure that Somebody would do it.

Anybody could have done it, but Nobody did it.

Somebody got angry about that because it was Everybodys job.

Everybody thought that Anybody could do it, but Nobody realized that Everybody wouldn't do it.

It ended up that Everybody blamed Somebody when Nobody did what Anybody could have done.

Staff need information:
We are so needy of this resource that if we cant get the real thing we just make it up.

Trauma Informed

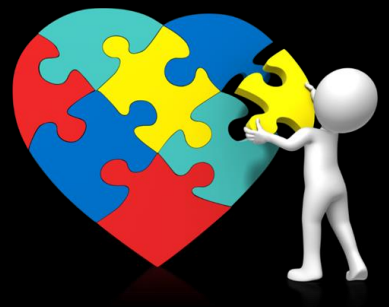
Trauma Informed
Trauma Responsive
Trauma Specific

The most elemental aspect of becoming Trauma Informed is education. Trauma recovery begins with psychological education or education about the self.

ACE Aware

The majority of children referred to Cotswold Chine School will have been exposed to multiple traumatic events impacting on immediate and long-term outcomes, a history of adverse childhood experiences and developmental trauma.

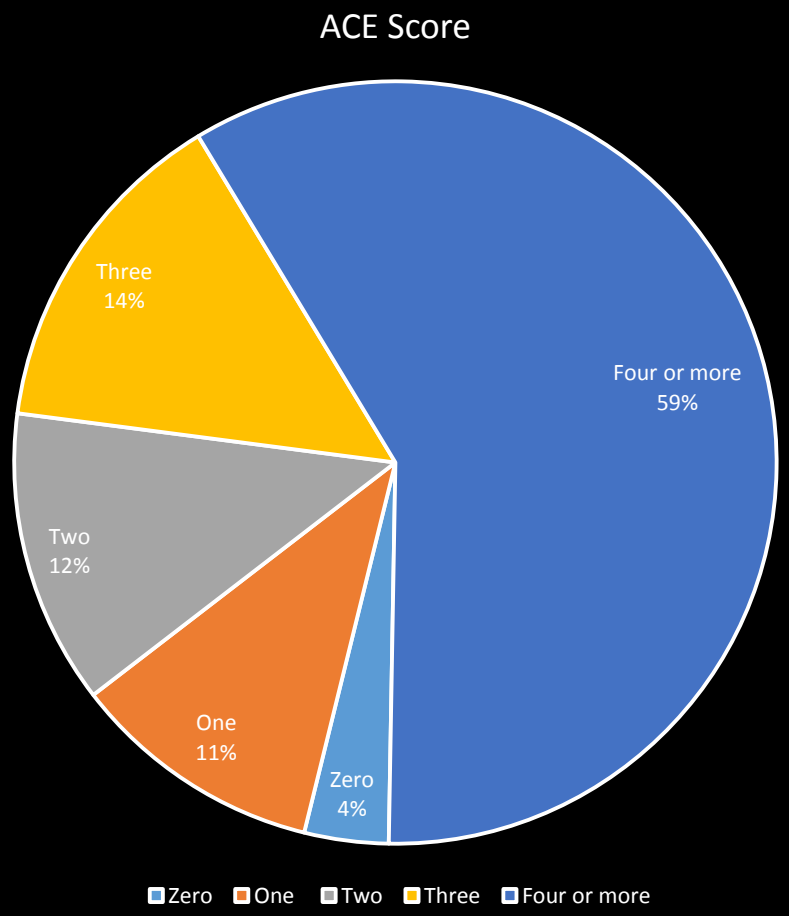
Based on data for 56 children & young people (aged 7-19 years old) at Cotswold Chine School 60% of have ACES scores of 4 and above with 20% having a score of 8

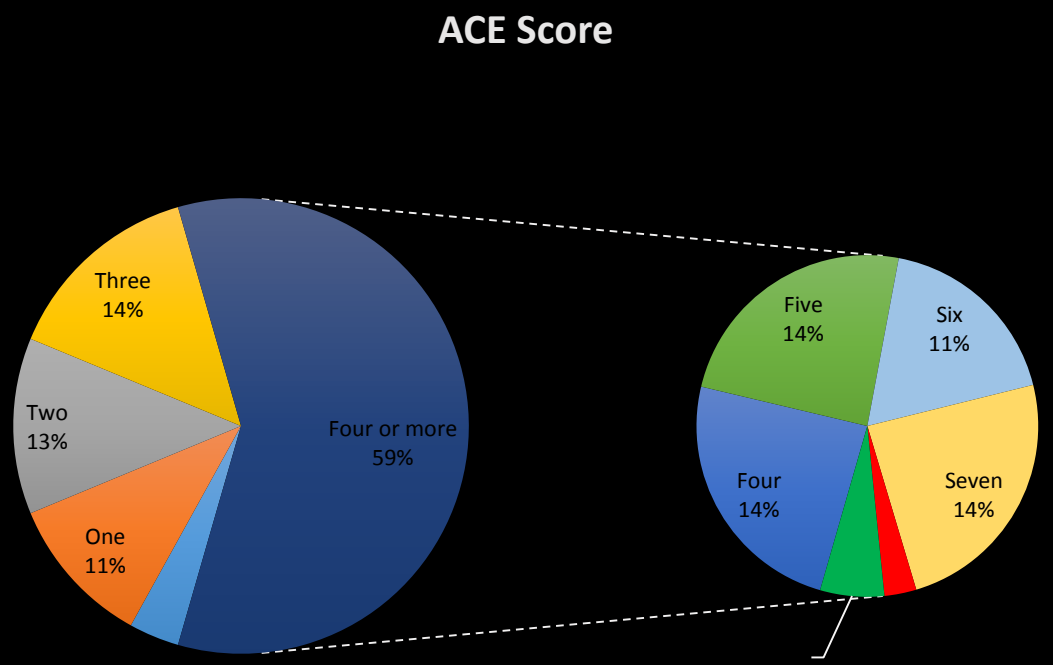


ACES Adverse Childhood Experiences

ACE Score	%
Zero	3%
One	10%
Two	12%
Three	14%
Four	14%
Five	14%
Six	10%
Seven	14%
Eight	2%
Nine	3%

Zero	3%
One	10%
Two	12%
Three	14%
Four or more	59%





Based on data for 56 young people (aged 7-19 years old) at Cotswold Chine School who have been assessed and scored using 9 items from the Adverse Childhood Experience (ACE) Questionnaire.

