WHAT IS NMT?

The Neurosequential Model of Therapeutics is a neuroscience-informed, developmentally-sensitive, approach to the clinical problem solving process.

It is not a therapy – and does not specifically imply, endorse or require – any single therapeutic technique or method.


Neurosequential Model

The brain mediates our thoughts, feelings, actions and connections to others and the world.

Understanding core principles of neuroscience, including neuroplasticity and neurodevelopment, can help us better understand ourselves and others.

The Neurosequential Model

Each person has a unique pathway to the present and deserves individualized care.

“One-size fits all” approaches rarely meet the needs of the individual – more often they meet a need of the provider (or system).
The Neurosequential Model

Humans are complex – individually, in families, communities, cultures and across generations.

Overly simple constructs – including the Neurosequential Model – do not capture the depth and breadth of the human experience.

It is important to understand mechanisms underlying current functioning.

Your understanding determines your solution
- Stuart Ablon (CPS, 2010)

Relational Complexity in Groups

<table>
<thead>
<tr>
<th>Size of Group</th>
<th>Number of Relationships</th>
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<tbody>
<tr>
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<td>8</td>
<td>&gt;3000</td>
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Adapted from Kephart, W.M. (1950) A quantitative analysis of intragroup relationships. American Journal of Sociology 60: 544-549

Neurosequential Model

Sequential Vulnerability

Age Targeted Programs (Education, Mental Health, Caregiving): Early Childhood

Developmental lag – the younger you are, the easier it is to tolerate the "lag"

BECAUSE WE HAVE MINIMAL EARLY IDENTIFICATION AND INTERVENTION

Children Who Start Behind Stay Behind

Of 50 Children Who Have Trouble Reading in First Grade
44 Will Still Have Trouble in Fourth Grade

First Graders

Fourth Graders
Age Targeted Programs (Education, Mental Health, Caregiving):

**Childhood**

Typical

Grade 5

Developmental lag – as you get older, the skills “lag” becomes viewed through various lens – (e.g., ADHD, oppositional defiant, “reading” disorder)

Age Targeted Programs (Education, Mental Health, Caregiving):

**Youth**

Grade 11

Developmental lag – and, ultimately, these skill “lags” can result in- and are viewed as - ‘anti-social’ or even criminal.

---

Heuristic (hjyr'istik; Greek: “Εὑρίσκω”, “find” or “discover”) refers to experience-based techniques for problem solving, learning, and discovery that that employs a practical method not guaranteed to be optimal, but sufficient for immediate goals. Where finding an optimal solution is impractical, heuristic methods are used to speed up the process of finding a satisfactory solution via mental shortcuts to ease the cognitive load of making a decision. Examples of this method include using a rule of thumb, an educated guess, an intuitive judgment, stereotyping, or common sense.

In more precise terms, heuristics are strategies using readily accessible, though loosely applicable, information to control problem solving in human beings and machines.
The Neurosequential Model is not “On the Shelf”

86% of clinical research is never used in direct patient care (Balas & Boren, 2000)

- It takes an average of 17 years for the 14% of research that influences clinical practice to get there (Morris, Wooding, & Grant, 2011)
- NMT was first manualized in 2008 when the NMT Certification Process was developed
- Since then:
  - 35,000 metrics completed
  - over 2000 Phase I trained clinicians
  - 10 Flagship Sites in three countries (US, Canada, Australia)
  - 100 Phase I Certified Clinical Sites & Programs in 16 countries
### NMT Certified Clinicians

- **2nd International NMT Symposium: 2016**
- **Inaugural NMT Symposium: 2014**

### NMT Metric Reports

- **Inaugural NMT Symposium: 2014**

### Cumulative Clinicians, Teachers, Caregivers Exposed to the Neurosequential Model

<table>
<thead>
<tr>
<th>YEAR</th>
<th>Web, Webinars, Books, Live Training</th>
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<tr>
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### NMT Metric Reports

- **Inaugural NMT Symposium: 2014**

### Yearly Metrics

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Total Metrics: 33455

### NMT Level I, II Training Sites

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<td>2017</td>
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Total NMT Level I: 425
Total NMT Level II: 648

### Site User Statistics

<table>
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<tr>
<th>Site Users</th>
<th>Individual Users</th>
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<td>1411</td>
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<tr>
<td>2668</td>
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</table>
"Self-regulation" (SR)

Somatosensory regulation/self-soothing (SS)
- Bottom-Up: Primary
  - Starts in womb; suck/swallow
  - Tied to intrauterine and perinatal associations
  - Breathing, walking, running, rocking, swimming, rhythm
  - Doodle, hum, swing, jump, dance
  - Cortical Modulation (CM)
  - Tied to cortical development & state-dependence
  - Slower process -
  - Dissociation (Diss)

