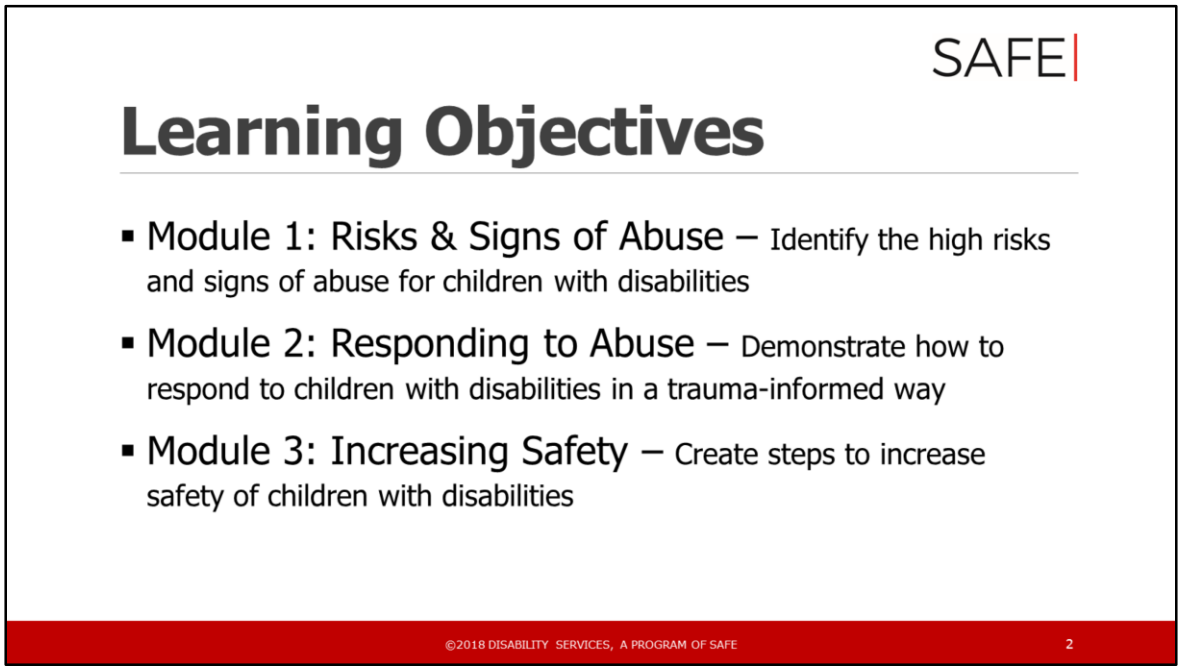
Facilitator's Notes:

Introduction to topic. Go over contents of folder (supplemental materials). Give times for when the training will start and stop, breaks and lunch (if applicable).
Welcome all participants.
Housekeeping: Give directions to bathrooms, ask people to silence cell phones.

ICE BREAKER. *Ask participants to briefly share the length of their experience living or working with children with disabilities and what drew them to this training, if time permits.*



Facilitator's Notes:

Go over objectives on slide. Identify which modules you will be teaching.

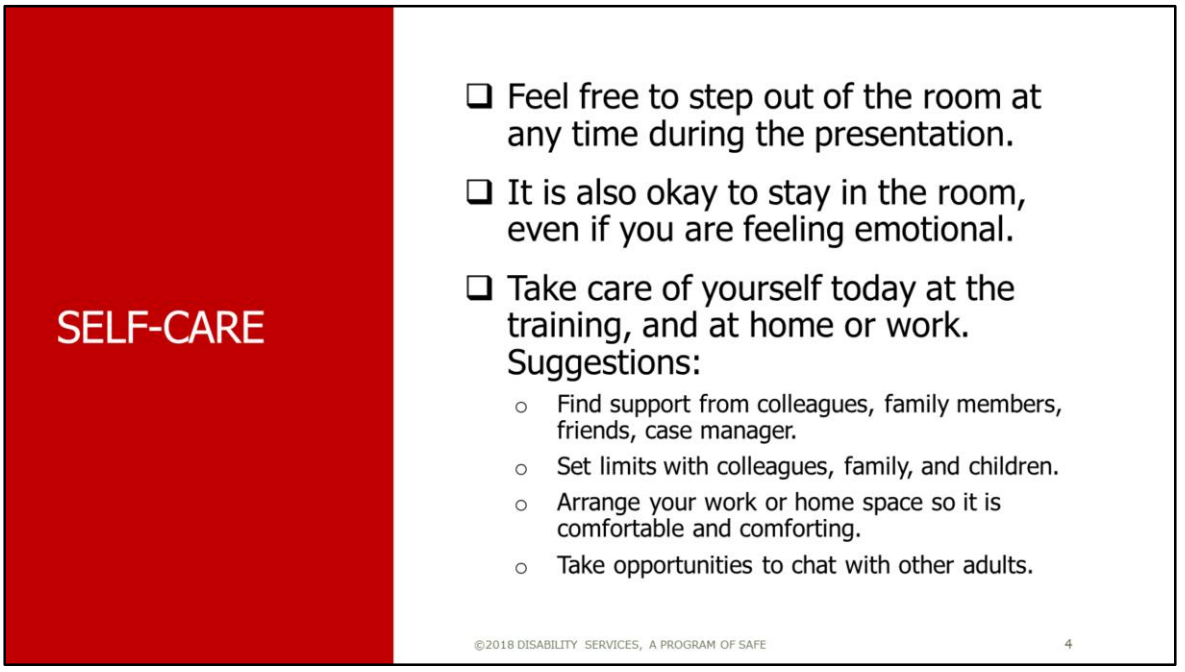
For the first objective, point out that the high risk of abuse and neglect for children with disabilities continues even after being placed with foster families or residential services.

SAFE

MODULE 1

Risks & Signs of Abuse

CHILDREN WITH DISABILITIES AT RISK FOR ABUSE

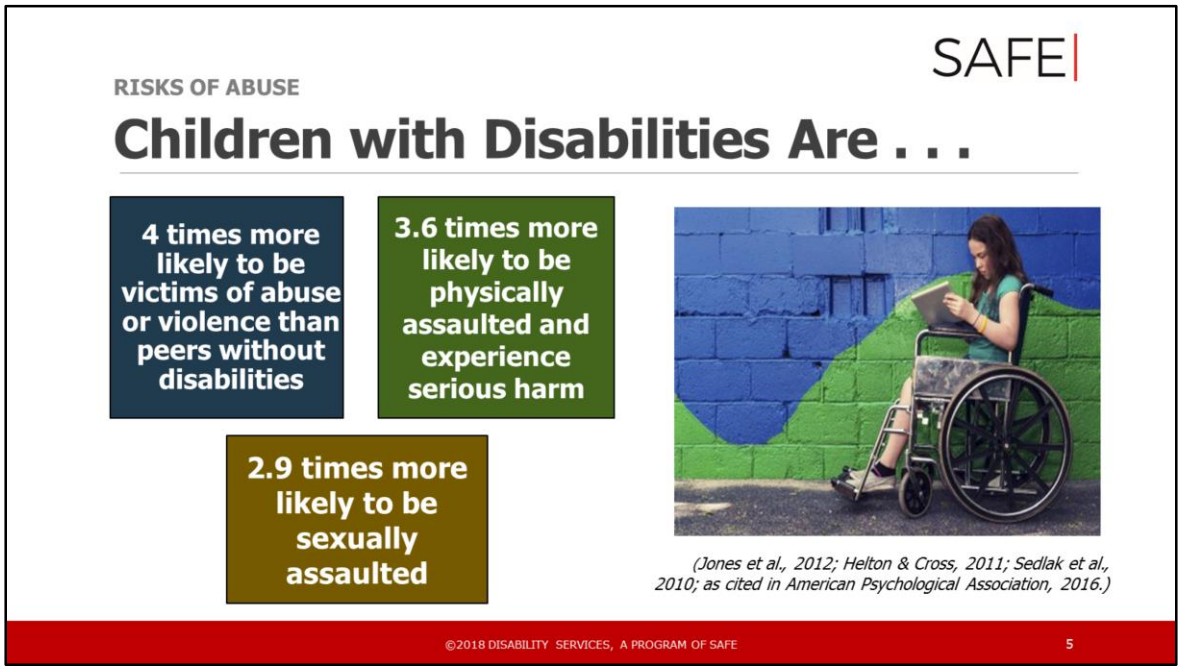


Facilitator's Notes:

SAY: *We will be sharing tips on how to take care of ourselves for each module.* ***One of your handouts is Taking Care of Yourself.***
Some of the information covered in this module may be difficult to hear. It may bring up difficult memories about children and families you have worked with, or about your own experiences. Please take care of yourself throughout this training. If you need to step out of the room at any point, do. It's also okay to stay in the room if you are feeling emotional from the training.

It is also important to take care of yourself at home and work. Our self care impacts our service delivery, and how we are able to relate to children. In addition to your handout, we will share some tips as we train. Ways to take care of yourself as you support children with disabilities include setting limits, finding child care, arranging a comfortable home or work space, taking time during the day to talk with other adults, and identifying and doing what supports you.

DISCUSSION QUESTION: *Are there any other things you can do to take care of yourself – either in this training, work, or home?*



Facilitator's Notes:

Children with disabilities are at high risk for physical and sexual abuse, and are almost four times more likely to be victims of violence than are children without disabilities.

Children with disabilities are 3.6 times more likely to be physically assaulted and 2.9 times more likely to be sexually assaulted than children without disabilities.

Children with disabilities are more likely to be seriously injured or harmed from assaults than children without disabilities. Abuse can further damage or compromise the health and development of children with physical disabilities. (Helton & Cross, 2011; Sedlak et al., 2010).

If children came to you from CPS, they have already experienced abuse or neglect. But don't be lulled into thinking that they are safe now because they are in your care. They are still at higher risk than children without disabilities.

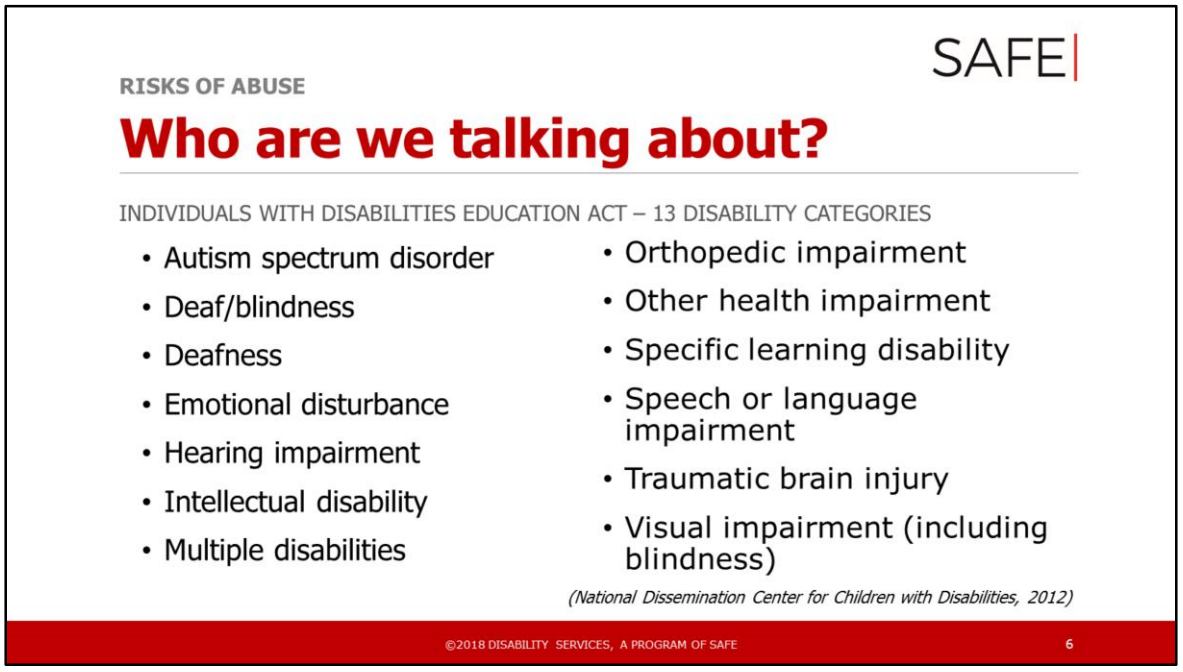
REFERENCE:

American Psychological Association. (2016). *Resolution on the Maltreatment of Children*

with Disabilities. Retrieved from: http://www.apa.org/about/policy/maltreatment-children.aspx

Which contained citations from:

- Jones, L., Bellis, M. A., Wood, S., Hughes, K., McCoy, E., Eckley, L., et al. (2012). Prevalence and risk of violence against children with disabilities: A systematic review and meta-analysis of observational studies. *Lancet*, *380*, 899-907.
- Helton, J. J. & Cross, T. P. (2011). The relationship of child functioning to parental physical assault: Linear and curvilinear models*. Child Maltreatment, 16,* 126-136.
- Sedlak, A., & Mettenburg, J. Basena, M., Petta, I., McPherson, K, Greene, A., & Li, S. (2010). *Fourth National Incidence Study of Child Abuse and Neglect (NIS-4)*. Report to Congress. Washington, D.C.: U.S. Department of Health and Human Services, Administration for Children and Families.



Facilitator's Notes:

NOTE: Without reading the slide, let people know that this is a list of specific types of disabilities listed by the Individuals with Disabilities Education Act.

The Individuals with Disabilities Education Act – known as IDEA – is a federal law that defines 13 disability categories for children and youth from 3-21.
IDEA was a major milestone in the advancement of civil rights for people with disabilities, and it ensures that students with disabilities are provided a free appropriate public education that is tailored to their individual needs.

Reference:
National Dissemination Center for Children with Disabilities. (2012, March). *Categories of disability under IDEA. www.parentcenterhub.org/wp-content/uploads/repo_items/gr3.pdf*

Facilitator's Notes:

Another way of looking at disabilities is seeing how they affect children's ability to interact with the world and navigate their environment.

These categories are a broad oversimplification, and children often have more than one disability.

Physical – affects basic physical activities, such as walking, climbing stairs, reaching, lifting, or carrying

Cognitive, intellectual and/or developmental – affects the person's ability to think, learn, and comprehend

Sensory – affects how a person receives sensory information through sight, hearing, taste, touch, and smell

Mental health need – affects a person's mood, thinking, and the ability to cope with everyday life

Facilitator's Notes:

NOTE: Simply go over the information on the slide, unless you would like to give the audience more detail, which is included below.

Opportunity

- There are more opportunities for perpetrators of abuse because children with disabilities tend to be more isolated, and often receive intimate care from multiple caregivers, including family and paid caregivers.
    - Children may need help with using the toilet, bathing, or dressing, and may not know the difference between sexual and non-sexual touches.
    - Abusers may believe that children with disabilities, particularly children with intellectual disabilities, are easier to trick, bribe, or coerce.
    - Children with disabilities are often taught to comply with authority.

Social Bias

- Children and adults with adults are still treated as being <u>less valuable</u>, <u>invisible</u>, and <u>different than</u> others.
- Society generally views children with disabilities as non-sexual, lacking intelligence,

and not credible witnesses.

Children lack information

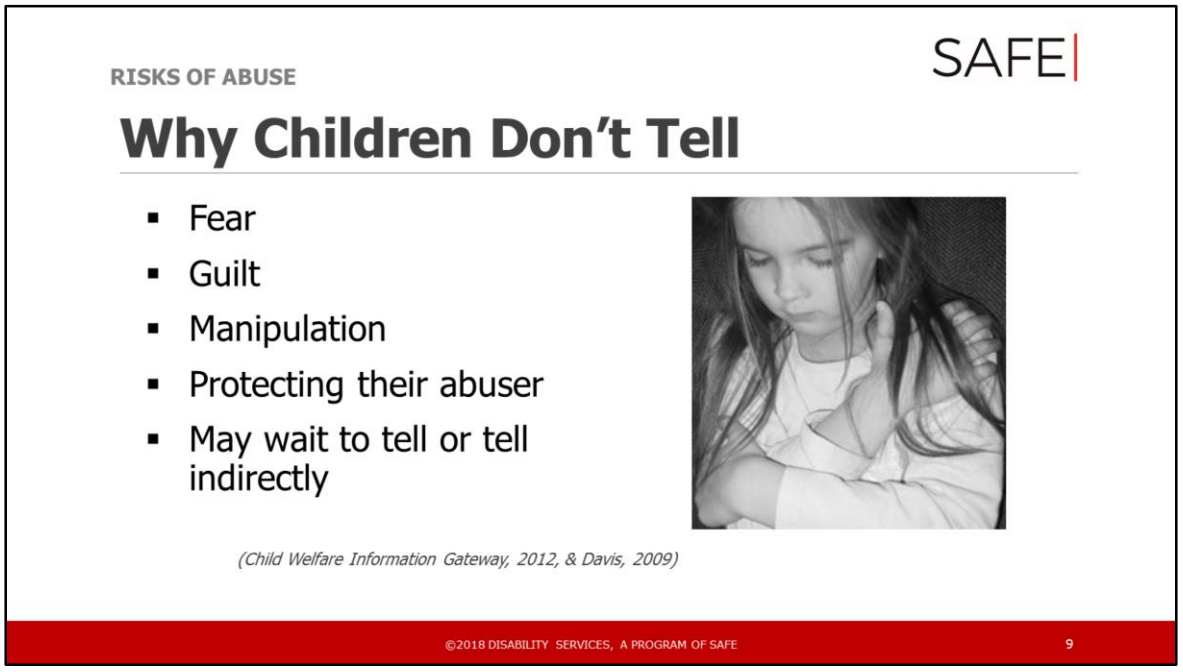
- Children with disabilities are often not given sexuality education that could help them recognize that what is happening is abuse.
- All children need education about their bodies, sexuality, and how to protect themselves.

Adults may not recognize the signs

- Adults often may not know the high risks of abuse or recognize signs of abuse.
- Changes in behavior by children with disabilities are often assumed to be related to the disability, rather than a symptom of abuse.

Barriers to reporting

- Children with communication disabilities may have difficulty telling people what happened.
- When abuse of children with disabilities is discovered, it is often not reported because of the child's disability.



Facilitator's Notes:

There are a number of reasons that children with and without disabilities do not tell someone about the abuse.

DISCUSSION QUESTION: *Does anybody have anything to add to the reasons on this list?*

Fear. Abusers may threaten to hurt the child, a pet, or their family if they tell.
Children can be afraid their parents or caregivers will not believe them, or that they will be punished.
All of the tools of manipulation/power/control are intended to frighten the child just enough so that they are not likely to tell.

Guilt. The child may feel guilty for letting the abuse happen, particularly if some of what the abuser does feels good.

Manipulation. Abusers can convince the child that they share a rare relationship, and that what the abuser does is because the child is special.

Protecting abuser. The child may be afraid of getting the abuser in trouble, particularly if it is a family member, friend, or service provider. Children may not want to upset their parents, guardian, or other family members.

May wait to tell or tell indirectly. When children do tell, it may be long after the abuse. Or they may tell indirectly. They may test their listener by giving the story in small pieces, or talk about someone else who was hurt, giving hints that are easy to miss.

REFERENCES:

Child Welfare Information Gateway. (2012, March). *The risk and prevention of maltreatment of children with disabilities.* Bulletin for Professionals. Retrieved from www.childwelfare.gov/pubs/prevenres/focus/focus.pdf

Davis, L.A. (2009, August.) *Abuse of children with intellectual disability.* The Arc. Retrieved from www.thearc.org/what-we-do/resources/fact-sheets/abuse

Facilitator's Notes:

Children with disabilities often experience more than one type of abuse. Abuse can come from family, friends, caregivers, transportation providers, school staff, and peers. Abusers may blame the child's disability for the abuse.

Physical: In addition to all of the common aspects of physical abuse, such as hitting, pushing, slapping, and choking, children with disabilities can also be abused by force feeding and restraining too tightly.

Sexual: Children with disabilities can be abused sexually the same way as children without disabilities. That may include inappropriate touching or fondling, making the child look at pornography, exposing genitals, all the way to rape. To keep children quiet, predators may blame the child's disability for the abuse, may say things like, "you are lucky you have me, nobody else would ever want you."