Novalis Trust

- Novalis Trust is a charity that operates Cotswold Chine School and Paradise House. Founded in 1954 we provide for the education of children, young people and adults, including those with emotional and behavioural difficulties, and special learning needs.
-
    - Novalis Trust has an established practice model which is:
    - trauma informed, attachment focused and relationship based, implemented through a low arousal socially safe and sensitive environmental approach.

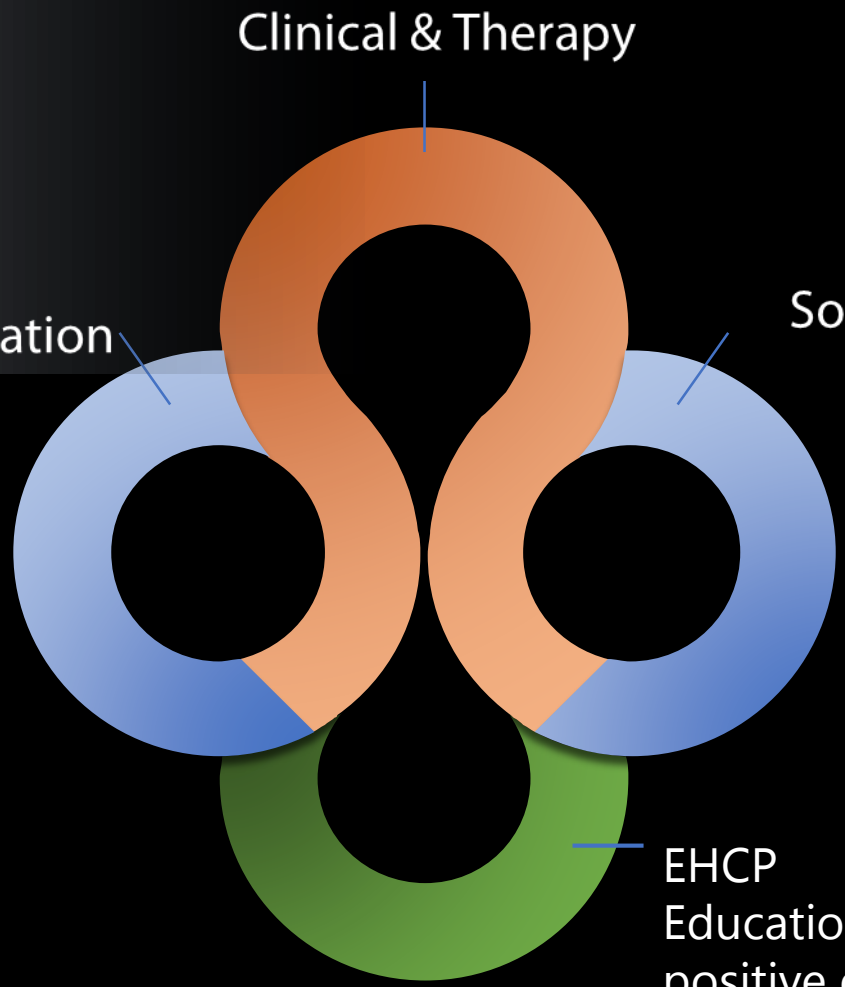
- Cotswold Chine School, is for children and young people with complex needs and associated social, emotional and behavioural difficulties.
- 42 residential pupils (aged between 7 and 21) and 18 day pupils, giving a total admission number of 60. the majority of young people have experienced childhood trauma and adversity.

The Novalis Model of Approach

Trauma Informed, Attachment Focused, Relationship Based, Evidenced Supported, Low Arousal Therapeutic School & Home Where Children & Young People Live

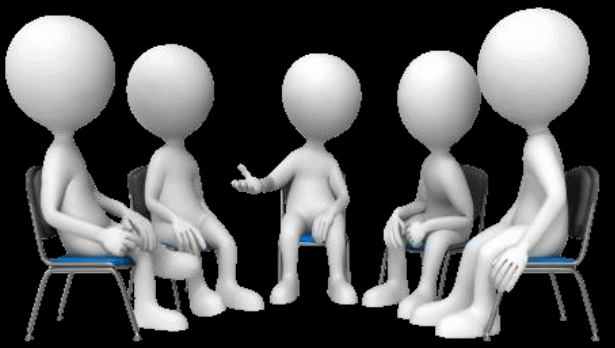
Cotswold Chine School

Trauma Informed
Attachment Focused
Relationship Based
Evidence Supported
Low Arousal Therapeutic School &
Home Where Children and Young People Live



The Novalis Model & Approach

Trauma Informed- means that children and adults who have been traumatised can be supported by trauma informed staff to recover and feel safe.



Attachment Focused

- **Attachment Focused**-is established by facilitating a secure attachment with care staff and teachers.
- Staff are trained to express empathy and acceptance of young peoples particular needs. At the same time staff are supported to encourage the young peoples ability to form positive relationships with key adults.
- Within the safety of these relationships, young people are able to finally face and resolve difficulties.
- Young people at Cotswold Chine gradually develop a secure attachment and a positive sense of themselves, this encourages skills of emotional regulation, self care and life skills ready for moving on.

Relationship Based

- Relationship Based-children young people and adults thrive through the establishment of positive relationships. Good relational health promotes a sense of physical, psychological, social and moral safety, a learning environment where needs are met and achievements are celebrated by everyone.

School Celebration Day 2016-2017

Evidence Supported Practice
Practice Supported Evidence

- The school regularly reviews the quality of education, care and health in a number of ways.
- EHCP, (Education, Health, Care Plans) therapy goals and other outcomes
- Practitioner Expertise
- Young people and staff consultations / questionnaires, interviews, supervision and appraisals.
- Research outcomes and expertise in collaboration with academic and professionals working in the field.

Low Arousal Therapeutic School & Home where Children Live

- Cotswold Chine Schools low arousal Therapeutic Approach provides an environment in which young people are likely to be more relaxed than would otherwise be the case.
- The school and home environments play a key role in managing arousal levels, keeping anxiety, stress and sensory stimulation under control.

- Reducing sensory information in the environment such as noise, strong lighting and bold colour schemes helps.
- Enabling young people to remain calm, relaxed and free to engage in educational and leisure activities and to interact with other people.
- Providing an environment in which stress is reduced is, therefore, a core element of the school and home.

- Some young people have sensory difficulties and needs. The low arousal Therapeutic Approach enables people to engage more effectively in educational and leisure activities and to interact with other people.

