

Bringing Hope to Child Welfare

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Questions #1-2

8/26/16



1. Memories are based upon:

- a) Recall of the stories we can tell
- b) Sensory fragments**

2. Procedural enactments are:

- a) Verbal narratives
- b) Non-verbal narratives**
- c) Acting older than one is
- d) Acting younger than one is

1. Pre= 81% Post= 95% Increase: 14%

2. Pre= 81% Post= 89% Increase: 8%

Questions #3-4



3. Young children with traumatic histories most often identify with the role of the:

- a) Victim
- b) Perpetrator**
- c) Protector

4. When one has lost developmental gains:

- a) Keep moving forward in order to not waste time
- b) If possible, take a break from treatment to reduce stress
- c) Recommend returning to the previous conditions wherein development was progressing**

3. Pre= 51% Post= 86% Increase: 35%

4. Pre= 81% Post= 86% Increase: 5%

Questions #5-9



5-8: Match the zones with associated feelings.

B 5. Feelings of loss and sadness

A- Green Zone

D 6. Feelings of being violated

B- Blue Zone

A 7. Feelings of safety, joy, and pride

C- Combo Zone

C 8. Feelings of fear

D- Red Zone

9. One cannot know how to work with a young child unless one gets a thorough history. FALSE

5. Pre= 93% Post= 95% Increase: 2%

6. Pre= 74% Post= 81% Increase: 7%

7. Pre= 100% Post= 97% Increase: -3%

8. Pre= 65% Post= 78% Increase: 13%

9. Pre= 42% Post= 89% Increase: 47%

Setting our Frame...

- Cultural Awareness Activity



Hope...



- **A visionary sees light in the dark...**
- “Hope is found in the willingness to endure pain and to embrace it...”
- “Hope is rooted in community and grows as we are present to one another...”

– From George Johnson, *Beyond Guilt*

What are the facts?

DCFS Facts in Los Angeles



- Almost 1 in 5 of youth emancipated from the child welfare system in LA County first entered the system when they were age 3 or younger
- Babies under age 1 make up almost 1 in 5 of our Foster Care Entry Population
- Children under 5 make up 45% of our foster care population
- Developmental screening done with DCFS, 78% had a mod to high risk for developmental delays

What are the facts?

Reentry of Infants into Foster Care



- Nearly 1 in 3 infants who were reunified with their parents returned to foster care
- Reentry rate generally higher than for older children
- For infants who were placed with relatives, nearly 1 in 7 returned to foster care

Source: Wulczyn, et al.,
The Foster Care Baby Boom Revisited



What are the facts?

National Statistics



- In 2010 alone, neglect accounts for 78% of all child maltreatment cases nationwide, far more than physical abuse (17%), sexual abuse (9%), and psychological abuse (8%) *combined*. *In Brief, The Science of Neglect*, pg 2.
- The vast majority of children who die as a result of child maltreatment are victims of neglect (70%), rather than other forms of child maltreatment (DHHS, 2013)
- "...estimate that over 80% of foster children they examined suffered from developmental, behavioral, or emotional problems (between two and eight times the national averages)." Stock & Fisher, 2006, Child Welfare League of America, pg. 446.

What are the costs?



- It has been estimated that child abuse and neglect imposes an annual cost of 80.3 billion to society (Gelles & Perlman, 2012)
- Given the devastating consequences of child maltreatment, both the World Health Organization (WHO) and the Center for Disease Control (CDC) have recognized child abuse and neglect as a major public health crisis (CDC, 2010, 2012; Fang et al., 2012; Putnam-Hornstein et al., 2011; WHO, 2013)

The cascade effect of neglect...



1. *Alters the biological stress response systems*
2. The deprivation of the early serve and return interpersonal engagement is damaging to brain networks
3. Damage to brain networks requires that the full effect of developmental lags be addressed across multiple brain systems

Consequences of child maltreatment



Disruptions in:

- 1) Neurobiological development
- 2) Physical development
- 3) Socio-emotional development
- 4) Behavioral development
- 5) Cognitive development



Adverse Childhood Experiences

- Linear increase in negative health/mental health outcomes as number of adverse childhood experiences increase
 - **Events include:**

Abuse

Physical Abuse

Emotional Abuse

Sexual Abuse

Neglect

Physical Neglect

Emotional Neglect

Household Dysfunction

Family Violence

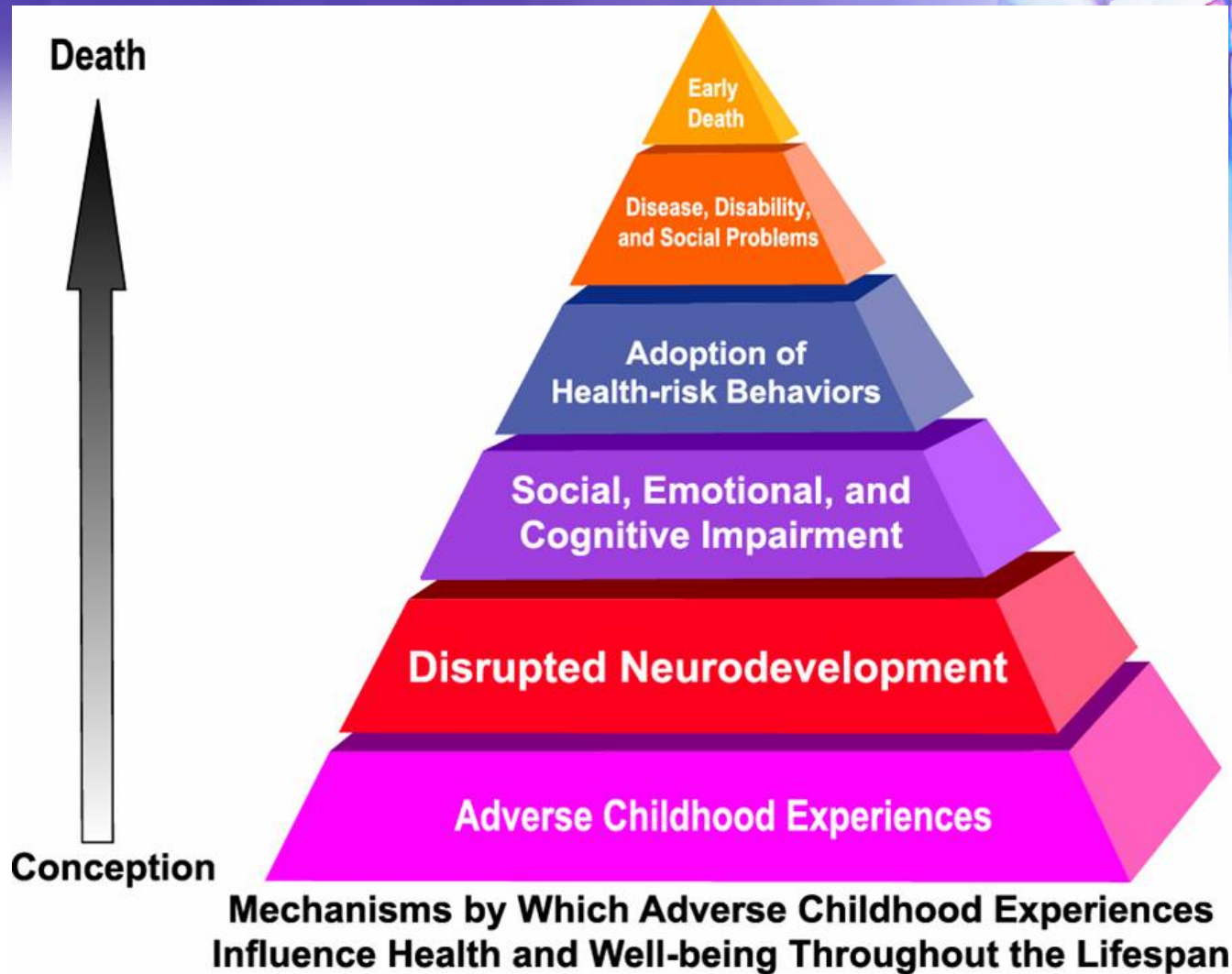
Parental Mental Illness

Separation or loss of a parent

Parental Incarceration

Parental Substance Abuse

The Progression of ACE's



- <http://www.yukonwellness.ca/stressbrain.php#.UYsTkKzN4U>

From Simple to Messy



- In terms of **messy public health problems**, the “lack of progress in effectively managing complex problems is due in part to the predominance of a particular approach to engagement called the ***isolated-impact approach*** (Kania & Kramer, 2011). In the isolated-impact approach, universities and communities collaborate to design and implement interventions that address a particular problem, with limited attention paid to the contextual factors that perpetuate the problem. Such interventions, if designed well and implemented with fidelity, ***may have strong short-term effects within a narrow range of outcomes for targeted populations, but the dynamics of the larger system that generated the problem remain unchanged.*** In addition, isolated-impact efforts are frequently conducted as stand-alone projects that are disconnected from other related efforts, ***thereby failing to realize the synergies possible with more coordinated strategies.*** Journal of Higher Education Outreach and Engagement, 2015.
- Solutions have to be complex, based in an ecological-transactional model

National Institute of Health & Mental Health



Category	Historical Position	Future Directions
Clinical Practice	Simple problems, simple solutions	Complex (dynamic systems - for “messy” problems)
Population Samples	Laboratory	Real-world
Category	Categorical Diagnoses, DSM	Underlying Dimensions, DSM no longer gold stand.
Research Methodologies	Linear	Non-linear, systems science
Research Perspectives	Isolated laboratories, “cottage industries”	Translational, Interdisciplinary, & Community-Based Participatory Research

The Neurorelational Framework (NRF)

“translates” what matters in early brain development into three clinical steps:



Three Core Concepts:

- Stress Resilience versus Toxic Stress
- “Serve & return” levels of high quality engagement
- Development of brain networks and circuits