Emotional or verbal abuse: Emotional abuse includes intimidation, cruelty, rejection, intimidation, threats. Abusers may also use the child's disability to shame, belittle, criticize, reject, call names; may treat the child differently because of their disability;

may deny the child's rights, necessities, privileges, and opportunities.

Neglect: For children with disabilities, neglect can include withholding basic care or food, but can also include: withholding medication; withholding medical care; isolation; and not advocating for medical equipment, like a wheelchair that fits.

SAFE

RISKS OF ABUSE

Examples of Caregiving Abuse

- Leaving child in bed too long
- Over or under medicating
- Leaving on toilet too long or not changing diaper
- Ignoring dietary restrictions
- Leaving alone for too long
- Verbal abuse

(Zero Tolerance Initiative, n.d.)

Facilitator's Notes:
DISCUSSION QUESTION: *Does anybody have any other examples of caregiver's abuse?*

Any time an adult is responsible for making decisions and provides care for the child, there's a power imbalance. The responsibility is on us to make sure we have not been using that power to harm children.

In addition to physical, sexual and emotional abuse, caregivers can abuse by **neglecting to give the care** the child needs. **Toileting abuse** can be not letting a child get to the toilet in time, or leaving on the toilet too long, not changing diaper. Abuse can also be **not giving medication, giving too much medication** so the child sleeps too much or is compliant, not **feeding children the food they need** to be healthy, or ignoring their dietary restrictions.

REFERENCE:
Zero Tolerance Initiative. (n.d.) *Common signs and symptoms of abuse, neglect, and exploitation.* Retrieved from Apd.myflorida.com/zero-tolerance/common-signs/#/

Facilitator's Notes:
In addition to abuse and neglect, children with disabilities commonly experience other types of traumatic events.

- Medical trauma. Children with medical or health disabilities may have repeated surgeries, painful procedures, constant pain. All of these things can make a child's world feel unsafe.

- Bullying. Children with disabilities are at high risk of being bullied by their peers, teachers, siblings, etc.

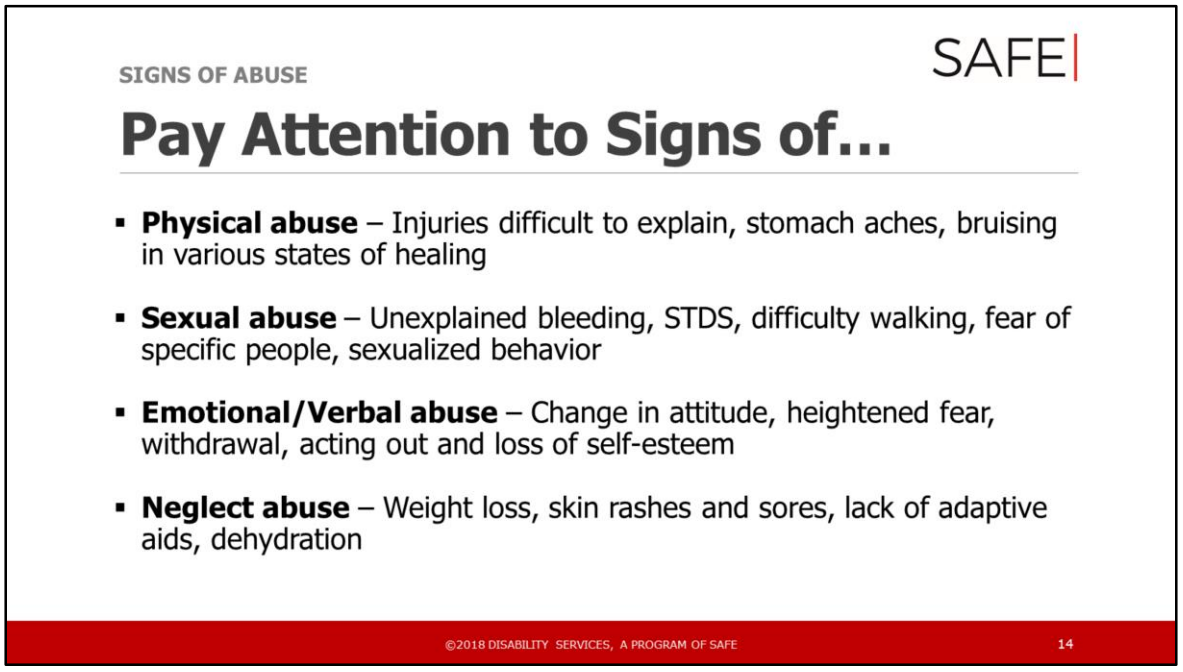
- Institutionalization, restraint, and seclusion. Children with severe disabilities or mental health disabilities are still being housed in large institutions. Use of restraints and seclusion in these settings is decreasing, as we learn more about alternatives, but they are still used in some settings.

- Isolation, loss, grief, loneliness. Children with disabilities are still often segregated and isolated. They also may become attached to care providers or staff who change frequently, or may have lived in multiple foster homes or residential settings.

Signs of Abuse

Facilitator's Notes:

In this next section, we'll talk about signs of abuse or neglect of children with disabilities.



Facilitator's Notes:

NOTE: Participants may spontaneously share other examples. Take 2-3 examples and then move on.

Abuse is going to look different for different kids. What to look for in all categories of abuse are physical and emotional changes in children.

Physical

- Unusual bruising that cannot be explained. Bruising that shows up on both sides of the body, such as the arms or face, can be from rough handling or from someone grabbing the child with both hands.
- Bruises in various states of healing can indicate consistent abuse.
- A patterned bruise of an object, such as a hairbrush or belt.

Sexual Abuse

Sexual abuse is also going to look differently in different children.

- Unexplained bleeding
- STDS

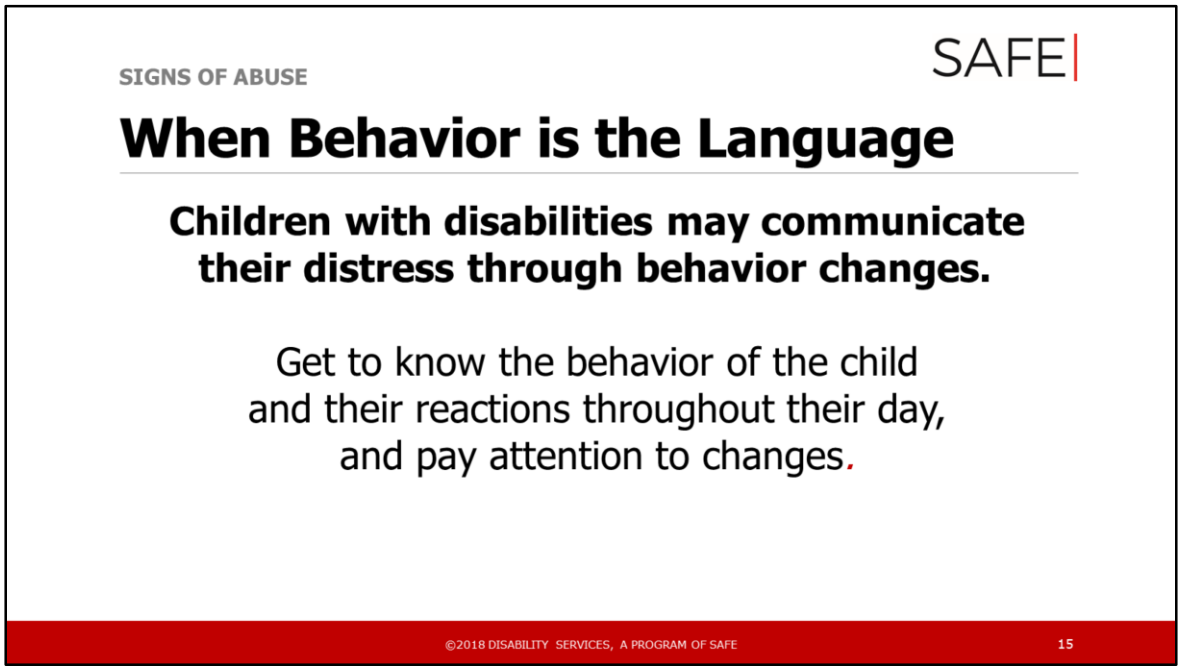
- Difficulty walking or sitting
- Avoiding physical touch. (Note: Some disabilities can also make children uncomfortable with touch.)
- Withdrawal
- Fear of specific people
- Sexualized behavior: Sexuality beyond their years – acting out sexual acts, being aware of sexuality beyond developmental or chronological age.

Emotional/Verbal

Children who have been abused emotionally might **show changes in attitude and increased insecurity, be fearful, withdraw, act out through anger.** A young child who doesn't have a sense of stranger danger, and goes up to everybody, might suddenly start clinging to you. It can be the opposite: A child who was shy can become more outgoing. The question to ask yourself is, what has changed for or happened to this child? There may be a good explanation for the change: A favorite teacher left, a developmental stage. But you might have to be a detective and explore if changes are sudden or don't go away.

Neglect

Neglect of children with disabilities can range from not having clean clothes or not living in a clean environment to not having the medication or care they need to live. Children with medical health issues who are neglected may have skin rashes, pressure sores, kidney/bladder infections, dehydration, and malnutrition. Children with any type of disability may also lose weight, not have the adaptive aids they need to function, not be getting enough sleep to function well, etc. Signs of neglect can include diaper rash from sitting in a diaper all day, having decreased muscle tone from not having their stretching exercises done.



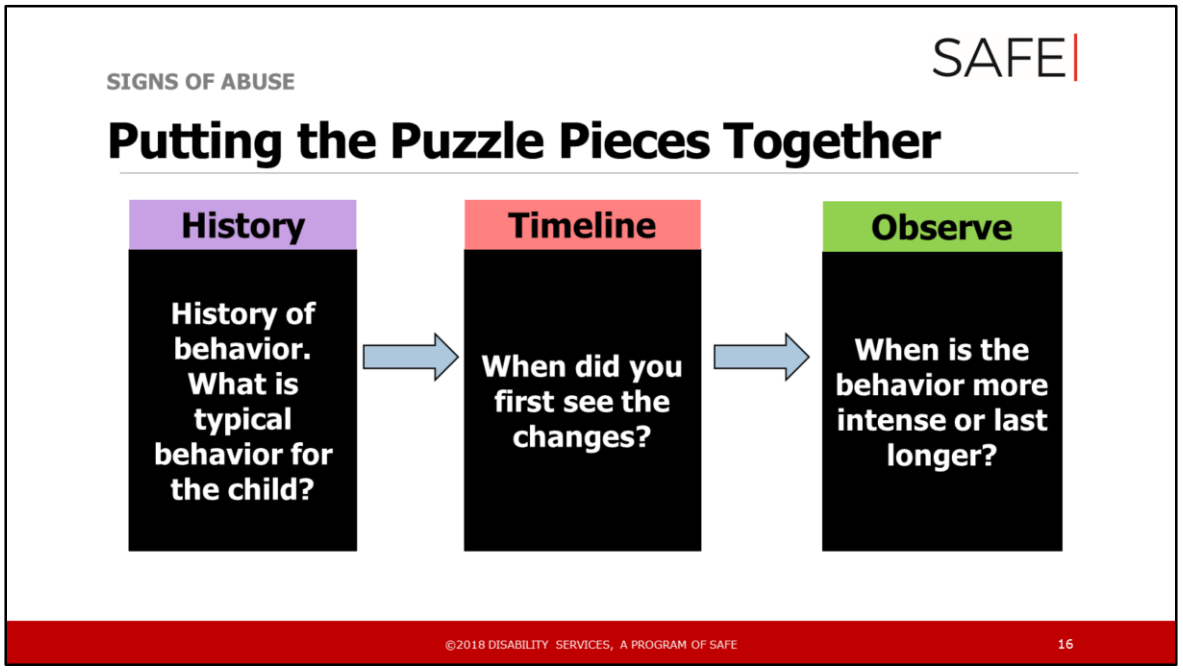
Facilitator's Notes:

For some children, behavior may be their only way to communicate that something is happening to them. One girl with a developmental disability became more outgoing and affectionate. A teacher noticed the change and brought it up with others, which led to the discovery that the child was being sexually abused.

Signs of abuse can be difficult to notice. Yet significant changes in behavior that can't be traced to something else in the child's life, such as moving or losing someone important to them, could be related to the impacts of abuse. If children are new to your care, watch for their responses. This will take time. One residential service provider estimated that it takes about 6 months to get to know the language of each child who does not use spoken language to communicate.

When you are first working or living with a child, they may have high levels of fear and signs of trauma. Once they have built a sense of security and safety with you, if you notice changes, pay closer attention, visit or drop by childcare or school at unexpected times, and watch how they respond to peers, relatives, staff, etc.

DISCUSSION QUESTION: *What are your experiences with children who communicate through behavioral changes?*



Facilitator's Notes:

DISCUSSION QUESTION: *Does anybody have any examples of behaviors they've seen in children with disabilities that could be linked to abuse?*

HANDOUT: Let participants know that their packet contains two fact sheets on this topic: *Supporting Children with Developmental Disabilities* and *Questions to Ask about Children Who are New to Your Care.*

Again, you can recognize behavior that may be linked to abuse by knowing the child's common, every day behaviors. If you do not know, speak to others who do. Could something have happened the day before that changed the child's typical way of relating?

Sometimes we don't know the child's history. Going back to our example of the girl who became more outgoing: the teacher knew the child's history of behavior, and what was typical for her. By paying attention to an unexpected change, the abuse was discovered.

We aren't telling you to become investigators. We're saying that if a child's behavior changes, it is important to rule out other things in the child's life – divorce, moves, teacher leaving – to make sure the change is not related to abusive treatment.

Facilitator's Notes:

These are common changes in how children function when they are experiencing traumatic events or abuse.

DISCUSSION QUESTION: *Have you noticed any of these changes in the children you live or work with that have given you concern? What did you do?*

Changes in communication. Some children may begin to draw violent art. One young child with a disability began coloring pictures with black, angry lines after being bullied.

Increased risk taking. Youth may begin to experiment with drugs, alcohol, sex, self-abusive behaviors, or may run away or take other unsafe risks. Younger children may begin pulling their hair, scratching themselves, hurting themselves. If they begin doing any of these things all of a sudden, it's something to pay close attention to.

Increase in sexual behaviors.

- Suddenly acting out or drawing sexual pictures that do not fit their developmental or chronological age.

- Being sexually aggressive with younger children.
- Children between the ages of 3-5 may become sexually inappropriate in a public setting or with their peers.

Eating. Children may eat less or eat more. Suddenly lose or gain weight.

Sleeping

- Sleep more or less
- Have nightmares
- Have trouble going to sleep at night
- Be frightened of going to sleep
- Fall asleep during the day
- Sleep patterns revert to earlier age

Self-Care

- Stop taking care of themselves, such as neglecting to wash their hair or their bodies, or wearing the same clothes over and over.
- Refuse to take baths or take too many baths.
- Younger children may become afraid of baths, and may cry or have tantrums at bath time.

Physical complaints: Stomach aches and headaches are common signs of trauma and stress.

Regress developmentally to earlier stage. Younger children may regress to an earlier age:

- Stop feeding themselves, stop getting themselves dressed
- Wetting bed
- Clinging to parent or caregiver

Changes in school and daycare behavior.

- Children may have difficulty concentrating in childcare or school
- Become less cooperative
- Babies, toddlers, and young children may stop engaging in play, or may not move around and explore as much.
- Older children may skip school.
- Older children may start wearing jackets and hoodies to keep their heads covered when they are being abused, or when a former abuser reenters their life. It's a way to withdraw and isolate.

SIGNS OF ABUSE

SAFE

Common Emotional Changes

- Mood swings (anxiety, depression, anger)
- Personal interactions
  - Withdrawal
  - Clingy
  - Eager to please
- Increased fear & aggression

(Zero Tolerance Initiative, n.d.)

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Facilitator's Notes:

Be aware of any changes in children's moods, emotions, & responses to other people. They can be subtle. One five year old who was living with abuse wanted to be held more, wanted to have a sippy cup rather than an open cup. ***Ask for any other examples.***

Changes in moods/emotions.

- May be more anxious, upset, angry, depressed.
- May see more outbursts or disengagement.
- Children who do not speak may increase lashing out, be angry, or easily upset.

Interactions

- May become withdrawn, alternated with aggression
- More eager to please or more compliant

Fears

- Children may become fearful of:
  - going to school, going home

    - being in the dark
    - riding the bus
    - all men or all women
    - a certain person or a place
- Stop wanting to be with someone who has been in their lives.
- May be specific to the person who abuses them or generalized to other people and places.
- May react fearfully at sudden moves or touch.
- May not want to leave home or go home.

Aggression

Aggressive behavior is widespread among victims of abuse. It is a fear/protective fight response and is a way of showing: “If I’m a big enough monster, you’ll stay away from me and I’ll be safe.”

- Younger children may have more temper tantrums or cry more.
- Children of all ages may be more destructive of toys or belongings.
- Some children may begin hurting themselves or show aggressive behaviors such as yelling, hitting, or throwing things.
- A child who is yelled at, spanked or beaten may yell or hit smaller children or others.
- May indicate through violent drawings, stories and play.

REFERENCE:

Zero Tolerance Initiative. (n.d.) *Common signs and symptoms of abuse, neglect, and exploitation*. Retrieved from Apd.myflorida.com/zero-tolerance/common-signs/#/

Facilitator's Notes:

One child with a significant cognitive/communication disability was taken from his home because he was constantly covered in bruises. He was placed in a residential center for children with disabilities, where he continued to collect fresh bruises. That residential facility, however, documented every bruise. They documented where it occurred on the body, when it happened, how it happened. What they discovered was that the boy acquired bruises not from abuse, but from play, from falling, from every day life. At the end of 6 months, when it was clear that the bruises were not associated with abuse, the boy was returned to his home.

It can be confusing try to figure out if an injury is from abuse or an accident, especially if the child is not able to share what happened.

One way is to look at **where the injury was**: Common sites of accidental injuries include knees, elbows, shins, forehead. Uncommon sites are backs, thighs, genitals, buttocks, back of legs and face. These places are less likely to have accidental contact with objects that could cause injury.

Children or caregivers may share what happened, but if what **they describe does not match the injury, ask more questions**. An example is if a child says they cut their head when they fell down, but the only injury they have is on their forehead, and their knees, hands and elbows don't have scrapes.

Consider developmental stages of child: An 8 year old learning to climb trees is more likely to break an arm. A toddler learning to walk and run is more likely to have scraped knees.

Reference

Zero Tolerance Initiative. (n.d.) *Common signs and symptoms of abuse, neglect, and exploitation*. Retrieved from Apd.myflorida.com/zero-tolerance/common-signs/#/

SAFE

SIGNS OF ABUSE

Is it abuse or disability?

Common conditions of disability that can look like abuse:

- Injuries due to falling
- Skin breakdowns
- Self-injury
- Failure to thrive
- Fractures
- Sensitivity to touch

(Zero Tolerance Initiative, n.d.)

Facilitator's Notes:

DISCUSSION QUESTION: *Have there been times when you weren't sure if what was happening was abuse or part of a child's disability? What were the circumstances?*

Sometimes it is difficult to know if what is happening is abuse or the child's disability. Symptoms can be similar. This can be especially difficult because each child is different, even if they have the same disability.
Children with developmental disabilities may have frequent falls. Some children may have a sensory processing disorder, when the brain has trouble receiving and responding to information that comes through the senses. It can make children very sensitive to touch, textures, tastes, temperatures. They may not want to hug or have their face washed, or make eye contact. All of those reactions can also be symptoms of abuse.

Reference:
Zero Tolerance Initiative. (n.d.) *Common signs and symptoms of abuse, neglect, and exploitation*. Retrieved from Apd.myflorida.com/zero-tolerance/common-signs/#/

Facilitator's Notes:

HANDOUT: Let participants know that one of the electronic handouts that you will send out after the training contains online resources about specific disabilities.