How have we done this?

- Adopting the 6 Core Strategies
- Creating and teaching a Trauma Informed level 4 diploma award to all our staff
- Training in the NMT
- Time In Meetings with Senior Staff
- Unannounced Visits to the homes to support
- Adopting Collaborative Problem Solving
  (particularly in the School)
- Creating new roles Clinical Therapy Assistants, Youth Support Workers
- Working with families

Training & Professional Development

- 17th November 2011 - CALM conference
- Trauma theory – David Leadbetter
- Positive behavioural support – Dr Chris Lee
- Trauma informed care – Ruth Warwick
- 16th February 2012 - CALM theory of attachment (Dr Brodie Paterson)
- February 2012 – DDP Level 1 (Dan Hughes)
- 2012 – CALM conference
- Defining our model (Jake Lukas)
- Trauma informed practice in the UK (David Leadbetter & Brodie Paterson)
- Introducing the sanctuary model (Dr Sandra Bloom, Dr Lyndra Bills & Dr Elizabeth Kuh)
- September 2012 – a Trauma informed school vs a trauma organised school (Dr Sandra Bloom)
- September 2012 – Trauma art narrative therapy (Dr Lyndra Bills)
- November 2018 – NMT group 2
- September 2019 – Systemic family work reflective workshop

- 28th October 2013 CALM conference 2013 (Dr Sandra Bloom)
- 13th October 2014 Sanctuary Launch Day
- 18th March 2016 Sanctuary Relaunch day
- 11th April 2016 6 steps to restraint reduction (Dr Kevin Huckshorn Dr Janice LeBel)
- 11th May 2016 3 Day Sanctuary Training
- January 2017 NMT group 1
- January 2018 TANT Training Level 1 (Dr Lyndra Bills)
- January 2018 Level 4 Trauma Informed Care
- October 2018 Conference
- Working with families from a trauma informed perspective
- (Dr Jeff Friedman)
- Working to reduce the use of seclusion and restraint
- (Dr Kevin Huckshorn Dr Janice LeBel)
- The amazing adolescent brain (Dr Liz Kuh)
- Building bridges initiative (Dr Janice LeBel)

- October 2018 – NMT phase 2 train the trainer

Successful de-escalation strategies and Positive Behaviour Support

Collection of most successful de-escalation strategies used with the young people and any near misses during the week

Data is fed into Support, Advice and Strategy meeting/ Clinical Therapy meeting to review effective strategies. Update to monthly Restrictive Practice Analysis report and individual Positive Support Plans

Direct training to staff on effective de-escalation strategies (informed by current data), relational health , near misses, lessons learned and proactive behaviour support. Training also informed by work and research by Dr Bruce Perry and Kevin Ann Huckshorn's Six Core Strategies

Consultation with staff team about de-escalation strategies that have been effective with young people and what lessons have been learned. Use of case studies.

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Training in the Six Core Strategies

Janice Lebel and Kevin Anne Huckshorn,
Restraint reduction & Creating positive cultures in care and education

The Six Core Strategies Are:

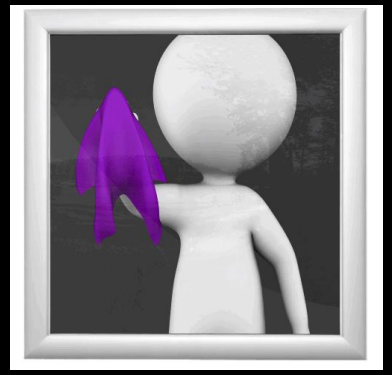
- Leadership in organisational culture change.
- Using data to inform practice.
- Workforce development.
- Inclusion of families and peers.
- Specific reduction interventions (using risk assessment, trauma assessment, crisis planning, sensory modulation and customer services).
- Rigorous debriefing.

Dyadic Developmental Psychotherapy

(Psychotherapy is a way of helping people find a way to tolerate what they are feeling and what they are experiencing within their bodies, Van Der Kalk 2018)

PACE

Playfulness, Acceptance, Curiosity Empathy



“Connection before Correction”

Dan Hughes 2010

A dialogue not a monologue

Playfulness

Its great to see you I thought I was going to be sat on my own again today!

I'm so forgetful have we met before?

Sorry for going on about this but I cant even remember what day it is sometimes it must be my age, can you help me with this.

Acceptance

I get it that you don't want to meet like this.

Well, I don't experience you as being bad, I see you make some mistakes at times like we all do, but not bad.

It's a really difficult feeling to carry around with you.

Curiosity

How does this seem to you?

Tell me about that.

You seem to be really looking forward to that.

You seem to be having a hard time, what is it?"

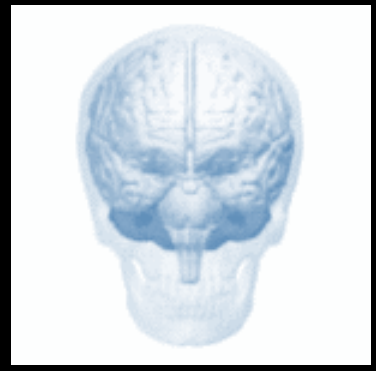
Empathy

My feeling is this is really hard for you.
I can see your worried about telling me how you feel.

I can see its difficult for you to hold on to these feelings.

It must be hard for you to think your not liked.

The Neurosequential Model of Therapeutics is a "trauma-informed," developmentally-sensitive, approach to the clinical problem solving process. It is not – and does not specifically imply, endorse or require – any single therapeutic technique or method.