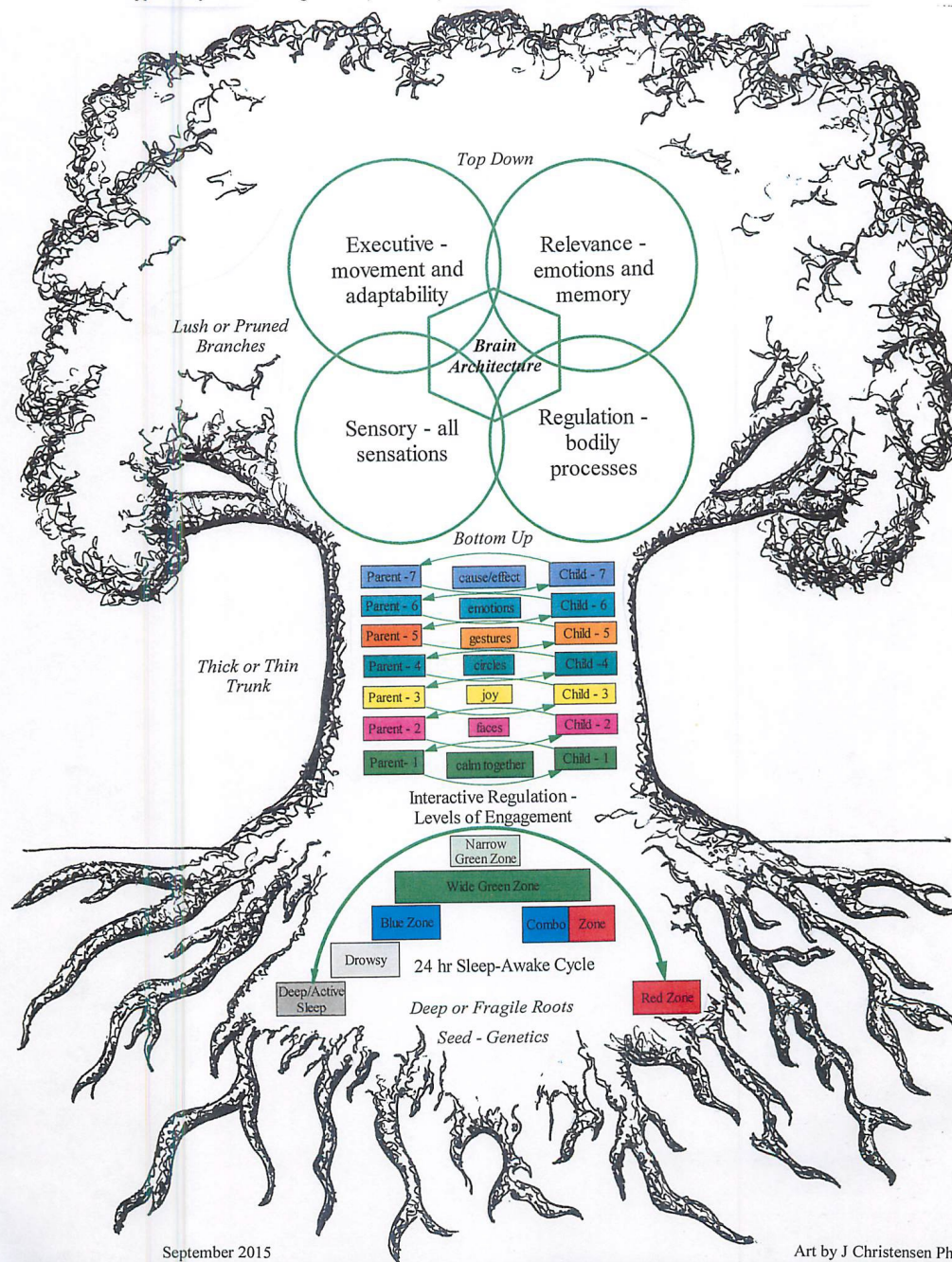
Harvard Child Development:

Assess & Intervene:

- *Step 1:* Adaptive vs. toxic stress
(roots to a tree)
- *Step 2:* Age appropriate vs. low levels of relational engagement
(trunk of a tree)
- *Step 3:* Age appropriate developmental & functional brain capacities vs. delays or disorders
(branches of a tree)

The Neurorelational Framework's Three Clinical Steps

C Lillas PhD (adapted from Lillas & Turnbull, 2009) with CA Hapchyn MD
Supported by Nathaniel Osgood PhD, University of Saskatchewan and the Interdisciplinary Training Institute



Independent Baby Court Team



- This not funded, hence, one case at a time
- This is not a national Zero To Three Safe Baby Court Team
- Differences include
 - Private non-legal (not in legal records) meetings with parents, legal team, and clinical team
 - Not mandatory, voluntary
 - Inter- to trans-disciplinary efforts; integrated by the Infant Mental Health Specialist (vs a court coordinator)
 - Use of video taping for mentoring birth parents and professional cross-system collaboration

Fostering Family Partnerships Philosophy



- #1 goal is to provide “best practice in concurrent planning” by stabilizing the infant’s relationships (step #1, 2, 3)
- #2 provide additional birth parent support through coaching and modeling for reunification
- #3 provide coaching and mentoring to all involved in infant’s life
- #4 support “shared parenting” approach between all parents
- #5 provide open-ended relationships for all parties

Fostering Family Partnerships Team



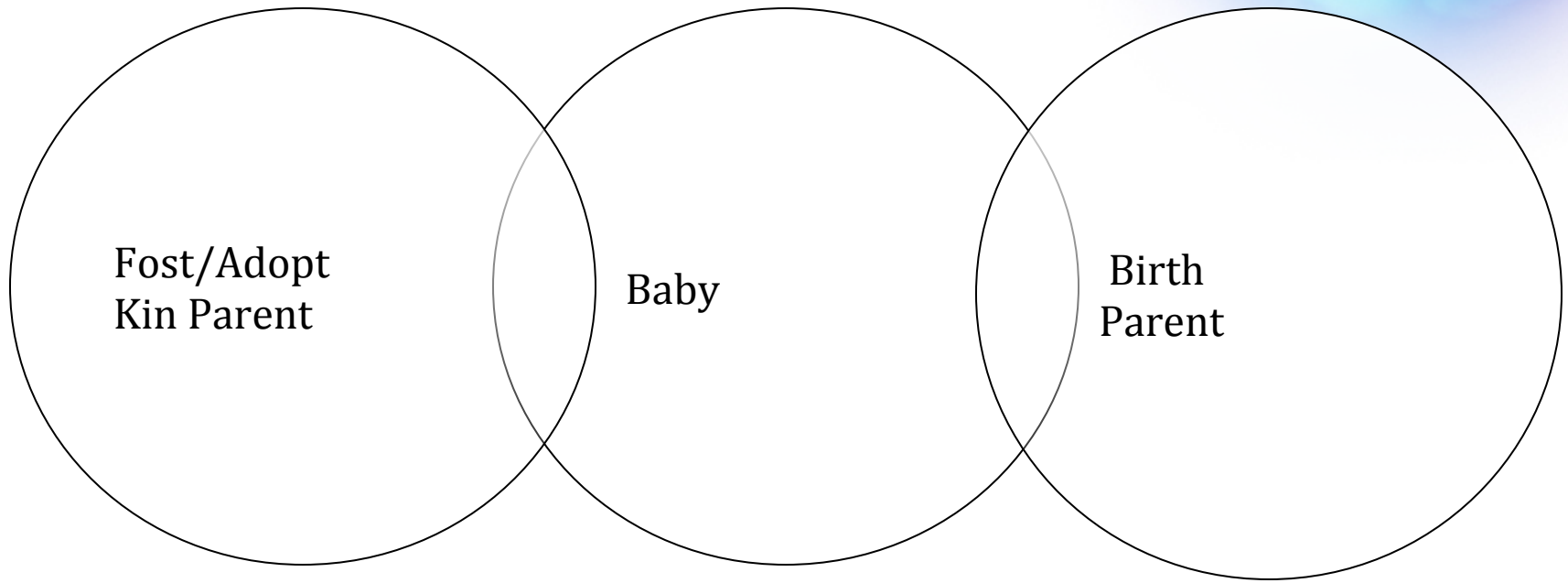
Team Members

- Judge Amy Pellman
- Patricia Vidal-King, Supervising Social Worker
- Angela Duran, Case Carrying Social Worker
- Amy Mejia, JD
 - The Alliance for Children's Rights Attorney

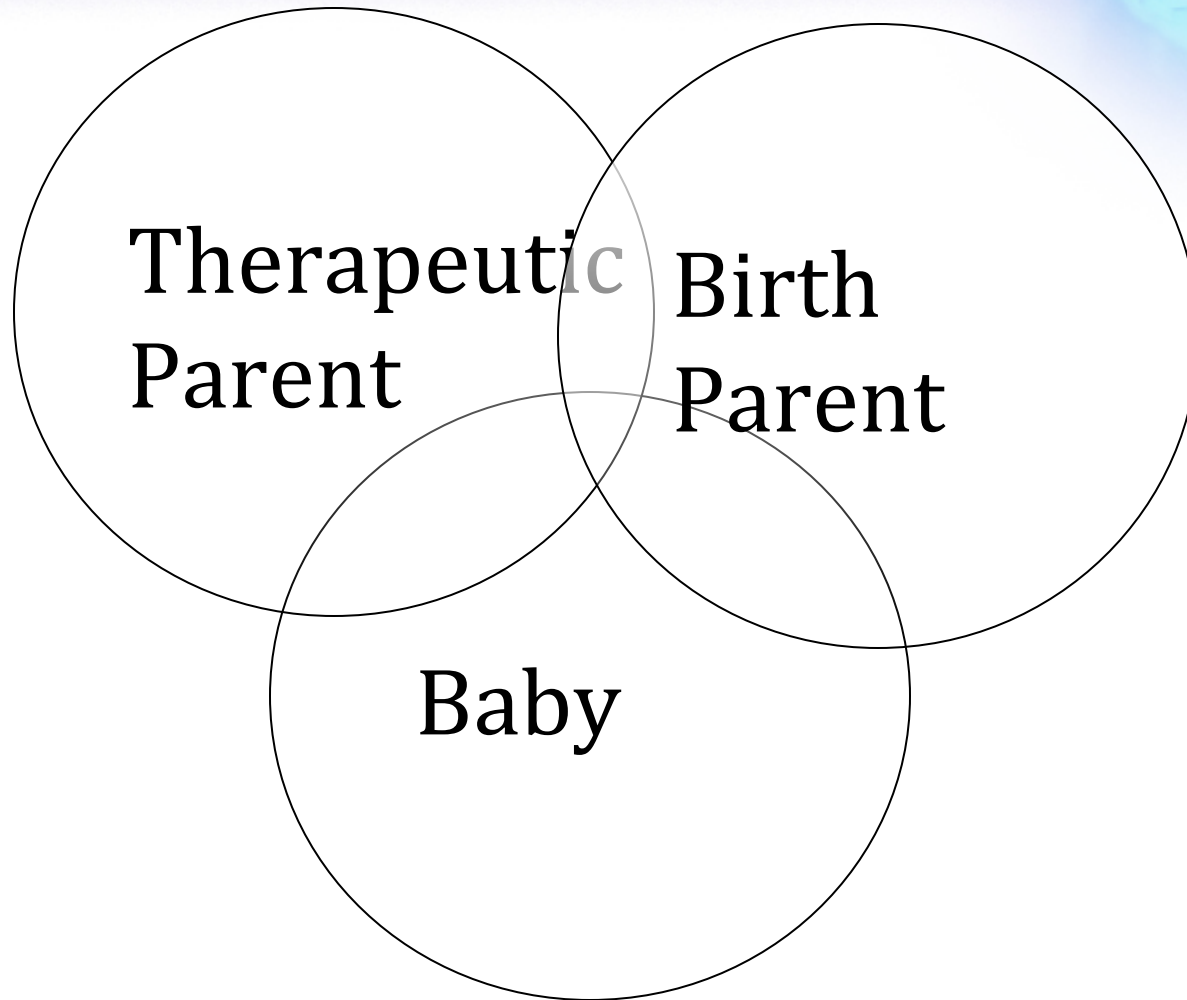
Volunteer Staff

- Connie Lillas, Court Team Liaison
- Jessica Richards, MS & MSW, LCSW
 - Infant Mental Health Specialist
- Susan Hollar, SLP
- Uyen Nguyen, OTD

Old System



Shared Parenting – Fostering Family Partnerships



Adverse Childhood Experiences

Linear increase in negative health/mental health outcomes as number of adverse childhood experiences increase



Mom's Events include - 3:

Abuse

Physical Abuse

Emotional Abuse

Sexual Abuse

Neglect

Physical Neglect

Emotional Neglect

Household Dysfunction

Family Violence

Parental Mental Illness

Separation or loss of a parent

Parental Incarceration

Parental Substance Abuse

Child's Events include - 4:

