Module two

Understanding the past for a child or young person

Session plan
<table>
<thead>
<tr>
<th>Time</th>
<th>Resources</th>
<th>Method of delivery</th>
<th>Learning outcomes</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>3hrs</td>
<td>Name Tags</td>
<td>Lecture; large group; brainstorm; activities</td>
<td>At the end of this module participants will be able to: 1. Understand the basic developmental stages of childhood and adolescence 2. Understand what attachment means for a child, and how separation impacts on attachment 3. Identify the types of losses that may be experienced by children who come into care 4. Understand the experience of abuse and how it impacts on children 5. Demonstrate understanding of behaviour management options.</td>
<td>The assessment necessary for each participant will be based on: Participation and observation in discussions and training activities Completion of worksheets at the end of the session and Completion of self-assessment pro formas.</td>
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<tr>
<td></td>
<td>Alternative activity if applicable – cardboard boxes/pens.</td>
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<tr>
<td></td>
<td>Source posters from local child health agencies displaying developmental stages of childhood.</td>
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<tr>
<td></td>
<td>Resources can be obtained from CSSC staff or via a search of the Child Safety internet, Infonet or within the Child Safety Practice Manual.</td>
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<tr>
<td>Time</td>
<td>Content</td>
<td>Resources/Additional comments or questions</td>
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<td><strong>Introductions and welcome activities</strong></td>
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</table>

**Acknowledgement of Country**

I would like to respectfully acknowledge the Traditional Owners of the land on which we are meeting and remind people that we are on Aboriginal land.

I also would like to acknowledge and pay my respect to the Elders (both past and present) and extend that respect to other Aboriginal Australians who are present.

Thank you |
|      | **Distribute name tags and show Slide 1.** | Name Tags - Slide 1 |
|      | **Introduce trainers** |  

*Brief overview as participants should have this knowledge from Module one.*

**Housekeeping details** – provide the location of exits and toilets, breaks and catering, arrangements for smokers, phone messages. Include here fire, evacuation and emergency exit and meeting points as well as any other WH&S procedures required. |
|      | **Brief overview as participants should have this knowledge from Module one** |  


<table>
<thead>
<tr>
<th>Group Rules</th>
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</table>
| These should be sourced from the group - ask what people would need from the group in order to feel comfortable. Ensure that the following are covered:  
1. Confidentiality – any information that is shared in the group will be confidential to the group – link to need to respect confidences in a placement situation;  
2. Mutual respect and tolerance for a diversity of opinions and experiences;  
3. Punctuality and respectful processes in discussion. |

<table>
<thead>
<tr>
<th>Brief overview as participants should have covered this part in Module one.</th>
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</table>

**Overall aim of Quality Care: Pre service training.**  
Explain that at the completion of all the training modules participants will be assessed on the learning objectives and their ability to:  
1. Demonstrate an awareness of why children and young people require out-of-care home placements, how children come into care, and the impact this process has on children and young people;  
2. Demonstrate an understanding of the past issues affecting a child or young person in an out-of-home placement;  
3. Develop the knowledge and skills to meet the physical, emotional and social needs of children and young people subject to statutory intervention, and develop an understanding of the importance of participation by children and young people and their families in decision making; and  
4. Demonstrate an understanding of the partnerships that exist between children, their families, foster carers and workers (both in the government and non-government sectors), and their roles and responsibilities of working together as a team.  

Remind participants that Pre-service training is provided in 4 parts and this is Module two.
1. Brief Re-Cap of Module One: Context of Foster Care

**Show Slide 2**

In module one we covered the following:

- Why do you want to be a foster carer?
- Why does a child or young person need an out of home care placement?
- How do children and young people come into care and who makes decisions?
- Roles and responsibilities of foster carers in meeting the needs of children and young people and the differing roles between the Department of Communities Child Safety and Disability Services (Child Safety), and Licensed Care Services

Module Two: Understanding the past for a child or young person

Show and discuss the learning outcomes for these modules.

**Show Slide 3**

**Show Slide 4 – Content of Module 2**

*Highlight time allocated for each session.*

1. Stages of Development - **30 mins**
2. Responding to Attachment - **40 mins**
3. The longing to Belong – Loss and Grief Reactions - **30 mins**
4. The Experience of Abuse - **40 mins**
5. Responding to Challenging Behaviours - **30 mins**
### Introduction Module two

Module 2 will focus on understanding the past of a child coming into care and the impact of this on their current and future care needs.

Children in care often respond to situations in ways we are not expecting.

**Show slide 5**

Most have **experienced harm or neglect**. Often their **relationships and attachments** to significant people have been disrupted which impacts on their wellbeing, emotional and behavioural responses. Their experiences of **abuse, grief, loss and separation** will impact significantly on their fears, anxiety, behaviour, sense of self and wellbeing.

**Show Slide 6**

The impacts of these experiences mean that children in care might be at **different stages of development** than other children their age and might struggle with relationships and to regulate their behaviour and emotions.