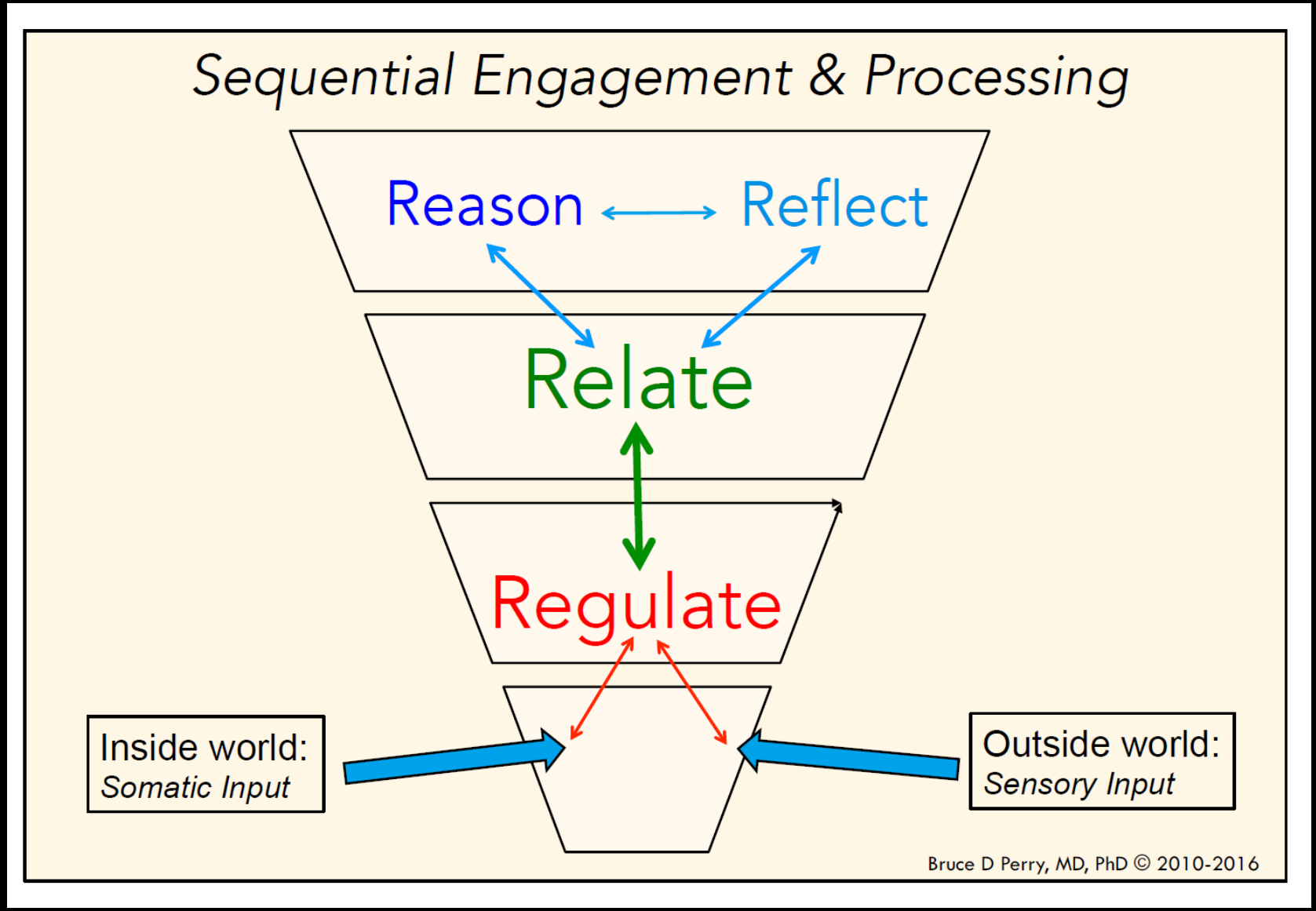
The children and young people we work with are often hyper aroused and hyper vigilant, they have experienced childhood trauma and adversity:

The state function with our young people means that they are often in an

arousal state,

An individuals true cognitive and relational capabilities cannot be accurately

determined until they are regulated.



Our Clinical & Therapeutic Provision

- Therapy Dogs
- Deputy therapy manager
- Clinical Psychologist
- Child and Adolescent Psychotherapist
- Occupational Therapists
- Health & Wellbeing Coordinator
- Speech and Language Therapists
- Music Therapists
- Clinical Therapy Practitioner
- Behaviour support analyst
- Teacher liaison
- Therapy Assistants
- Student Support
- Admissions Coordinator

COTSWOLD CHINE SCHOOL

Your Own Attachment Histories

Its argued that to undertake attachment focused work you should explore your own attachment history.

Identify which feelings stem from our histories and which ones stem from the child's history

Our own trauma experiences need to be understood and to some extent resolved.

"Since often the way we work with children has been influenced by the way we were brought up,

"I wonder what growing up was like for you?"

Safety Plans

A safety plan is one of the foundational tools of the Novalis Model. The goal is to have everyone using safety plan, and displaying them in some way to serve a s visual reminder of the need to manage emotions in the community.

Experience with trauma survivors over the years has shown that focusing on safety as an ongoing concern is vital. Survivors often have trouble identifying with safe behaviour and anticipating future events and the consequences of unsafe behaviour. Safety planning requires attending to the physical, psychological, social and moral elements of safety simultaneously and coming up with a plan for avoiding danger.

Qualification Specification

Level 4 Award in Trauma Informed Care

Level 4 Certificate in Trauma Informed Care

NOVALIS TRUST

1.2 Overview of knowledge, understanding and skills

These qualifications are designed for learners who wish to gain a deeper understanding of the effects of trauma, in order to inform their professional practice.

These qualifications consist of 10 units of which Units 1,2 and 3 must be taken for the Award and all 10 for the Certificate:

Unit 1 – The Context of Trauma Informed Care
This unit explores the prevalence of trauma and takes a general view of the individual, familial and societal impact of trauma. It considers how humans have evolved to be resilient to danger and covers historical approaches to trauma as well as current thinking for care of those affected by Post Traumatic Stress Disorder (PTSD) and Complex Trauma.

Unit 2 – The Impact of Toxic Stress and Adversity on Individuals
This unit considers the biological, social and relational impact of exposure to chronic stress and adversity. It explores the significant long term outcomes are for people exposed to childhood trauma, primarily using the ACES study. Finally it explores how this information can be used to inform the care of individuals who have experienced childhood adversity.

Unit 3 – The Role of Attachment and Relational Health in Trauma Informed Care
This unit introduces the key principles of attachment and relational health. It explores how neglect and abuse can determine an individual's attachment style which can impact on relational health throughout life. It considers the typical development of children and how this is facilitated by the key attachment relationships at the earliest stages of life. Finally it explores how attachment relationships support the development of our ability to deal with stress and adversity.

Unit 4 - Trauma Responsive Care
This unit asks learners to reflect on fundamental aspects of care and how they can be delivered in a way that is sensitive to individuals with Complex Trauma. This includes a range of aspects from safe environments to managing interpersonal relationships. The unit encourages the learner to explore how they are able to maintain safety, whilst supporting the individual in developing functional independence and a future unaffected by traumatic experience.