Abuse

Physical Abuse

Emotional Abuse

Sexual Abuse

Neglect

Physical Neglect

Emotional Neglect

Household Dysfunction

Family Violence

Parental Mental Illness

Separation or loss of a parent

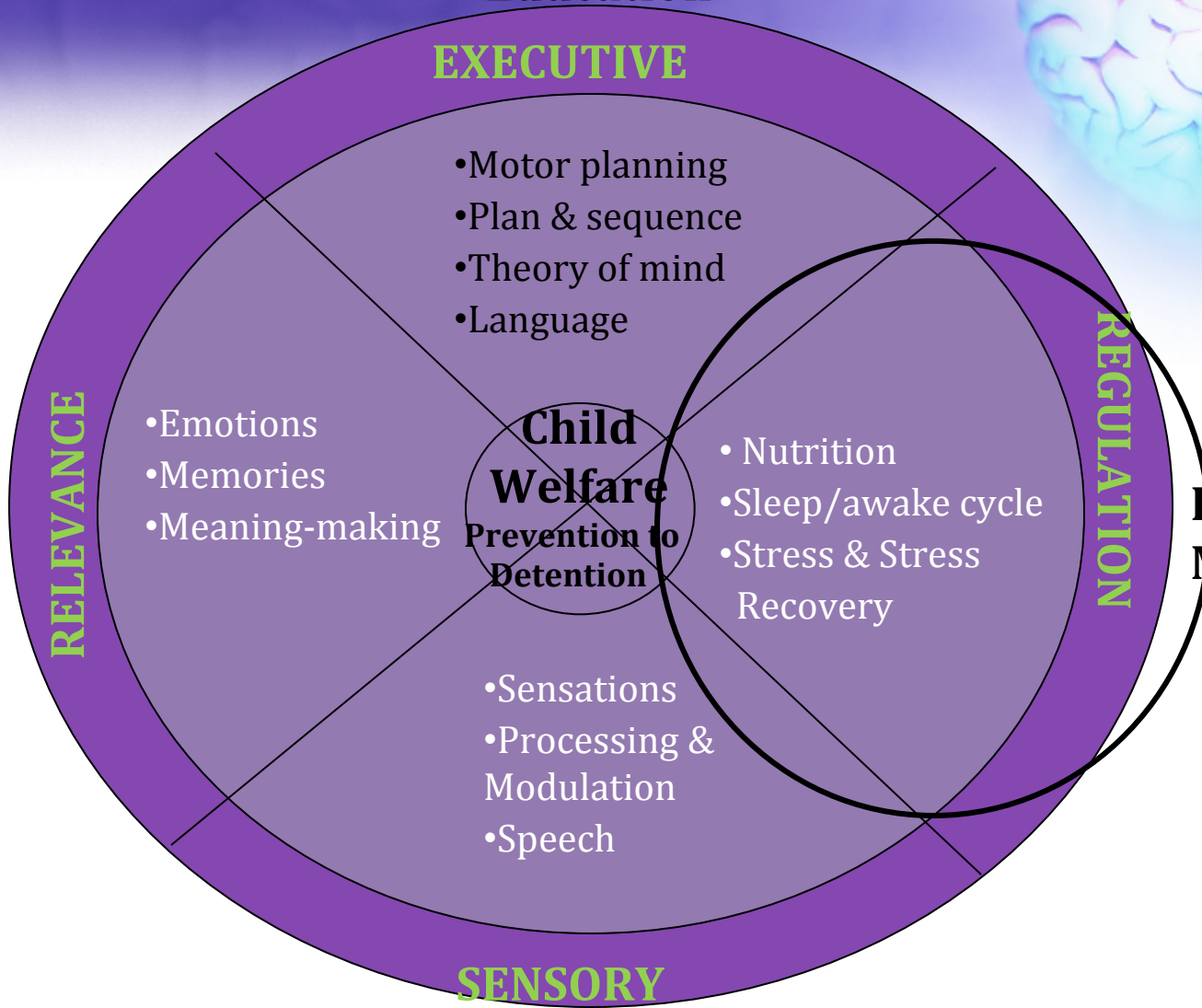
Parental Incarceration

Parental Substance Abuse

STEP 3: Brain Architecture - Micro & Macro Levels



**Mental
Health**



**Basic Needs/
Medical**

**Developmental
Disabilities**



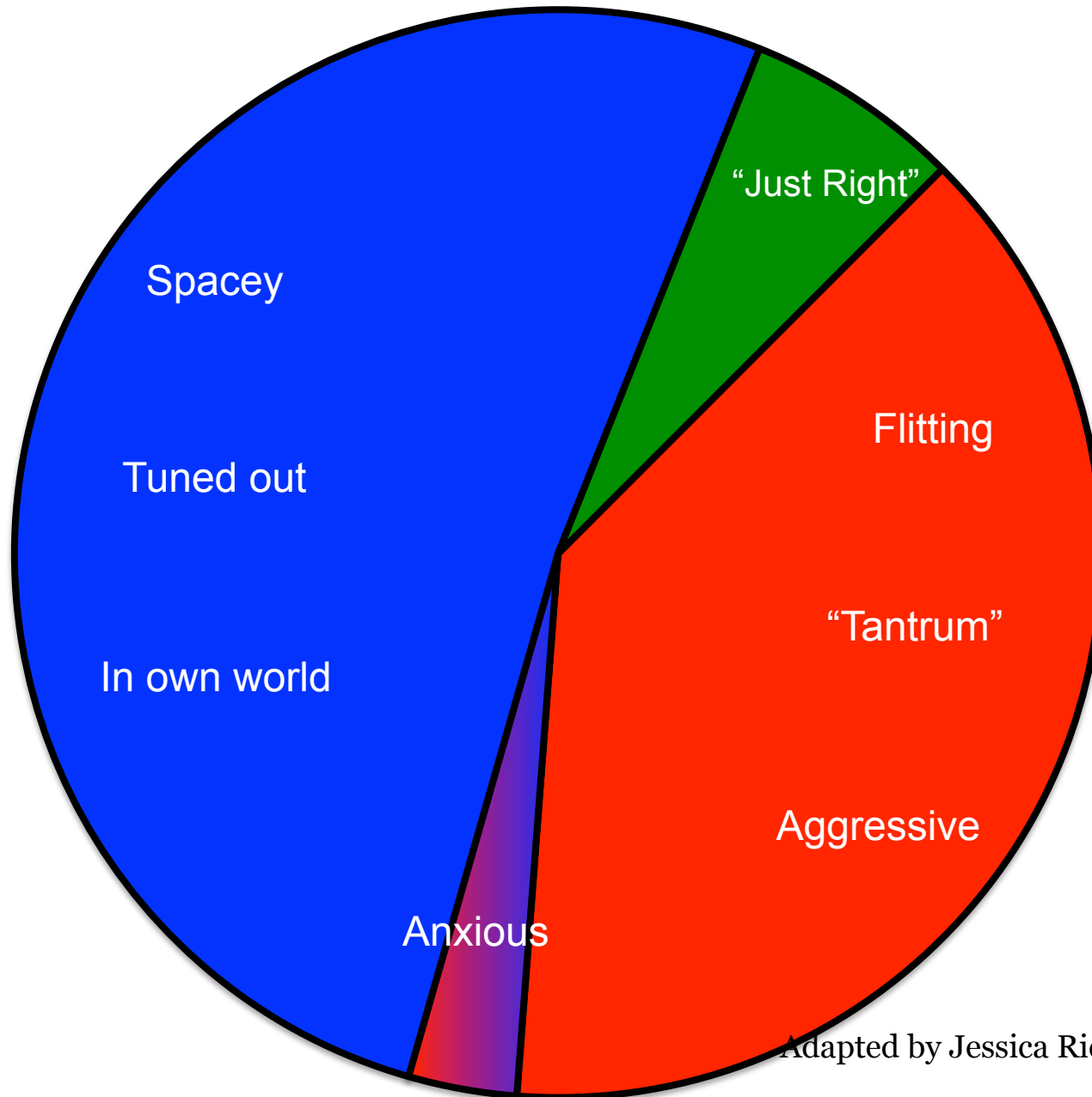
**Three
Regulation
Capacities**

=

**Flitting
around**

**Blue
Zone**

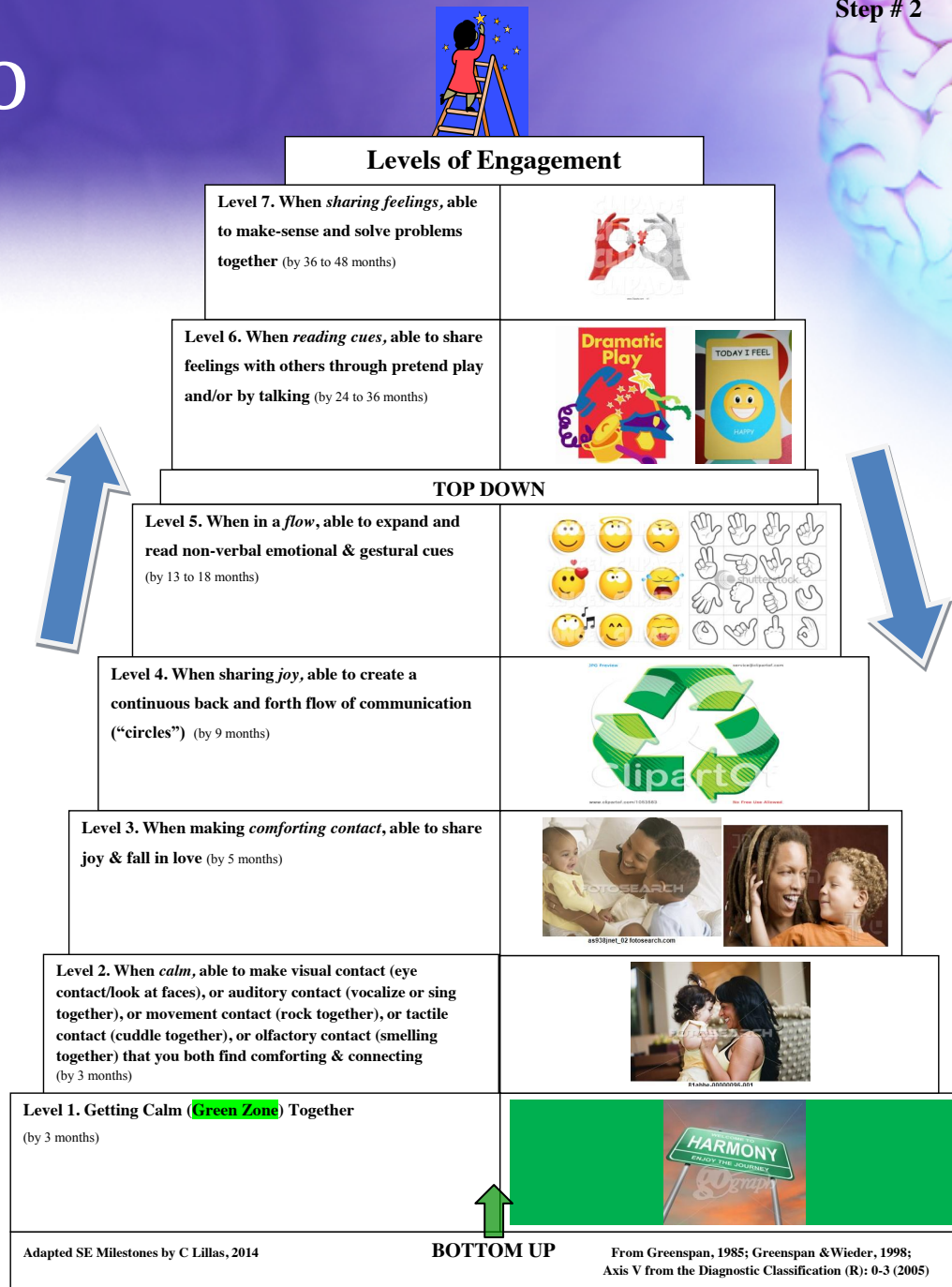
Step One



Green= 5%
Red=45%
Combo=2%
Blue=50%

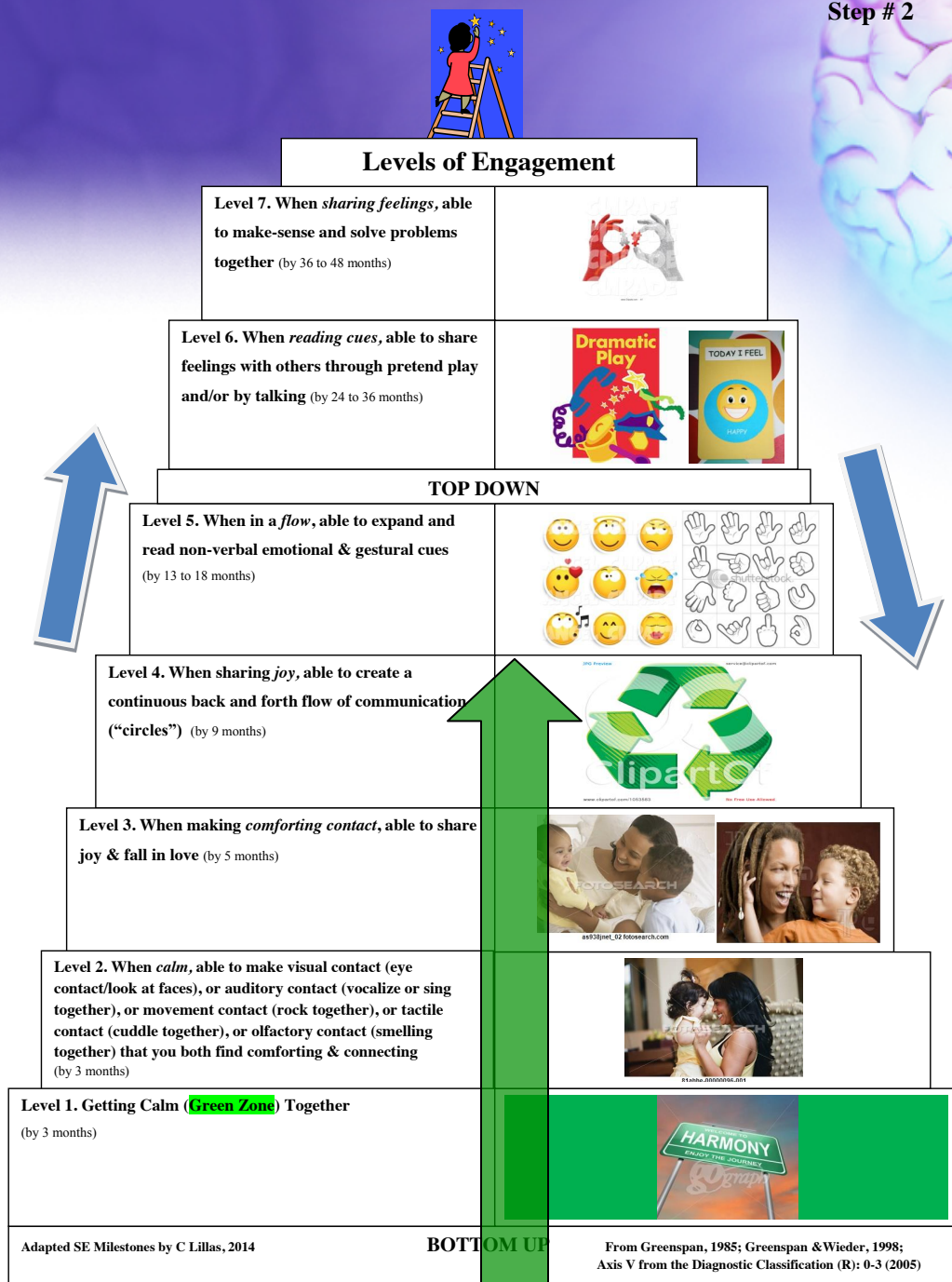
Step Two

Step # 2



Step Two

Step # 2



Teen Mom's First Dilemma



- Child shifts to grandma's...creates housing crisis for Teen Mom
- She shifts into unstable housing
