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They Said: We Are All in This Together.

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The current health care environment calls for the most efficient and effective practice models to meet the complex needs of individuals with challenges in everyday functioning. Many have suggested that an interprofessional model of practice is the best way to provide comprehensive care. Although there are clear benefits to working with other professions, there are also often challenges to working on an interprofessional team. The Southwest Michigan Children's Trauma Assessment Center (CTAC) at Western Michigan University (WMU) is a model center for interprofessional practice. However, even this team has worked to overcome barriers to interprofessional practice.

The CTAC opened in 2000, and for 17 years it has been a beacon for evaluating the impact of abuse, neglect, and prenatal exposure to substances on a child's developmental functioning. This team has completed more than 3600 evaluations and, through recommendations in the resulting comprehensive reports, has changed the life trajectories for many vulnerable children. The team's mission, priorities, and operation can be understood through learning about one of the many children served by this organization.

Andre, 10 years of age, standing 4 ft 5 inches (small for his age) arrived at the CTAC flanked by two exhausted and exasperated looking case managers. Jim Henry, director of the CTAC, met Andre in the lobby and greeted him with his legendary hearty, booming voice. The team that was poised to work with Andre that day had already sat together and reviewed his case history. The team knew that Andre had suffered severe sexual

and physical abuse at the hands of a foster care family after removal from his biological family for neglect. At 10 years of age, he was living in a residential facility after many foster care placements had failed him.

In the waiting room, Andre proceeded systematically to throw and tear apart the magazines while literally growling at anyone who passed. Jim spoke to Andre with a calm reassurance and welcomed him to the clinic. No longer physically violent, Andre sat on the floor and waited, frozen in fear and anticipation of what the day would bring. Jim went back to the team to prepare them to greet Andre.

The speech and language and occupational therapy students quickly prepared a picture schedule for Andre to provide him with the safety of knowing how the day would proceed. The social work student set up the treatment room with a snack to provide some nurturing to Andre when he first arrived in the room. With the support of this invested and collaborative evaluation team, Andre worked through the developmental assessment portion of the day with many "sensory breaks" in the large gym to allow him to regulate himself for the next task. Through this assessment, the team was able to quantify Andre's current intellectual functioning deficits, speech and language skill challenges, and motor issues. The team was on its way to helping others understand the reasons for Andre's behavior.

In the afternoon, the staff social worker sat with Andre to complete a psychosocial interview. The social worker first asked Andre to draw his family. Andre drew a large apple tree with a man

labeled Adam and a woman labeled Eve. Andre had never had nurturing parental figures and drew on the biblical story to provide himself with some sense of beginning.

Hearing Andre talk, one got a sense of someone floating in space with nothing to anchor him to other people or even to his own life. Gaining an understanding of Andre's sense of safety and family was essential to learning why he could not maintain a relationship with anyone for any extended period. At the end of the interview, Andre wondered out loud whether he was "lovable." There was not a dry eye in the observation room, and the team (even his previously frustrated care workers) was dedicated to changing Andre's circumstances.

Providing Andre with safety through nurturing, warmth, support for sensory processing, and communication challenges would not have been nearly as effective without the collaboration of the CTAC interprofessional team. Dr. Jim Henry, Dr. Ben Atchison, Dr. Yvette Hyter, Dr. Mark Sloan, and Ms. Connie Black-Pond founded the CTAC. Through their work, they have changed the child welfare system and the lives of many children who have experienced unspeakable hardship. They have agreed to document a conversation describing the decision to create this interprofessional team, the strategies that they used to facilitate the team's success, and some of the challenges of working interprofessionally. We present this conversation here in hopes that readers can benefit from the lessons learned from this practice model.

Guest Editor: Why did you choose an interprofessional model for the CTAC?

Dr. Hyter: In order to understand, we need to go back a little way. We were brought together 16 years ago by Jim and Connie [Black Pond]. They had worked in the child welfare field and saw how disconnected the services were, particularly for assessments of children who were in foster care. They had a vision. They wanted to include different disciplines, where everyone was working together, to help change the system of care. We all shared our vision for this new team. The experience that shaped my vision was working on a transdisciplinary team with children who had "severe emotional disturbances." As a speech and language pathologist, working together with a teacher, social worker, and a play therapist was phenomenal. The changes we were able to make in the lives of these children, in a short period of time, were just amazing. So I spent the rest of my life looking for an opportunity to work across disciplines. Role sharing, role release, collaboration, learning from each other, these were things that I knew could have a powerful impact on the children I wanted to serve.