Cortical regulation
- In-Chat: Universal
  - Irrepressible, unavoidable, painful - Universal
  - Adaptive continuum
  - Mind-wandering to threat-induced full dissociation
  - Used rhythmically ("in-out")

Somatosensory regulation (SS)
- Self vs Other

Relational regulation (Rel)
- Positive co-regulation
- Co-dysregulation
- Tied to primary relational templates

Pharmacological regulation (Rx)

Optimal regulatory interactions use "multiple" pathways
- SS and Rel
- Cort and SS
- Diss and SS

REGULATORY OPTIONS

The Six R's
Key Elements of Positive Developmental and Educational Settings
- Relevant (developmentally-matched)
- Rhythmic (resonant with neural patterns)
  - Repetitive (patterned)
  - Relational (safe)
  - Rewarding (pleasurable)
- Respectful (child, family, culture)

Creating the Relational ‘Space’ for Optimal Development, Learning & Healing
(or How do you like those Ps?)
- Present,
- Parallel,
- Patient &
  - Persistent in Providing
- Patterned, Predictable, Positive doses of
  - Protected (safe) experience
The Cycle of Learning

- Curiosity
- Exploration
- Practice
- Mastery
- Confidence
- Pleasure

The brain – particularly the human NEOCORTEX - allows us to absorb the accumulated and distilled experiences of thousands of previous generation – in a single lifetime.

The Relational Landscape is Changing

Children have fewer emotional, social and cognitive interactions with fewer people.

The impact of “modern” life on the developing child has yet to be fully understood.

Poverty of Relationships

The compartmentalization of our culture has resulted in material wealth yet poverty of social and emotional opportunity.

So What? Why does this matter?

Both the STRESS RESPONSE and the REWARD networks in the brain are shaped by relationships in early childhood – in healthy and unhealthy ways.

Relationships have a key role in global health, creativity and productivity of a group.
On Becoming Humane

Being born a human being does not ensure a child will become humane.

Humans become humane. The capacity to care, to share, to listen, value and be empathic – to be compassionate – develops from being cared for, shared with, listened to, valued and nurtured.

Humane caregiving expresses our capacity to be humane. Inhumane caregiving can decrease or even destroy this capacity.
Does the timing of exposure to trauma matter in terms of children's developmental outcomes?

Presented at 2017 American Psychological Association Annual Meeting, Division 53, Washington, DC.
Creating Policy and Practice that Capitalize on Biological Gifts

Democracy, public education, suffrage, civil rights – and, ultimately, early childhood investment and communities rich in relational health.

Mismatch between Opportunity and Investment

Spending on Programs to "Change the Brain"

Brain’s Capacity for Change

People not programs change people!

The effective agents of change in any successful program, project or system are human beings.

Yet successful programs provide the people, process and “program” elements that put the “right” people together in “right” ways at the “right” time.

The effective agents of change in any successful program, project or system are human beings.
The Challenge of “Diagnosis” in Mental Health

NIMH Research Domain Criteria

**RDoC**
- Focus on genetic, epigenetic, neural network and related biomarkers along with “symptoms”
- The major RDoC research domains:
  - Negative Valence Systems
  - Positive Valence Systems
  - Cognitive Systems
  - Systems for Social Processes
  - Arousal/Modulatory Systems

**DSM**
- “A diagnostic system limited to clinical presentation could confer reliability and consistency but not validity”
- Minimal focus on mechanism – fundamentally “descriptive” and symptom focused

The Challenge of “Diagnosis” in Mental Health

**Brain**
- 84 billion unique neurons
  - 5 times as many glia
  - Each neuron 5000 - 20,000 synaptic connections
  - Hundreds of neurotransmitters
  - Hundreds of major neural networks
  - Thousands of functions
  - 90% of children/youth in public MH Clinics have 1 of 8 “diseases” – often “co-morbid”

**Heart**
- 2 billion heart cells
- Dozens of major sub-systems
  - Nerve, muscle, vessels
- A handful of major “main” functions
- Hundreds of distinct cardiac “diseases”

---

**Stress**

- Unpredictable
  - Severe
  - Prolonged
- Vulnerability

- Predictable
  - Moderate
  - Controlled
- Resilience

**Tolerance**

**Sensitization**

**Differential “State” Reactivity**

- Terror
- Fear
- Alarm
- Alert
- Calm
- Baseline
- Stress
- Extreme Stress

Neurotypical

Sensitized

Resilient
All Brain Functioning is “State” Dependent

The brain is a rhythmic, dynamic organ. All functioning of the brain will vary depending upon the “state.”

- Asleep or wakeful the brain will have varying activation in cognitive, social, emotional, motor and all other brain mediated functions.
- Both sleep and wakefulness also have various states which involve shifts in the activity of key neural networks.
- Novelty, transition and threat will all shift internal state.