- We see a shift from her meeting all of the “demands” from both probation and family court to missing her appointments, not taking drug tests

Teen Mom's First Dilemma



- Judge Pellman, “You need to go to rehab.”
- Teen Mom, “I don’t want to be locked up.” (procedural memory of trauma)
- Agrees to check it out, but disappears
- Ends up living in a transient life

Collaborative vs. Legal



- Parents only have a short time to reunify, approximately one year
- The emphasis on reunification is finite because children cannot wait

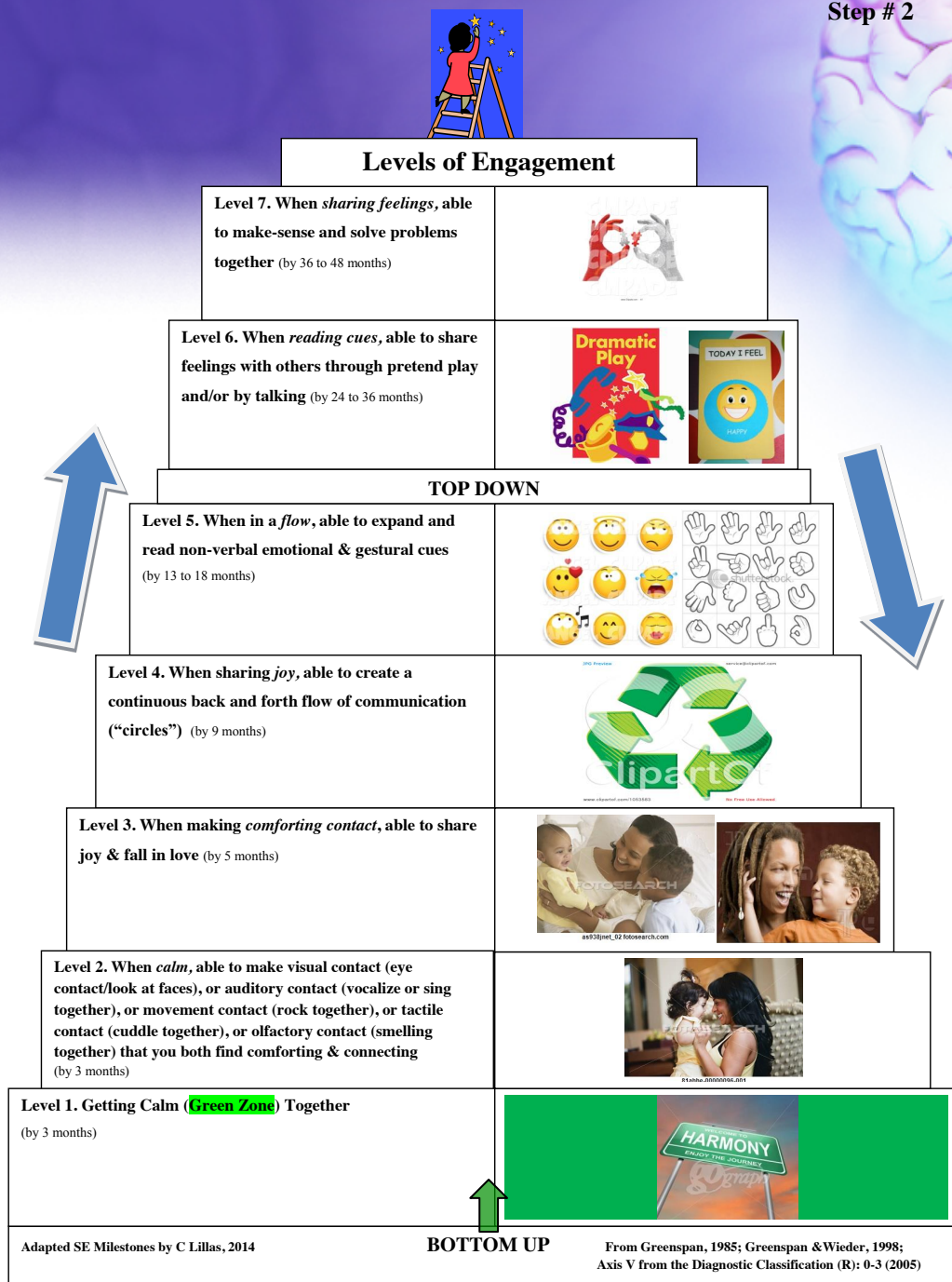
When we lost teen mom, we also lost our toddler



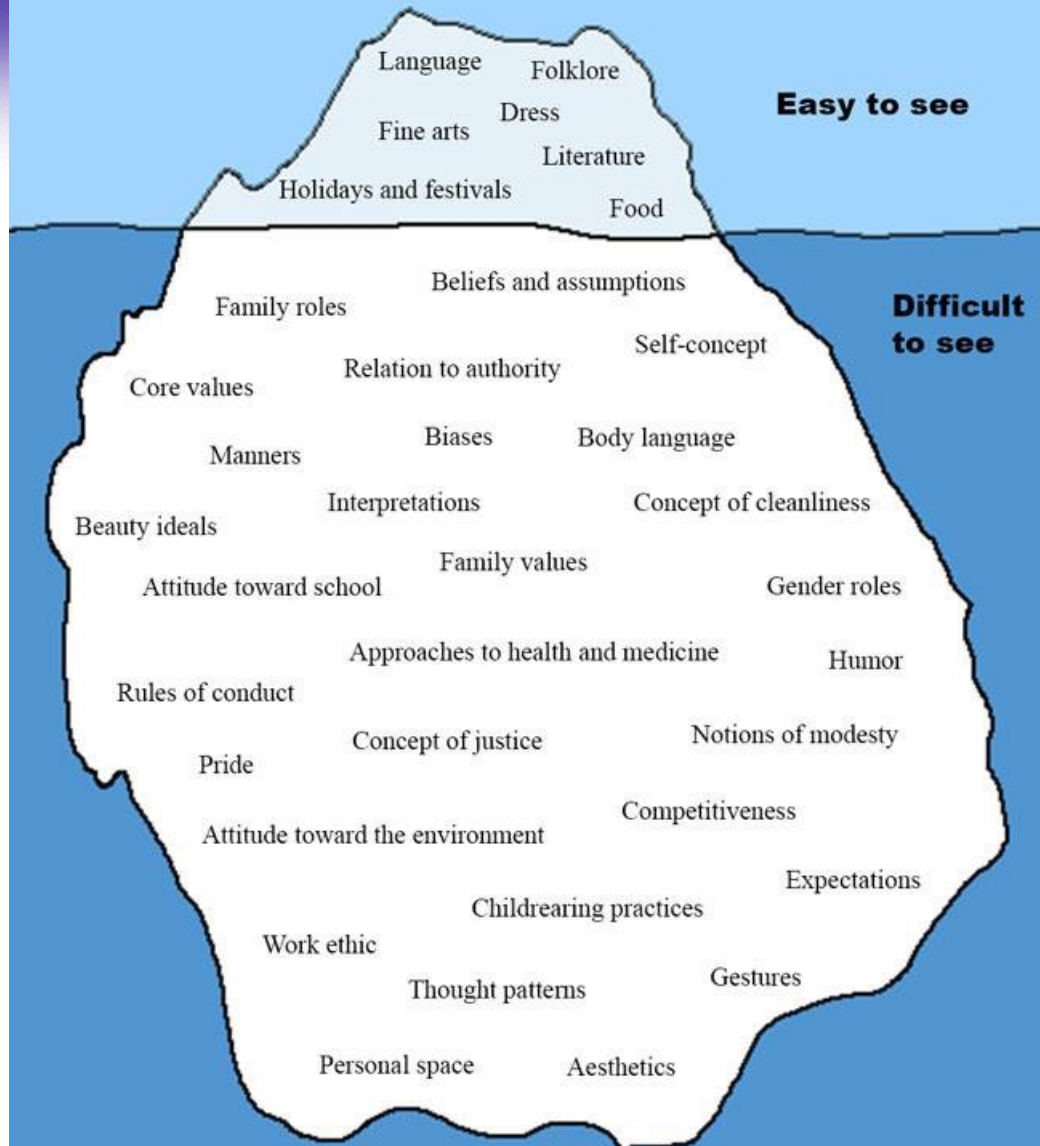
- A year of upheaval and regression
- Infant warehoused in his early care setting
- Left in a high chair, we suspect, for hours on end b/c he was in one no matter what time J showed up (no where near feeding time)
- We suspect it was a way to manage his flitting and red zoned, aggressive behavior

