Child Care Basics

Facilitator Guide

Tennessee Department of Children's Services| CHDE3055 | Ver. 20.3

Curriculum Information

- Training Credit: 3 hours
- Trainers should give participants one 15 minute break during the training.
- This curriculum was developed by the State of Tennessee Office of Training and Professional Development.
- Staff may receive T4T credit for this course by:
  - Attending the course T4T offering -- OR --
  - Attending an offering of the course taught by another trainer & debriefing with that trainer.

Learning Objectives

- Participants will be knowledgeable of childhood developmental milestones.
- Participants will learn and demonstrate basic child care practices.
- Participants will be knowledgeable of basic medical needs and when to seek treatment.
- Participants will understand the role caregivers play in strengthening child development.
- Participants will review strategies and discuss building resiliency in children.

Materials Checklist

Materials needed for this curriculum

- ☐ Participant Guide

Standard Training Tote

- ☐ Flip charts & Stands
- ☐ Markers
- ☐ Card Stock
- ☐ Dry Erase Markers
- ☐ Laptop & Projector
- ☐ Speakers
- ☐ Extension Cords
- ☐ Masking Tape
- ☐ Pencils
- ☐ Pens

Annotated Agenda

Agenda Item	Time	Learning Objectives	Activities
Lesson 1: Introduction and Icebreaker	15 minutes		• Icebreaker activity
Lesson 2: Developmental Milestones	45 minutes	• Participants will be knowledgeable of childhood developmental milestones.	• Dumping and Sorting video • Developmental Milestones activity • Developmental Milestones videos
Lesson 3: Promoting Safety and Development	60 minutes	• Participants will learn and demonstrate basic child care practices. • Participants will be knowledgeable of basic medical needs and when to seek treatment.	• How to prepare a bottle video • How to change a diaper video • Diapering practice
Lesson 4: Strengthening Development through Interaction	30 minutes	• Participants will understand the role caregivers play in strengthening child development. • Participants will review strategies and discuss building resiliency in children.	• Serve and Return video • Visitation Scenario activity
Lesson 5: Wrap Up	15 minutes		•

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Lesson 1: Introduction and Ice Breaker

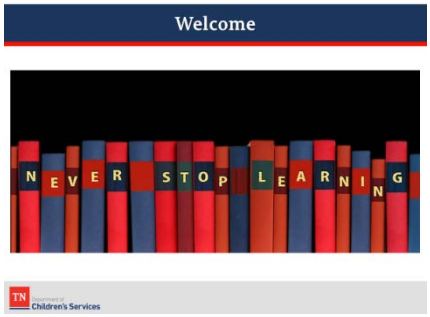
Estimated Time: 15 minutes

Supporting Materials:

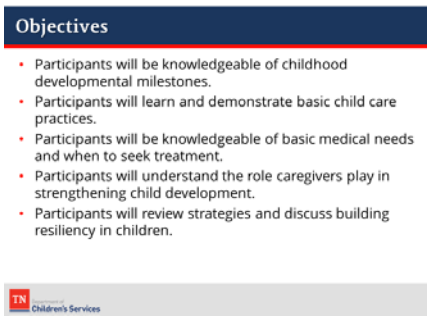
- Card stock for name tents
- Markers for name tents
- Projector/Speakers
- PowerPoint

Talking Points/Facilitator Instructions

- **WELCOME** participants to the training. Start on time and share housekeeping details with participants including the location of restrooms, break times, smoking areas, etc.
- **ASK** participants to make a name tent, folding card stock page in half, and write their name on both sides in large letters.