Responses to Stress, Distress, Trauma

- Heterogeneity of response patterns
- Adaptive changes in cognition
- Adaptive changes in affects
- Adaptive changes in behavior
- Adaptive changes in neurophysiology
- Adaptive changes in physiology

Dissociation/Arousal Balance

<table>
<thead>
<tr>
<th>Dissociation</th>
<th>Arousal</th>
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<tbody>
<tr>
<td>Females</td>
<td>Males</td>
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<tr>
<td>Young Children</td>
<td>Older Children</td>
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<tr>
<td>Torture/Pain</td>
<td>Observer</td>
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<tr>
<td>Inescapable Helplessness</td>
<td>Action</td>
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</table>

The Developmental Window

State Dependence & Differential “Dosing”

- Challenge
- Distress
- Extreme stress

- Terror
- Fear
- Alarm
- Alert
- Calm

All Brain Functioning is “State” Dependent

The brain is a rhythmic, dynamic organ. All functioning of the brain will vary depending upon the “state.”

- Asleep or wakeful the brain will have varying activation in cognitive, social, emotional, motor and all other brain mediated functions.
- Both sleep and wakefulness also have various states which involve shifts in the activity of key neural networks.
- Novelty, transition and threat will all shift internal state.
Flock, Freeze, Flight, Fight Continuum

Traditional Fight/Flight
- Reflect
- Flock
- Freeze
- Flight
- Fight

Primary secondary Brain Areas
- NEOCORTEX Subcortex
- SUBCORTEX Limbic
- LIMBIC Midbrain
- MIDBRAIN Brainstem
- BRAINSTEM Autonomic

Cognition
- Abstract
- Concrete
- Emotional
- Reactive
- Reflexive

Mental State
- CALM
- ALERT
- ALARM
- FEAR
- TERROR

Co-regulation
Reactive child and well-regulated teacher

Co-dysregulation
Reactive child and overwhelmed teacher

DISRUPT
Sensitized
Fear
Alarm
Alert
Calm

Engage

Neurotypical

DISRUPT
Sensitized
Fear
Alarm
Alert
Calm

Engage

Neurotypical

Time

Rhythm & Relationship = Regulation

Present, parallel, patient, persistent – facilitate multisensory, multi-domain, repetitive activity

Present, overwhelmed, frustrated, angry = escalation = increased incidents/restraint

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Semi-structured, quantitative assessment process:

- NMT Clinical Practice Tools (Metrics)
  - Developmental History
    - Genetic
    - Epigenetic
    - Adverse Experiences
      - Developmental Timing
        - Nature, Severity, Pattern
      - Relational Health
        - Developmental Timing
        - Bonding and attachment
        - Family supports
        - Community supports
  - Current Functioning
    - Individual CNS
    - Brainstem
    - Diencephalon/CBL
    - Limbic
    - Cortex/F TCTX
    - Relational
      - Family
      - Peers
      - School
      - Community
NMT Brain Mapping Process

- The key indicator of brain organization and neurophysiological status is function
- By creating a simplified construct – the brain map – assessment of key brain-mediated functions can help “localize” neurodevelopmental vulnerabilities and strengths
- This “localization” helps direct developmentally-sensitive interventions

Neurodevelopmental Risk

- The NMT process involves assessing the timing, nature and intensity of adverse events
- The timing, nature and quality of “buffering” relational health is assessed as well
- An estimate of “developmental risk” is obtained at various times during development by combining the AE and RH scores

Current Relational Health

- A major factor in healing appears to be the nature, quality, intensity and stability of a person’s relationships
- The NMT assessment process includes a simple metric that looks at current relational health
- The score on this metric is a key indicator of outcome – good relational stability predicts positive outcome – and poor relational health predicts poor outcomes
OUTCOMES

Sample Results from Residential Programs and Day Hospital Sites using NMT as a primary practice element

Changes in Brain Functioning:
5 years 11 mo to 7 years 8 mo

Residential Treatment for Children & Youth
https://doi.org/10.1080/0886571X.2018.1425651

Restraint and Critical Incident Rates with NMT Certification
(Percent Pre-NMT Certification Rate)

* = p<0.05; ** = p<0.005; *** p<0.001

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<th>Program</th>
<th>% Baseline (Months)</th>
<th>% Baseline (Months)</th>
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TOTAL % Pre NMT Cert 35.8 *** 47.5 **

Economic Benefits with Introduction of NMT

Ten sites
Three countries (eight states)
Avg duration of site review = 64 months (range 10-132 months)
2744 clients served in the 10 programs during the duration of the review period

Conservative economic benefit from just the reduction in restraints
$1,538,027
4,269 restraints (avoided)
51,228 "person-hours" required for "restraint" re-directed
NMT in Pre-school Setting (Study 1)