Step Two

Step # 2



The Cultural Iceberg



Cultural & Institutional Clash Dilemma



Jessica

- Concerned about low quality child care; blue zoned out
- Voiced concerns
- Concerned about cultural rupture
- Anxious to repair; feels falsely accused
- Using translator increases frustration & distrust
- Humiliation with me (never not been able to repair a therapy relationship)

Grandma

- Concerned about another transition (He's fine!)
- Grandma feels blamed (J is causing trouble)
- Grandma's further detachment and annoyance at J's calls with translator during work hours
- Grandma wants to fire J
- End result: Team unsure how to undo the grid lock

A Working Conceptualization of Historically Excluded (Target) and Historically Included (Non-Target) Groups

Types of Oppression	Variable	Historically Included Groups	Historically Excluded Groups
Racism	Race/Color/Ethnicity	White	People of Color (African, Asian, Native, Latino/ a Americans)
Sexism	Gender	Men	Women/Transgender
Classism	Socio-Economic Class	Middle, Upper Class	Poor, Working Class
Elitism	Education Level	Formally Educated	Informally Educated
	Place in Hierarchy	Managers, Exempt, Faculty	Clerical, Non-Exempt, Students
Religious Oppression		Christians, Protestants	Muslims/Catholics, and Others
Anti-Semitism	Religion	Christians	Jew
Militarism	Military Status	WW I&II, Korean, Gulf War Veterans	Vietnam Veterans
Ageism	Age	Young Adults	Elders
Adultism		Adults	Children/Youth
Heterosexism	Sexual Orientation	Heterosexuals	Gay, Lesbian, Bisexual ,
Ableism	Physical or Mental Ability	Temporarily Able-Bodied	Physically or Mentally Challenged
Xenophobia	Immigrant Status	US Born	Immigrant
Linguistic Oppression	Language	English	English as a Second Language Non-English

What would you do?




- Brain storm at your table...how can we work through this?
- Players: Jessica, Dr. Lillas, CSW Joanna (bicultural and bilingual), Alliance attorney (bilingual), Margarita (Latina Spanish speaking)
- Target/Non target(for grandma, me and Margarita)
- Expectations for development
- Stress responses (mine, grandma)
- Institutional barriers

Our default mode reactions towards cultural differences & oppression



- Heart responses
 - Dysfunctional rescuing
- Hand responses
 - Blaming the victim or the system
- Head responses
 - Denial or avoidance of cultural differences and oppression
 - Batts, Capitman, & Lundrum-Brown, 2011

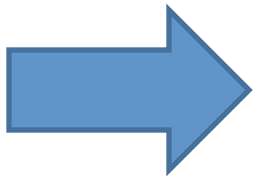
Heart, Hand, and Head Patterns

	Under Coordination		Under Stress	
Heart 1s	Warm Empathic Connect Repair	Functional helper Share info. Make contact Cross-sector communication	Overly accommodating Overly controlling Anxious to fix things	 Dysfunctional rescuing
Hand 2s	Assertive Directive, action oriented	Take the lead Confront Stand up Notice and share differences	Overly demanding Hostile attack	Blaming the victim Blaming the system
Head 3s	Neutral Reflective Problem-solve Dr. Connie Lillas	Take responsibility Learn, ask, & notice the impact Dr. Valerie Batts	Overly detached Overly dismissive Passive-aggressive anger Denial Dr. Connie Lillas	Passive avoidance Antagonistic avoidance Denial of differences across domains Dr. Valerie Batts

When an “ism” Happens



**Individual
Uniqueness
is Denied**



**One Aspect of
Collective Identity is
Given Negative
Connotation**

**Common Humanity is
Denied**

Heart, Hand, and Head Patterns

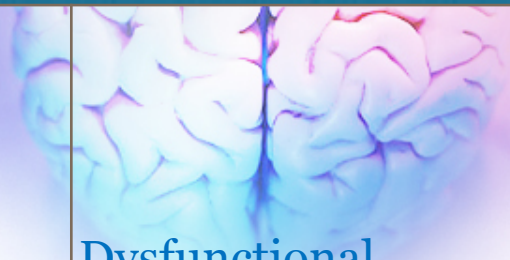
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Breaking through...



- Connie, myself and the social worker met on the weekend at grandma's home
- Listened to grandma's concerns
- Shared video clips of his blue zone and red zone and explained need for more green
- I called "after hours" without a translator

Heart, Hand, and Head Patterns

	Under Coordination		Under Stress	
Heart 1s	<p>Warm</p> <p>Empathic</p> <p>Connect</p> <p>Repair</p>	<p>Functional helper</p> <p>Share info.</p> <p>Make contact</p> <p>Cross-sector communication</p>	<p>Overly accommodating</p> <p>Overly controlling</p> <p>Anxious to fix things</p>	 <p>Dysfunctional rescuing</p>
Hand 2s	<p>Assertive</p> <p>Directive, action oriented</p>	<p>Take the lead</p> <p>Confront</p> <p>Stand up</p> <p>Notice and share differences</p>	<p>Overly demanding</p> <p>Hostile attack</p>	<p>Blaming the victim</p> <p>Blaming the system</p>
Head 3s	<p>Neutral</p> <p>Reflective</p> <p>Problem-solve</p>	<p>Take responsibility</p> <p>Learn, ask, & notice the impact</p>	<p>Overly detached</p> <p>Overly dismissive</p> <p>Passive-aggressive anger</p> <p>Denial</p>	<p>Passive avoidance</p> <p>Antagonistic avoidance</p> <p>Denial of differences across domains</p>
	Dr. Connie Lillas	Dr. Valerie Batts	Dr. Connie Lillas	Dr. Valerie Batts

Hear, See, Do...



- In small groups, jot down notes using the questions reflecting on a case you treat, supervise or met to assess
 - **Heart responses** - Dysfunctional rescuing
 - **Hand responses** - Blaming the victim or the system
 - **Head responses** - Denial or avoidance of cultural differences and oppression
 - **Where are you weighted dominant or non-dominant side?**
 - Your stress response?
 - **Is the family weighted on the dominant or non-dominant side?** -
 - Stress responses?

Who We Are At Our BEST!



HEART

HAND

HEAD



dreamstime.com

RESPONDS

DIRECTS

REFLECTS

We follow the lead –
we build trust

We take the lead –
we guide

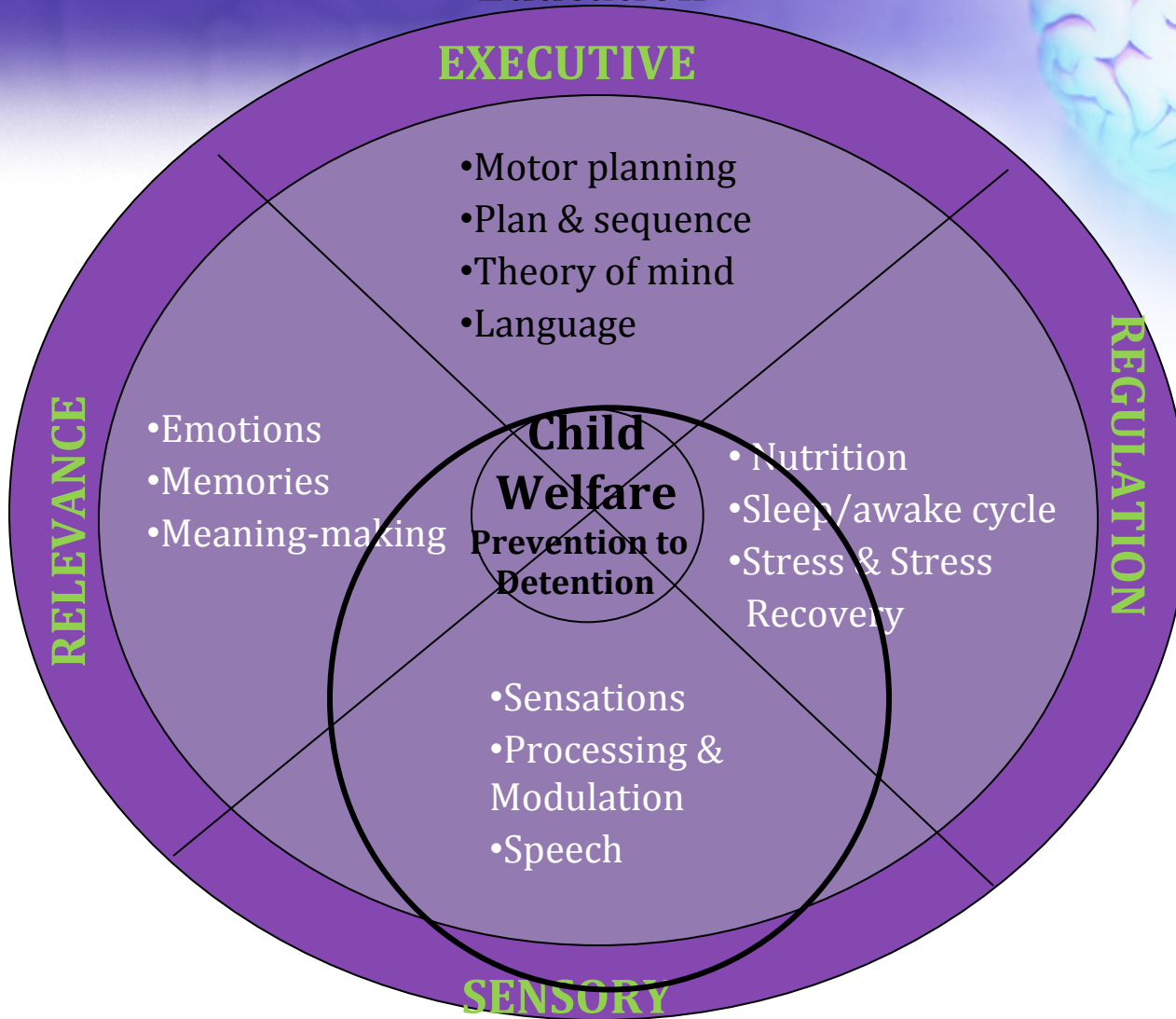
We follow & lead –
we collaborate

STEP 3: Brain Architecture - Micro & Macro Levels

Early Care &
Education



**Mental
Health**



**Basic Needs/
Medical**

**Developmental
Disabilities**

Back to little guy...