DISCUSSION QUESTION: *How would you begin to research a disability?*

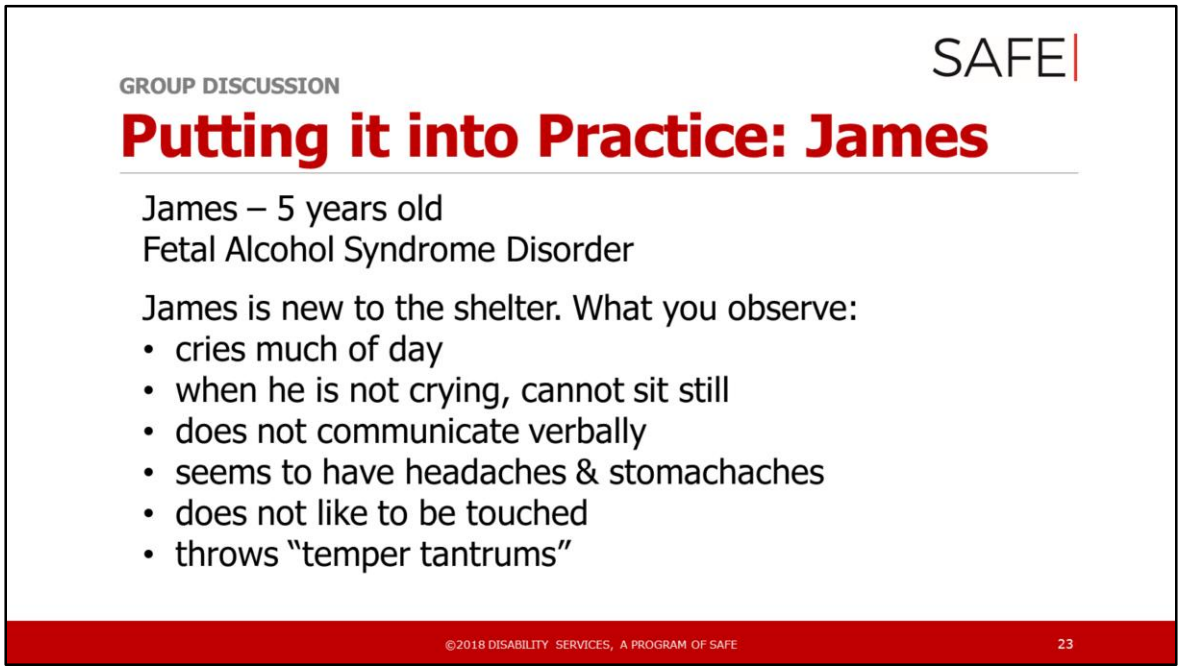
- When you begin fostering or working with a child with a disability, research the child's disability and find out the common symptoms. Examples:
    - children with Autism Spectrum Disorder often bang their heads against the wall.
    - children with seizure disorders may fall during seizures.
    - many disabilities may make children prone to anxiety.
- Rule out medical causes of behaviors or changes.
- Also learn about symptoms of childhood trauma, which we'll cover next.
- Most of the children you will be fostering or providing services to have experienced significant childhood trauma. For children who are preverbal or unable to communicate verbally, check in with nurses, caregivers, teachers, and others about any injuries or behavior changes.

- If something seems like a red flag, feels out of the ordinary, or just basically does not feel right, pay attention and ask questions. If you suspect or learn of abuse - report.

Facilitator's Notes:

Share that you will transition here to a small or large group activity, based on the size of your participant group.

Let participants know that they will now review a scenario, answer several questions, and apply what they have been learning about signs of abuse.



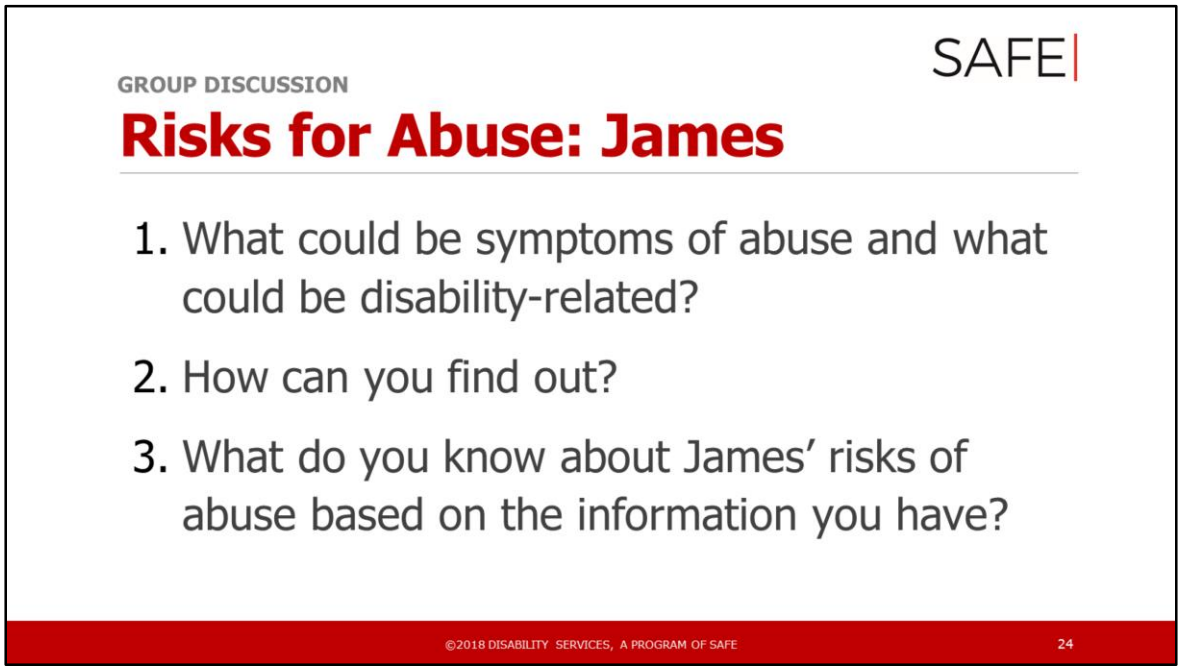
Facilitator's Notes:

Read the case study out loud to the entire group, or have someone from the audience read it aloud.

SAY: *Work as a group at your table (4-6 people) to answer the two questions on the next slide. In your groups, ask for a volunteer to take notes and for a volunteer to report back to the larger group. We'll work for five minutes and I'll let you know when it's time to come back to the larger group.*

Move to the next slide.

Set timer for five minutes.

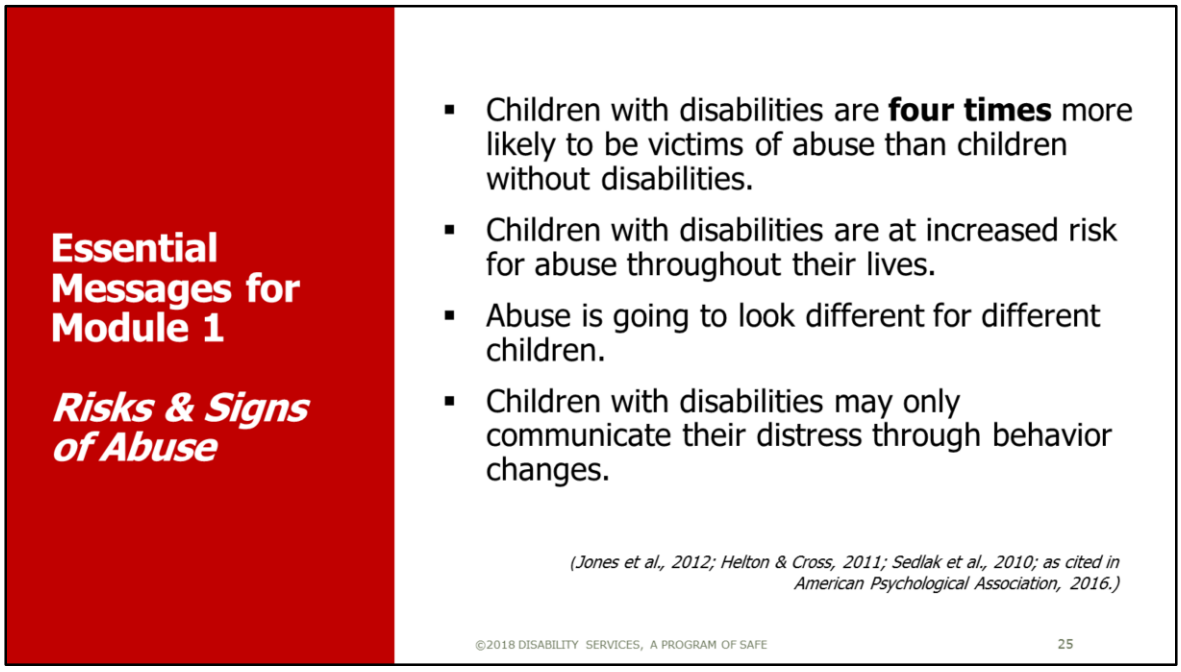


Facilitator's Notes:

- Leave this slide up for participants to refer to as they answer the questions.
- When the timer goes off, ask everyone to finish their thoughts and then turn their attention back to the larger group.
- Ask each table to share what they came up with for the larger group.
- Ask for a volunteer to take notes on chart paper or a dry-erase board.
- If the participant group is too large or too small, pose each of these questions one at a time to the entire group for discussion.

Sample responses are:

1. Of James' symptoms – crying, headaches, stomach aches, not liking to be touched, not communicating verbally – what could be symptoms of abuse and what could be disability related? *All of these symptoms could be related to the disability of Fetal Alcohol Syndrome and all could be related to abuse.*
2. How can you find out? *Research Fetal Alcohol Syndrome, take James to doctor, get his medical history*
3. What do you know about James' risks of abuse based on the information you have?
    - *Not being able to communicate verbally*
    - *Being a child with a disability*
    - *Multiple caregivers*



Facilitator's Notes:

Read the essential messages to the large group before starting Module 2. Ask if anybody has any other thoughts.

SAFE

MODULE 2

Responding to Abuse

OF CHILDREN WITH DISABILITIES

Facilitator's Notes:

Go over information on slide, or ask people to read. Check in and ask how everybody is doing.

ASK: *What are other self-care activities you use?*

Facilitator's Notes:

If you notice changes in a child's behavior, but do not know if the change is related to abuse, you can:

Share your observations with trusted care providers, school staff, teachers, bus drivers, others. If the child is in a residential center, ask other staff if they are noticing the same things. As an example, one child could not tolerate the overstimulation of the school bus, so every time he got off the bus he was distressed. One could not tolerate showers.

If you have just noticed changes but don't know what's going on, **ask the child open-ended questions.** You can ask questions whether the child can respond verbally or not, and note their responses.

Example:

- *I've noticed that when we pick you up from school you seem angry.*
- *You don't seem to be enjoying when we go to the park or when we go to visit your aunt.*

- *Is there something you are worrying about?*
- *What is your biggest worry right now?*

If children are too young to respond or cannot understand, consult other staff, your supervisor, the child's case manager.

Don't prompt children, or ask leading questions that make them feel like there's one way to answer.

Help children find a way to share. Engaging them in play or a sensory activity can help in calming their neurological system. It can help them relax, and they may become more open and comfortable in saying what they want.

If the child becomes upset, don't push the issue. But don't just ignore your concerns either. Find another way to get information from talking to other people, approaching the child another time, etc. Keep in mind that as you talk to other people in the daily life of a child, you may be talking to their abuser. Use discretion and be thoughtful about what you say.

Facilitator's Notes:

How do you respond if a child tells someone that they have been abused? A child may directly tell you that someone hurt them or may disclose indirectly through behavior changes, including some of the indicators of abuse we talked about earlier. Or a child can tell you just a small piece of what happened to test the waters.

DISCUSSION QUESTION: *Has anybody responded to a report or suspicion of abuse? What did you do that was helpful?*

Take every report by a child or changes in behavior seriously. Don't dismiss it.

Believe. One of the biggest mistakes people make is not believing the first time they disclose abuse, according to criminal justice staff who provided input into this training. .

- *Although children may not know that what happened to them is wrong, they rarely lie about abuse.*
- Children also react to abuse in different ways. They may tell about their experience without showing any emotion. That reaction can be part of a traumatic stress response to experiencing some kind of abuse.

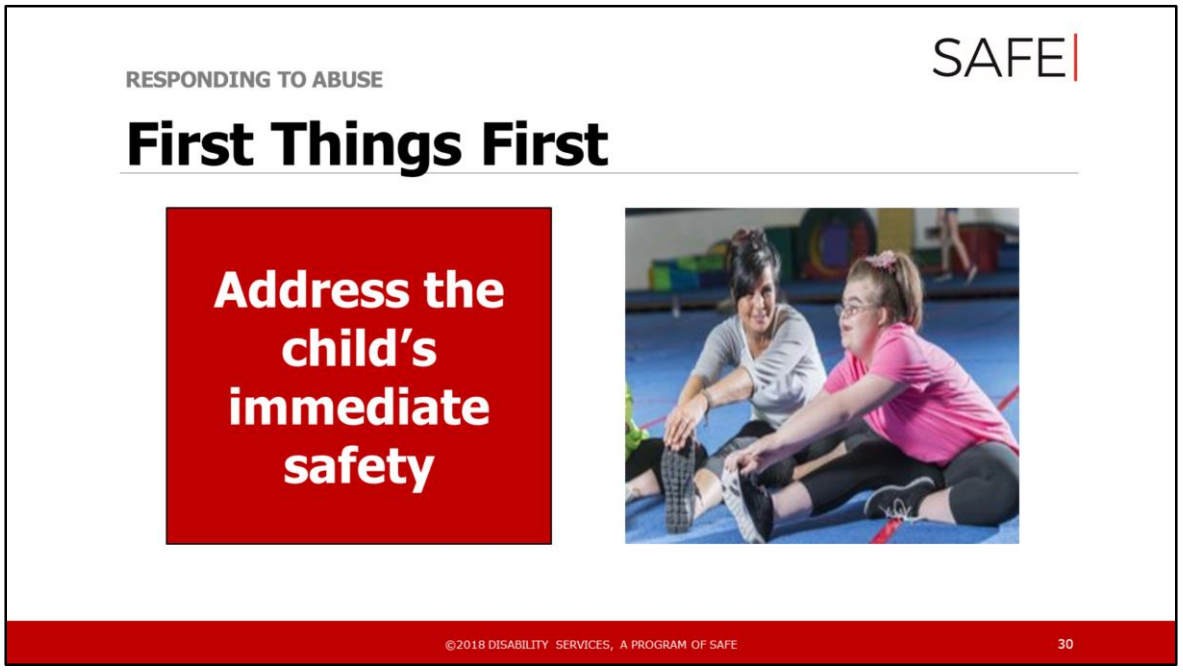
- If you question the truth of what they are saying or blame them in any way, children may be further harmed and are likely to stop telling you the truth or take back what they already shared.

Neutral body language & stay calm.

- If you are upset, children may get upset, or they may think they are at fault when you look angry or alarmed.
- It is okay if you need to stop to collect yourself. Take a few deep breaths or tell the child you're going to take a short break; perhaps to use the bathroom or to get water for both of you.

Be honest about what you are going to do next.

- For older children who understand what's going on, explain that you are going to report the abuse to some people who will work to help them be more safe (CPS, law enforcement). It does not mean that they've done anything wrong, but that it's the responsibility of adults to keep them safe.
- Keep in mind that for many children who have been abused, or children of color, the police and CPS may seem as scary, threatening, or a source of harm instead of help.
- For younger children, it's okay to say you don't know what is going to happen, but that everybody will be working to protect and keep them as safe as possible.



Facilitator's Notes:

Whatever the disclosure was about, assess the immediate safety of the child.

- Work to keep the child safe. If the child is afraid of punishment because the abuser is a member of the family, and if you are concerned the child is in immediate danger, call the police. If the child will continue to have contact with the alleged abuser, work with Child Protective Services or others to develop a safety plan for home, school, or any other setting. We will talk about safety planning a little later.

Facilitator's Notes:

Here are five messages that children – and adults – need to hear after they have disclosed abuse.

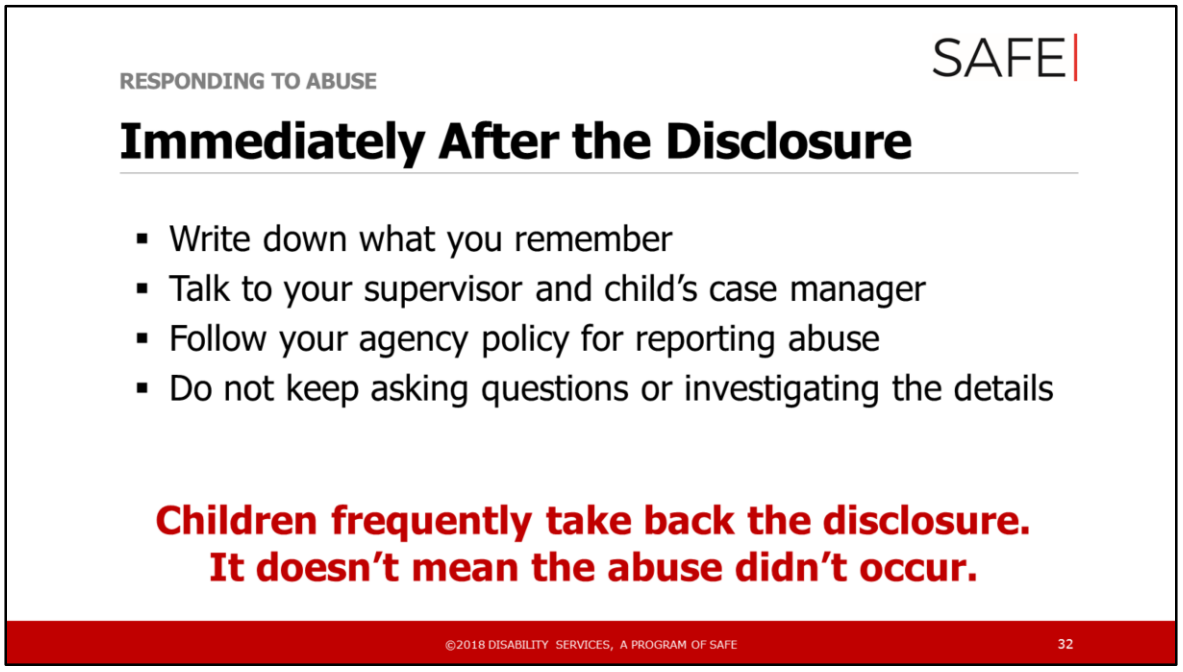
It's not their fault. Children often believe that not only was the abuse their fault, but that they will be blamed. The child may tell you that they "participated" in the sexual abuse. It's still not their fault. The person who exploited or hurt them is the one who did something wrong. Children may take on the guilt of the other person they trusted.

You care about them and that they are safe right now, with you. Make sure that you do not promise the child that this will never happen again. Abuse is a huge betrayal, and we do not want to promise something we cannot provide. At the same time, tell them you will be doing everything you can to make sure that they stay safe.

Tell the child you are glad they told you what happened. Children are often unsure about whether to disclose the abuse. They may fear that they will upset others, that they won't be believed, or that they will be blamed. If the care provider/parent is already stressed or struggling, the child may not want to cause more problems, and

may find it especially difficult to disclose. Tell the child you want to know what's going on because you care about their safety.

Tell the child that they are not in trouble. Children commonly feel ashamed and responsible for the abuse, and afraid they will be punished.



Facilitator's Notes:

The tasks are the same right after the disclosure for children with and without disabilities.

ASK: *Is there anything else you would add to this list?*

- **Write down what you remember.** After you talk, write down what the child said as accurately as you can, so you can share it with investigators.
    - If the child did not or cannot disclose abuse using language, write down what you noticed and why you are concerned.
    - Document everything that happens, any issue of concern, anything you suspect. CPS will ask about all the details you can remember.