Unit 5 – Sensory Integration and Trauma Responsive Care

This unit introduces learners to the theory and principles of sensory processing and sensory integration. Many individuals who have been exposed to traumatic experiences have difficulties in this area and present with a range of associated behaviours. This unit will explore the types of sensory experiences that will support people to develop sensory and regulatory skills.

Unit 6 – Trauma Specific Therapeutic Interventions
This unit introduces key principles of therapeutic interventions for people who have experienced trauma, and explores specific interventions and how they support recovery. Learners will be encouraged to identify how they use therapeutic principles in their work and give examples.

Unit 7 – Trauma Organised Organisations
This unit takes the focus away from the effects of trauma on individuals and onto the caring organisation as a whole. It introduces learners to the concept of the "trauma organised organisation"; the idea that organisations, like people, can be negatively affected by adversity and stress. It will highlight how organisations can process the experiences of its members, and other stress factors, and can become organisationally stressed, resulting in chaotic and corrupt cultures.

Unit 8 – Trauma Responsive Organisations
This unit considers how organisations can become more responsive and resilient to trauma. It will consider the shared values of Trauma Responsive Care and how these contribute to effective provisions, as well as how the physical environment can create a safe and therapeutic environment for recovery.
The unit also aims to help learners to identify strategies and tools that can be introduced in the work place to create positive, safe cultures that can support those affected by trauma. Finally the unit will explore strategies to support group living and how organisations can reduce restraint and seclusion.

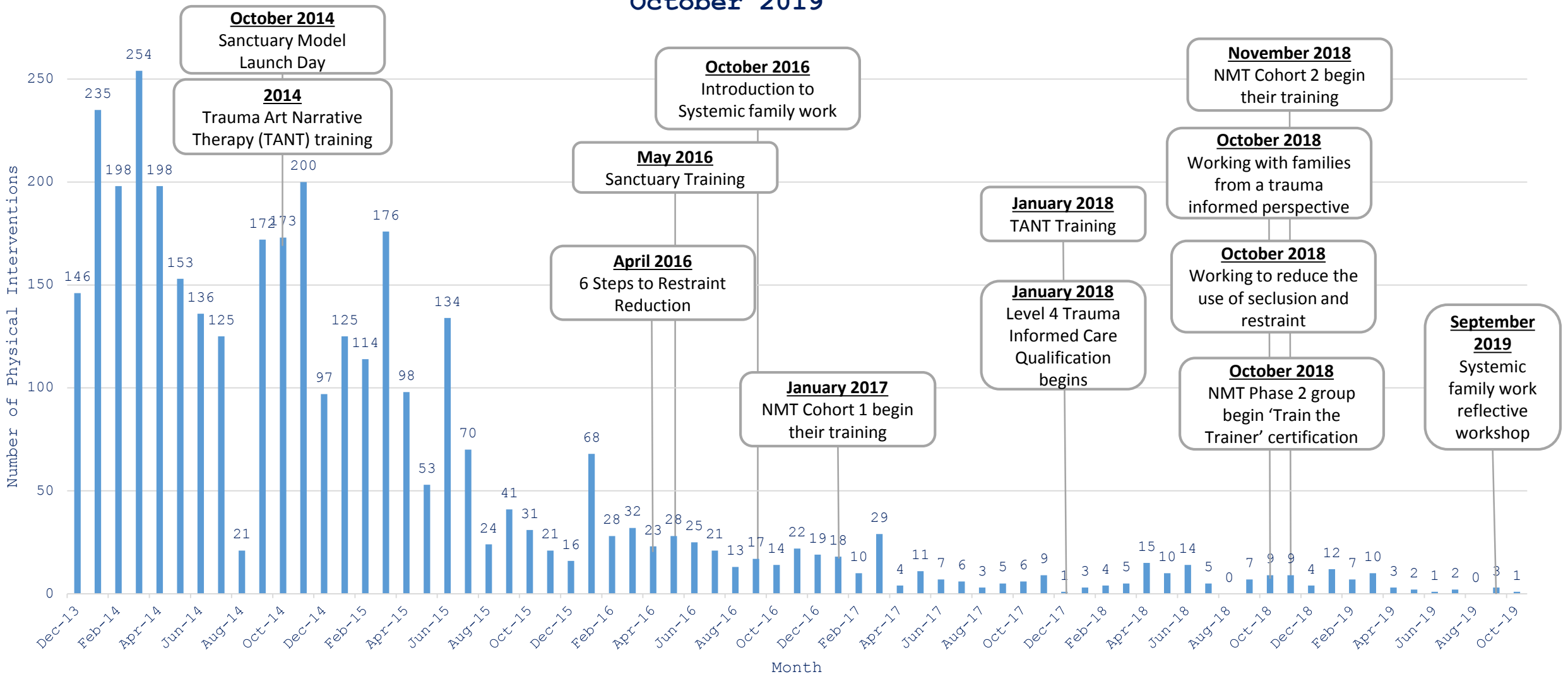
Unit 9 – Trauma Responsive Systems
This unit introduces learners to systems and structures that are important in effective trauma informed organisations. It aims to help learners understand the need for systematic processes in the planning, delivery and evaluation of services and how they can contribute to a safe, effective, therapeutic environment.

Unit 10 – Personal Growth, Development and Change in Trauma Responsive Care
This unit supports learners in understanding the importance of change and continual learning, both for carers and those in care, as well as change on an organisational level. It describes what trauma recovery looks like, and the stages and phases that individuals typically go through in order to heal and recover.
It also looks at the role of Continuing Professional Development and reflective practice in developing staff competence, as well as how to engage people in their own learning journeys.

Impact Outcomes:

The “So what”?