**Sensory
Capacities**

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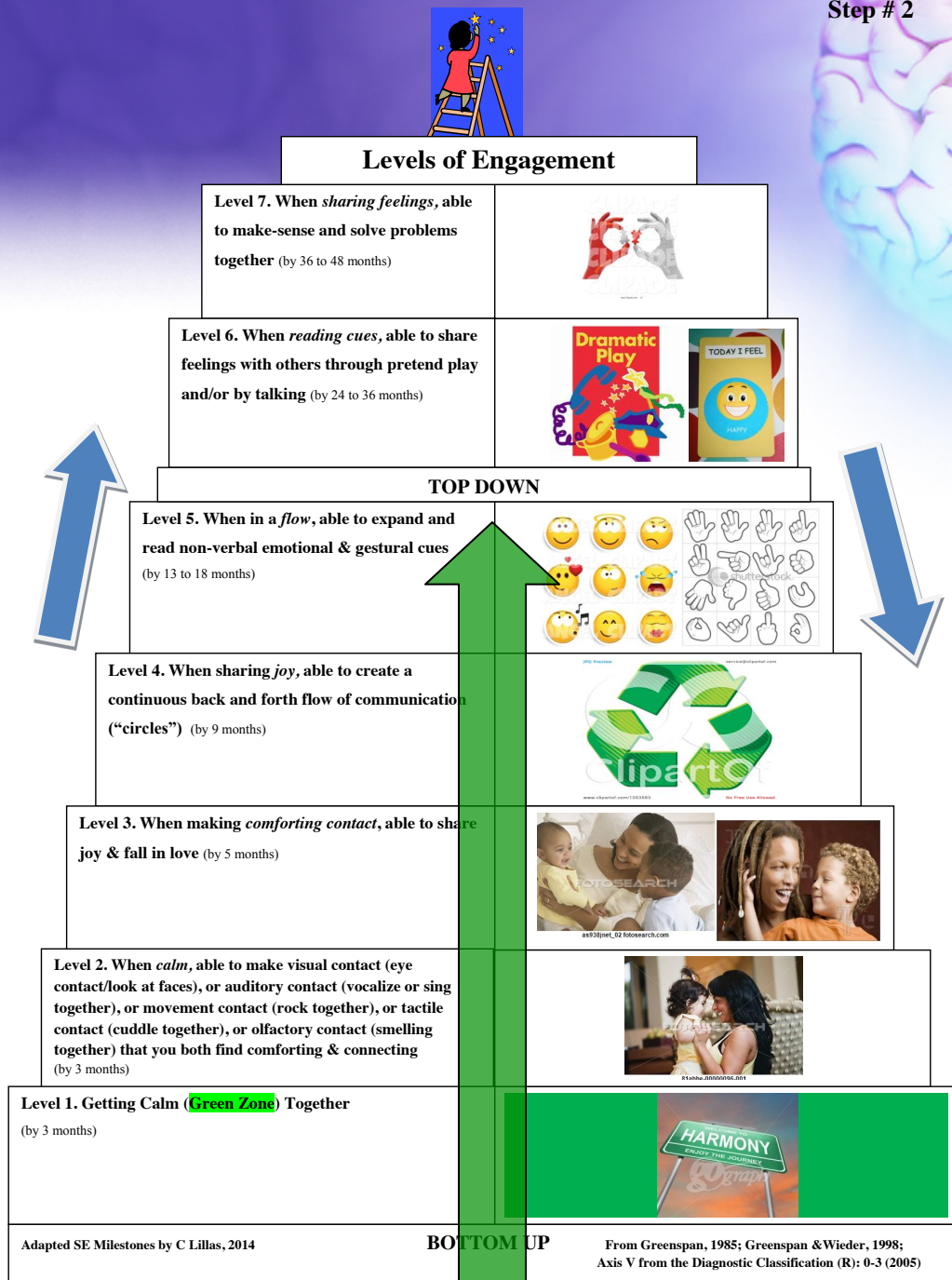
**Working
Bottom-Up**

*Getting
to Green
By...*

**Finding
sensory
Preferences**

Step Two

Step # 2



Teen Mom's Third Dilemma



A year and a half later...

- Reaches out to Jessica for help...
- Undocumented status poses extra challenge
- “I’m ready to turn myself in....” Goes through intake and ditches
- Mis match of clinical approach “Tough love”
- Unable to re-unify, lost to her substance use
- Where would you turn?

Step Three: History Worksheet



Step #3

Four Brain Systems- History Checklist

Parental/Adult Risk Factors

That Can Compromise Parents' Ability to Offer Their Child Support

Regulation

- ☐ Significant prenatal stressors
- ☐ No or poor prenatal care
- ☒ History of, or current substance abuse, smoking*
- ☐ Physical abuse*
- ☐ Physical neglect*
- ☐ Sexual abuse*
- ☒ Teenage pregnancy
- ☐ Poor nutrition
- ☐ Premature labor
- ☐ Multiple births
- ☐ Genetic disorder(s)
- ☐ Chronic medical condition(s)
- ☐ Chronic allergies
- ☐ Sleep difficulty duration (onset, time of awakening, including naps)
- ☐ Sleep difficulty quality (snoring, restlessness, night awakenings)
- ☐ Rigid or chaotic pattern of arousal energy that is entrenched (hypoalert, hyperalert, flooded)
- ☒ Low maternal education
- ☒ Few familial financial resources
- ☒ Unhygienic environment
- ☐ Inadequate food, shelter, or clothing
- ☒ Limited community resources
- ☐ Post-partum depression
- ☐ Birth complications (prolonged labor, traumatic birth, C-section (planned or emergency), breach birth)

8/23

Global Questions

Check the left box if you are certain and check the right box if you are uncertain

Regulation

- Are stress responses adaptive? That is, does a person show adequate recovery?
- Is the person's use of energy efficient and flexible or rigid and chaotic?
- How does the person conserve energy?

Sensory

- How quickly and efficiently does the adult process sensory information?
- How reactive is the adult to sensory information from relationships?
- Is the adult leaning toward types of sensory information that are considered safe as opposed to those that are threatening?

Relevance

Parental/Adult Risk Factors

That Can Compromise Parents' Ability to Offer Their Child Support

Sensory

- ☐ Loss of hearing or vision
- ☐ Inaccurate processing of information
- ☒ Slow processing of information
- ☐ Speech abnormality
- ☐ Learning disorder(s)
- ☐ Only overreactive to sensory information in at least one sensory domain
- ☒ Only underreactive to sensory information in at least one sensory domain
- ☐ Both overreactive and underreactive to sensory information in at least one sensory domain
- ☒ Over or under stimulating living environment
- ☐ Sensation seeker

3/10

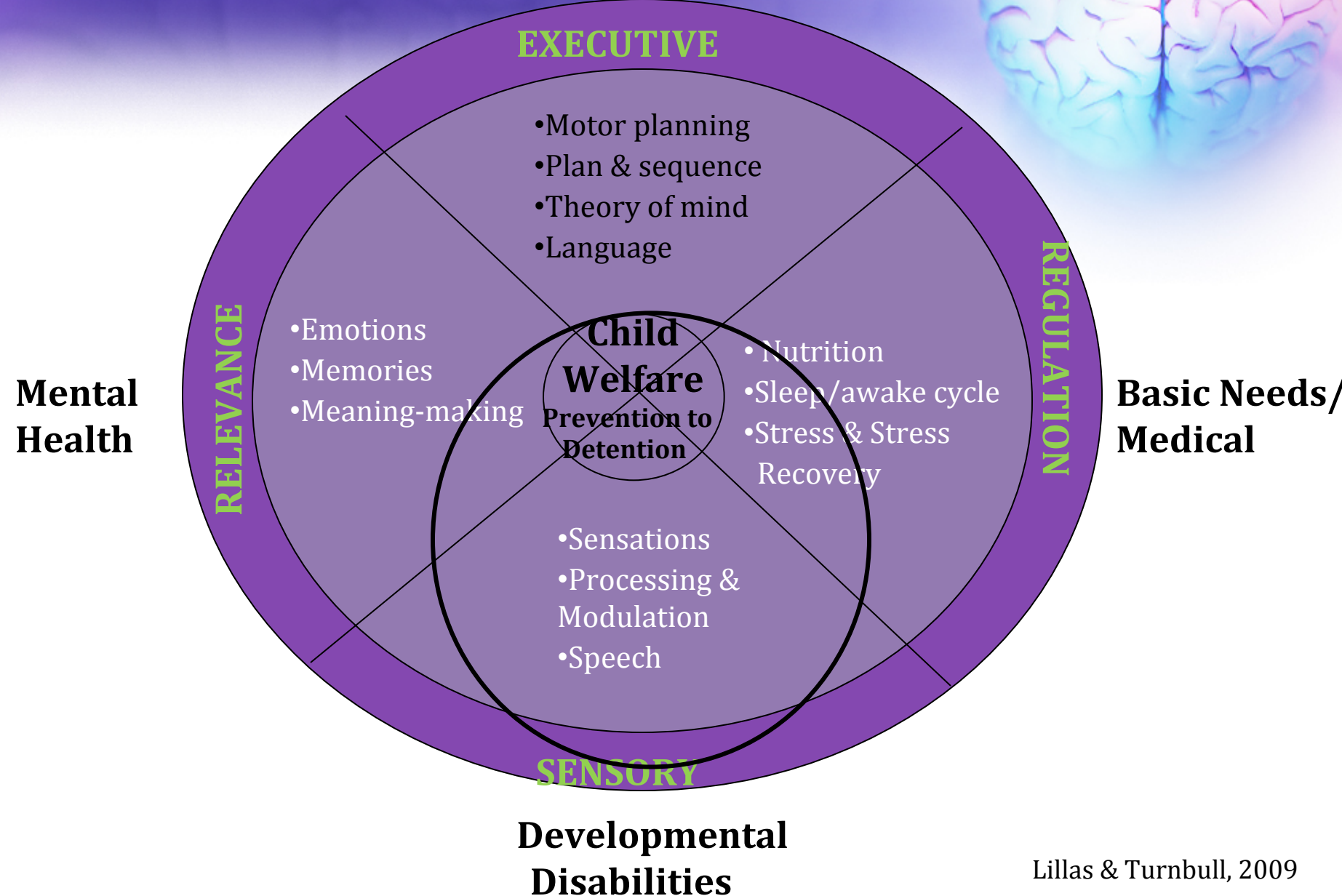
Speech Delay Dilemma



- His social emotional engagement was greatly improving but his speech development was at a dangerous plateau
- He had had one year of twice a week speech at this point with little to no improvement
- At 3 years of age, only 5 words that were difficult to understand with much articulation
- Volunteer SLP Consultant

STEP 3: Brain Architecture - Micro & Macro Levels

Early Care & Education



Basic Speech Principles



- Getting Language vs. Letting Language
 - Gestures come before words
- Overshooting language!