**Show Slide 7**

The child’s wellbeing, behaviours and care experiences are enhanced when carers have the ability to understand the complex interplay of the child’s past, grief and loss, child development and attachment issues, particularly in times of conflict and stress.

The carers role is to develop a deep understanding of where the child is at, **show compassion** for the child’s suffering, **provide stability** and to **assist and support** the child with new social and behavioural skills.
The child’s new learnt skills will improve their connections to you as a carer and to others by developing skills to manage relationships, rules and boundaries as they age. As you connect with children in new ways, they can also begin to see themselves in a more positive light.

Research conducted by CREATE also shows that 95 per cent of children and young people rated having a say and being listened to whilst in care as ‘very important’.

**Maintaining positive relationships with siblings, extended family and community members** is also crucial, especially for Aboriginal and Torres Strait Islander children. It is important to remember that children may be connected to, and require contact with, various community and family members as they may have experienced collective parenting from a range of family and community members.

### 30 mins

#### 2. Stages of development

**Activity – Brainstorm Show Slide 8**

Ask the participants to brainstorm “milestones” that children and young people achieve as they grow. Ensure the following is covered: for example:

- physical (walking, coordination)
- cognitive (thinking, speech development)
- emotional (trust, attachment)
- self confidence
- self-reliance
- social (sharing and cooperating) and
- moral (sense of right and wrong, consequences).

**Slide 8**

Display posters of child development from child health agencies around the room

Whiteboard/Pens

Mark the years from 0-18 in increments of 2 years on the whiteboard.

Now ask the participants to slot “milestones” against the age levels.
Emphasise that all young people grow at different rates in all areas of development. Encourage discussion of how all children are different.

Discuss why all children are different? Compare children whom participants have known. Discuss the environment, social conditioning and biology as reasons for differences.

What is likely to be happening for children in care? Use the case examples to show possible reasons for delays in development.

Handout
Hand out and Refer to the Department of Human Services “Child Development and Trauma Guides

Links to print guides and information pages of guides is:


Brainstorm

Stay on Slide 8
Ask the group what carers can do to assist a child or young person in meeting developmental levels? This should be an interactive session with participants giving examples from their experience/knowledge.
### Physical

- need to develop physical and coordination skills. Examples of what carer can provide –
  - safety
  - food
  - shelter
  - allow freedom to explore the environment
  - encourage physical activities.

### Cognitive

- need to think, communicate, interpret the world. Carer can help develop:
  - speech
  - hold family discussions
  - allow child or young person to take responsibility for tasks such as helping with shopping and menus.

### Emotional

- need a sense of trust, good self esteem and exhibit appropriate behaviours. Carer can provide sense of:
  - safety and security
  - special room
  - consistency
  - encourage child or young person to identify and name feelings and deal with them in a positive way.

### Social

- need to develop relationships. Carer can provide opportunities for:
  - social interaction
  - invite friends home
  - role model relationship skills.

### Moral

- need a sense of right and wrong, take responsibility for own behaviour. Carer can set:
  - boundaries
  - discuss consequences for behaviour and
  - draw parallels from TV shows or books
Highlight that if a carer has concerns about developmental delays, they should discuss this with the CSO. A letter of support from a Doctor, Teacher or other can also be helpful in securing support for a referral.

### 20 mins

#### 3. Responding to attachment issues (Transforming care excerpt)

**Show Slide 9**

Trainers are able to use any resource (video, DVD, handouts, own slides), relevant to their training group, that will assist them to explain this section and meet the required competencies.

A DVD resource is available at British Association for Adoption and Fostering (BAAF) website e.g [Attachment for foster care and adoption - A training programme](#)

This section is to assist you to understand the basic principles of attachment and how attachment occurs. There is an advanced module – ‘Attachment’ that carers should consider which provides more about attachment theory and impacts for children in care. This attachment session is only one theory on child rearing and development and is relevant mostly to care environments for non Aboriginal or Torres Strait Islander children.

If you are asked to care for an Aboriginal or Torres Strait Islander child it is crucial that you understand the collective attachments and child rearing practices relevant for that child. This information can be obtained from the child’s CSO. Parenting and child rearing practices are very different for Aboriginal and Torres Strait Islanders than non indigenous carers. Collective practices includes a greater tendency to think of oneself in terms of affiliation with others, community and country. Children are often cared for by a range of women, including older children, as well as their mother. Children may also have lengthy stays away from their birth parents due to cultural ceremonies. Children are encouraged to be self reliant at an early age. Autonomy in daily functioning is more common, including children feeding themselves at an earlier age. To minimise any cultural biases it is important to seek out advice prior to agreeing on a placement.

Attachment is often described as the emotional connection developed between an infant and their primary parent or care giver, often starting just hours after birth.
While attachment is often talked about in relation to an infant and their parent or primary caregiver, infants, children and young people can and do develop and build attachment relationships with additional people throughout their lives. Eg. Grandparents, babysitters, uncles/aunts, foster and kinship carers as well as community members and elders.