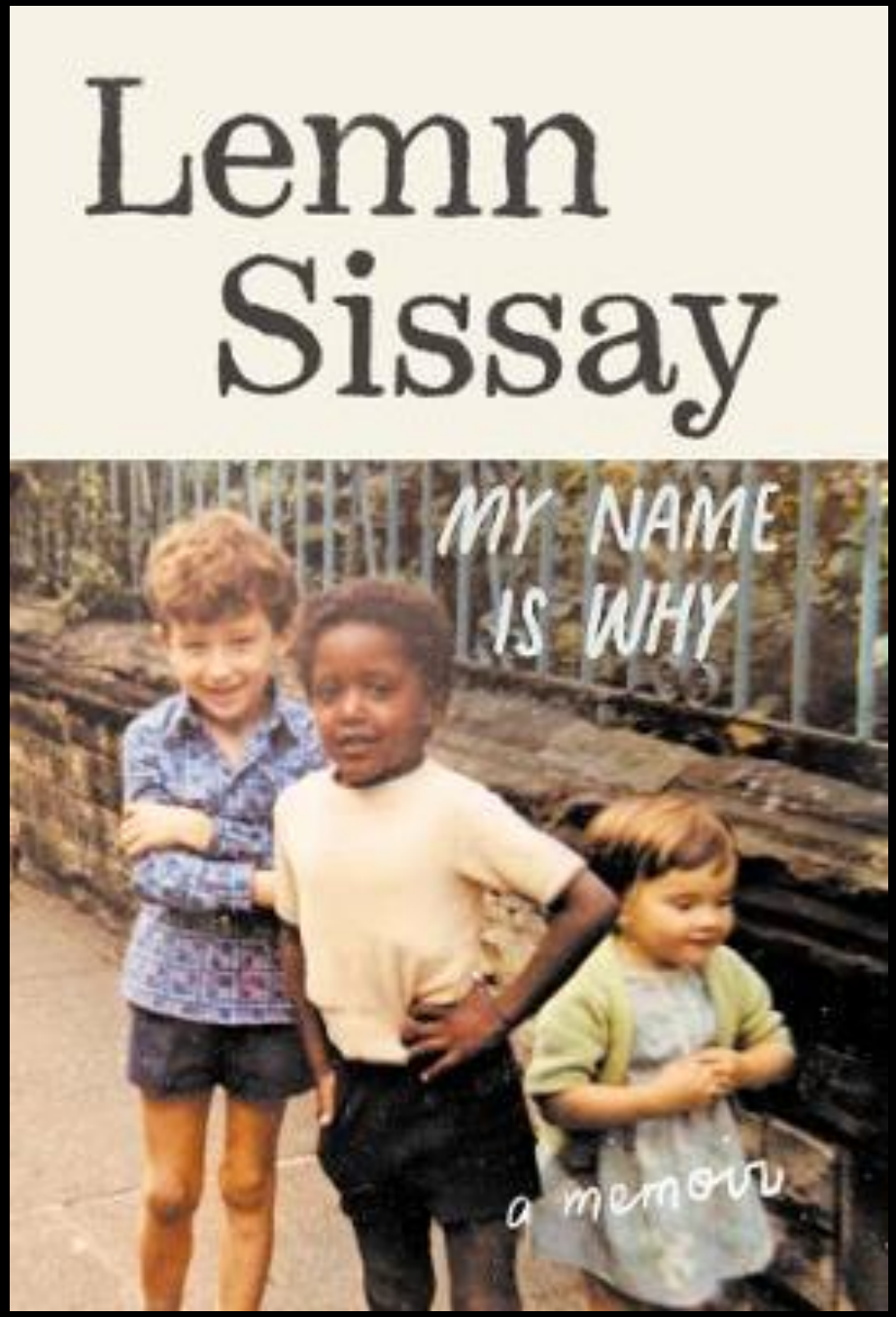
Restrictive Physical Interventions + Training Input : December 2013 - October 2019



For us its less about
Restraint Reduction & more about the
Promotion of Positive Rational Health

“Connection before Correction”

Dan Hughes 2010



Just after he was born in 1967, Sissay and his mother – a young Ethiopian student who had recently arrived in England – were taken to St Margaret's Home for Unmarried Mothers in Wigan. Their short stay ended when, against his mother's wishes, social services placed Lemn (renamed Norman by an insistent social worker) into "long term foster care" with a white, working-class Baptist family who lived in Ashton-in-Makerfield, south of Wigan.

When he was 12, tensions peaked and he was sent to a children's home.

He would spend the next five years – during which time his mental health deteriorated – in a succession of these loveless facilities. With unflinching honesty

Lemn Sissay MBE is a British author and broadcaster. Sissay was the official poet of the 2012 London Olympics, has been Chancellor of the University of Manchester since 2015.

“The assessments centres job was to keep us in order at all times-meal times-recreation, gardening, and education. Anyone who stepped out of line was beaten. There was no “outside” now: This was a lock up”

“The officers were mainly men. Men who wanted to be somewhere else. Men who didn’t hide their displeasure in us. Men who viewed us as weaklings. Men who got a rush out of fighting. Ex-police officers, ex-probation officers, ex-army officers. Weight lifting men. Men who stood like bouncers outside clubs. Men in the middle of divorces, men with drinking problems, men with sexual problems, men trying to forget that they were not who they wanted to be when they were boys like us. Men with anger issues. Broken men. Hurt men. Dangerous. Men who hated their dads”

Lemn Sissay

Why I use Aggressive Behaviour

"Aggressive behaviour starts when I'm in a bad mood or if I feel somebody is having a go at me, or if Im unable to control myself I need to take myself away from the group when I feel like Im going to get out of hand.

Then a restraint never needs to happen I need to talk about my problems.

I want a peaceful life and to live comfortably so if I feel in a bad mood I need to be asked to take myself away to calm my thoughts.

I am finding it difficult at the moment I am going to remove myself from this situation and chill out in my room and be mature to move myself away from the group so I don't cause a disturbance

email me what you think about it to talk to you later I am very sorry"

Jamie P Cotswold Chine Young Person email following Physical Intervention

“If you follow me, you want to fight me”

Young Persons first words during “time In” de-briefing

Boys at the Workbench

Inspired by the Mens Sheds Movement in Australia:

Dedicated to the memory of Vaughn Bowie

Young men distressed or even depressed by major life transitions may express aspects of this state in irritation, aggression and sometimes violence against themselves or others.

Our aim is to provide activities and experiences where they can regain a sense of meaning, direction and purpose.

Young men are often going through challenging and disorientating planned or un-planned life transitions and may lack a sense of belonging and purpose.

Some are not equipped with the skills or support networks to identify what is happening, how they are thinking and feeling how to express and work through it and when appropriate seek help to do so.

The workshop environment aims to creates a physical and emotional location where young men can experience being, belonging and becoming.

Raphael et al (1999)

Enabling them to regain a sense of meaning, direction and purpose by co-creating a young men friendly place and shared experience.

The “boys at the workbench” project is activity based manual activities around small projects such as making and restoring furniture, and creating items such as benches and garden furniture for local charities..

Creating a safe place where young men can engage in meaningful activities and begin to talk, and share, this is very much an extension of Novalis Models “Time in” approach to supporting children, young people, and staff.