Dr. Sloane: When I met with the team the first time, I remember thinking, I really like these people. I want to work with them. But, my worry was related to some of my past experiences. In my mind, "interdisciplinary" meant everyone parks in a room and the kids move to each person. The reports are written by each discipline separately, and no one does any integration. I hated those

reports because they just didn't say anything except, here's my part and I don't need to know anything else. But after meeting with this new team, I had a feeling that this would be different.

Dr. Henry: We knew that we wanted to take this holistic perspective but weren't sure how it would look. When Ben and Yvette brought articles about interdisciplinary practice to one of our first meetings, I thought wow, this might be how we are able to integrate all of the child's strengths and needs into a comprehensive understanding of the whole child.

Dr. Atchison: When I was asked if I was interested in working on an assessment team for kids that had been abused, I wanted to learn how we could put the child in the middle and form a circle around the child to bring our knowledge and skills to the table to do what was best for the child. To me, that was best practice. The first day we met, our chemistry was just there. We had this comfort with the idea that we would leave our egos at the door. It wasn't about our professional development. It was about what can we do to provide service to these kids that need it. That to me was the theme from day one, the first hour we met. Everybody was in.

Dr. Henry: My experience up until we met was that we weren't meeting the needs of our kids. And that, I think, was the driving force. These were the most complex, vulnerable kids and their life decisions were being made based on a diagnosis. And that wasn't being made based on the whole child and how [his or her] brain had been affected by trauma.

Ms. Black-Pond: Fast forwarding, that is what makes the CTAC assessments different from any of the other interdisciplinary teams. There is a translation of findings into a larger context of what information is needed to adequately and sensitively influence decisions. We make life altering recommendations with confidence because we do it together as a team.

Dr. Atchison: The thing for me is that everyone has active participation. From the very beginning, when we start talking about the child in our morning assessment, to the end of the day everyone has talked to one another at the same time. It just seems that we don't miss anything as much as you would if you were in a multidisciplinary where everyone goes to these different silos and you really don't talk to each other. Here, we talk, we argue, we discuss, but it all comes back to what is BEST for the child. At the end of the day, you feel like you have covered it all. You didn't leave anything out. We all know what the child needs.

Ms. Black-Pond: A fun outcome of this team has been to hear interns talking about what they have learned as part of this team. Even when the interns are not with the team, they carry some of the other disciplines' knowledge and can have an internal conversation. For social workers, there is a little OT in there, a little speech and language, a little bit of medicine. You have people walking out of here with skills that allow them to look at the child completely differently than a single discipline does in other settings.

Dr. Sloane: Yes! Being part of this team, now I am part SLP, part OT, part social worker. This template is sitting there as a beacon. I wish it was the standard of practice everywhere.

Dr. Henry: Through learning from folks in OT, speech, and nursing, I have changed tremendously. I thought I knew stuff, and I am just so humbled. I am so different 16 years later in how I approach kids because of the people around this table. I have learned things that our education doesn't give us. We have had 300 social work interns, and when I asked them the best part of their experience, they say working together. That is the best part for us, and all of us have expanded our base.

Dr. Sloane: Expanded and learned all while feeling valued at the same time.

Dr. Atchison: This is a great model for students. I tell students that working as part of this team has raised the bar for me. This is what you should expect. Expect that you will get together with your closest colleagues and really address the issues for that client. Never think that one person is better than another. It is not about that.

Dr. Hyter: Every student, every semester, says that they learned so much that they would like to figure out how to come back. If they can't come back to the CTAC, they want to figure out how they can do this as their job. It just changes everybody's perspective.

Dr. Atchison: But, there are sometimes challenges in working with an interprofessional team. We have seen that in the teams we have tried to train around the state and country. We were lucky that we quickly developed an easy flow. We were very comfortable in sharing our opinions and ideas without ever feeling disregarded; students see that. How we treat each other. How we recognize the skills that our teammates bring. In my opinion, they walk away with increased confidence and a model of how to treat each other.