Attachment is described as a relationship, stronger than a bond which involves a connection between the infant and a caregiver through behaviours such as smiling and cooing. Attachment is the development of a nurturing, soothing and trusting relationship where the infant finds security and safety in the context of this relationship.

For example; An infant becomes hungry (has a need for food) and responds to stress by crying; a responsive carer ensures that the infant is fed (and comforted) and the infant moves into a period of calm. This is part of what is called the attunement cycle. Attunement is the reading and responding to the cues of another accurately and consistently.

Show Slide 10

The repeated reliable actions of the attachment figure create periods of calmness and stillness for the infant. In time, as the adult reliably responds to the infants needs, the infant develops a sense of trust and safety and a specific attachment to the carer.

As children get older they learn to have their needs met in increasingly independent ways. Secure toddlers learn that it works to ask for something to eat rather than cry and later they are able to get some food for themselves. Older children may need less frequent reassurance but still may need support if upset with friends.

Attachment theory suggests that a child’s behaviour, emotional responses and psychological development, both positive and negative, is learnt through attachment relationships throughout the life course. Understanding that behaviour is learnt allows us to move away from viewing a child as ‘bad’ and to understand they are using strategies they have learnt in order to survive very difficult situations.

This means that as foster carers the type of relationship you have and a commitment to a positive relationship or attachment to the child in your care can significantly improve their future relationships, problem solving and behaviour skills as they age, even if you care for them for just a short period.
This is important to remember when things get tough or you are dealing with the behavioural effects of the child’s past relationships. The way you respond in times of conflict or crisis will influence not only your relationship with the child but also how they will see, experience and behave in their own future relationships.

**Show Slide 11**

Where **care giving is sensitive responsive and attuned to the child’s needs** the attachment is considered to be **secure** (solid, healthy and comforting) leading to emotional stability and adaptable behaviours to new experiences.

However, other attachment relationships are considered to be **insecure** (chaotic, avoidant, distressing and confusing) sometimes leading to behavioural, emotional, psychological and social challenges for the child (avoidance of intimacy, fearful, anxious, hyper vigilant, frustrated, hostile behaviours).

Attachment issues can occur when something goes wrong in the attunement cycle and the parents or carers response is not congruent with the infant’s or the child’s needs. Some children learn extreme behaviours in an attempt to secure their parent’s attention and/or learn there is no point in expecting adults to respond.

**Show Slide 12**

Attachment theorists describe **Three Insecure Attachment Style including:**

1. **Avoidant/Resistant** style: where infants have experienced parenting that is poorly attuned to their needs. Such babies show little distress when their primary care giver leaves them and pay no particular attention or actively turns away when they return.

2. **Anxious/Ambivalent** style: where carer attunement has been erratic, over stimulated or inconsistent to the infant’s needs. Infant behaviours include clinging to their carer, distress when they leave and show little joy upon the carers return.

3. **Disorganised/Disoriented** style: in which infants have experienced parenting that is chaotic, intrusive or hostile in nature. These infants display negative and overwhelmed reactions to all new experiences and often spend time as if in a trance. Infants can freeze or engage in motions such as rocking or head shaking. They also engage in “approach avoidance” behaviour, unsure of whether they should approach the carer when they appear (Noller et al, 2001)
**Show Slides 13 and 14**

**Activity**

Matching Activity: ask participants to match the child and care giving (the child's carers) behaviours in the slide boxes to the four attachment type Secure, Avoidant, Ambivalent and Disorganised. Slowly read out the definitions of these as described for the trainer above next to slide 12 to assist the carers.

The trainer could also print out or write the definitions to assist the participants make the match.

Then come back to the bigger group and discuss the answers

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**Brainstorm**

Ask participants what might happen to prevent development of positive attachments for children. Examples might be:

- The person providing the care is unpredictable. This could occur because that person’s own needs are overwhelming (eg substance abuse), or they are experiencing domestic violence, or they are not able to parent effectively because of their own history and background or medical condition.

- The child or young person may have experienced repeated rejections by parents or foster carers. This may occur with repeated placement changes. Children learn that adults cannot be trusted.

- Inconsistencies in care or punishment techniques. This can occur with extremely stressful events – for example, abuse.
Show Slide 15

Proceed with discussion of how help can be given to children and young people with attachment difficulties

Discuss with the group what a carer can do to help children with attachment difficulties?

1. **Preserve attachments.** E.g., every effort should be made to maintain and further strengthen existing attachment relationships. This is equally the responsibility of the CSO, foster carer and family.

2. Provide **consistent, predictable and repetitive** environments. This may make a child feel safer and know what to expect.

3. **Understand why** a child could be behaving in a certain way. This may change the way you respond to their behaviours and their issues.