- **INTRODUCE** yourself to the group and share information about your previous experiences working with children and families from the child welfare system.
- **ASK** participants to introduce themselves by stating their name and how long they have been working at DCS.
- **CREATE** a working agreement/ ground rules as large group. **ASK** participants what they would like to see on the working agreement.
  - Place phones on silent
  - Participate in all training activities
  - Avoid doing tasks that are unrelated to the training
  - Be sensitive to other participants
  - Return from breaks on time
  - Confidentiality
  - Have fun! ☺
- **DISCUSS** training expectations: **ASK** the class what their hopes and expectations for the training are and record responses on a flipchart.
- **REVIEW** the Learning Objectives Slide:



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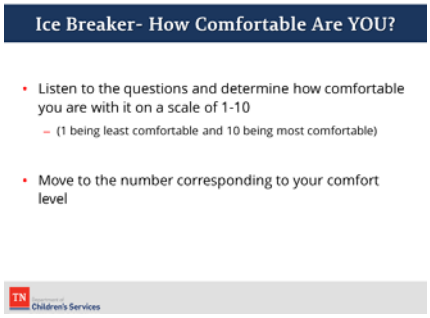


- **CONDUCT** the Ice Breaker activity
  - Prior to training, place numbers 1 to 10 on cardstock and place them on the floor or wall. **ASK** participants to respond to the following questions by standing at the number that represents their comfort level with 1 being not comfortable at all to 10 being completely comfortable.
    - How comfortable are you changing a baby/child's diaper?
    - How comfortable are you feeding a baby a bottle or baby food?
    - How comfortable are you in knowing what nutritious food and snacks are appropriate to give a toddler?
    - How comfortable are you helping a child in the bathroom?
    - How comfortable are you giving recommendations to birth parents?
    - How comfortable are you assessing attachment?
  - **DEBRIEF** with participants by asking them what has helped them rank themselves at that number? What would help them to become more comfortable?
- **PRESENT** the foundation for the training:
  - **INFORM** participants that the class was created in order to help caseworkers gain some knowledge about how to care for babies and children on their caseloads. Caseworkers play a vital role in modeling and assessing for appropriate developmental milestones and healthy parent child interactions; therefore, it is important that they have or can access the needed information to provide guidance and feedback to caregivers.
  - **EXPLAIN** that the class will not go into great depth about any of the topics, but it is meant to provide working knowledge of various guidelines when it comes to caring for children. The American Academy of Pediatrics, Healthychildren.org, and the Center for Disease Control are excellent resources to get additional information.

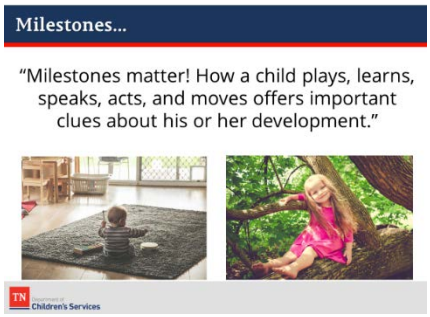
Lesson 2: Developmental Milestones

Estimated Time: 45 minutes

Supporting Materials:

- PowerPoint
- Projector
- Flip Chart
- Markers
- Speakers

Talking Points/Facilitator Instructions



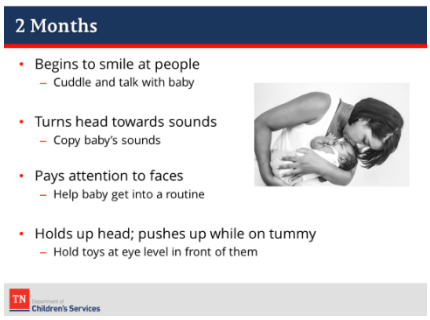
- **ASK** What are developmental milestones?
  - Developmental milestones are things most children can do by a certain age.
  - Skills such as taking a first step, smiling for the first time, and waving "bye-bye" are called developmental milestones. Children reach milestones in how they play, learn, speak, act, and move. You see children reach milestones every day. Though all children develop at their own pace, most children reach developmental milestones at or about the same age.
- **EXPLAIN** that milestones are not concrete, and many babies may hit certain milestones ahead of time while others reach milestones behind other children their age.