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Trauma-Informed Movement in Education (TIME)

Introduction of NME
Columbus Public Schools (2014-2015)

TIME modeled after the ChildTrauma Academy’s Neurosequential Model in Education
Long Beach Unified School District and Beach High School

Introduction of NME
Columbus Public Schools (2014-2015)

TIME modeled after the ChildTrauma Academy’s Neurosequential Model in Education
Long Beach Unified School District and Beach High School

First Grade teacher in Columbus City Schools:
"I would say that I became acutely aware of when I needed regulation and was able to quickly put an activity that allowed me to regulate myself which in turn kept my kids calm. I found myself reverting less to the kids and instead wondering why are they doing this and how can I approach it differently to help them. In my classroom we actually kept data for an ed psych student and we were able to get transitions between activities from 11 to 12 minutes down to under 4 minutes consistently. I just used the tools you gave us and set a system in place where they had specific instructions and expectations and after less than a day they made a significant cut in time and in about a week we met our goal. I can also say that I opened up a half hour of instruction time each day from bathroom breaks. Once we started doing the rhythm activities in the hallway our bathroom breaks went from about 25 minutes to 15 minutes.

The NMT training explained how to address behavioral disruptions that weren’t pertain to the child but still helped the child to make better choices. Once I changed my approach with (male child in class) and gave him acceptable choices his office referrals significantly decreased. I seriously think it was about 2 or 4 weeks to less than 1 week and I wasn’t stressed out by his behavior. I think you gave me the reminder that I can’t control my student’s behavior but I can teach them appropriate ways to deal with their thoughts and feelings. It’s not about having a silent, seemingly perfect class. It’s about building relationships with my kids and giving them the tools and space to become the wonderful little people that they are.

Preliminary Principal in Columbus City Schools:
"We have decreased our discipline referrals by almost 50% in one year. This means kids are in the classroom more and are developing self-regulation strategies that will help them be successful not only in school but in life."

"I, as the principal, am able to have more time to be in classrooms observing and providing feedback to teachers because my staff is equipped to deal with behaviors in the classroom instead of referring kids to the office for me to deal with."

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Beyond Point and Level Systems: Moving Toward Child-Centered Programming

Wanda K. Mohr, PhD, APRN, FAAN
University of Medicine and Dentistry, New Jersey

James N. Olson, PhD
University of Texas-Pan American

Andrea Martin, MD
Yale University

Andrea J. Pumaria, MD
Temple University

Many Medicaid treatment facilities and child care centers in the United States have been structured by an array of institutional programs regarding the care and education of children. This article presents basic principles in this area. First, the authors present the assumptions upon which point and level systems are based. They do not hold up to close empirical scrutiny or theoretical validity, and point and level systems are actually counterproductive for some children, and at times, can precipitate dangerous clinical situations, such as selection and restriction. In this article, the authors critique point and level culminating, and developmentally appropriate treatments, and they offer the evidence and histories of changing national ways of “doing things.” Finally, the authors delineate a new approach to establishing a recovery-oriented, diagnostic problem-solving approach and argue that other systemic models of treatment have been based.

American Journal of Orthopsychiatry
2009, Vol. 79, No. 1, 8–18

The award-winning Napa Infant-Parent Mental Health Fellowship is nationally and internationally recognized as the premier training program in the Infant and Early Childhood Mental Health field.

The ChildTrauma Academy Leadership

Jana Rosenfelt, M.Ed.
Executive Director
Bruce D. Perry, M.D., Ph.D.
Senior Fellow
Gene Griffin, J.D., Ph.D.
Senior Fellow for Policy & Practice
Erin Hambrock, Ph.D.
Director of Research
Emily Perry, M.A.
Director of Education and Training
Steve Graner, M.S.
NME Project Director
Diane Vines, LMFT, LPC, RPT
NMT Program Coordinator

Nothing influences lifelong health and well-being, or development of the brain, more than the quality of relationships and other experiences before age 6.

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The ChildTrauma Academy
www.ChildTrauma.org

Classes start in January 2016 in Napa, CA

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For information, email: NapaFellowship@gmail.com

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Nothing influences lifelong health and well-being, or development of the brain, more than the quality of relationships and other experiences before age 6.
SAVE THE DATE
3rd International Neurosequential Model Symposium
Reflecting on a Decade of Progress – Envisioning a Better Future for Children
Featured speakers include Bruce Perry, Stuart Ablon, John Lyons, Gina Samuels, Bryan Samuels, and Rowena Fong
June 12 – 14, 2018
The Banff Centre, Banff, Alberta, Canada
CTA will also offer an NMT Phase I Boot Camp and NMC Boot Camp in coordination with the 2018 Symposium
Hosted by The ChildTrauma Academy and Hull Services