Dr. Sloane: It is not what you say, it is what you do. Lots of teams don't model the connectedness. We love each other, it is very clear. From [a] student's perspective, I can't imagine having that when I was training. That was never the case in medical school!

Dr. Henry: The other thing that we try to model for students is how to bring the head and heart together. How do you connect that and model that, and how do we honor and give a space for the students to do that? To me, this work, I am a human being first, and I am not my role. I want to think, and I want to feel. The CTAC is a place where we are allowed to feel because this is so painful. If we don't keep our hearts open, the next week we won't be nearly as responsive to our children. Instead, if you don't allow yourself to feel and be supported by your teammates, you are going to protect yourself because it hurts. We are not afraid of the pain. I have learned and have tried to teach students that it is okay to feel, and that we all need others to help us get through. Also, for me, I have changed in this

process. The kids are changing me. It is a reciprocal process. I see the world differently, I see myself differently. We contextualize around this as “we are all in this together.” [This is] our motto.

Dr. Hyter: I also think there are some disciplines, like SLP, where people are actively taught to separate what you do from what you feel. We are told that there is no room for feeling in the clinical setting. Then you come here, that is one of the things that really [touched] me, it was cognitive dissonance at one point because this is my discipline. [We are] not supposed to show how we are feeling, but how can we not? You have to deal with that and overcome that.

Guest Editor: You have talked about how you have come together and how you support each other and students through taking in the stories of these children and advocating for their best interests. What have been the challenges your team has faced?

Dr. Hyter: Well, we have grown a lot, and that is good. Mostly. I try not to be an old fogie, and I don't want to hold the team back, but there always is a nostalgia for a time that was. I think we were more in synergy when we were smaller. I think that in order to do all the work we have done for our children, and in child welfare, growth was necessary. Otherwise, how could we have affected so many systems, so many people? But when we were small, we could sustain each other even with all of our different personality quirks. This is so much harder with so many people and so many

quirks! One challenge has been to sustain our level of engagement. We all have the same level of respect for each other and love for each other. But, you know, things just change.

Dr. Henry: Yvette, you said it so well, and I obviously have some grief about changes, too. I think part of being successful is that it breeds opportunity. We have trained 10 centers of teams, gotten 11 million dollars in grant money, and served more than 37,000 kids. We have needed to change and grow to meet the needs of our communities and kids.

Ms. Black-Pond: The challenge has been how do you move and transform a team that worked so well together as a small unit. Some things have needed to be different. I see the loss of some of that connectedness as [the] biggest challenge. There has been some crisis connected to that. But also opportunity. But what we did in our forties a lot of our staff are not prepared to do today. They are not at the same point in their profession that we were when we started. When we started, we were in a place where we all could take a huge risk.

Dr. Henry: And it was a risk for all of us. I want to emphasize that. We all took a huge risk because we believed we could make this work and make a difference. Everyone around this table took a significant risk. And I think that is really important. We were really willing to do that to make it work. What we have seen in other teams [is] they set up boundaries. They resist, or they can't give a part of themselves to this work. We have all done that.

We didn't have to do it, [not] one of us! It was not our job. But this work had meaning to us. Today, the synergy has shifted and we are trying to help others come together around our kids that need us to advocate for them.

Ms. Black-Pond: At this point, we are all working to hand this over to people who might do things very differently. But, they need to take their own risks. We are trying to create a spot for people to pick this up and take this and feel confident to do that. That is huge. That closeness that sustained our team for the first 5 years was important and now that has shifted and changed. However, it is amazing to me that we are all still around this table 16 years later; it's overwhelming. Not without pain, not without sadness, not without anger or disappointment. Sixteen years! There was nothing that said we needed to stay here. All of us, we could have gotten any number of jobs. But this was important. Because the kid was in the middle and we are dedicated to these vulnerable kids. For me, and I think all of us, this work has given meaning to life.