4. Remember that the child or young person may display emotional behaviour that is not consistent with their age level. For this reason it is important to **respond according to their emotional level.** E.g. it may be inappropriate to reason with a child who is tearful and overwhelmed.

5. **Be patient and have realistic expectations.** Model appropriate behaviour and explain what you are doing and why. Try not to make a child or young person feel bad or guilty about their behaviour.

In the case of **Aboriginal and Torres Strait Islander children and young people** it is important to remember that attachment may occur within a **broader context of extended family and community. Preservation of relationships** within that context becomes critical in order to maintain positive attachments with others.

30 mins

4. **The longing to belong – loss and grief reactions**

Show Slide 16

**Handout** - “Stages of grief and loss” and refer participant to handout “The longing to belong – loss and grief reactions”

Note: Information available in Handout
As we have seen, sometimes children and young people who come into care have not had the opportunity to develop secure attachments.

Rejection or perceived rejection by the person who provides primary care can lead to insecure attachment.

If a child or young person experiences rejection or abuse, or lives with inconsistencies in care, it is likely that they will feel confused about their relationship with the person providing that care. On the one hand they may not be able to get close to that person, but they still feel some attachment to them. A sense of loss and pain can occur.

Be careful though when thinking about these stages. People rarely move neatly into the next stage and in an upward direction to acceptance.

It is very common that a child or young person will move in and out of stages depending on the situation.

For example, a child may show anger and withdrawal after family contact. This can be seen by carers that the experience of contact wasn’t good. However, it could be that contact was good but the experience of separation from family again sends the child back into denial, anger and sadness. Children can also be triggered into a grief reaction by sight, smell, touch and taste stimulus. A memory of a parent may be recalled if they can smell their favourite dinner cooking.

Show Slide 17

When a child or young person has to leave home to live with foster carers there are further losses for them.

Existing bonds – even though those bonds may themselves be unsatisfactory - are disrupted, and children or young people may struggle to maintain an attachment to a harmful family situation or unavailable parent.

The following behaviour may be evident:

- Running away from a placement to return home
- Strong defence of parental behaviour, even when promises are broken
- Fantasising about parents and the home situation
- Self harming behaviour
- Fear of getting close to others

<table>
<thead>
<tr>
<th>Loss of a relationship</th>
<th>The <strong>loss of a relationship</strong> with parents or significant others will be compounded by changes in other familiar things, such as schooling, friends, and shops.</th>
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<tbody>
<tr>
<td></td>
<td>There is also a <strong>loss of a sense of belonging and a rupture of “what is known”</strong>.</td>
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<td></td>
<td>For a child or young person coming into care there may be a <strong>number of crises, separations, moves and losses</strong>. They may not have dealt with one before another happens.</td>
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<td></td>
<td>Thus children or young people in care may be far more emotionally vulnerable when another loss occur.</td>
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<table>
<thead>
<tr>
<th>Some common reactions of children and young people:</th>
<th>Some common reactions of children and young people:</th>
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</thead>
<tbody>
<tr>
<td>- “It’s all my fault – I’m no good”.</td>
<td>- “It’s all my fault – I’m no good”.</td>
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<tr>
<td>- “Everyone is against me”.</td>
<td>- “Everyone is against me”.</td>
</tr>
<tr>
<td>- “I don’t need anyone”.</td>
<td>- “I don’t need anyone”.</td>
</tr>
<tr>
<td>- “I hate everyone”.</td>
<td>- “I hate everyone”.</td>
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</table>

### Loss and grief and re-learning the world

*Show slide 18*

After a significant loss there is a period of grief that is an important part of moving forward to cope with a changed world. It is not a matter of just learning information about the new world, but more a process of learning how to “be and act” differently in this changed world.
There are 4 significant areas of “re-learning” that a child or young person must cope with when they move to a placement.

1. **Re-learning physical surroundings.** Ask participants to think about the things that have changed in the physical environment when a child or young person moves. What new things will they need to “learn” about their physical environment?

2. **Re-learning relationships with parents, other family members, carers** and others. Ask participants how relationships may have changed with natural family and what might be difficult about learning new relationships.

3. **Re-learning self.** Often a child or young person who comes into care is still learning how to be themselves in a chaotic and unpredictable world. Suddenly they are challenged to adjust to new unknown situations and there can be impacts on sense of self, confidence and self esteem.

4. **Re-learning place in space and time.** Often a child or young person is confused and wishes they were somewhere else. Memories can be triggered at any time and a child or young person may be responding to a situation from the past.

### Needs of Aboriginal and Torres Strait Islander children

Issues of placement outside extended family networks take on greater significance in terms of grieving, especially where placement cannot always occur within the same community grouping. **Highlight the importance of placing a child with their family and community and how reunification is the primary goal of child protection work.**

### 45 mins 5. Summary - The experience of abuse

One of the most challenging parts of foster and kinship care is understanding the past of a child in care and dealing with the behaviour they have learnt to survive their pain, fear, confusion and hurt.
We have just discussed the impact an abusive past can have on developmental milestones, social skills, maintaining relationships, attachments and grief and loss.