PARENT-CHILD RELATIONSHIP MILESTONES


Child: _____ Caregiver: _____ Examiner: _____ Date: _____ Diagnosis: _____

	1	2	3	4	5	6
Place an X in the box that matches the milestone and achievement levels	Age appropriate under all conditions, including stress, with a full range of emotions	Age appropriate but vulnerable to stress and/or constricted range of emotions	Has capacity but not at age appropriate level	Inconsistent/needs sensorimotor support and structure to function at this capacity	Barely evidences capacity even with support	Has not reached this level
Functional Capacities						
BOTTOM-UP						
Level 1. Getting Calm (Green Zone) Together (by 3 months)						
These functions are built upon the capacity to be calm together						
Level 2. When <i>calm</i>, able to make visual contact (eye contact/look at faces), or auditory contact (vocalize or sing together), or movement contact (rock together), or tactile contact (cuddle together), or olfactory contact (smelling together) that you both find comforting & connecting (by 3 months)						
Level 3. When making <i>comforting contact</i>, able to share joy & fall in love (by 5 months)						
Level 4. When sharing <i>joy</i>, able to create a continuous back and forth flow of communication (“circles”) (by 9 months)						
Level 5. When in a <i>flow</i>, able to expand and read non-verbal emotional & gestural cues (by 13 to 18 months)						
TOP-DOWN						
Level 6. When <i>reading cues</i>, able to share feelings with others through pretend play and/or by talking (by 24 to 36 months)						
Level 7. When <i>sharing feelings</i>, able to make-sense and solve problems together (by 36 to 48 months)						

Speech Principles



- Apraxia – Can look like Autism
- Levels of Engagement
 - Working on Levels 1 to 5
 - Especially the use of Gestures to Communicate
- Use of Action Verbs vs. Use of Nouns
 - Vowels vs. Consonants



**Sensory
Strategies**

=

**Working
Bottom-Up**

**Slowing
Down the
Rate & Rhythms**

Sensory-Motor Dilemma



- Despite all of his improvement in engagement, there was a lack of visual motor integration with his body in space; clumsy/tripping, several serious falls, requiring stitches
- Impulsive & hyperactive
- Video tape taken to the Regional Center
- Supervising OT involved in supporting services
- After getting OT services 1x per week at a Center Based Program, not enough improvement...
- Volunteer OT Consultant

Occupational Therapy Principles



- Identify sensory challenges
- Helping a child feel grounded in his/her body
- Build strong trunk to support fine-motor development (trunk first!)



**Sensory-Motor
Strategies**

=

**Working
Bottom-Up**

**Strengthening
Core Strength**

Occupational Therapy Trans-disciplinary Work



- Meet the child as his/her physical level and where s/he is comfortable
- Rewards emanate through the relationship of role transferring work

It Takes a Village

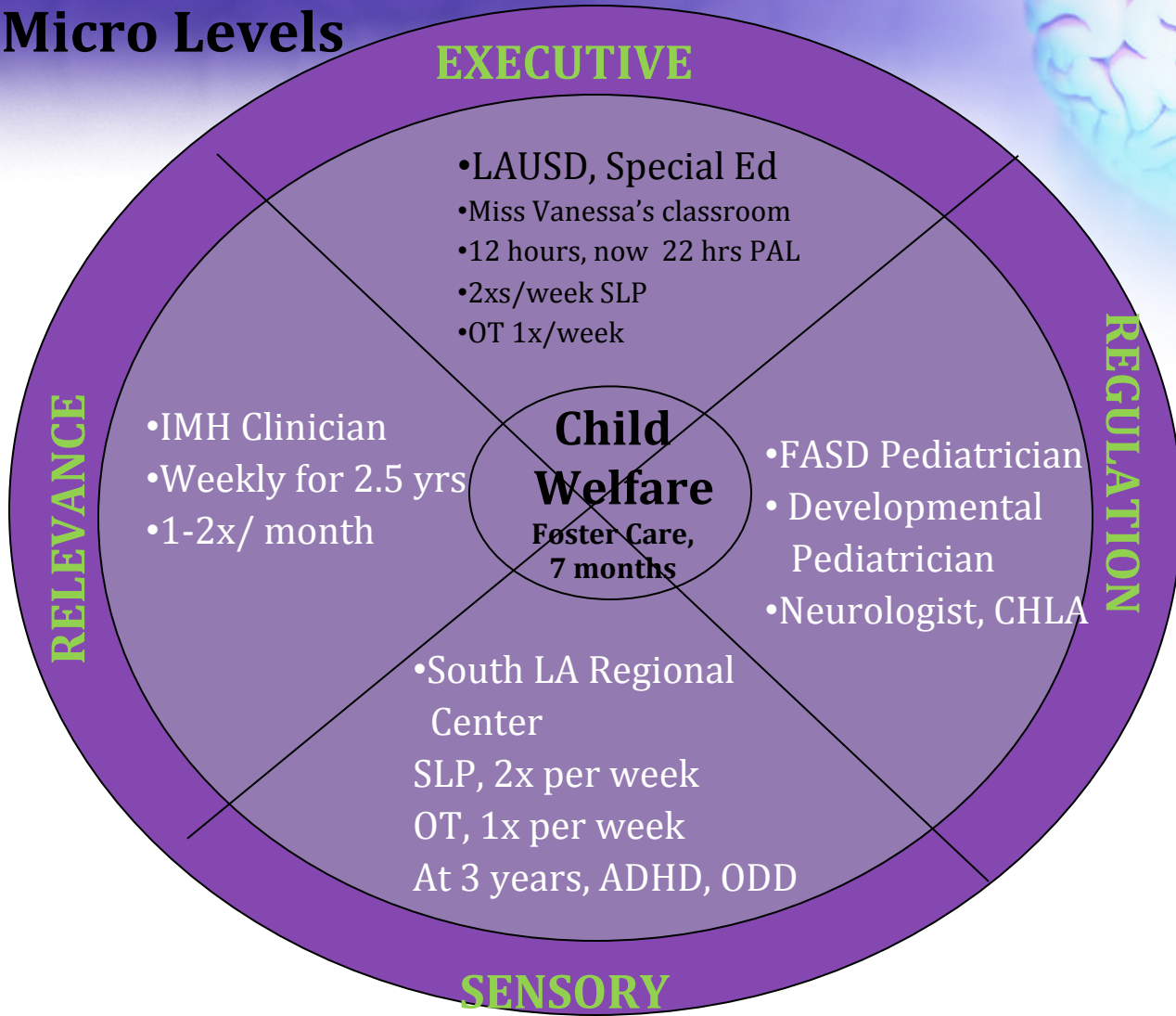


- Seeing the vision of creating a little village with a team of professionals:
- OT consultant
- Speech consultant
- Mental health therapist
- Special Education teacher
- Children's Social Worker
- Attorney from The Alliance for Children's Rights