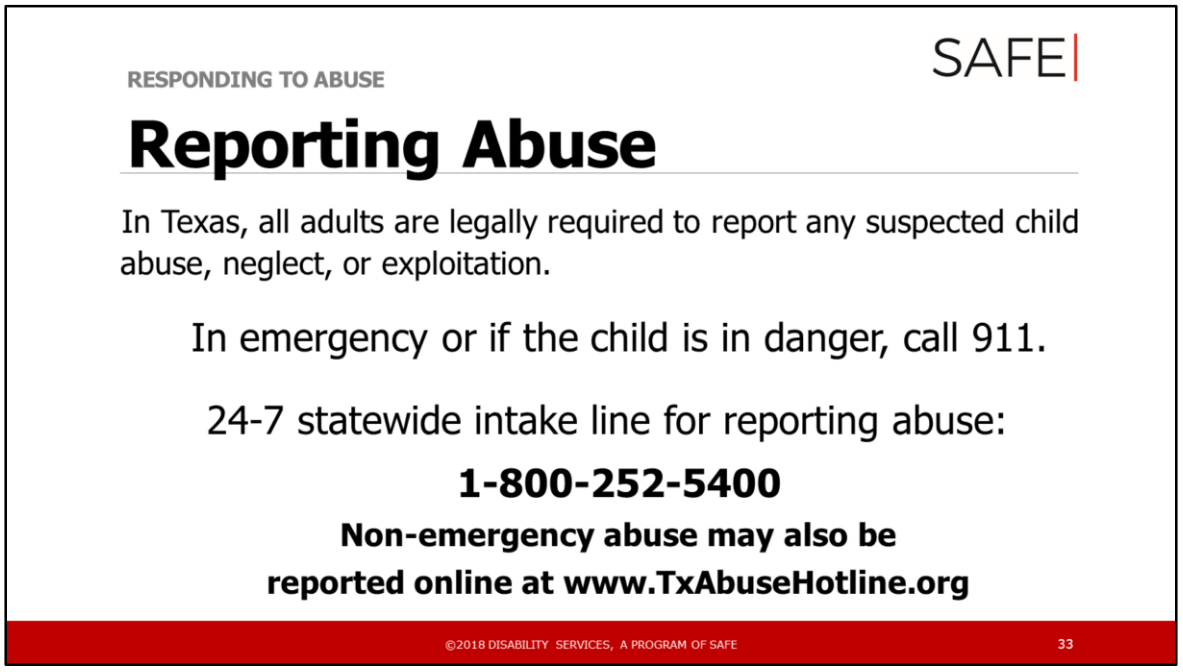
- **Talk to your supervisor or the child's case manager about what you observed.**

- **Report the abuse or your suspicions of abuse.** Often, people don't report abuse to Child Protective Services or law enforcement out of fear that they do not have enough information to report. However, in Texas, it is a legal requirement for all

citizens to report any known or ***suspected*** abuse against a child.

- **Do not keep questioning the child,** or talking about abuse in front of the child. It's not your role to investigate or dig out the details. That's the role for Child Protective Services.

- **Realize that when children take back a disclosure, it doesn't mean the abuse didn't happen**. Children frequently disclose abuse and then try to take it back. They may want their family life to return to normal, they don't want to see everyone upset any more, or they want their abusing parent to be able to come home. *When children try to take back their disclosure, it DOES NOT usually mean the abuse didn't happen.*



Facilitator's Notes:

All adults in Texas are legally required to report any suspected child abuse, neglect, or exploitation.

In the process of reporting abuse, children are often lost in the shuffle. Don't forget the well-being of the child and what they continue to need during this process.

In an emergency, or if the child is in danger, always call 911 or your local law enforcement agency.

The statewide intake line for reporting abuse of children is available 24 hours a day, seven days a week: **1-800-252-5400**

When you report the abuse, explain any fears you may have about the child's safety. Non-emergency abuse may also be reported online at www.TxAbuseHotline.org It can take up to 24 hours for staff to process the website report, so for a faster response, use the telephone intake line.

People who are Deaf, hard-of-hearing, or have a speech-disability can report by using VRS (Video Relay Services) through Relay Texas by dialing 711 or 1-800-735-2989. Tell the relay agent that you need to call the Texas Abuse Hotline at 1-800-252-5400. Or, you can report using www.TxAbuseHotline.org

- Keep the call ID number you are provided in case you need to follow up.
- The reporter's name is kept confidential unless otherwise ordered by a court. Child Protective Services (CPS) also tries to take identifying information out of reports.
- While you can report anonymously by phone, if you are comfortable leaving your name and a contact number, it can be helpful to the investigators should they have questions about what you observed or were told by the child. Online reports cannot be anonymous.
- If two people see or suspect the abuse, both people are required by law to report it; however, they can submit a joint report. You cannot ask someone else to report the abuse on your behalf.
- *In Texas, anyone who does not report suspected abuse can be held liable for a misdemeanor or felony.*
- Keep in mind, it is not your role to investigate or determine the truth of a disclosure or suspected abuse.
- Your role is to tell a CPS intake worker what you've observed or been told.

Facilitator's notes:

Continue to:

Address emotional safety. Seek emotional support for the child.

- If you are a foster parent, the child may want to sleep with you, sleep with the light on, not go to school for a day or two.
- They may not want you to share what they said to other family members, to other teachers, or to other children in school.
- Let the child know who you must tell, and why. Be as careful of their privacy as you can.
- A child who did not disclose abuse directly and is confused about why things are suddenly changing in their world will need some kind of context for what is happening and reassurance that they are not in trouble.

Children with severe cognitive disabilities may not understand what is happening, and may not be able to share what's going on with them. They may not understand the concepts of shame and blame. But they <u>are</u> impacted by the abuse, the investigation, and the distress of the adults around them. Provide more of whatever comforts them:

Gentle words, your presence, stuffed animals, exercise, art, favorite television shows. Continue to tell them that they are safe right now, and that you and others are working to take good care of them.

Know that a child's story can change over time. Trauma impacts memories for both children and adults. Every child's memory is different, and some children remember more over time.

If the child loves the abuser, be neutral. If you threaten the person or talk bad about them, the child may feel guilty or protective and take back their disclosure. If the child does not want to be separated from the abuser, explain that what happened wasn't okay. One way to explain this is to say that the person did something wrong, and needs help.

Get support. Hearing about child abuse and neglect is extremely stressful. Seek counseling or other support and practice self-care.

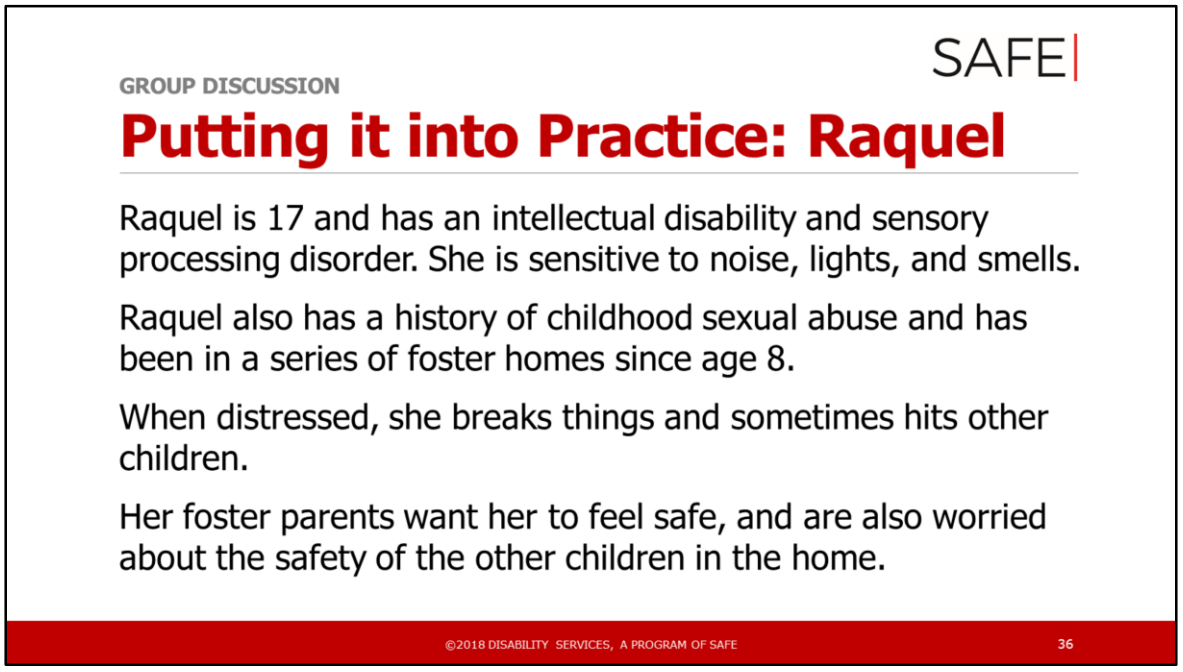
References:

- Personal communications with Mikey Betancourt, Executive Director, Children's Alliance of South Texas – A Child Advocacy Center; Tim Cromie, Sergeant Detective, Dickinson Police Department; Lindsey Jordan, LMSW, Children's Advocacy Centers of Texas; Anna Phillips, Education Specialist, Region 17 Education Service Center; and Dr. David Scott, University of Texas at Tyler, Department of Social Sciences.
- Stop it Now. (n.d.) *What should I do after a child tells?* www.stopitnow.org/ohc-content/what-should-i-do-after-a-child-tells
- ChildHelp. (n.d.) *Handling child abuse disclosures.* www.childhelp.org/story-resource-center/handling-child-abuse-disclosures/

Facilitator's Notes:

SAY: *Our second scenario is about a teenager named Raquel, who disclosed abuse after school one day.*

Let participants know that they will now review a scenario, answer several questions, and apply what they have been discussing.

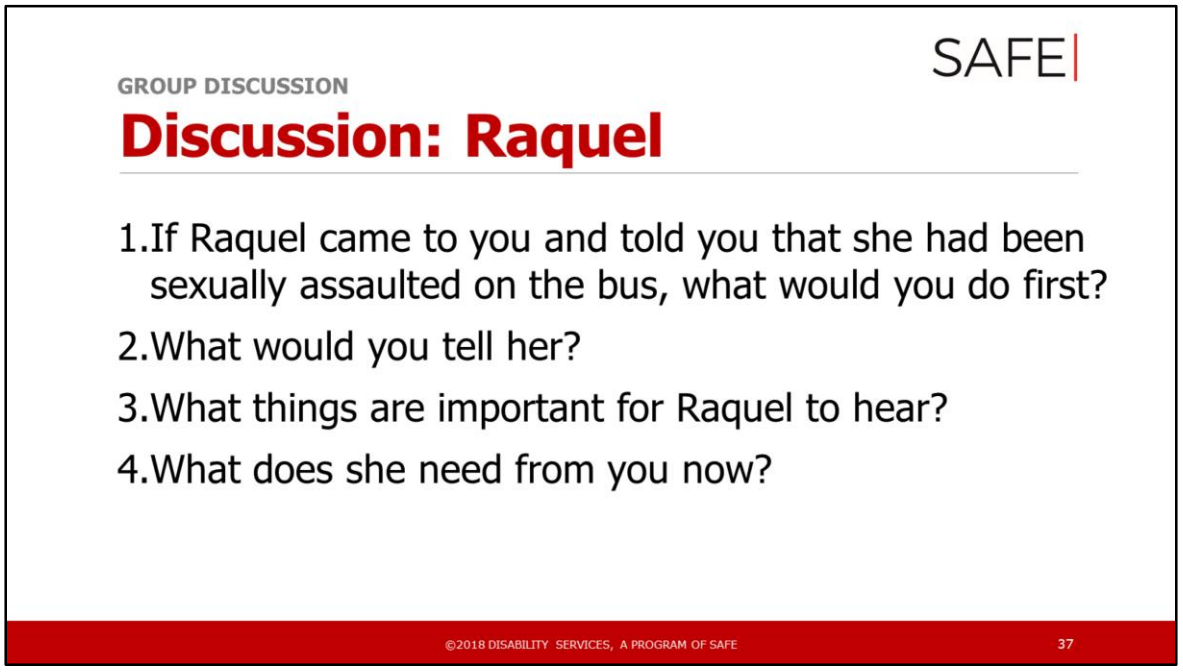


Facilitator's Notes:

Read the case study out loud to the entire group, or have someone from the audience read it aloud.

SAY: *Work as a group at your table (4-6 people) to answer the questions on the next slide. In your groups, ask for a volunteer to take notes and a volunteer to report back to the larger group. We'll work for ten minutes, and I'll let you know when it's time to come back to the larger group.*
Move to next slide.

Set timer for ten minutes.



Facilitator's Notes:

- Leave this slide up for participants to refer to as they answer the questions.
- When the timer goes off, ask everyone to finish their thoughts and then turn their attention back to the larger group.
- Ask each table to share what they came up with for the larger group.
- Ask for a volunteer to take notes on chart paper or a dry-erase board.
- If the participant group is too large or too small, pose each of these questions one at a time to the entire group for discussion.

Sample responses are:

1. If Raquel came to you and told you that she had been sexually assaulted on the school bus, what would you do first? *Believe her. Keep your facial expressions calm and pleasant. Don't question what she is telling you or in any way indicate that you blame her for what happened. Call 911.*

2. What would you tell her? *That you believe her. That you have to report the abuse, and what might happen next.*

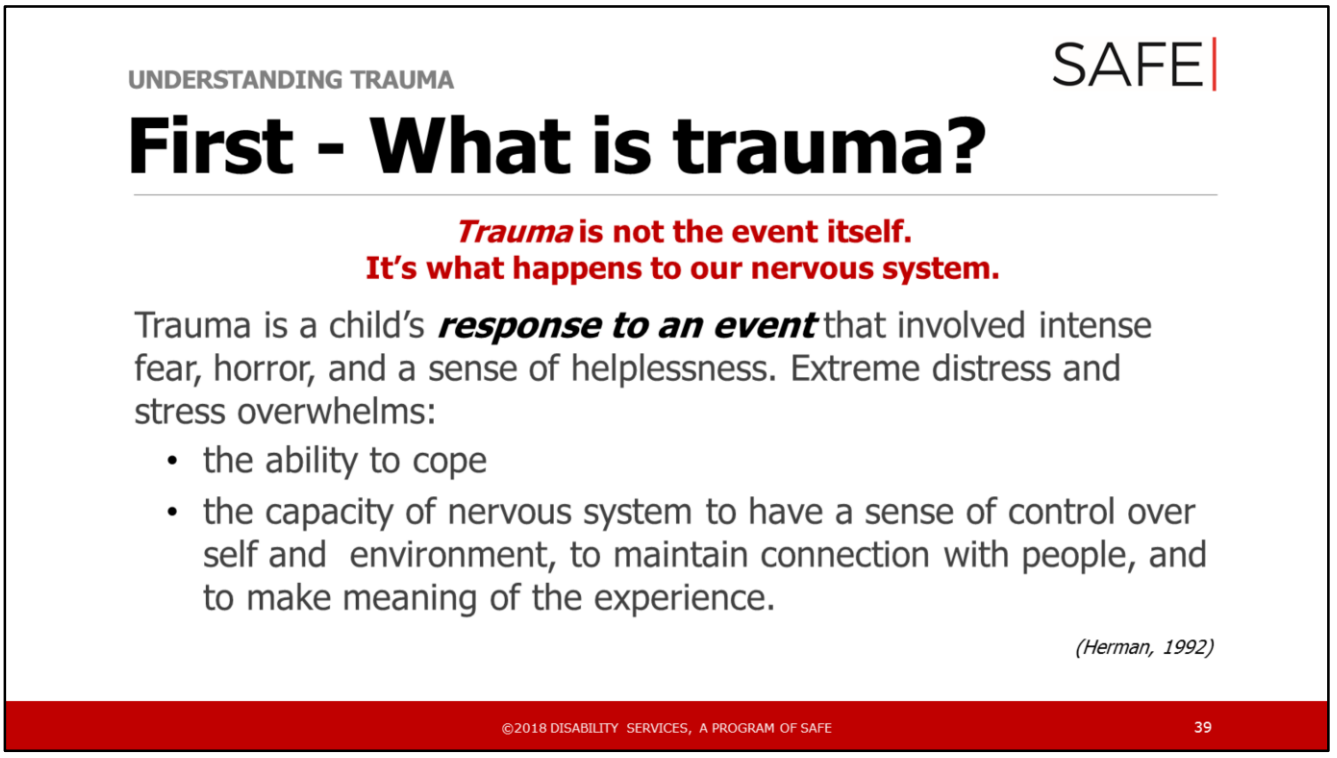
3. What things are important for Raquel to hear? *That what happened was not her fault. That you will work to keep her safe. That you care about her.*

4. What does she need from you now? *She needs you to stay neutral, to be calm and pleasant in her presence, to address your own distress privately with a trusted friend or therapist, and to help her find emotional support for recovery.*

Facilitator's Notes:

Trauma has a definite impact on child development, and we'll discuss how in this next section.

HANDOUTS: Let participants know that they have a handouts on this topic: *Common Reactions and Possible Responses to Children and Youth with Trauma Histories.* After the training, you will email interested participants *Resources on Trauma,* which has online links to information.

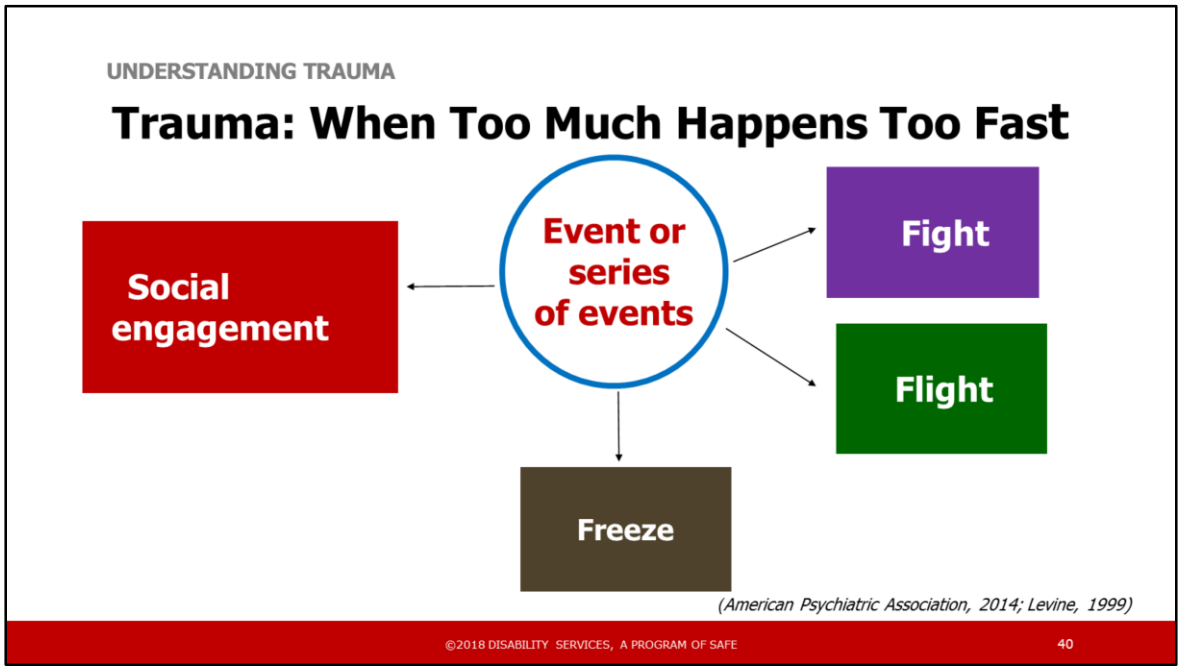


Facilitator's Notes:

- Trauma is a child's ***response to an event*** that involved intense fear, horror and a sense of helplessness.
- The child experiences extreme distress and stress that overwhelms their ability to cope.
- The event also overwhelms the capacity of the child's nervous system to have a sense of control over their self and their environment, to maintain their connection with other people, and to make meaning of the experience.
- *Trauma* is not the event itself, it's what happens to our nervous system.

Reference:

Herman, J. (1992). *Trauma and recovery*, Harper Publishing.