Research has shown that a safe place for young men can begin to establish a link between depression, aggression and violence it could be expected that such places would in some instances have a positive impact on lowering the related aggressiveness.

Cochran, S. V., & Rabinowitz, F. E. (2000).

Time In ***Not*** Time Out

- Light touch type supervision can help children follow the routines and activities with encouragement and support when there could easily be an attempt for avoidance strategies and negative feelings to come into play.

- To be effective supervision needs to be presented with a positive attitude rather then a negative consequence of misbehaviour.

- Supervision should be seen as a “gift” and not a “punishment”.

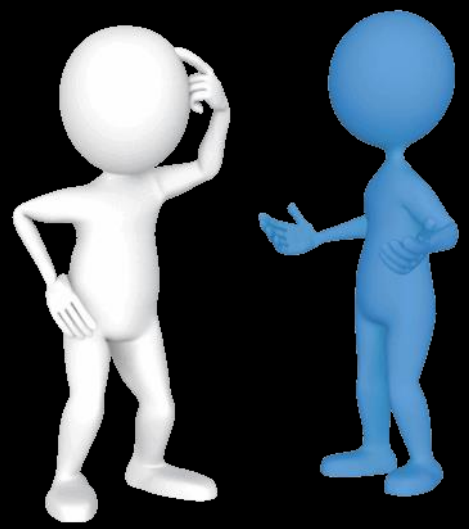
Emotional resilience can be developed through, a shared value base, positive relationships, reflective practice, support and empathy within likeminded people.

(Perry 2001)

Beware of Evaluation:

Evaluation can be a barrier to personal growth, positive evaluation can be as threatening in the long run as a negative one, since informing someone that they are good implies that you have the "right" to tell them they are bad.

The skill is to use the concept of empathy especially when working with young people in the need to give feedback or evaluate.



Structure & Predictability

- Groups should have clear and frequent rituals or routines, that make it evident that the young people are members of the group and as a result have a value. The routines are integrated parts of daily, weekly and yearly life schedules.

- They provide continuity within the group, they encourage the development of attachment as a central part of any young person and staff members identity. With patience and empathy, the child's active participation in these routines is calmly, firmly expected.

- A relationship that is characterised by attachment security, facilitates development within young people.

- Physical and emotional regulation, self reliance, resilience, social competence with peers, empathy for others, problem solving, intellectual development, communication and language skills, self integration and self worth.

Give Gentle Supervision

- Supervision provides a child with a sense of safety through basic physical proximity

- In the absence of close support children can fall into a pattern of negative attention seeking due to the fact that they are alone and cannot regulate their own emotions or anxieties.

- Light touch type supervision can help children follow the routines and activities with encouragement and support when there could easily be an attempt for avoidance strategies and negative feelings to come into play.

- To be effective supervision needs to be presented with a positive attitude rather then a negative consequence of misbehaviour.

- Supervision should be seen as a “gift” and not a “punishment”.

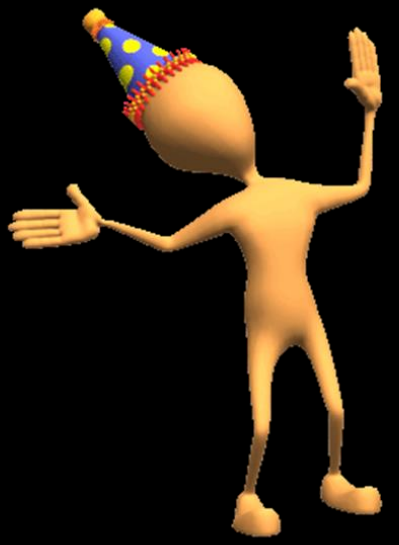
Relationship Repair not Relationship Withdrawal

- Daily life often presents circumstances that reduce the young peoples sense of safety.

- Conflict between young people, an unpredictable event, or something that brings back painful memories of the past can present as a sudden change in perceived safety and leave young people anxious and uncertain.

Humour with children allows for relationship repair often in times where negative affect states become too difficult for children to bear, laughter enables both adults and children to enter into a playful interaction……

Dan Hughes Attachment Focused Family Therapy 2007



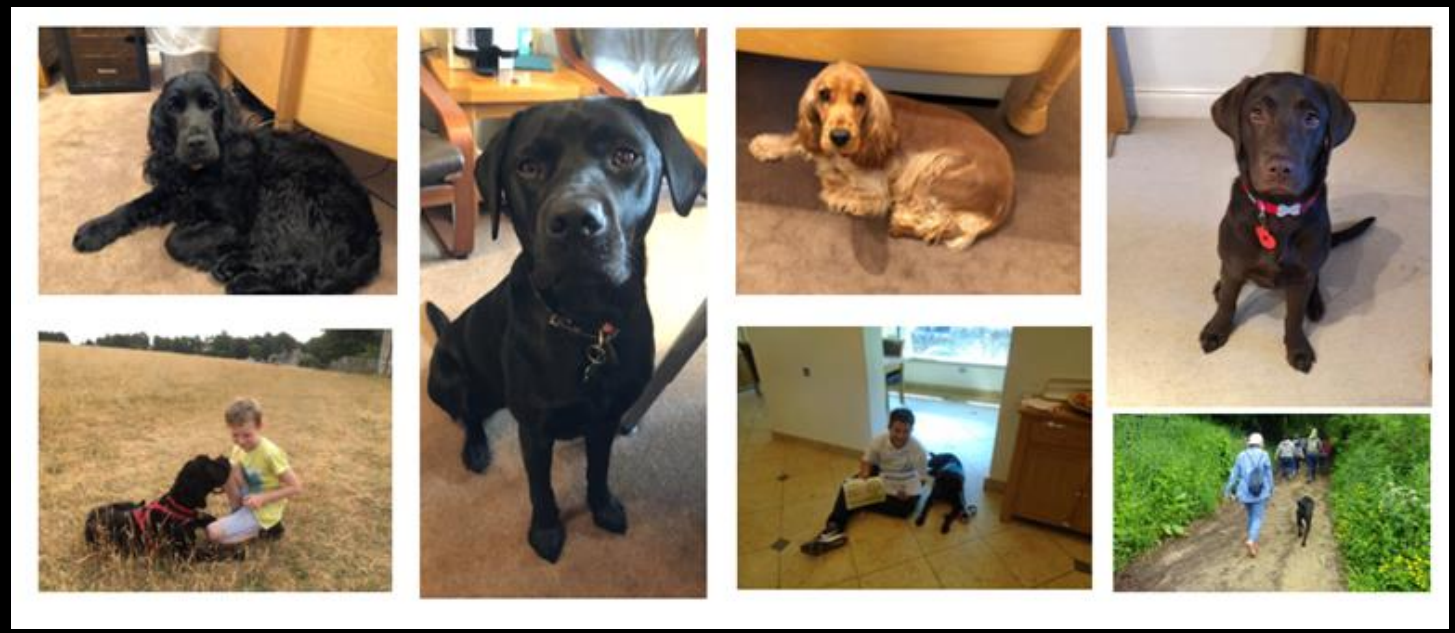
Healthy human beings enjoy laughing, playing, and having a good time. They experience humour as a form of personal and shared intimacy between people.