Step 3
Four Brain Systems:
Macro & Micro Levels



**Mental
Health**

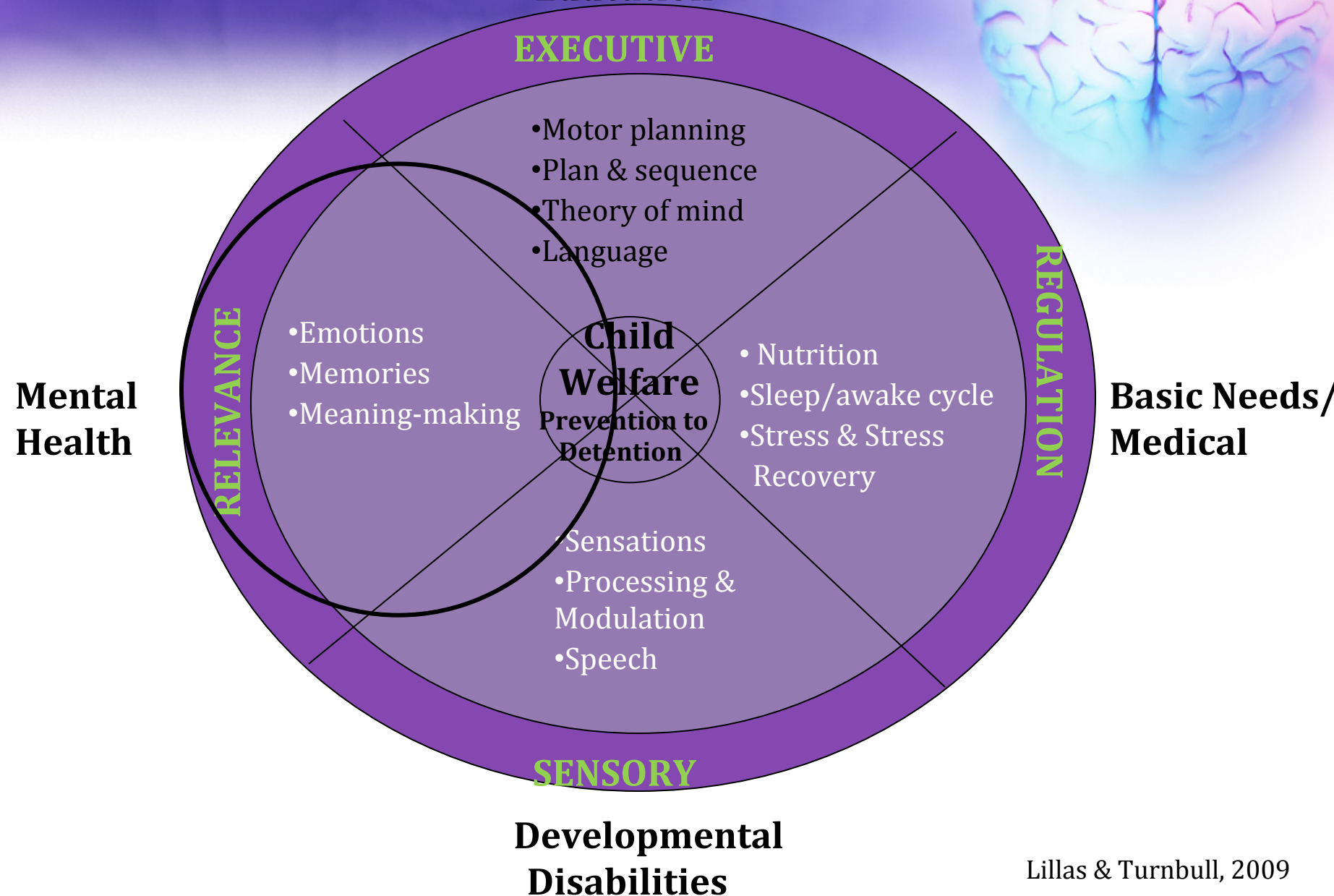


**Basic Needs/
Medical**

**Developmental
Disabilities**

STEP 3: Brain Architecture - Micro & Macro Levels

Early Care &
Education





**Relevance
Capacities**

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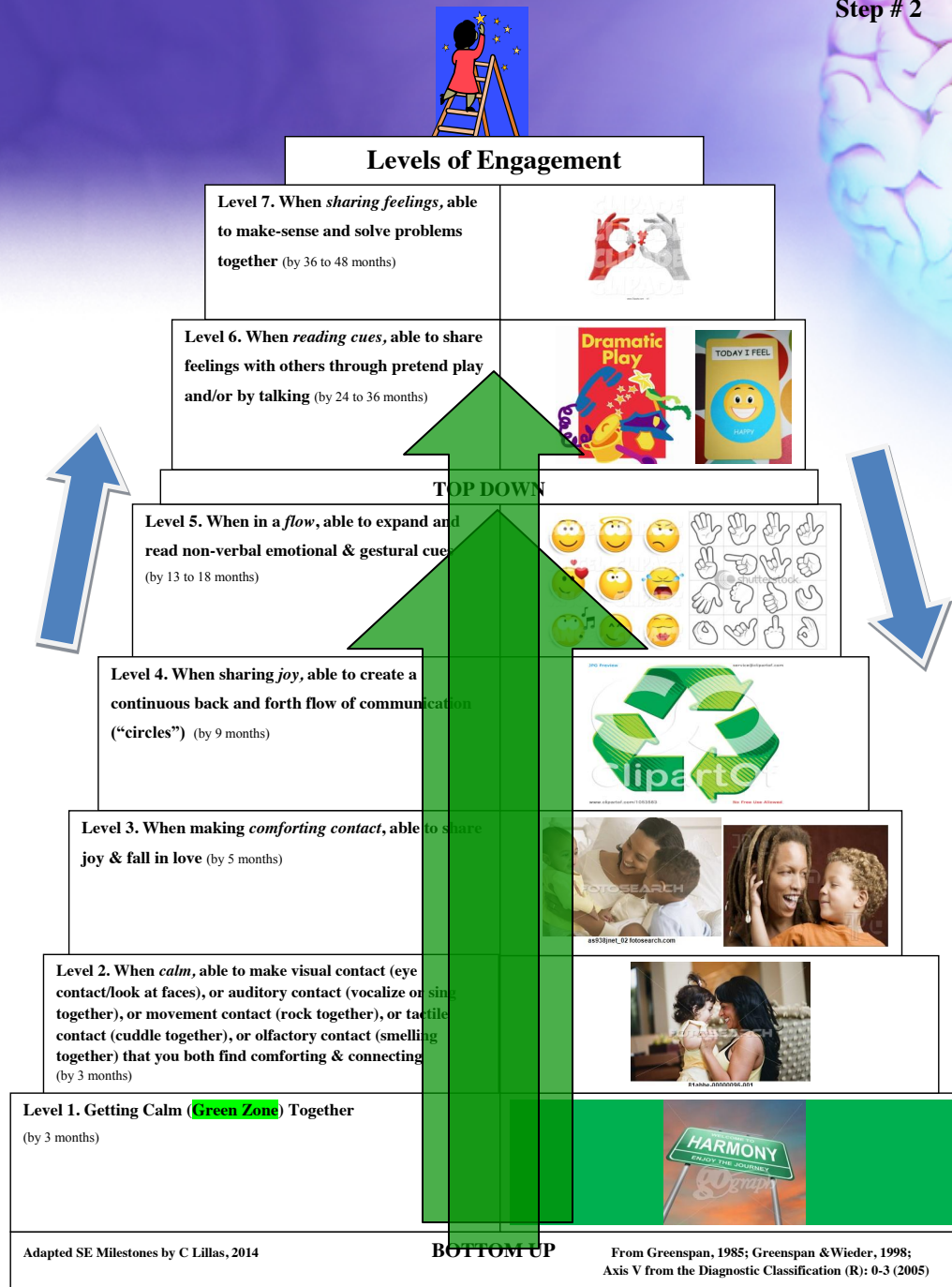
**Range of
Emotions**

**Meaning-
Making**

**Early
Symbolic
Play**

Step Two

Step # 2



PARENT-CHILD RELATIONSHIP MILESTONES

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Functional Capacities						
BOTTOM-UP						
Level 1. Getting Calm (Green Zone) Together (by 3 months)						
These functions are built upon the capacity to be calm together						
Level 2. When <i>calm</i>, able to make visual contact (eye contact/look at faces), or auditory contact (vocalize or sing together), or movement contact (rock together), or tactile contact (cuddle together), or olfactory contact (smelling together) that you both find comforting & connecting (by 3 months)						
Level 3. When making <i>comforting contact</i>, able to share joy & fall in love (by 5 months)						
Level 4. When sharing <i>joy</i>, able to create a continuous back and forth flow of communication (“circles”) (by 9 months)						
Level 5. When in a <i>flow</i>, able to expand and read non-verbal emotional & gestural cues (by 13 to 18 months)						
TOP-DOWN						
Level 6. When <i>reading cues</i>, able to share feelings with others through pretend play and/or by talking (by 24 to 36 months)						
Level 7. When <i>sharing feelings</i>, able to make-sense and solve problems together (by 36 to 48 months)						

PARENT-CHILD RELATIONSHIP MILESTONES

Child: _____ Caregiver: _____ Examiner: _____ Date: _____ Diagnosis: _____

	1	2	3	4	5	6
Place an X in the box that matches the milestone and achievement levels	Age appropriate under all conditions, including stress, with a full range of emotions	Age appropriate but vulnerable to stress and/or constricted range of emotions	Has capacity but not at age appropriate level	Inconsistent/needs sensorimotor support and structure to function at this capacity	Barely evidences capacity even with support	Has not reached this level
Functional Capacities						
BOTTOM-UP						
Level 1. Getting Calm (Green Zone) Together (by 3 months)						
These functions are built upon the capacity to be calm together						
Level 2. When <i>calm</i>, able to make visual contact (eye contact/look at faces), or auditory contact (vocalize or sing together), or movement contact (rock together), or tactile contact (cuddle together), or olfactory contact (smelling together) that you both find comforting & connecting (by 3 months)						
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TOP-DOWN						
Level 6. When <i>reading cues</i>, able to share feelings with others through pretend play and/or by talking (by 24 to 36 months)						
Level 7. When <i>sharing feelings</i>, able to make-sense and solve problems together (by 36 to 48 months)						

Fourth Dilemma



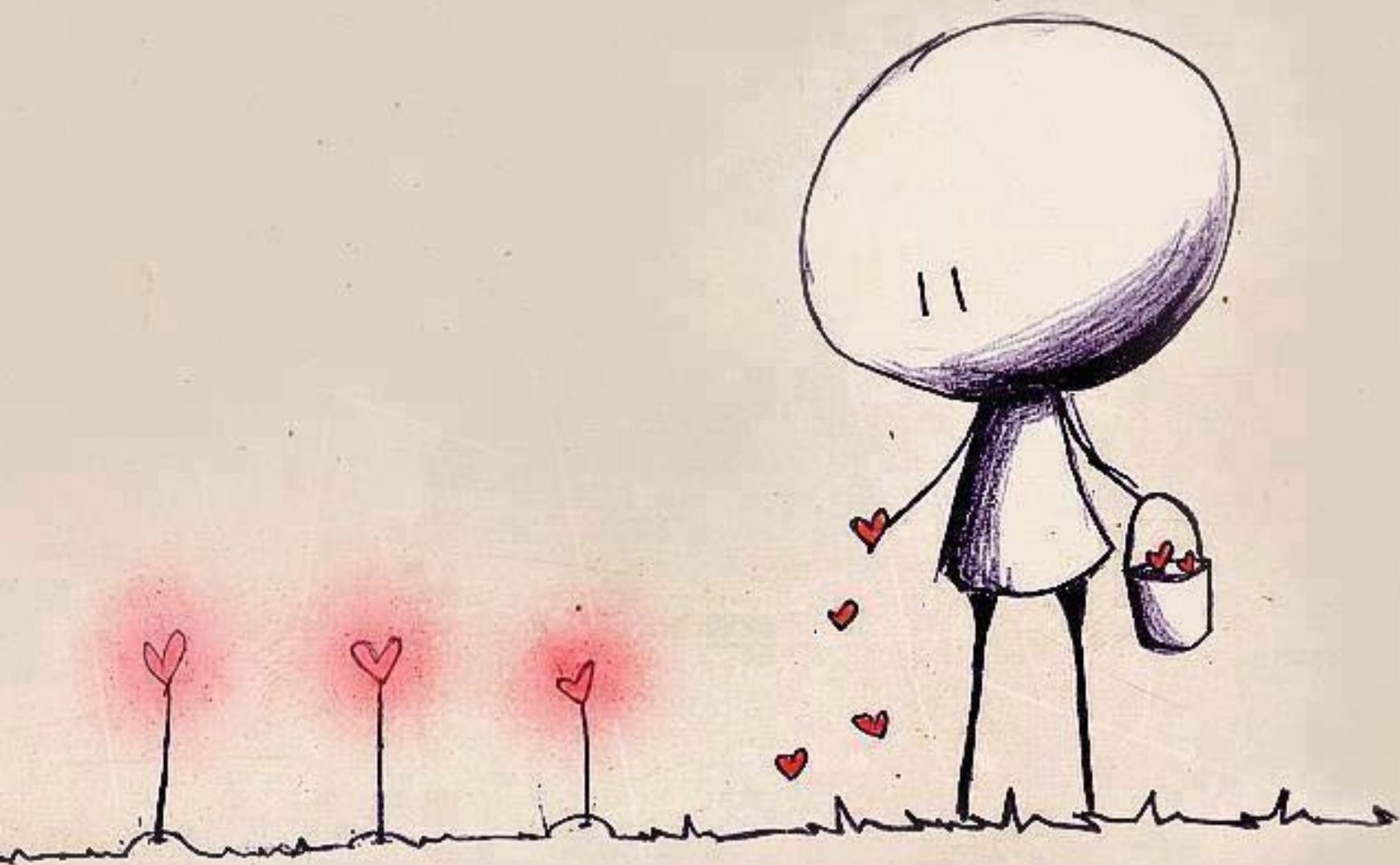
- Teen mom reconnects with Jessica
- She's held a job for the last year and a half and had her own apartment
- Chaos and conflict hits our team when an unexpected twist arises
- Legal perspective vs. clinical

Open-ended coaching & mentoring with support



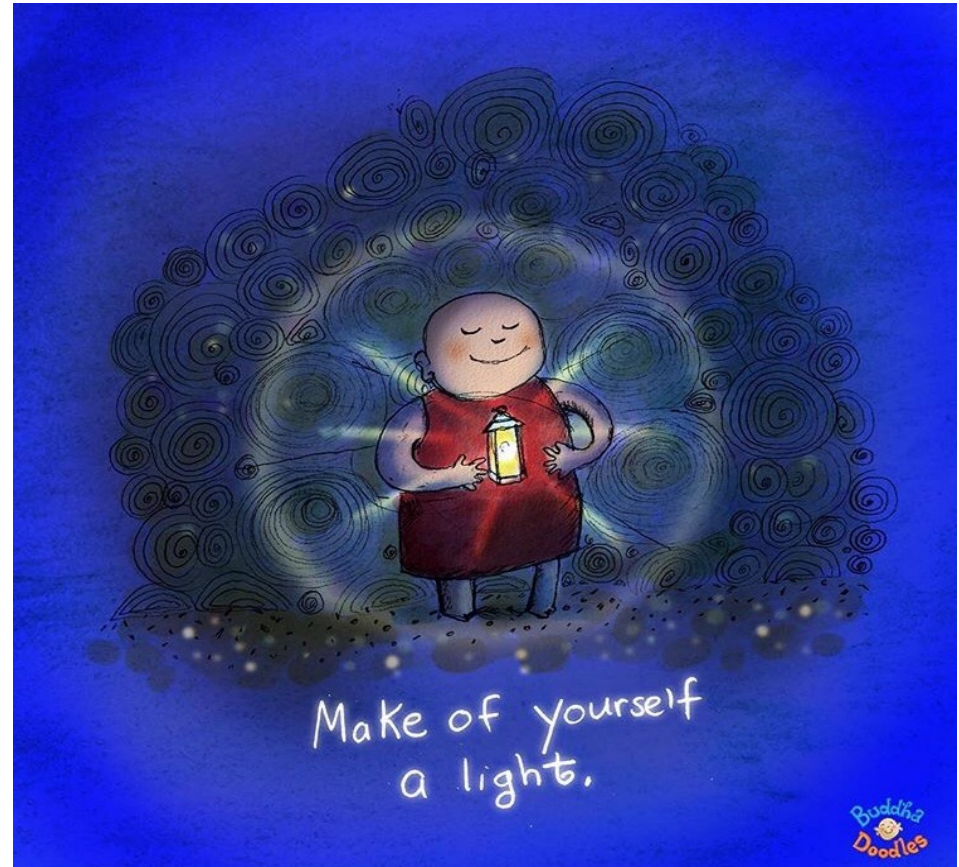
- New procedural memories are created over time
- Change rarely occurs in a straight line, and is more likely to occur in a spiral pattern
- Every time you go around a rung, you trust you are a little higher up,
& sometimes,
you go back a few
rungs...





A visionary sees light in the dark...

- Small, volunteer efforts provide a light
- If you are visionary, how can you help spread the light?





Thank You!