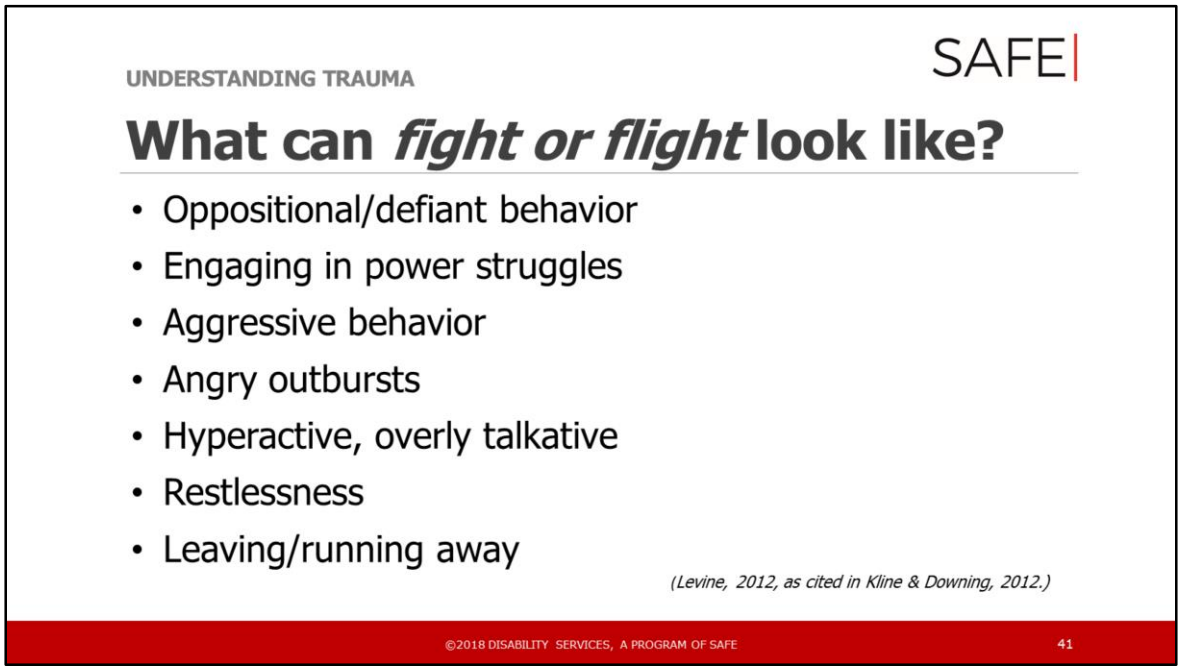
Facilitator's Notes:

What is trauma? It's when too much happens too fast. It's an event or a series of events. After a traumatic event, children's first line of defense **is social engagement—they look for help from other people** – family, friends, teachers. They may try to negotiate with the threat if it's another person.

If that doesn't work, children **may fight or flee.** They may push the abuser away and leave; run away and hide, for example.

These reactions are all driven by instinct. When social engagement, fight or flight do not work, the child's next line of defense may be to **freeze.** The freeze state allows children to conserve energy and is related to our primitive drives for survival when we are under threat from a predator.

These instinctual drives for survival reside in our nervous systems (NS) which include the brain and spinal cord and all the nerves that run throughout the body. The nervous systems also regulates the autonomic functions in the body (i.e., digestion, heart rate) and sensory-motor movements (the body's movements during regular life activities and also during fight, flight, and freeze).



Facilitator's Notes:

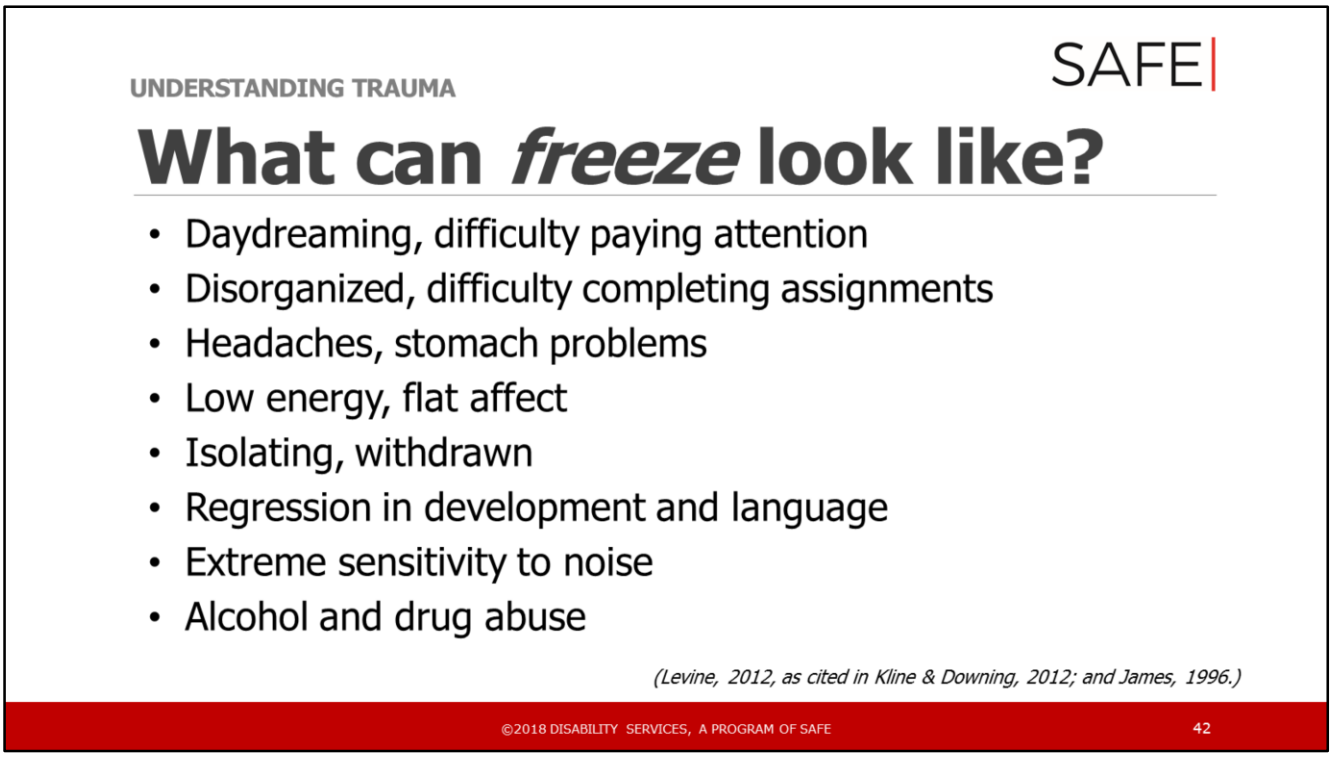
As we discussed, if there is no help from another person, children who perceive danger are most likely to fight or flee (try to get away from the danger).

Even after the traumatic event, children can have the same fight or flight reactions to stress. When that happens, rational thinking and reasoning is not effective. This is not a teachable moment.

This slide lists some of the reactions that can come with fight or flight reactions, which can occur long after the original traumatic events.

Reference:

Kline, M., and Downing, K. (2012). Based on the works of Peter Levine & Somatic Experiencing



Facilitator's notes:

The **freeze response** is what happens when social engagement, fighting, or fleeing did not keep the child from harm.

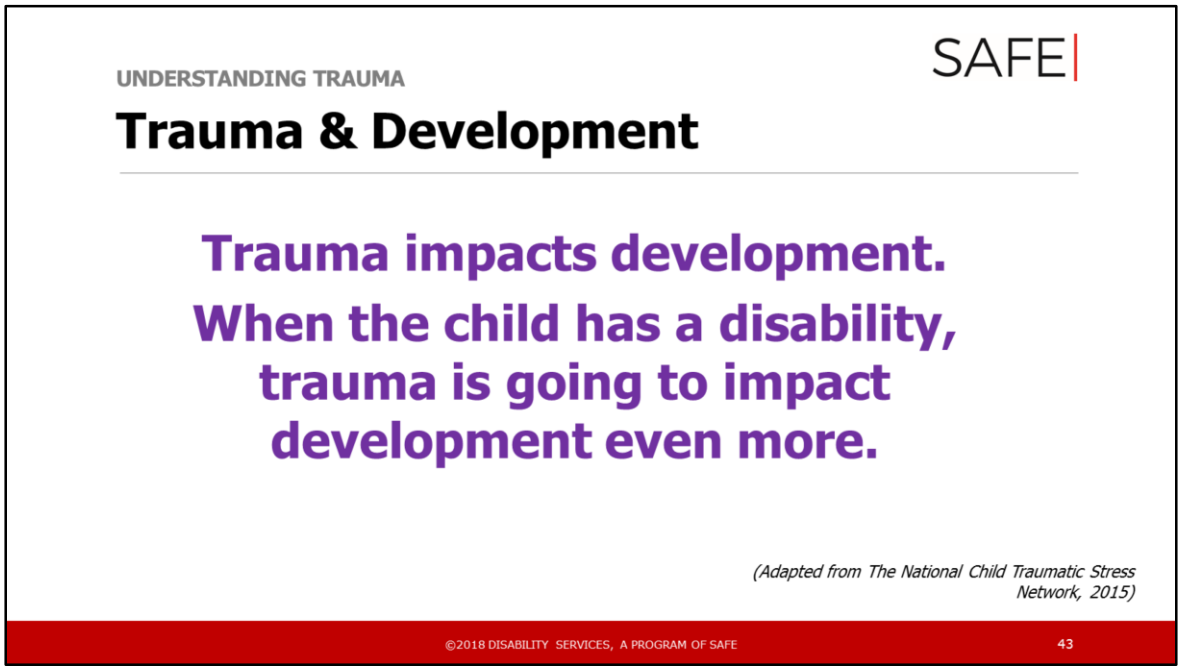
When a child is in a state of freeze or stuck in freeze, they will appear less stimulated and less traumatized. Freeze is related to the most extremely fearful situations. The child's nervous system has responded to the overwhelming impacts or reminders of the trauma by shutting down. This supports the child in coping – getting through the day. It's a reasonable and neuro-biologically based response.

When a child trauma survivor establishes a sense of being safe – and this often means the child is receiving some kind of intervention, such as therapy – the nervous system has an opportunity to settle. They may be less numb and underlying thoughts/feelings may begin to emerge. This can include rage linked to not being able to successfully defend or protect themselves when in danger.

Now, the child's behaviors and actions become more consistent with fight and flight. As a child's nervous system moves out of freeze (its state of energy conservation), they may become very distressed. I mention this shift or change because it can be interpreted that the child is doing regressing or losing gains made in recovery. However, this is common and a somewhat predictable stage in recovery from trauma. Overall, this is a time when children and their helpers need a lot of support in normalizing what they are experiencing.

Reference:

- Kline, M., and Downing, K. (2012). Based on the works of Peter Levine & Somatic Experiencing
- James, B. (1996). *Treating traumatized children: New insights & creative interventions.* (pp. 50-51.) The Free Press.

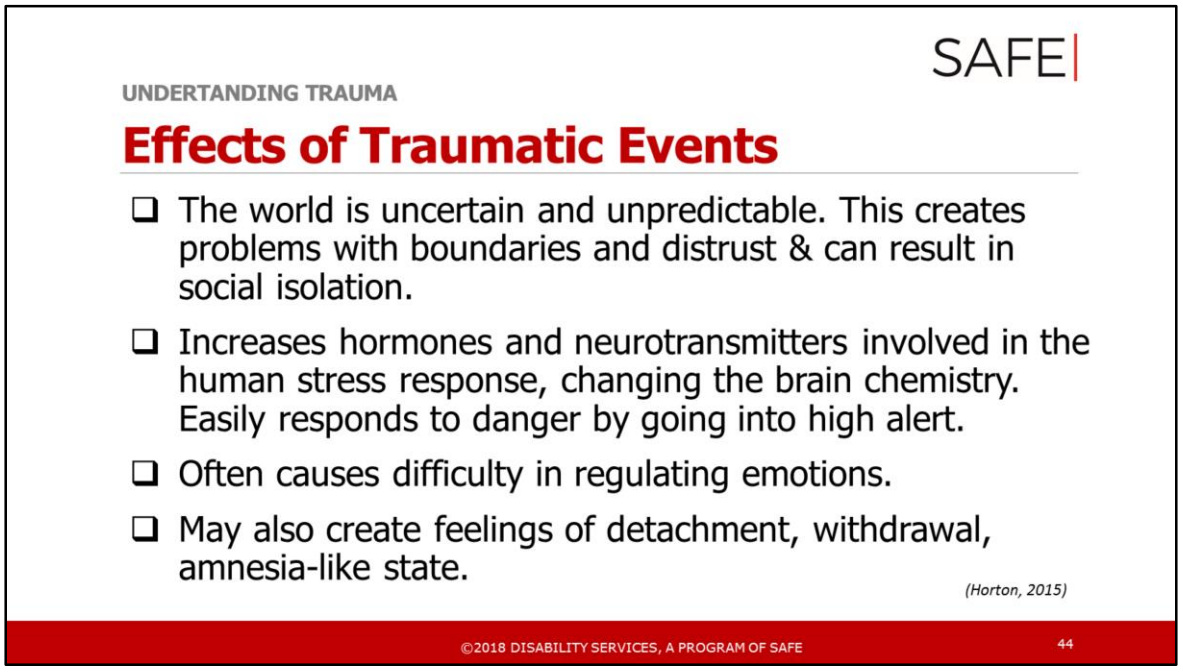


Facilitator's Notes:

If a child has disabilities and is experiencing abuse, and is simply trying to stay as safe as possible, they won't always have the ability to progress through developmental stages.

Reference:

The National Child Traumatic Stress Network. (2015, November). *Road to Recovery: Supporting children with intellectual and developmental disabilities who have experienced trauma.* Hogg Foundation for Mental Health.



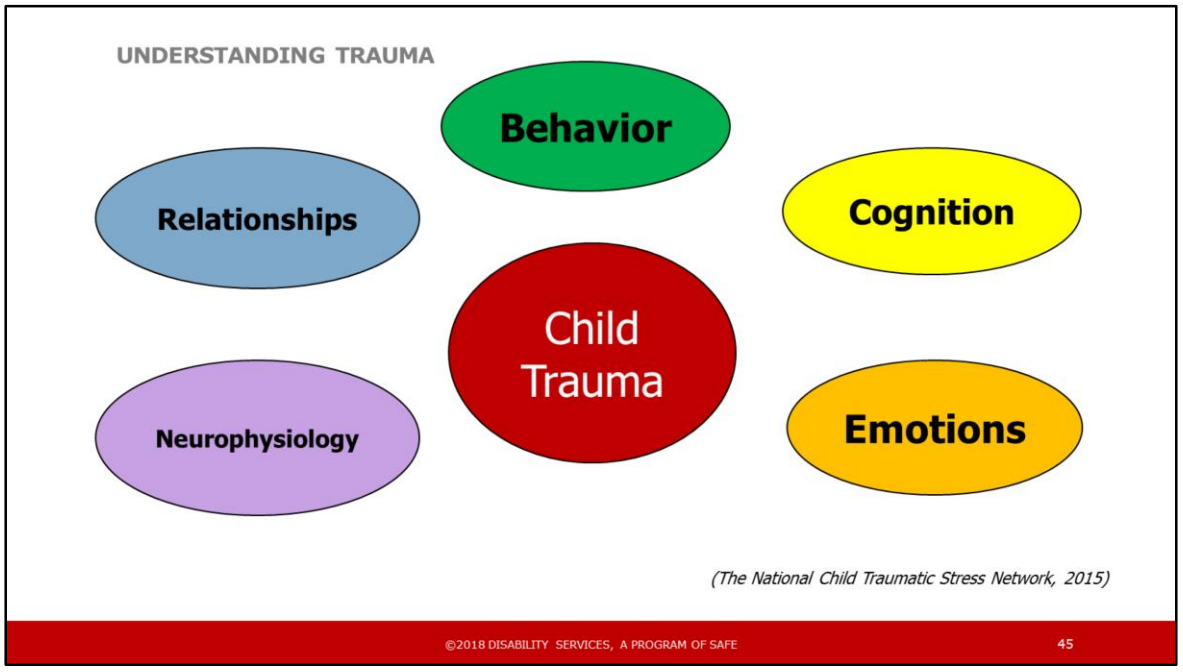
Facilitator's Notes:

NOTE: Go over information on slide.

Reference:

Horton, C. (2015). The Hogg Foundation for Mental Health. University of Texas.

(Horton, 2015)



Facilitator Notes:

SAY: *When children experience trauma, all of these aspects of their bodies and their lives are affected.*

If class members need more information, below are more examples.

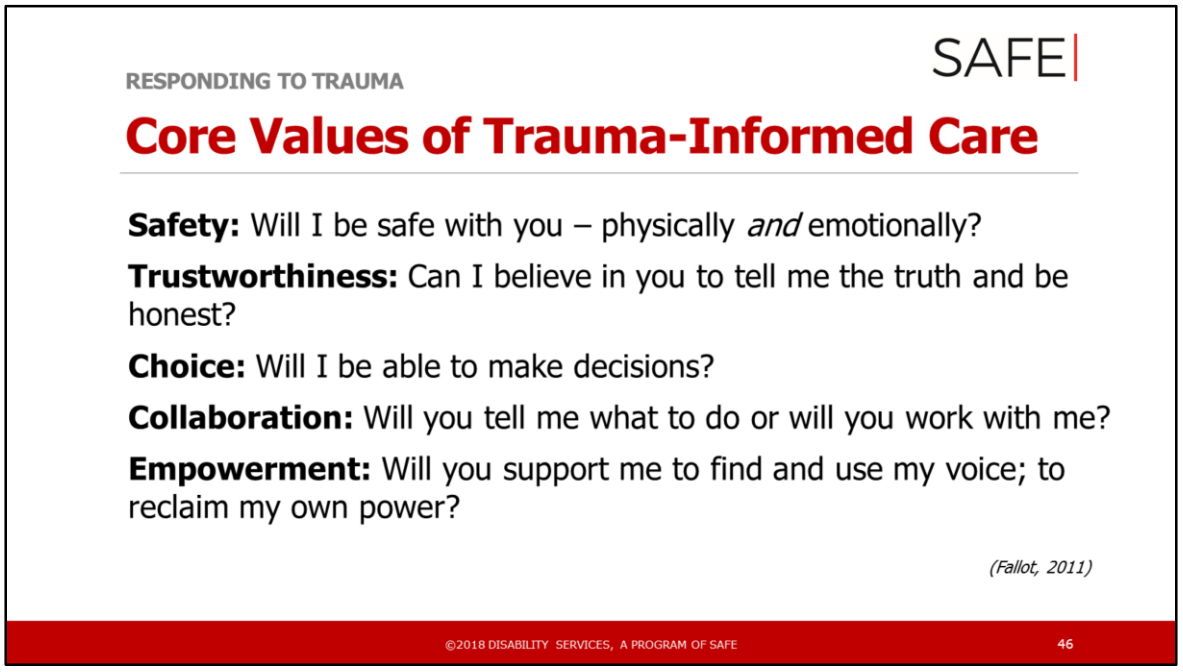
In summary, trauma impacts children's:

- Behavior
    - At-risk behaviors
    - Regressive behaviors
    - School difficulties
    - Behavioral dysregulation
- Cognition
    - Memory deficits
    - Attention problems
    - Learning difficulties
    - Language development

- Emotions
    - Emotional regulation
    - Depression
    - Anxiety
    - Describing feelings
- Neurophysiology
    - The nervous system organizes around the fear response
    - Hyper arousal
    - Disassociation
    - Alterations in brain maturation
- Relationships
    - Attachment difficulties
    - Risk future trauma
    - Social avoidance
    - Loss of trust and safety

Reference:

The National Child Traumatic Stress Network. (2015, November). *Road to Recovery: Supporting children with intellectual and developmental disabilities who have experienced trauma.* Hogg Foundation for Mental Health.