- **SHARE** these are some things we know about child development:

  - **Children grow in stages**. During each stage of development, children display a particular set of physical, psychological, and emotional characteristics and develop a particular set of skills and abilities. Developmental tasks follow a predictable sequence. All children must accomplish the same tasks, and the tasks follow a relatively predictable sequence. Each set of developmental tasks is more complex than the previous one and is based on the learning of the previous state, so stages cannot be skipped, but the range of task achievement varies from minimal to mastery.
  - **The capacity to accomplish a task is biologically based**. Children cannot be pushed to move faster than their biological capabilities allow. For example, accomplishing the task of toilet training is dependent upon certain physiological capabilities that aren't present until a certain age.
  - **What is considered "normal" for each age varies widely**. A child approaches each developmental task with her or his own unique personality, set of circumstances, and physical attributes. Therefore, what is considered "normal" behavior for each stage may vary widely. For example, some children walk at 8 months while others don't walk until 15 months. A child who has not begun to walk by 3 years of age may have developmental delays.

- **EXPLAIN** there are many milestone resource guides out there and the Milestone Checklists resource from the Centers for Disease Control and Prevention is included in your participant guide. Have participants take a few minutes to look over Milestone Checklists in their participant guide. Share that we will be referring to this guide throughout the training today.

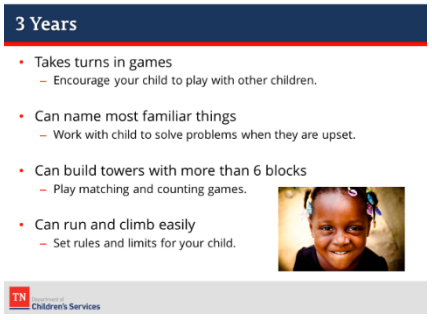
- **SHOW** video about spotting milestones like dumping and sorting https://youtu.be/GgBvMnPhahQ
- **ACTIVITY: Developmental Milestones**
  - Divide participants into 5 groups. Assign each group an age category (2 months, 4 months, 6 months, 9 months and 1 year).
  - Prior to the training, create flipcharts with the age categories on them and a T-chart with "developmental milestones" on one side and "parent interactions" on the other.
  - Utilizing the Milestone Checklists resource in their Participant Guide have the small groups summarize the key developmental milestone for their age group and list parenting practices that support child development on the created flipchart.
  - Groups will report out in chronological order beginning with 2-months.
    - After the 6-month group reports out, play the following video and briefly discuss: https://youtu.be/PqkS9Fg5LC0
    - After the 9-month group reports out, play the following video and briefly discuss: https://youtu.be/kynBaPiiqo0
    - After the 12-month group reports out, play the following video and briefly discuss: https://www.youtube.com/watch?v=-ymRgo_hKaM&feature=youtu.be https://youtu.be/ymRgo_hKaM



- After each group reports out, acknowledge and praise responses, then display PowerPoint slide for corresponding age group and cover any information the group missed.

- **CONDUCT** a facilitated discussion around children who are 18 months, 2 years, 3 years, 4 years, and 5 years by asking the group what developmental milestones should be observed for each age category and what parenting interactions are important to support development. **ENCOURAGE** participants to share case examples.

  - After discussing children who are 18 months, play following video and briefly discuss: https://youtu.be/Jc4umXQ4A_c
  - After discussing children who are 2 years, play the following video and briefly discuss: https://youtu.be/QVTaSjAkR6Q
  - After discussing children who are 3 years, play the following video and briefly discuss: https://youtu.be/ZawAkzTkGCQ

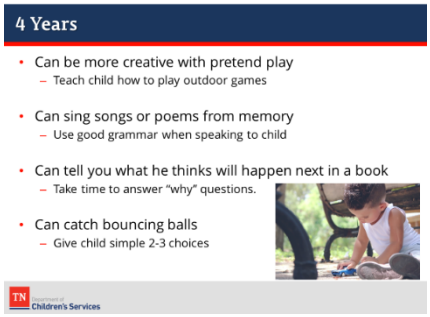


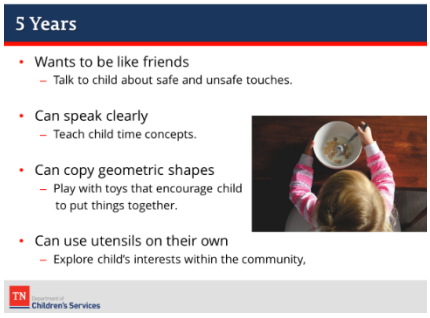
Lesson 3: Promoting Safety and Development