The behaviours highlighted in today’s module are indicators only and it is always important to see these in the context of normal behaviour patterns for each individual child or young person. For example – temper tantrums/ aggression are often present in normal developmental milestones. It is important to consider not only the impacts of abuse, attachment issues and grief and loss but also the normal development milestones that were discussed earlier.

**Activity - behaviours of children who have experienced abuse.**

*Explain that further information has been added to the case studies, although they are still about the same children.*

Refer to Handouts “Case Studies 1, 2 and 3 - Part 2”. We have looked earlier at how each child would be feeling and the role the carer might play in meeting their needs. We will now consider the links between the experience of abuse and the child’s behaviour.

**Consider the case studies again with Part 2. Ask participants to identify any behavioural indicators related to developmental stages, attachment issues and grief and loss for each child**

Whiteboard/pens

As a large group consider the following questions:

1. **What is the range of behaviours (both positive and negative) that each child is exhibiting? E.g. Possible behaviours – aggression, violence, attention seeking, self-harm, running away, clingy behaviour, overly dependent behaviour, lying, stealing**

2. **How could these behaviours be linked to the experience of abuse?**

**Experience of sexual abuse**

Sexual abuse is common in our community. While exact figures of sexual abuse towards children are unknown some research suggests that one in four girls and one in seven boys will have experienced some form of sexual abuse before the age of eighteen years.

Note: Information available in Handout and on the True website www.true.org.au
Highlight that this issue may evoke strong feelings in participants and offer de-briefing for anyone who may feel the need to talk to someone afterwards. Make it clear that participants do not need to reveal anything about their own experiences in the group.

<table>
<thead>
<tr>
<th>It is common for children in care to have experienced sexual abuse. Ask participants to get into small groups and complete the true/false activity “The Facts about Sexual Abuse”</th>
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</thead>
</table>

Show Slide 19

The **effects of sexual abuse** can last a lifetime and may be observed in children and young people as:

- **A pre-occupation with sexual matters that are not age appropriate**, including a detailed knowledge of adult sexual behaviour. Ask the group to identify sexual behaviours that are both age, and not age, appropriate;
- **Sexual themes in play, artwork etc.** It is important to bear in mind that the behaviour must be persistent and the child must appear obsessed with acting out sexual themes;
- **Inappropriate sexualised behaviour that is persistent** e.g. at school, with friends, siblings;
- **A fear of going to bed, bathing, getting changed, being left alone with an adult.** Sleep disturbances can also occur.

Evidence of one of these behaviours is not an automatic indication that sexual assault has occurred. However it would alert you to the possibility and you should **discuss it immediately with the CSO**.

Show Slide 20

What the foster carer can do:

- How you respond to a disclosure or behavioural indicators will have a significant effect on the child or young person’s adjustment. It is important to **listen** to what the child or young person is saying or doing. **Experienced foster carers may give examples of what might be said by the child or young person to communicate the problem.** Facilitate group discussion.
- **Define rules and boundaries** in the home to allow respect for individual privacy, particularly around dressing, bathing and sleeping. Be aware of the appropriateness of touching or personal space, particularly with respect to kissing, touching, hugging. Children and young
people who have experienced sexual abuse may not know how to interpret this behaviour. The experienced carer might want to give examples of the rules and boundaries they use and how to avoid misinterpretation of behaviour and possible allegations.

- Assist the child or young person by **building self esteem, teaching assertiveness and teaching self-protective skills** and behaviours.
- Discuss the need for **sexual abuse counselling**. This is usually required to ensure that the child or young person deals with feelings about the abuse and becomes a “survivor”. A carer can assist in the healing process by being respectful and available to the child or young person according to their needs.
- Be aware that children and young people who have been sexually abused may be vulnerable in a number of ways. **Refer to Indicators of Child Sexual Abuse from the handout.** One possible behavioural indicator may be that the child or young person has a preoccupation with sexual activity, and may engage in inappropriate actions with other children in the placement. Carers must carefully **consider the level of supervision required in the household.**

**Activity – optional – experienced foster carer can facilitate**

Ask the participants to get into small groups to discuss some ways they could reduce the likelihood that misunderstandings can occur or allegations can be raised about them.

Bring back to the bigger group and discuss.

**Resources available**

‘True’ has various fact sheets, DVD’s and brochures that can assist carers. Please write on the whiteboard their website address at [www.true.org.au/All-resources](http://www.true.org.au/All-resources)

**Handout – ‘True’ resource – sexual behaviours in children and adolescents**

**Self Harm Behaviours**

There is no universal definition of self harm or age that a child may start self harm or suicidal behaviours.
Generally, **self harm** is understood to involve **a person deliberately causing themselves physical pain** as a means of managing difficult or painful emotions, or as a way of communicating distress.