Facilitator's Notes:

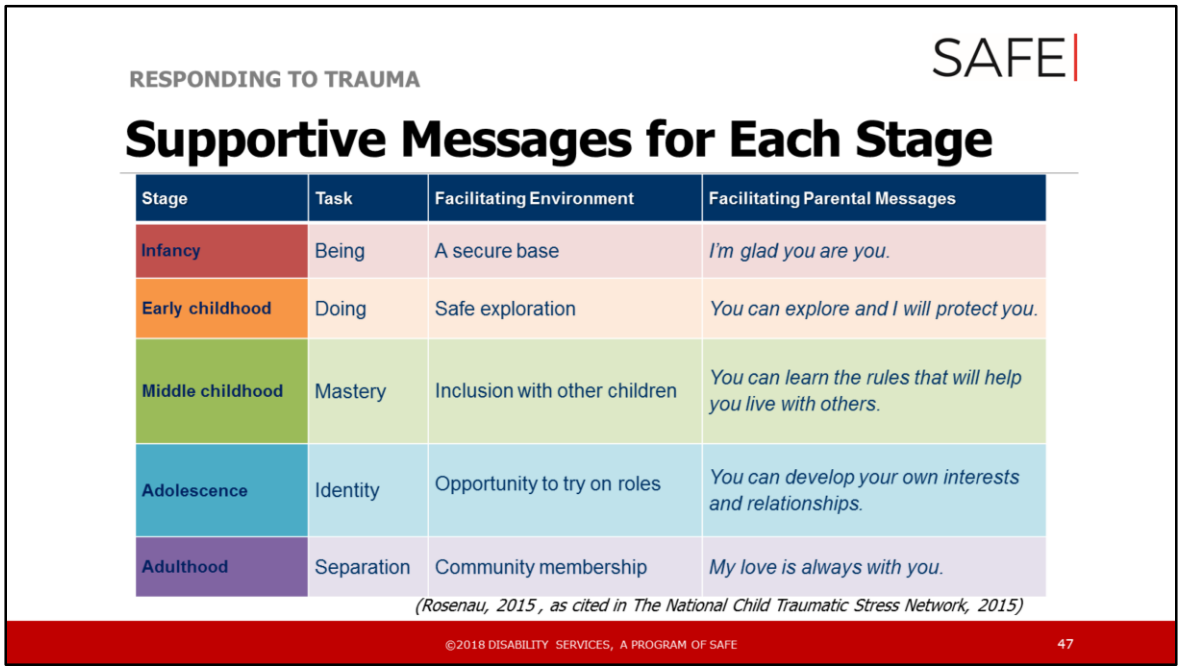
There is another way to look at how to support children after trauma. This slide outlines the five core values of trauma-informed care: Safety, trustworthiness, choice, collaboration, and empowerment. As you are working with children, look for practical ways every day to reflect these core values.

These values highlight the importance of:

1) establishing initial safety/trust with the child/felt safety
2) supporting children in making their own decisions – encouraging choices that fit their age and developmental stage
3) building a sense of collaboration to support children's choices and plans
4) supporting children to find and use their own voice – and to reclaim their own legitimate, age-appropriate power

Reference:

Fallot, R.D., & Harris, M. (2009, July). *Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol.*



Facilitator Notes:

- Children progress through key developmental tasks during each stage of development. Foster parents and residential staff can help by understanding what task children are trying to complete, and share messages to help children be successful.
- These messages can be verbal or nonverbal. Your body language, voice tone, facial expressions all can convey acceptance and appreciation.
- Children with disabilities may master these tasks at different times.

    - In **infancy**, **their task is just to be**. They eat and sleep, and if their world is safe, they grow in security. The message they need from the people who love them is: *I'm glad you are you.*
    - In **early childhood**, children's **task is "doing**." They tend to be all over the place. They want something and then they don't. They engage in power struggles with their caretakers. To grow in this stage, they need to be able to explore safely. The message they need from caretakers is: *You can explore, and I will protect you*.
    - In **middle childhood**, children **grow in mastery of tasks**. They need to be

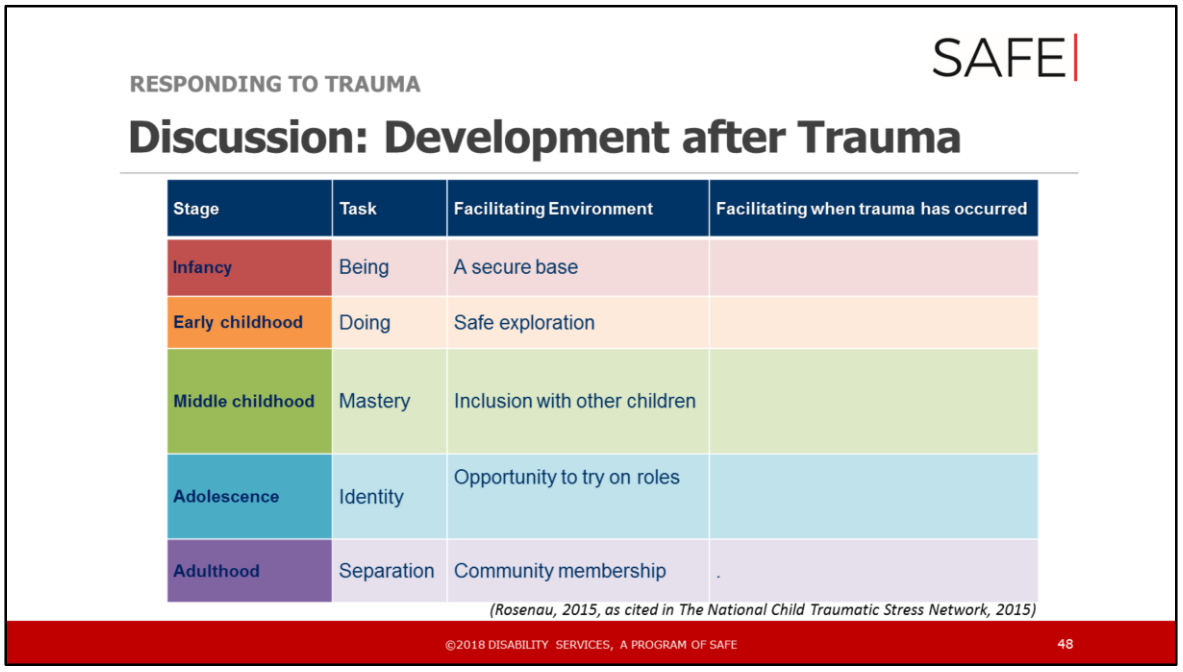
included with other children, and the message they need from caretakers is: *You can learn the rules that will help you live with others.*

- In **adolescence**, **youth begin to take on their identity**. They need to have the opportunity to try on new roles, new versions of themselves. The message that caregivers can share that will help them grow is: *You are allowed to develop your own relationships and interests*.
- In **adulthood, youth learn to separate from their caregivers**, and to become part of a community. The message that will help them is: *My love is always with you.*

Reference:

Rosenau, N. (2015). Facilitating Development [Chart]. Adapted from Human Development Chart- Erik Erikson's Model of Human Development. Retrieved from http://mcnellie.com/erikson.html.

As cited in: The National Child Traumatic Stress Network. (2015, November). *Road to Recovery: Supporting children with intellectual and developmental disabilities who have experienced trauma.* Hogg Foundation for Mental Health.



Facilitator Notes:

NOTE: *This slide involves a discussion, as class members try to fill in the last column.*

SAY: *Let's re-visit the developmental tasks that we discussed in a previous slide and look at it when trauma has occurred. At each developmental stage, how can we help a child complete their task? How can we use the five trauma-informed values of safety, trustworthiness, choice, collaboration, & empowerment to help?*

Example answers to cover during discussion:

- **Infancy:** Need to re-establish some attachment to a caring adult. We can help establish that security by touching, talking, providing the acceptance and love that the child didn't get initially. When traumatized, babies do a lot of crying. To help recover, do a lot of bonding, baby wearing, feeding them when hungry, changing when needed, so they can begin to trust that their needs will get met.
- **Early childhood:** Children practice exploration. When children experience trauma, disorganization and fight or flight is really heightened. Make sure the environment is safe for exploration. Don't overwhelm them with stuff. As a general rule, not too many activities, not too many toys; both can overwhelm children who did not

complete this task because of trauma.

- **Middle childhood and adolescent:** Children practice mastery of tasks. You're going to see a lot more trauma responses from these children in a different way. If they're verbal we're going to hear about it a little bit more, or we may see disengagement, or more aggression. When trauma has occurred, we can work with youth and prepare them for what will be happening socially. Who they are going to meet in different settings, what those settings will be like, what they can expect from different settings: new school, visit to doctor, visit to therapist. Provide a lot of structure and let them know what to expect**.**
- **Adolescence** is the opportunity to try on new roles and identities. This is difficult when coming from trauma. Goes back to being the safe person, being the safe base for them. Let them know that they can try something, and if it doesn't work, they can try it again, or try something different. Provide positive reinforcement to help build up their resilience.
- **Young adulthood** is where people learn to separate. Young adults benefit from being part of the community, trying on new roles, learning social skills.

Reference:

Rosenau, N. (2015). Facilitating Development [Chart]. Adapted from Human Development Chart- Erik Erikson's Model of Human Development. Retrieved from http://mcnellie.com/erikson.html.

As cited in: The National Child Traumatic Stress Network. (2015, November). *Road to Recovery: Supporting children with intellectual and developmental disabilities who have experienced trauma.* Hogg Foundation for Mental Health.

RESPONDING TO TRAUMA

SAFE

What else do children need?

- Validation of their feelings
- Outlets for expressing emotions
- Nurturing, support, and reassurance
- Finding their strengths
- Supportive people

(Levine, 2012, as cited in Kline & Downing, 2012; Campbell, 2012.)

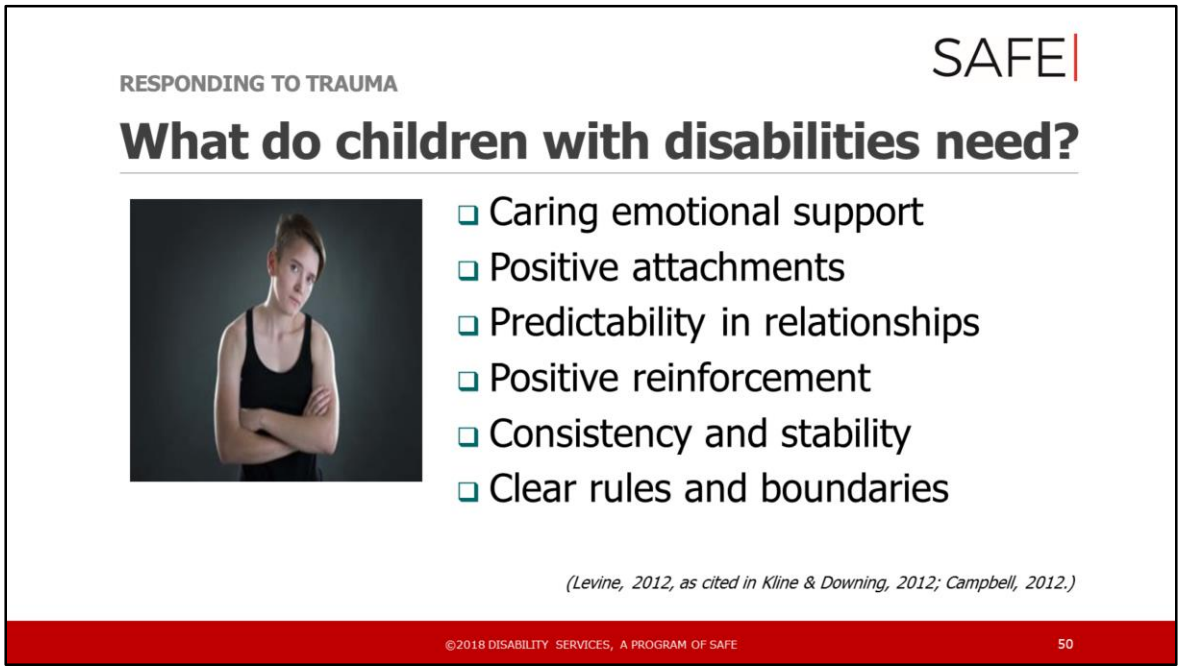
Facilitator's Notes:

Children need:

- Sensitivity to and validation of their feelings. Children need to be taught that any emotion they have is okay.
- Safe and appropriate outlets for expressing their emotions. They also need to be taught safe ways to express the hard, overwhelming emotions. Options can include music, art, dance, nature.
- Nurturing, support and reassurance: All children need to be nurtured, to be supported, to be reassured about themselves and their future.
- Support children in finding their strengths and people who will support them. All children have strengths. Children with disabilities who have been abused may need help finding and relying on their own strengths, the activities that they are good at, and the people who can help support them.

Reference:

- Kline, M., and Downing, K. (2012). Based on the work of Peter Levine & Somatic Experiencing.
- Campbell, R. (2012, December 3.) *The neurobiology of sexual assault.* U.S. Department of Justice, Office of Justice Programs. NIJ Research for the Real World Seminar.



Facilitator's Notes:

Caring emotional support is key for children with disabilities who have experienced traumatic events. Empathy and understanding from adults can help settle traumatic stress levels.

Positive attachments directly re-wires the frontal cortex of the brain. This can help balance children's nervous systems.

Children also need **predictability in their relationships**. They need people who do what they say they are going to do, who are there when they are say they will be. Don't promise what you are not sure you can deliver.

They also need:

- **Age-appropriate choices**. Children with disabilities often have few choices or things they can control in their lives. Making choices/decisions helps develop the frontal cortex of the brain, and supports recovery from abuse.
- **Positive reinforcement**: Examples: *I like the way you help me set the table, I noticed that you really enjoyed that book.* It is easy for parents and caregivers to focus on

correction. Reinforcement is much more effective.

- **Consistency and stability** in their schedules, how they are treated, what they can expect. Without being rigid, having dinner at the same time, bedtime at the same time, regular activities.
- **Clear rules and boundaries**, along with appropriate limits.

REFERENCE:

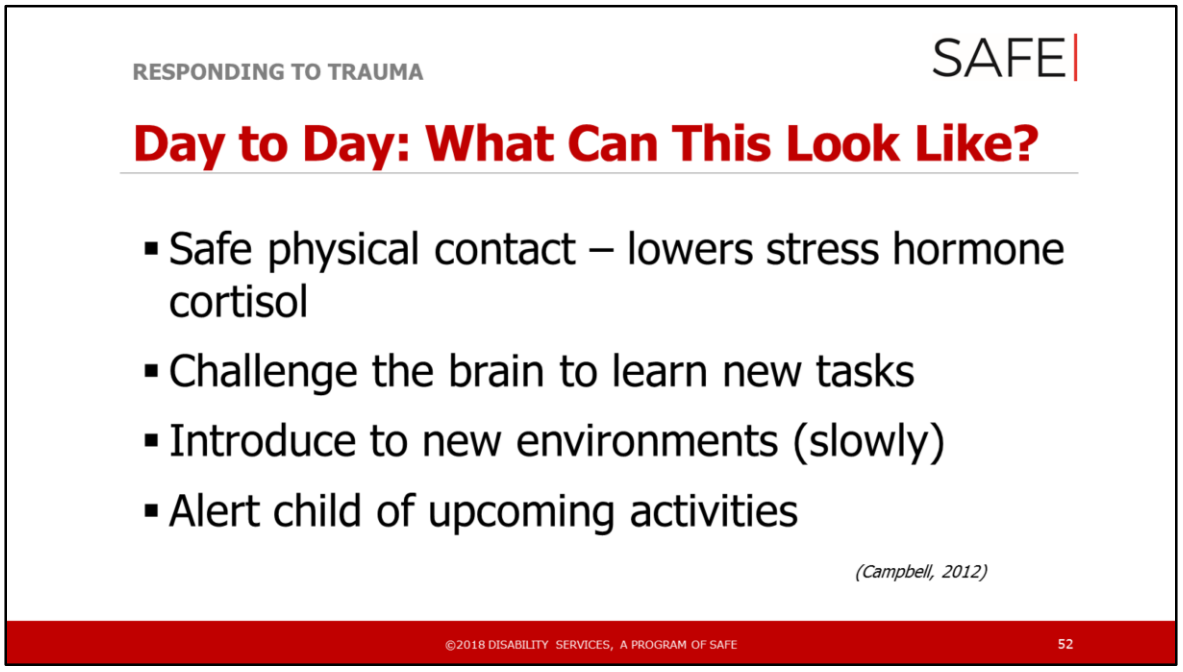
- Kline, M., and Downing, K. (2012). Based on the work of Peter Levine & Somatic Experiencing.
- Campbell, R. (2012, December 3.) *The neurobiology of sexual assault.* U.S. Department of Justice, Office of Justice Programs. NIJ Research for the Real World Seminar. http://nij.gov/multimedia/presenter/presenter-campbell/pages/presenter-campbell-transcript.aspx

Facilitator's Notes:

- **Kind gestures**. Simply treat children with kindness in your day-to-day interactions. Treat them as someone you value and care for.
- **Develop trust**. Honesty and truthfulness is key. This will look different for each age and each child. Let them know they can trust you to do what you say, that you will tell them the truth, even when it is difficult.
- **Prevent sensory overload.** Intense sights, sounds or bodily sensations may frighten or bewilder children. Create a calm, quiet environment as much as possible. This will be more important for some children than others. Avoid places that will overload children's nervous systems as much as possible, such as playgrounds with lots of children, loud restaurants, crowded stores.
- **Speak simply and repeat or rephrase** if needed. After traumatic events for children with intellectual disabilities, it can be helpful to explain things in plain language. Repeat in different words if children still do not understand.

Reference:

Campbell, R. (2012, December 3.) *The neurobiology of sexual assault.* U.S. Department of Justice, Office of Justice Programs. NIJ Research for the Real World Seminar.



Facilitator's Notes:

DISCUSSION QUESTION: *We know what children need. How can we make that happen in their day-to-day lives?*

- Safe physical contact lowers stress hormone cortisol. Adults can teach them: This is my safe bubble, this is yours. They can ask people if they want a hug.
- Challenge the brain to learn new tasks: Challenging the brain to learn new tasks and skills helps rewire it in different ways. Use more than one sense at a time (example: music and dance).
- Introduce child to **new environments**: It's important to introduce to new things, slowly. Let them know: *this is what it's going to look like, this is what's going to happen.*
- Alert child of upcoming activities: *We're going to go out, in five minutes, three minutes, one minute.*

Reference:

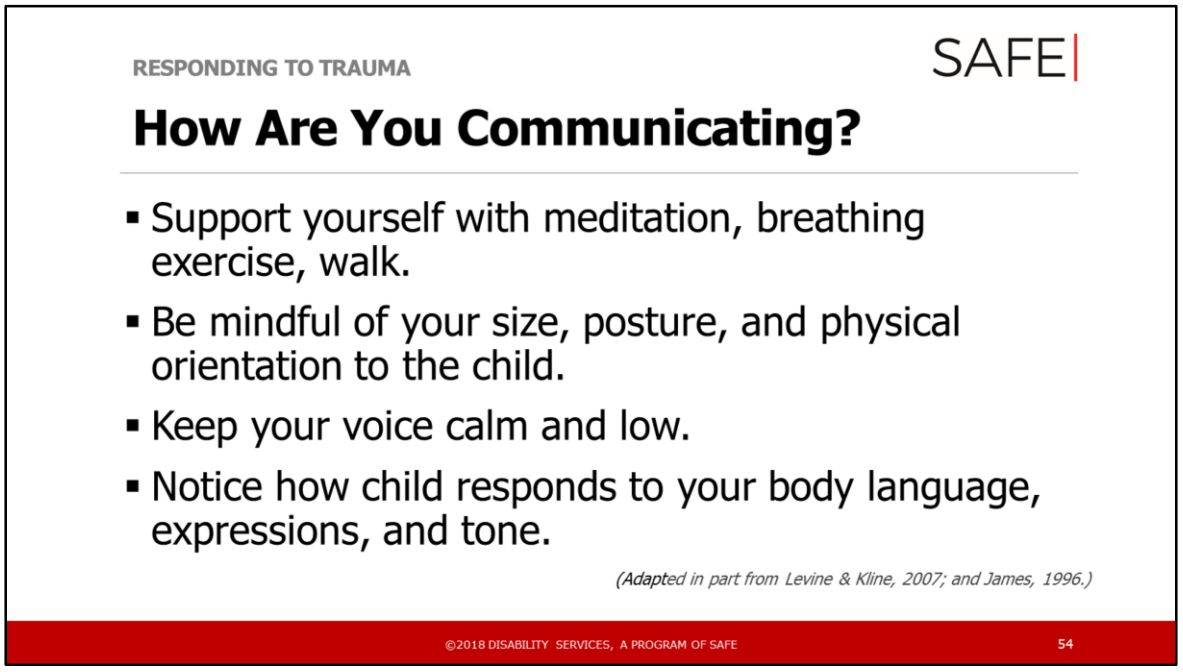
Campbell, R. (2012, December 3.) *The neurobiology of sexual assault.* U.S. Department of Justice, Office of Justice Programs. NIJ Research for the Real World Seminar.