Estimated Time: 60 minutes

Supporting Materials:

- PowerPoint
- Projector
- Flip Chart
- Markers

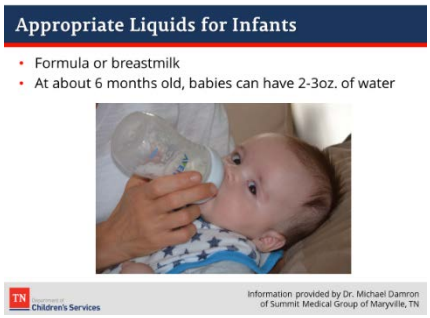




Talking Points/Facilitator Instructions

- **FACILITATE** an open discussion around the role culture plays in parenting practices. Refer to talking points for additional information.
- Parents and caregivers, typically, want what is best for their children. Parenting techniques or styles vary across cultures and we cannot allow this bias or difference to hinder permanency or reunification. If there are concerns that the parenting style poses a danger to the child, these should be addressed as a team in a CFTM.
- General guidelines for taking care of infants and children have been provided throughout this training. It is important to remember that parenting or taking care of a young child is not concrete in many situations. According to Dr. Michael Damron of Summit Medical Group, pediatricians will, typically, try to listen to a parent's questions, carefully, and then counsel or educate them on risks involved. As long as a child's immediate safety is not at risk, then considering the parent's cultural preferences is appropriate. As Caseworkers, we may need to suggest to birth parents talking with a pediatrician is best.
- **STATE** we are going to first discuss some basics for feeding an infant and the recommendations around introducing solid foods.

- **SHARE** slide Appropriate Liquids and **ASK** participants to share what information they know about feeding an infant?



- Ensure the following talking points are covered.
  - Babies, ages 0-1, only need formula or breastmilk to drink. These foods are complete and gives them all of the water they need daily.
  - When babies turn 6 months old, it is acceptable to give them 2-3oz. of water if you are outside and it is hot, or you do not have any formula or breastmilk available.
  - When feeding an infant, it is best to have them in a reclined, sitting position to help them digest their food better.
  - Propping a bottle for a baby in their carrier or crib is not recommended as it is linked to ear infections and choking. If their teeth have started coming in, it can lead to tooth decay.
- If there are concerns about dehydration, babies can be given Pedialyte in some situations, but always consult a pediatrician if the baby has significant vomiting.
- Babies do not need juice, soda, tea, Kool-Aid, or other drinks as sugary drinks can lead to dental decay and poor nutrition.
- It is important to discuss any feeding concerns with the infant's pediatrician since all babies are different and their stomachs can be sensitive.
- We discussed culture earlier and feeding infants and children is an area where cultural bias can occur, so it is important to ask questions to gain an understanding of the family's culture around feeding and assess the safety risk the actions may propose.

- **SHARE** Feeding Infants Slide and state newborns, typically, start out needing 8-12 feedings a day as they may eat every 2-4 hours. This will decrease as they get older but varies by child.

  - As babies get older, they take in more formula or breastmilk in less time at each feeding.
  - Cow's milk should not be added to the diet of a baby under the age of 1 because it does not provide the right nutrients for babies. Caregivers should avoid giving honey of any and all kinds for children under the age of 1 as it can cause a type of botulism. **Trainer's note**: Botulism is a serious illness caused by a botulinum toxin that causes paralysis. The paralysis starts in the face and moves to the limbs and if it reaches the breathing muscles it can cause respiratory failure.
  - Babies who are breastfed may differ in how often they eat from babies who are formula fed.