<table>
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<tr>
<th>Risk Factors</th>
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<tbody>
<tr>
<td><strong>Reasons</strong> for self harming are often diverse and may be a response to <strong>low self esteem, family and relationship breakdowns, anger, emotional difficulties, traumatic life experiences or grief.</strong></td>
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</tbody>
</table>

Self harming behaviours can be linked to substance abuse and mental health issues, for example, depression, personality disorders, eating disorders and anxiety.

### Self Harm and Suicide

Usually, the motivation for self harming behaviour is to **cope with painful emotions and distressing personal experiences and not to result in death.** *Eg. If I physically hurt, it’s better than crying or yelling.*

Any action deliberately intended to cause death is regarded as a suicide attempt. Any deliberate attempt on one’s life that results in death is suicide.

### Show Slide 21 and 22

**Indicators of Self Harm** – things for carers to look out for:

*Discuss the content of the slides with participants.*

**Slide 21 and 22**

<table>
<thead>
<tr>
<th>Physical Signs:</th>
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<tr>
<td>• Loss of interest in personal hygiene</td>
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<tr>
<td>• Loss of interest in personal appearance</td>
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<tr>
<td>• Signs of self-harm: cuts, burns, marks</td>
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<table>
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<tr>
<th>Emotional Signs:</th>
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</thead>
<tbody>
<tr>
<td>• Increased anxiety</td>
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<tr>
<td>• Decreased interest in activities</td>
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<tr>
<td>• Excessive crying</td>
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<table>
<thead>
<tr>
<th>Behaviours:</th>
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<tbody>
<tr>
<td>• Withdrawing from friends and family</td>
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<tr>
<td>• Avoiding school or work</td>
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<tr>
<td>• Changes in eating habits</td>
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</table>

*Discuss the content of the slides with participants.*
Some basic **practical strategies** to use if a child is self-harming or has suicide ideation include:

- not leaving the child or young person alone;
- removing or safely securing any available means of self-harm and suicide, for example, weapons, medications, alcohol and other drugs, access to a car;
- Don’t judge a young person’s problems or minimise the significance for them;
- Don’t ignore the situation and hope they ‘will get over it’;
- Be honest, supportive and loving;
- Tell them what you have noticed – share your concern;
- Ask them directly if they are thinking about suicide;
- Listen to their pain – what’s on their mind and why it matters so much to them;
- Provide personal support that helps keep them safe;
- Seek further help – from family and friends, from people who care, from a local GP, a counsellor or a psychologist.

*Trainer can refer to or use the following information and fact sheets*


What to do if a child or young person discloses abuse to a foster carer

**Show Slide 24 “Responding to disclosures”**

**Slide 24**

**Responding to Disclosures**

- Be a listener not an investigator and encourage children to talk in their language and ask just enough questions to act protectively.
- Ask “How have you felt about that?” and “What happened next?” Do not ask about any form of interview with the child.
- As soon as possible after the disclosure make referrals including where you are and where the disclosure took place. Pay attention to body cues such as changes in their behaviour, feelings, and words they used.

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**Show Slide 25 “Responding to disclosures” continued**

**Slide 24**

**Responding to Disclosures**

- Be a listener and reassure the child or young person that it’s alright to talk about this and they have not done the wrong thing.
- Listen carefully and demonstrate that you are taking them seriously.
- Tell the child or young person that you will now talk it to their CSSD. You should arrange the child or young person in the way the information needs to be shared with someone and ask them if you can help with this.
- It is vital to call your CSSD even if you do not have all the details.

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Role play activity
| Presenters to role play a young person disclosing abuse to a foster carer.  
Demonstrate an appropriate response:  
- Remain calm and reassure the child that it is ok to talk about this. Tell them they have not done anything wrong  
- Acknowledge their feelings  
- Show them that you are listening to what they are saying and that you are taking it seriously  
- Don't conduct an interview or cross examine the child. Ask enough questions to act protectively eg “can you tell me some more about that?” “what happened next?”  
- Refrain from offering your own opinions  
- Tell the child or young person that you will both need to talk to their CSO together.  |
|---|---|

**30 mins  5. Responding to challenging behaviours**

In previous sessions we have looked at the impact of abuse, poor attachments and the experience of loss and grief for children and young people. As discussed these experiences can have a significant impact on a child or young person’s behaviour and actions.  

| Carers need to consider these issues when deciding on suitable behaviour management and support strategies. Children and young people in foster care may present with behaviour that is extreme and more difficult to manage than one would expect from one’s own children.  |
|---|---|

Handover to the experienced foster carer to discuss some experiences they have had, strategies they use and to facilitate brainstorm exercise. Ensure experienced foster carer is utilised well throughout this session.