Facilitator's Notes:

- Comfort and grounding with animals/pets: If they cannot have a pet, see about therapy pets, visiting petting zoos, being in nature with wildlife
- Creative expression (use more than one sense – music and dancing, art and cooking)
- Physical exercise
- Sleep
- Healthy foods/hydration. Look at food allergies, responses to different foods.

Reference:

Campbell, R. (2012, December 3.) *The neurobiology of sexual assault.* U.S. Department of Justice, Office of Justice Programs. NIJ Research for the Real World Seminar.



Facilitator's Notes:

We need to also identify what we are bringing to a stressful situation.
Are we adding to the stress with our responses? Are we increasing the child's feelings of being unsafe and having no control over what is happening to them?

- If they get loud, we tend to get loud. A better way is when they get loud, we get softer.
- Acknowledge their distress. "I can see that you seem to be very upset."

If you are stressed, do what you need to do to ground yourself: meditation, breathing exercises, a walk.

- Try to be the calm in the storm when you meet with the child.
- Pay attention to your body in relationship to the child – are you standing over the child? Behind the child? Or in front of the child at eye level?
- Be careful about if and how you use touch and how you approach a child in distress or crisis. Use safe and nonthreatening touch: Shoulder, elbow.
- Notice how the child is responding to your eye contact, expressions, tone of voice, and body language, and make adjustments as needed.

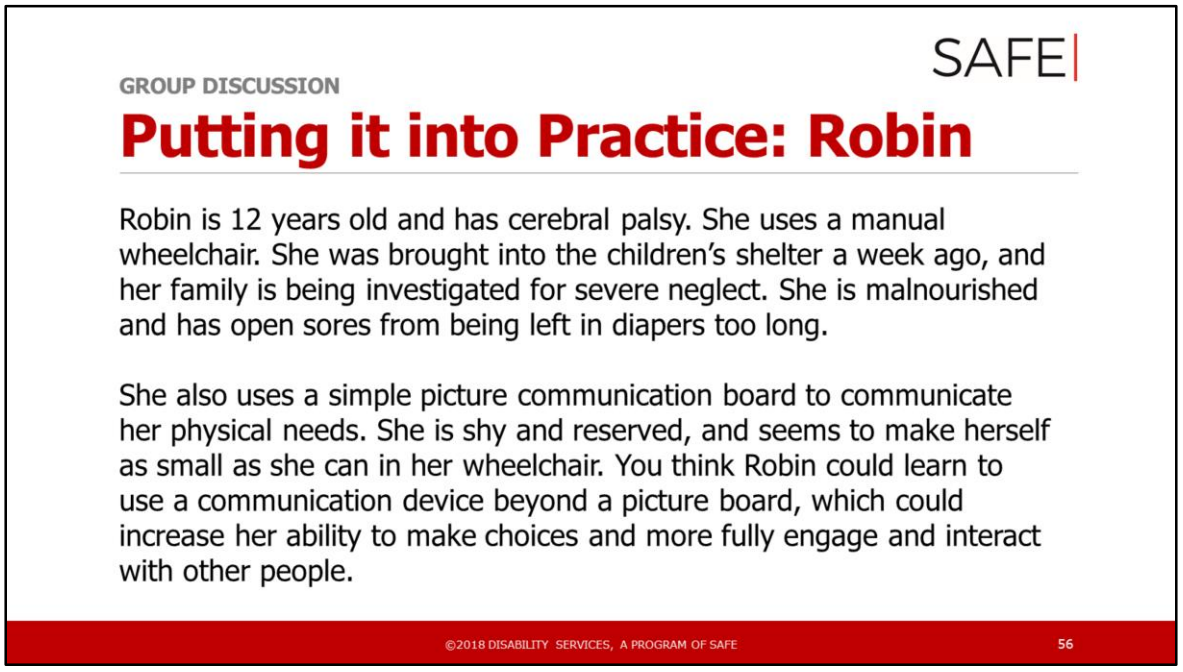
Reference:

- Kline, M., and Downing, K. (2012). Based on the work of Peter Levine & Somatic Experiencing
- James, B. (1996). *Treating traumatized children: New insights and creative interventions.* pp.50-51. New York, NY: The Free Press

Facilitator's Notes:

SAY: *Our third case study is about a 12-year-old girl named Robin, who was moved out of her family home because of severe neglect.*

Let participants know that they will answer several questions about how to use the trauma-informed values in their response to Robin.



Facilitator's Notes:

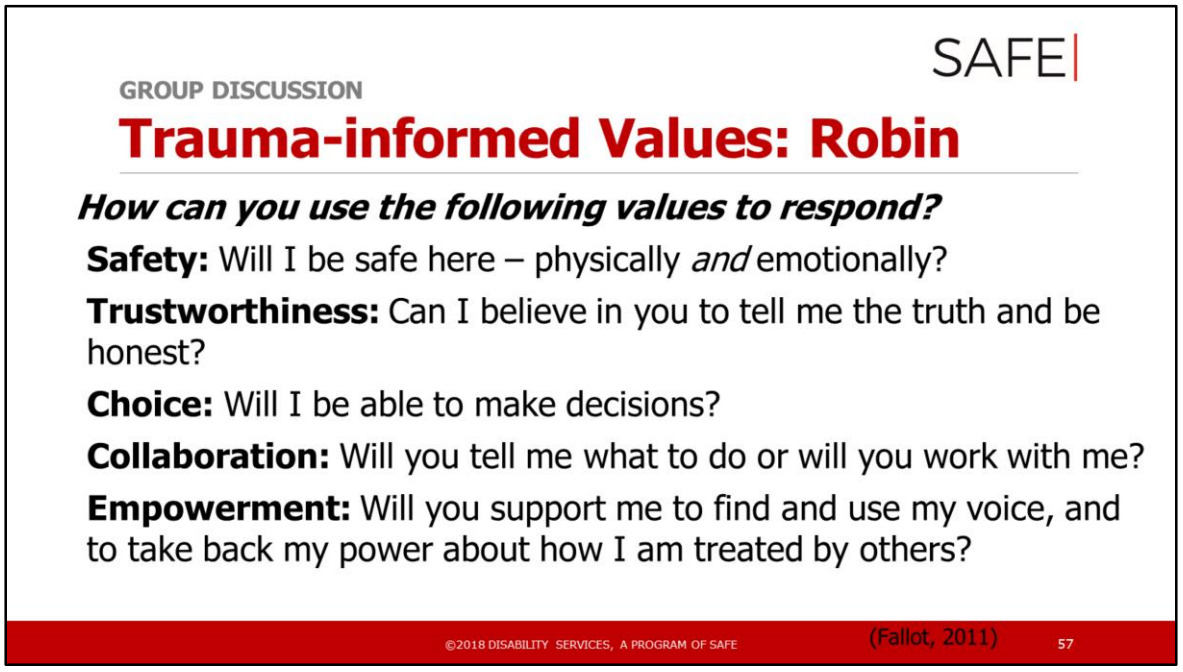
Read the case study out loud to the entire group, or have someone from the audience read it aloud.

SAY: *Work at your table to brainstorm as a group how you could use the values of trauma-informed care as you respond to Robin. In your group, as for a volunteer to take notes and for a volunteer to report back to the larger group. We'll work for 10 minutes and I'll let you know when it's time to come back to the larger group.*

Move to the next slide.

Set timer for ten minutes.

Note: Facilitators can walk around the room, listen for a brief time at each table, and answer any questions that come up.



Facilitator's Notes:

Ask for a volunteer to write responses on chart paper or a dry erase board. Ask the class their ideas for using trauma-informed values to support Robin's healing and comfort in her new home.

Provide sample answers if class members do not share them:
Safety: Will I be safe here – physically *and* emotionally? Provide physical safety by watching for signs of current abuse or neglect, and by making sure Robin feels as safe as possible in a new environment. Provide emotional safety by being patient, kind, responsive; and watching how other people in her daily life respond to her. You can also provide safety by addressing her body language. For example, if she is hiding in her wheelchair, one response is; *I see that you feel safe in your chair. I want you to know you are also safe here with us. Or, We know you are unsure about us, but we are safe and we will work to keep you safe here.*

Trustworthiness: Can I believe in you to tell me the truth and be honest? Be honest with Robin about what is going to happen day by day, and how long she might be with you, if you know. Tell her things like, *You can trust we will be working hard to keep you*

safe here.

Choice: Will I be able to make choices and decisions? Provide Robin options for making choices about what she would like to eat, what TV shows she would like to watch, and other daily activities that will help her feel some mastery over her life. In addition, ask Robin if she would like to look at other communication devices. Share that*: We want you to be able to ask for what you need or tell us if you don't want to do something. Is that something you are interested in exploring with us?* Listen to her answers and watch for changes in her body language. If she is not ready yet to change how she communicates, go slowly.

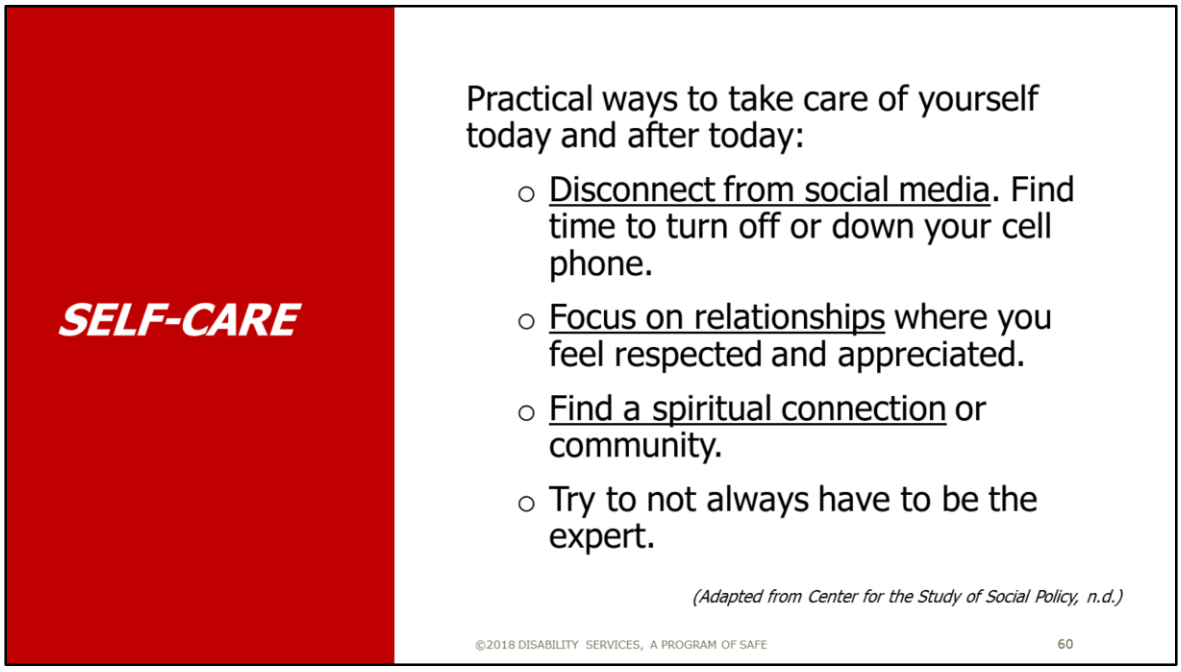
Collaboration: Will you tell me what to do or will you work with me? As noted, seek and listen to Robin's preferences on communication devices. Research different options together, and ask for her opinion. Tell her: *We can work together so you can feel safe here.* Paying attention and asking what she likes will help build on her strengths, which in turn builds safety.

Empowerment: Will you support me to find and use my voice? During pre-adolescence, children are learning who they are in the world and building some independence. During her time with you, Robin can learn about and get reinforcement about her skills. Pay attention to what skills she is mastering in his new situation, and share your insights with her. Listen to what she is telling you with her actions. Find ways to incorporate her feedback into decisions.

Facilitator's Notes:

Go over the essential messages and ask if anybody has any questions or anything to add.

HANDOUT: Let participants know that they have two handouts on safety and abuse in their packets: *Increasing Children's Sense of Safety through Connection*, and *Safety Planning with Children with Disabilities*. You will email an online handout, *Resources for Foster Parents and Caregivers,* after the training to people who signed up to receive electronic handouts.



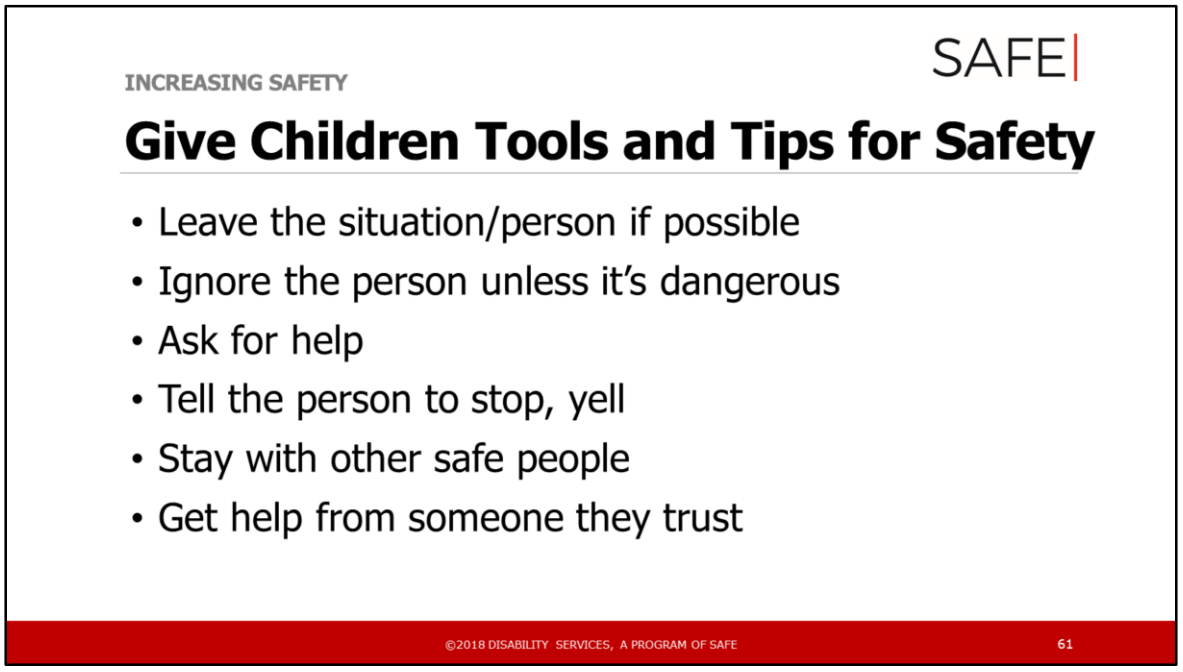
Facilitator's Notes:

Check in: *How is everybody doing?*

DISCUSSION QUESTIONS:
Before we begin this last module on increasing the safety of children with disabilities, here are a few more self-care tips.

- *Does anyone have a strategy or example of what's been helpful to them in self-care?*
- *What are some potential barriers to self-care? How have you gotten around them?"*

Reference:
Center for the Study of Social Policy. (n.d.). *Taking care of yourself: Tips for foster and resource parents.* Strengthening Families. Retrieved September 27, 2017, from https://www.cssp.org/reform/strengtheningfamilies/practice/body/Self-Care-for-Foster-Parents.pdf



Facilitator's Notes:

Go over slide information.

DISCUSSION QUESTION: *What else have you shared with children to increase their safety?*

Children with disabilities need to know that they can say no, get away, and go to tell someone.

However, they also need to know that sometimes it is not always safe to say no. Sometimes they will not be able to get away, and they also may not know who to tell.

Spend some time talking about this with children in your care. They need to know who they can come to for help. Help children think about and choose someone in each setting they can trust and turn to. Each child needs both someone who lives at home and someone out of the home to go to, in case the abuser lives in the home. We all need safe people in our lives.

Facilitator's Notes:

- Work with children on how to let you know if something is happening that is not okay or that makes them afraid or uncomfortable.
- Children with communication disabilities can use a code. A single word, motion, or gesture can mean that something happened that didn't feel safe or okay.
- Make sure communication device or board includes words or symbols for safety, sexuality, and abuse. Common words and symbols: *male and female genitalia, breasts, buttocks, hitting, punching, pushing, spanking,* or *touching*.
- Other options: a switch with a pre-recorded message, whistle, or other personal alarm device for signaling emergencies.

DISCUSSION QUESTION: *Are there any other words you can think of that should be added to a communication device?*

Facilitator's Notes:

Educate yourself and children with disabilities about sexual development. All children need to know about sexuality so they know if something happens that is not okay. In addition, children with disabilities are sexual, just like their peers without disabilities. Children with disabilities may develop in some areas of sexuality according to their developmental age, and in some areas according to their cognitive or emotional development.

Ask the child's school to provide abuse prevention/risk reduction education, sexuality education, and personal safety skills education and training to reinforce the concepts taught at home.
Teach children information about sexuality and safety that is appropriate to their age and developmental stage.

For resources about these topics, see:
http://childabuseanddisabilities.safeaustin.org/resources/parents-guardians-caregivers/

INCREASING SAFETY

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Safety for a Young Child

Adult protector
Notice unusual behaviors
Ask questions

Facilitator's Notes:

A safety plan for a young child would include having an adult protector who helps keep them out of abusive or violent situations, notices unusual behaviors in the child that might be linked to distress or trauma, and then asks questions to the child (if old enough) and others in the child's life about what might be happening.

Facilitator's Notes:

Pay attention & stay alert

- Listen to what a child tells you, especially if they are uncomfortable or seem distressed. Again, watch for signs of changes in behavior and emotions, or withdrawal.
- Pay attention if a child shares or indicates they are uncomfortable with someone: Parent, caregiver, peer, family, friend.
- Monitor the situation and ask questions. If the child continues to be uncomfortable or you continue to have concerns, trust your instincts and address the situation. Change caregivers, ask school staff to separate or monitor closely, etc.
- Don't be lulled into thinking that children are more safe in segregated settings like educational programs or group homes for children and youth with disabilities.
- Abuse can happen anywhere. The more isolated and closed the system or setting, and the fewer people who are watching, the greater the risks for abuse, exploitation, & neglect.

Enlist people who can help support and look out for children.

- Share information with caregivers about the prevalence and signs of sexual and

physical abuse in the lives of children with disabilities.
- Let them know what information about sexuality you are sharing with children, what safety steps you are taking, and how they can help.

Monitor care providers
- Be clear about your expectations, check references, do background checks, and provide ongoing supervision and feedback.
- Spend time with the child and care providers, and if there is anything in the interaction that makes you uneasy or uncomfortable, don't ignore or explain away – pay attention.

Protect children's privacy and boundaries. If the child needs personal assistance with using the toilet or changing at school or daycare, check to see if the changing or bathroom area provides privacy for students. Make sure you and the child are comfortable with staff responsible for your child's hygiene. Talk to caregivers in the company of the child about privacy and what boundaries are important for safety.