Dr. Ben J. Atchison is the managing editor of the *Open Journal of Occupational Therapy* (OJOT) and has served in this role since 2012. He is chair emeritus and professor emeritus in the Department of Occupational Therapy at Western Michigan University (WMU). When he retired on June 30, 2017, Dr. Atchison celebrated 42 years of a career that included teaching, service, and scholarship with expertise in pediatrics with a special emphasis in childhood trauma. He is a co-founder of the Southwest Michigan Children's Trauma Assessment Center (CTAC) at WMU and fellow of the American Occupational Therapy Association.

Dr. Jim Henry is a professor in the School of Social Work at WMU. Dr. Henry joined the faculty in 1997 after 17 years of working directly in child protective services as both a case worker and a supervisor. Dr. Henry teaches courses in child sexual abuse, child welfare, advanced treatment of children,

and human behavior. In 1999, Dr. Henry co-founded the CTAC and continues to serve as the director of this interprofessional assessment clinic for abused and traumatized children as well as serving as the co-chair of the Kalamazoo Community Mental Health Board. His leadership has resulted in the acquisition of 11.5 million dollars in federal, state, and foundation grant funding. Dr. Henry is a recognized scholar with a record of extensive publications related to child trauma, and he continues to be sought out by professional communities across the US for his knowledge and expertise. In addition to workshops and training on child trauma assessment and treatment, Dr. Henry is an expert in secondary trauma and shares his knowledge with those working directly in child trauma.

Dr. Yvette D. Hyter is an ASHA fellow, and professor of speech, language, and hearing sciences at WMU. Her work focuses on culturally and linguistically responsive services for children and families at risk for being marginalized in the education and health systems and macrolevel structures that affect full participation in daily life. As a founding member of the CTAC, she addresses social pragmatic language and communication skills of children with histories of abuse, neglect, and prenatal alcohol exposure. She also prepares transdisciplinary teams to serve those from diverse cultural, linguistic, and national backgrounds, and in 2012 co-created a social pragmatic communication assessment battery for young children called the Assessment of Pragmatic Language and Social Communication. Dr. Hyter serves in leadership positions regarding diversity, social justice, inclusion, and global matters. She served as chair of the WMU College of Health and Human Services Committee on Diversity and Inclusion, chair of the Child Language Committee of the International Association of Logopedics and Phoniatrics (IALP), and was a member of the Board of Directors of the IALP.

Dr. Mark A. Sloane, DO, has been a board-certified practicing pediatrician for more than 34 years and has been interested in behavioral and developmental pediatrics for 32 years. He is currently considered a local, regional, and statewide expert in the diagnosis and treatment of pediatric disorders of mood, behavior, learning, and attention. He has evaluated and treated over 10,000 children with these disorders, and from 2003 to 2013 (after 20 years in primary care pediatrics) he owned and operated a specialty practice limited to neurobehavioral and neurodevelopmental pediatrics. He now serves as a trauma-informed medical consultant and provides trauma-informed training and consultation for a variety of primary care practices throughout MI and CO. Sloane, a 1979 graduate of Michigan State University, College of Osteopathic Medicine, has completed specialized (fellowship) training in adolescent behavioral medicine at Michigan State University, Kalamazoo Center for Medical Studies. He is a founding member and current medical director of the CTAC.

Ms. Connie Black-Pond, MA, LMSW, LPC, is co-founder and clinical director of the CTAC. She has over 30 years of experience working with children and families in the child welfare system, including 26 years as a mental health therapist assessing and treating traumatized children and adults. Connie

has co-developed the comprehensive assessment protocol at the CTAC and has provided training and consultation for multiple teams across MI to replicate the model in their own agencies. Connie has also been co-principal investigator on six federal grants. Each of the grants focused on developing trauma-informed and resiliency-based practices for traumatized children and their families with a focus on the child welfare population. As a developer trained TF-CBT supervisor, and with permission from TF-CBT developers, Connie has also facilitated and provided TF-CBT consultation with over 25 cohorts of therapists in MI, including those participating in the MI DHHS Trauma Initiative since 2008. Connie has participated in multiple NCTSN product development efforts and is presently co-chair of the birth parent trauma subcommittee, providing leadership in the development of the birth parent curriculum for child welfare workers and the piloting of parent coaching strategies that honor patterns of intergenerational trauma and the impact of a parent's own history of trauma on their parenting responses.