| Brainstorm  
Ask participants why children and young people in care may exhibit more extreme patterns of behaviour.  |

| Experienced foster carer trainer to facilitate  
Bruce Perry DVD on trauma - It’s a jungle out there  |
| **Ask the group what some of those inappropriate behaviours might be?** |
| **Relate these behaviours to the negative messages children and young people have learned about the world.** |
**Handout – Practice resource: Support Levels and behaviour characteristics, discuss briefly the different levels.**

| **Remember that carers are real people and are not expected to be superheroes. Children and young people need carers who can change and grow, acknowledge their own mistakes and when necessary say sorry. This is a good model for children to observe.** |

| **Why is it not ok to use physical punishment?** |
| **The reasons for precluding the use of physical discipline for children and young people in care are that:** |
| **Children and young people in care will have experienced some kind of abuse in the past and been hurt in the past. Even mild smacking may trigger reactions based on those past hurtful experiences. It demonstrates to the child that you are no different to the adults who have hurt them in the past. This vulnerability is a significant reason for avoiding physical punishment.** |
| **Physical punishment may reinforce a child or young person’s view of themselves as “deserving” cruelty and victimisation. Sometimes it is the only attention they have been able to get – so they feel that is all they are worth.** |
| **Physical punishment models aggressive behaviour and teaches a child that bigger people use physical force to get their own way. Violence is modelled as a way to overcome frustration.** |
| **It does not encourage a child or young person to learn to take responsibility for their own behaviour – it encourages them to devise ways to avoid being found out. It teaches children what not to do-not what to do.** |

**Handout - Practice resource: Support levels and behaviour characteristics**
Children and young people who come into care have the right to a high standard of care and should not be placed in any situation that might potentially place them at further risk.

Show Slide 26
Positive Behaviour Support

Using appropriate behaviour management techniques and promoting positive behaviours is a key role of a foster and kinship carer. The Child Protection Act 1999 is clear that techniques for managing behaviour must not include corporal punishment or punishment that humiliates, frightens or threatens the child in any way likely to cause emotional harm.

The Positive Behaviour Support policy was implemented to help carers and staff meet their legislative responsibilities when responding to a child’s behaviour and includes guidelines for the use of interventions when responding to extreme or dangerous behaviours.

Positive Behaviour Support is defined as responses that assist a child to learn acceptable behaviours through positive strategies such as role modelling, positive reinforcement, skill development and collaborative and inclusive approaches.

Positive Behaviour Support and carers

Information about the child’s behaviour is gathered over the period the child is in care and this will include notes or reports from foster carers. If any children are identified as having significant behavioural issues or are at risk of displaying behaviours which may have a negative consequence for the child or young person and/or others a behaviour support plan will be developed as part of the child’s case plan.

Part of the plan may include referrals to specialist services such as Evolve Interagency Services and Disability Services to assist in developing a comprehensive behaviour support plan.

Case work support to the carer will include assisting them to plan and implement strategies to de-escalate negative behaviours through positive responses such as re-direction, changing the environment and removal of privileges or attention for a period of time.
At times children and young people may display behaviour of such intensity, frequency and duration that the behaviour places their safety and/or the safety of others at risk. In such circumstances, it may be necessary for carers to respond quickly or take emergency actions.

This may involve the use of **reactive responses**, particularly for children and young people whose actions include self-harming, violence towards others, sexualised behaviours, offending behaviours and substance misuse.

**Reactive Response**

**Show Slide 27**

When responding to unsafe behaviours of children and young people, carers may be required to intervene with reasonable force to protect the child, themselves and others.

Reasonable force is defined as **the minimum force necessary** to protect the child, oneself and others from injury or harm.

Where reasonable force is used, this must only be in conjunction with the use of a reactive response and **not** a prohibited practice.

Reasonable responses are defined as **immediate** responses where reasonable force is necessary to respond to a child or young person’s behaviour to ensure the safety of those involved while avoiding potential escalation of the behaviour.

Reactive responses may include:

- Temporary physical restraint of a child or young person to prevent an injury or accident. This involves restricting the child or young person’s freedom of physical movement to ensure their immediate safety or the safety of others. **Physical restraint is the holding of any body part and should only continue so long as necessary for the child or young person to no longer be at risk of significant immediate harm to themselves or others.**

- Removal of illegal or harmful objects that may be used to harm self or others

- Relocation of a child or young person to another area that provides safety.
Refer back to the policy and explain the reporting requirements and if there has been a breach of the standards of care, briefly explain the responding to concerns about Standards of Care process and this will be explored in later modules.

**Prohibited Practices**

**Show Slide 28 and 29**

Prohibited practices are responses to the behaviour of a child or young person which interfere with basic human rights.

Unlawful and unethical practices are prohibited practices, as are practices which cause a high level of discomfort and trauma.

Any action which is contrary to section 122 of the *Child Protection Act 1999* because it frightens, threatens or humiliates a child or young person is a prohibited practice.