References:

- Stop it **now!** (n.d.). *Tip sheet: Family safety planning for parents of children with disabilities.* www.stopitnow.org/ohc-content/tip-sheet-family-safety-planning-for-parents-of-children-with-disabilities
- Chicago Children's Advocacy Center (n.d.) *How to talk to your child to reduce vulnerability to sexual abuse. www.chicagocac.org/wp-content/uploads/2015/04/ChicagoCAC-How-to-Talk-to-your-Child.pdf*

Facilitator's Notes:

DISCUSSION QUESTION: *Can you think of ways to role play safety?* (Examples: Shopping in a store, making change, if someone approaches them in a bathroom, etc.)

In your packet is a safety planning handout.

Identify safe people.

- Children should know which people in their everyday lives are safe and could help if they were in trouble or in danger.
- They should also know who to generally trust in the community.
- For each setting in a child's life, identify or help the child identify several people they could ask for help. The people on this list will change over time.

Teach what's not okay. Share with children what is okay and not okay for people to do to their bodies, or for them to do to other people.

Go beyond stranger danger

- We emphasize stranger danger with children, but abuse is much more likely to

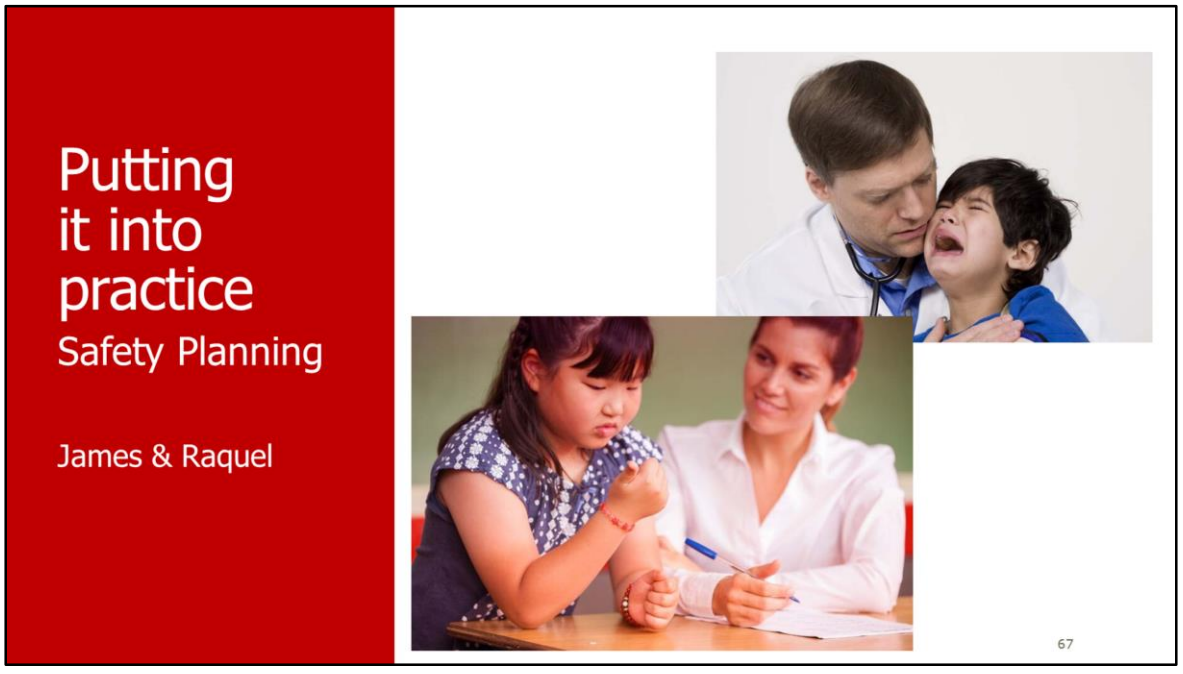
come from someone they know.

- Teach children that there are things that are not okay for adults, other children, or siblings to do to them, or for them to do to other people.
- Some touches are okay, like a goodnight kiss from family, high fives with friends, or medical checkups.
- Some are not, like hitting, pulling hair, or touching another person's genitals, buttocks, or breasts without permission.
- Help children learn that they have some control over what happens to their bodies by asking permission or telling them what is going to happen before touching: *Is it okay if I hug you? I'm going to change your diaper now.*

Practice safety in different settings and with different people. Role play in real settings where children spend time.

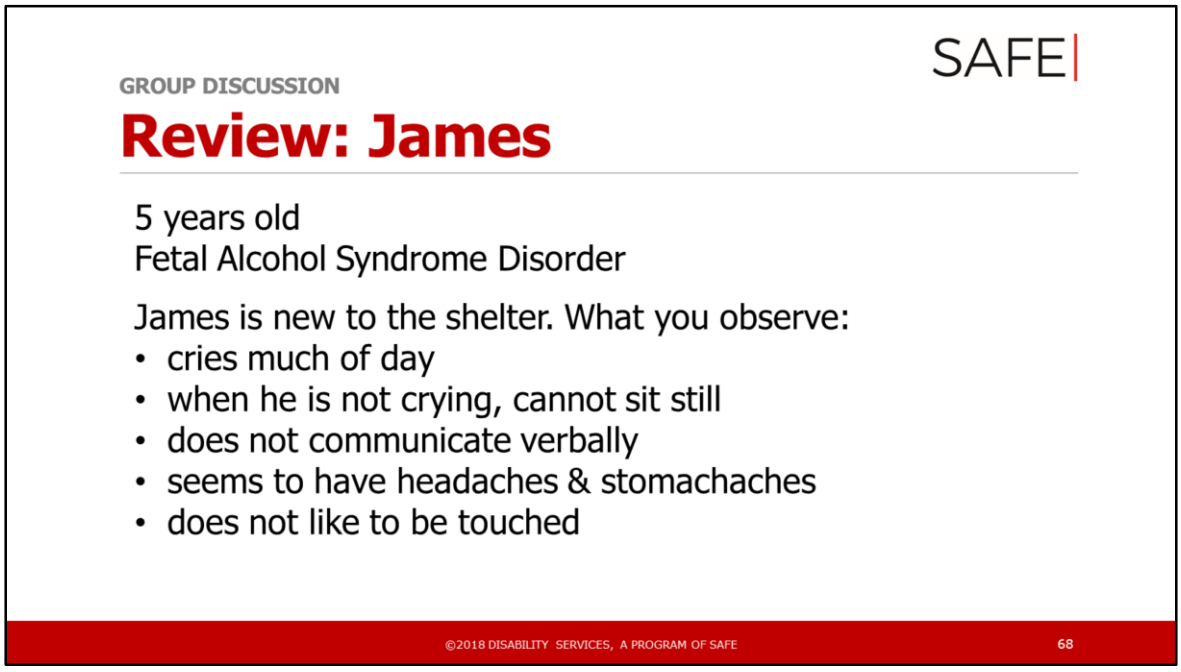
You can role play with pre-schoolers as well as older children.

- Use picture cards of different scenarios. Ask what's okay, and what's not okay in a public place.
- Let the child know that you are one safe person, and help them identify another person.
- At home, with different people, children can practice saying no firmly and loudly, walking quickly away, and telling someone when they feel unsafe.



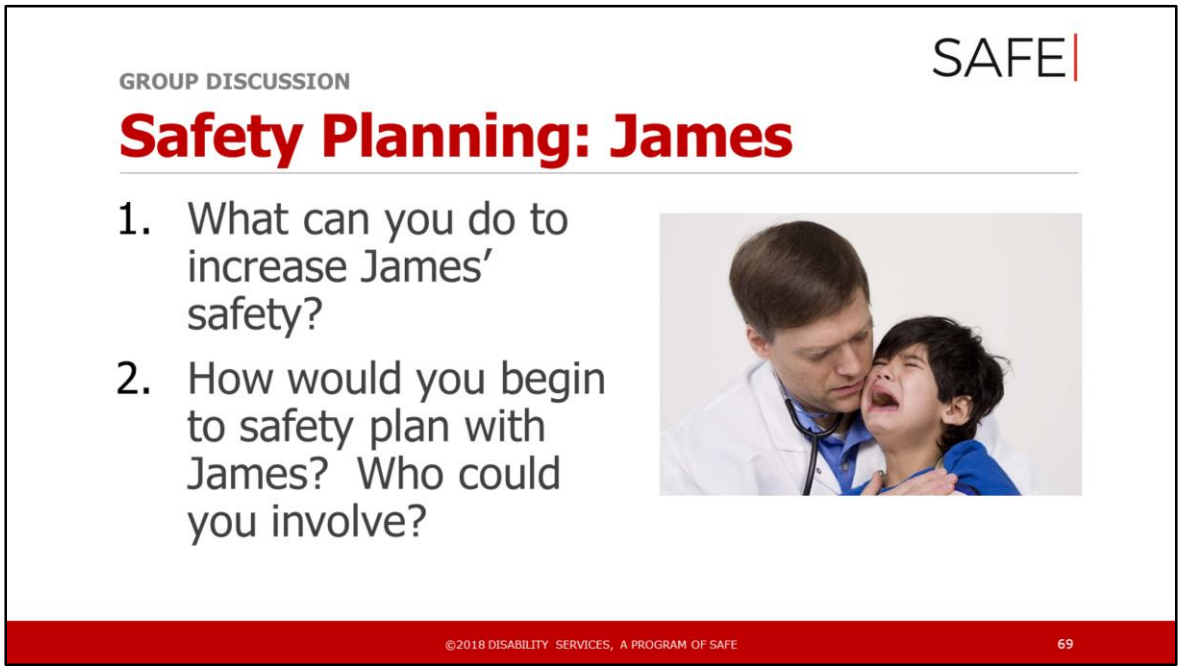
Facilitator's Notes:

Share that for the last large group activity, participants will revisit James and Raquel, and discuss how to safety plan for young children and teenagers. Rather than breaking into small groups, everybody will answer the questions together. Ask for a volunteer to take notes on chart paper or a dry erase board.



Facilitator's Notes:

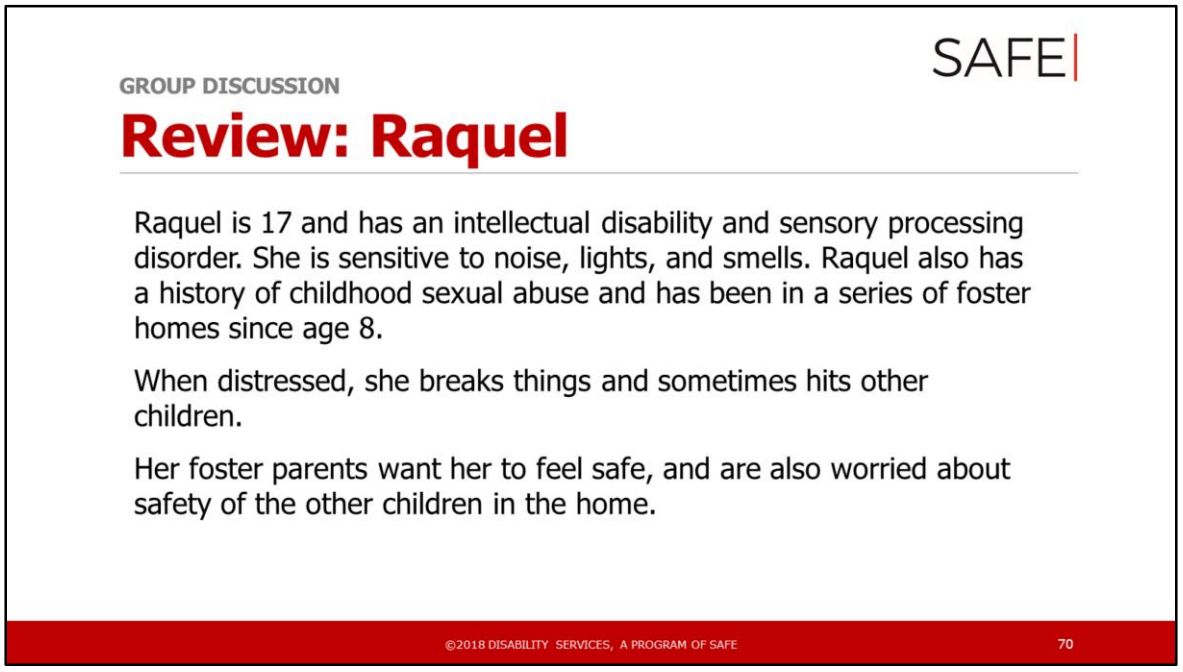
Briefly review the details about James, then move to the next slide.



Facilitator's Notes:
Leave this slide up and read the first question out loud to the group. Ask the volunteer to take notes. As needed, include the sample answers below. Then ask the second question and invite participants to share their ideas. When the group has answered both questions, briefly review the notes.

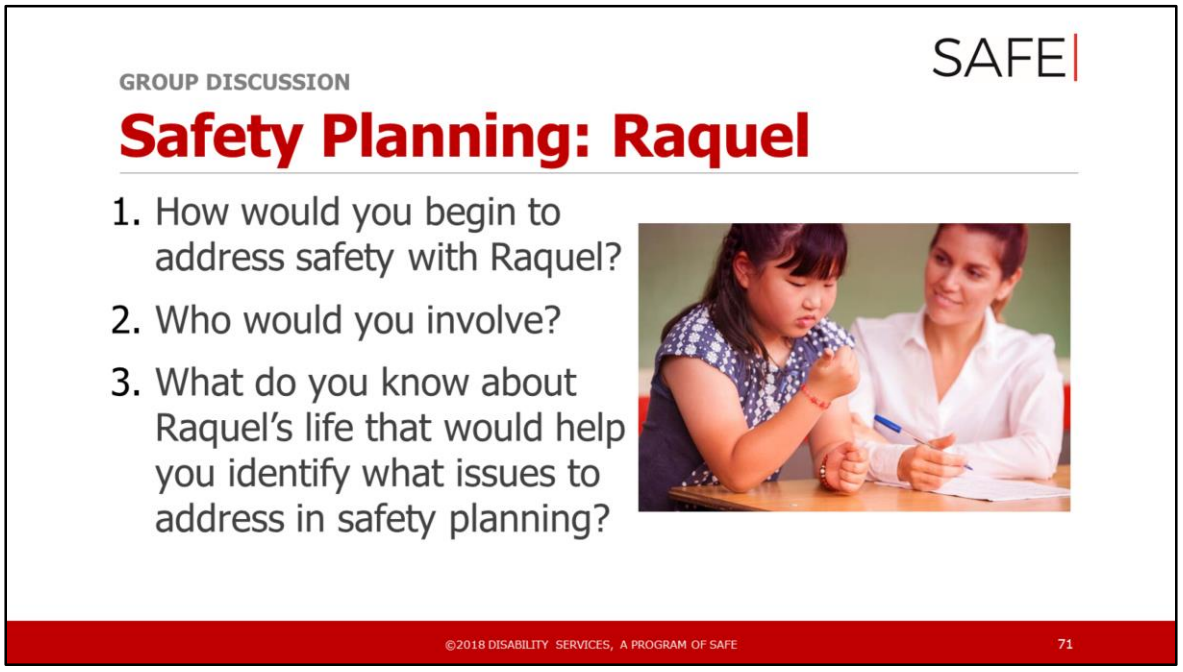
Sample responses are:

1. What can you do to increase James' safety? *Pay attention to any new changes in behaviors. Monitor other care providers. Do background checks on any new care providers. Ask questions if something concerns you. Report any suspicion of abuse. Find at least one trusted adult in each setting that James can go to.*
2. How would you begin to safety plan with James? *Begin role plays saying no, getting away, letting someone know that something is going on.* Who could you involve? *Staff at James' school, other care providers, other foster family members*.



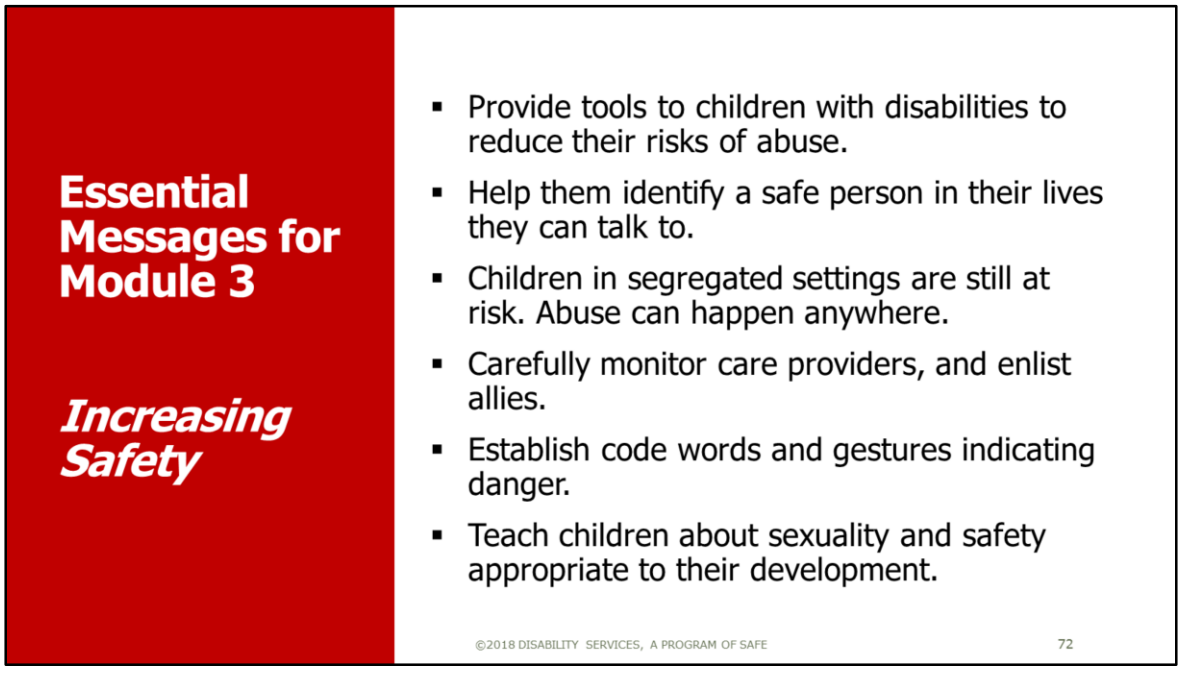
Facilitator's Notes:

Briefly review the information about Raquel, then move to the next slide.



Facilitator's Notes:
Leave this slide up and read the first question out loud to the group. Ask the volunteer to take notes. As needed, include the sample answers below. Then ask the second question and invite participants to share their ideas. Finally, ask the third question and invite responses. When the group has answered all three questions, briefly review the notes.

1. How would you begin to address safety with Raquel? *Talk to Raquel about ways to increase her safety, including leaving situations that make her uncomfortable, asking for help, ignoring bullies, telling the person to stop, getting help from someone she trusts. Getting therapy to address her former trauma and her angry reactions when she is distressed.*
2. Who would you involve? *Teachers, other care providers, caseworkers, other foster family members.*
3. What do you know about Raquel's life that would help you identify what issues to address in safety planning? *That she experienced childhood sexual abuse, that she's had frequent moves, that one reaction she has to distress is to act out.*



Facilitator's Notes:

Go over essential messages for Module 3. Ask if anybody has anything to add.

Facilitator's notes:

In the end, connecting or re-connecting with safe and health relationships supports trauma recovery, healing, and growth.

Hand out your program evaluations.

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Personal communications with Mikey Betancourt, Executive Director, Children's Alliance of South Texas – A Child Advocacy Center; Tim Cromie, Sergeant Detective, Dickinson Police Department; Lindsey Jordan, LMSW, Children's Advocacy Centers of Texas; Anna Phillips, Education Specialist, Region 17 Education Service Center; and Dr. David Scott, University of Texas at Tyler, Department of Social Sciences.

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Stop it **now!** (n.d.) *What should I do after a child tells?* www.stopitnow.org/ohc-content/what-should-i-do-after-a-child-tells

Zero Tolerance Initiative. (n.d.) *Common signs and symptoms of abuse, neglect, and exploitation.* Apd.myflorida.com/zero-tolerance/common-signs/#/

Pick up evaluations.