Dr Sandra Bloom Creating Sanctuary 1997

A Collaborative Relational Approach at Cotswold Chine School to Promote Positive Relational Health

"People Support what they help to create"

Kanter 1977



House Group Staff Team

The staff team for each house consist of Key workers, Youth Support Workers, and Therapy Assistants all of whom are assigned to support a particular Novalis Trust Clinician or Therapist.

The house group team collaborate to support the education, health and care needs of each young person

Key Workers

A Key Workers main area of focus is to act as a key safety attachment figure for young people

All young people need support and guidance from a key adult to develop a secure attachment and a positiv sense of themselves; this encourages skills of emotional regulation, self-care and life skills in preparation for adult life after the school.

Key workers are trained to support young people through

Life Story & Family Work, tasks relating to health and well-being and essentially acting as a key point of contact.

Youth Support Workers

Youth Support Workers: work closely with the young people's key workers and allocated class teachers in creating bespoke, individual and group activity plans to create the basis of a waking day curriculum.

They actively support young people at outside clubs and social groups safely for them to access community-based opportunities in line with their developmental needs.

They also fulfil a key role in assisting the promotion of healthy active lifestyles. Ensuring young people are consulted, and their views and wishes influence future activity and social group planning is an essential element of the role.

Clinical Therapy Assistants

Clinical & Therapy Assistants: are members of the clinical and therapy team participating in meetings as directed. Their role is to assist a nominated therapist in the implementation of therapeutic support strategies in the care, therapy and education settings. Techniques and therapy programs are always devised and directed by a qualified Clinician or Therapist. Clinical & Therapy Assistants will accompany a young people attending therapy sessions at the support centre, will then assist and support young people with their therapy or clinical goals outside of the session, this would typically be within the education department, home environment or out in public.

The aim is to help and empower young people to overcome any barriers they may have in their education, health and well-being. They evaluate progress and assist in the auditing and monitoring of Education, Health and Care Outcomes.

Working With Families

Family Liaison:

- Supporting communication and maintaining a link with the young persons family, relevant professionals and Cotswold Chine School
- Gathering information to form a greater understanding of the young people in our care
- Creating Genograms
- Meeting with families on a regular basis in their homes
- Supporting families to access Family Therapy
- Supporting transitions between home/school
- Supporting families during holiday periods
- Keeping in touch with past students and their families

An underlying philosophy in working with families

Families have a key role in decision making concerning their own children, and policies & procedures that impact on their well being.

Guiding principles

Families should be given accurate, understandable, and complete information necessary to support agreed goals, choices and placement objectives.

Families & Novalis Trust to embrace the concept of sharing decision making ensuring decisions are in the best interest of young people.

Novalis Trust to train and allocate resources to children and to families to support positive relational health.

How have we developed family work?

Working with Dr Jeff Friedman and Dr Liz Kuh

Regularly Training Sessions & weekly video conference calling clinical supervision.

The appointment and creation of a family liaison Manager.

Arranging Family events

Offering family work in review meetings

All family members are welcome and encouraged to attend:

Areas covered to date:

- Young people who have been adopted, children who have been fostered, birth parents.
- Treating intergenerational trauma, all family relationships, sibling subsystem work, and transition support for a young person becoming residential.
- Arranging and supporting families to enjoy time together, holidays, activities.
- The systemic affect on other school operations, personal items such as clothing, gifts, school trips, school activities
- The attachment “push pull” & the “intimacy barrier”.....

The Family Meeting Itself

- Where to sit
- How put everyone at ease, drinks, tissues, resources
- Establishing therapeutic goals
- Agreed frequency of meetings
- Exploring family rules
- Exploring family rituals
- Family myths

Lead follow lead follow

Mulberry Cottage
Family Room

Cotswold Chine
School

Lessons from Sessions:

- Know thyself
- Its exhausting
- Its emotional
- Its all about thinking and feeling
- Know your own triggers
- Know your own limitations
- Hearing difficult issues sometimes about life in the home
- Split loyalties

Know thy colleague

The need for authenticity

What to do when everyone speaks at once

Living with and being comfortable with the silence.....

Body language!!!

Working with Families

Intervention principles derived from trauma literature

Trauma survivors need to experience safety and relationships that are different from original relationships.

There needs to be opportunities for new experiences that can over time reduce the associations that have been built around the trauma.

These corrective experiences need to be consistent, predictable, patterned and frequent.

We can all learn to watch the State of the children we work with. When calm they can be creative, when alert they can handle the stress of learning, when alarmed however they don't learn well, when in fear learning is impossible, when in terror, they will struggle to remember anything and are in essence reacting.

Implications for Practice:

The majority of children referred to Cotswold Chine School will have been exposed to multiple traumatic events impacting on immediate and long-term outcomes, a history of adverse childhood experiences and developmental trauma.

- To promote positive relational health supervision is seen as a "gift" and not a "punishment".
- The importance of Staff training your only as good as your newest, least experience staff member.
- Good relational health is a protective factor in recovering from adverse childhood experiences.
- Reducing Restrictive Practices is an organisational responsibility.
- Strategies facilitating Time in not time out, time with the social group and not time alone.
- Children need to experience safety and relationships that are different from original relationships. Children need opportunities for new experiences that can over time reduce the associations that have been built around the trauma.
- Its important to work with families.
- These corrective experiences need to be consistent, predictable, patterned and repetitive Perry 2006

The “Knower & the “Doer”

The “Knower”

The “Doer"

With the Knower and the Doer we forget the most important person the “Knowing Doer”

If we were a computer

- Positive attachment is our operating system, and trauma is the virus.

- Good Relational Health is our Anti Virus software.

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Questions & Comments