Prohibited practices must not be used in responding to the behaviour of children and young people who are placed in out-of-home care under section 82 (1) of the *Child Protection Act 1999*.
### Show Slide 30

Examples of Prohibited Practices include:

#### Confinement

**Containment or seclusion** where a child or young person is detained or forced to remain in a room or place they cannot leave. It does not include steps taken by a carer in a parenting role to discipline and respond to a child which are reasonable in all the circumstances surrounding the child’s behaviour and which do not frighten, threaten or humiliate the child.

For example, the use of short periods of “time out” type strategies consistent with accepted parenting practices (such as the Triple P program) is permitted, as is the normal use of age and developmentally appropriate items such as cots, play pens and rockers.

#### Aversive

The **application of painful or noxious conditions** (eg. Unwanted cold or hot baths, application of chilli powder on food or body parts, unwanted squirting of liquid) on a child’s face or body parts.

#### Mechanical Restraint

The **use of devices to intentionally restrict a child’s movement**. It does not include age and developmentally appropriate functional devices used to assist and support involuntary movement such as a wheel chair or age and developmentally appropriate aids and support devices used to prevent injury, such as a high chair, cot, harness or car seat.

However such devices are **prohibited** where they are used as punishment, for a lengthy period or where developmentally inappropriate.

#### Chemical Restraint

The intentional use of medication, without the prescription of a registered medical practitioner, to control behaviour, sedate for convenience sake or disciplinary purposes.
It also includes the misuse of medication prescribed by a registered medical practitioner, where it is used contrary to the instructions.

**Corporal Punishment**

Corporal or physical punishment is the *use of physical force intended to cause some degree of pain or discomfort* for discipline, correction, control, changing behaviour or in the belief of educating the child.

For example, hitting, slapping, whipping, caning, kicking, pinching, punching, pushing or shoving.

**Unethical Practices**

Examples of unethical practices include:
- Rewarding children or young people with cigarettes;
- Using family contact as a reward or the withdrawal of family contact as a punishment;
- Deprivation of meals, sleep, clothes, shelter, personal hygiene and medical care;
- Threats that a child may not participate in social or educational activities;
- Humiliation;
- Denial of visits to family, even where this appears to be causing escalation of behaviours;
- References to the security of the placement;
- Derogatory remarks about the child, their family or cultural background.

Any incident of the use of prohibited practices in relation to a child in out-of-home care must be immediately reported by the carer to the CSSC or AHCSSC. It will be responded to according to the Responding to Concerns about the Standards of Care Policy.

Information received by Child Safety in relation to the use of prohibited practices that may constitute a possible criminal offence must be immediately notified to the Queensland Police Service.
Refer back to the policy and explain the reporting requirements and if there has been a breach of the standards of care, briefly explain the responding to concerns about the Standards of Care process and this will be explored in later modules.

### Activity

Ask large group for examples of inappropriate behaviour they have experienced in children or young people, either their own children, or children they have known. Point out that most children and young people will display some form of inappropriate behaviour at some time.

Ask participants about their attitude to inappropriate behaviour – illustrate how we can all have different attitudes to behaviours. Make the following points:

- We may have different thresholds of tolerance to some events – perhaps because of previous experiences. It is important to recognise what the “hot spots” are for us. Link to our own upbringing.
- The context of the behaviour may influence our attitude towards it, eg we may expect, or be more ready to understand changes in behaviour if a person is upset or has experienced a traumatic event.

Ask the participants for examples of where they effectively managed some challenging behaviour - what worked, why and would they do the same again?

**Show slide 31 and 32**

*After the activity show slide 33 to provide other supports carers can use. Highlight the difficulties with providing general appropriate rules, boundaries and techniques to use because each child will be different and have experienced a different past. E.g. timeout might not be appropriate for children who have been abused by being left alone or excessively disciplined in this way.*
Alternative Activity

Alternatively you could use the following activity. Use some cardboard boxes and record on each box in large letters an example of one behaviour of a child. Ask for a volunteer to be a young person and ask them to hold each box as you identify the behaviour. Point out that this is how a child or young person will arrive on your doorstep. What will it mean for how you establish a relationship? How can you “relieve the load” – take each box away as the group identifies ways to respond to that behaviour?

Brainstorm appropriate disciplinary methods. Record on the whiteboard.

Discipline vs. punishment

Conclusion

*Summarise the content* - the experience of managing grief, loss and challenging behaviours can be difficult and frustrating at times. It is always important to reinforce gains that the child or young person has been making, and assure the child or young person that we are still on the right track, in spite of a setback. Remember that the child or young person may be expecting to be rejected – and may even behave in a way that seems to provoke that – so it is important to reinforce trust, commit to positive attachment and provide stability and security.

You do not have to deal with this by yourself. Support should be sought from your worker at the foster and kinship care agency or Child Safety about strategies to use to manage behaviour. If necessary you should advocate for professional help for yourself and the child or young person.

Refer to 2.4 Assessment.
Reminder to collect Worksheet questions from Module one.

Thank you