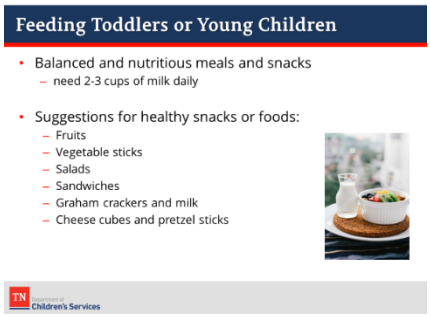
- **ASK** how do you know when a baby is hungry? Once participants respond, share the following if not discussed: Babies may bring their hands to mouth, suck on their fists or fingers, or smack their lips to show they are hungry. Fussing or crying can follow.

- **PLAY** the "How to prepare a bottle video" https://www.youtube.com/watch?v=EU3uWocz-TQ (54 seconds)
- **ASK** participants if they have any questions about how to prepare a bottle with formula.

- **REVIEW** the Introducing solids slide and provide an overview of the chart on the slide. Explain these are general guidelines.
- **REMIND** participants to consult a doctor for individual feeding plans based on their child's needs and developments.

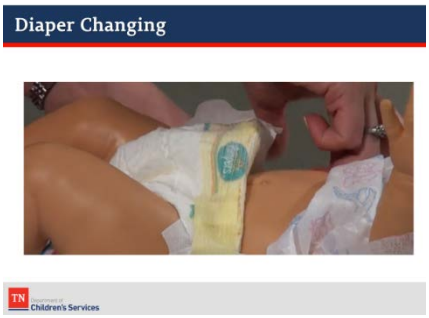
- It is important for toddlers and young children to have balanced and nutritious meals and snacks.
  - Toddlers will, typically, need 2-3 cups of milk daily, as well.

- **ASK** participants for some suggestions for healthy snacks or foods for toddlers and young children. Possible ideas include:
  - Fruits such as apples or peaches
  - Vegetable sticks
  - Creative salads
  - Sandwiches using a variety of bread types
  - Graham crackers and milk
  - Individual pizzas made with English muffins topped with tomato sauce and shredded cheese
  - Cheese cubes and pretzel sticks



- **ASK** participants what foods to avoid or be cautious about due to potential choking hazards. Possible suggestions include:
  - Grapes
  - Hotdogs
  - Popcorn
  - Chips
  - Hard Candy

- **TRANSITION** into a discussion around diapering. **ASK** participants who rated themselves as fairly comfortable with changing a diaper? **ASK** the participant to share what strategies they utilize when changing a diaper.



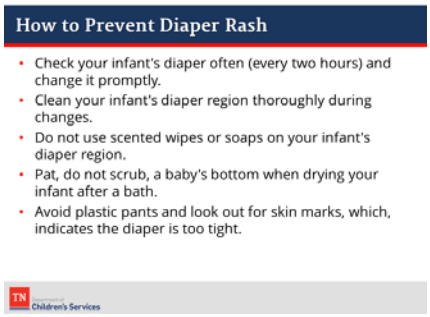
- **SHOW** video about how to change a diaper and answer any questions participants may have from the video. Do not assume that everyone knows how to change a diaper appropriately. **VIDEO** -Parenting and Infant Care | How to Change a Baby's Diaper | Woman's Hospital | Baton Rouge, La. - YouTube (2 minutes, 20 seconds)
- Steps to change a diaper include:
  1. Collect all needed items to change the diaper prior to laying the infant on the changing table or surface used to change the diaper.
  2. Lay your baby on his/her back. Remove any clothing that inhibits access to the diaper.
  3. Remove the soiled diaper. For disposable diapers, pull up the sticky tabs.
  4. Lift your baby up gently by both legs so you can scoot the diaper out from under his/ her bottom.
  5. Use wipes to clean your baby's diaper region. Always wipe from front to back to avoid infection, especially for girls.
  6. If the area is red or inflamed, soothe it with diaper rash ointment.
  7. Wait for your baby's skin to dry before putting on a fresh diaper.
  8. Take a fresh diaper and place it under your baby. Bring the front part up on your baby's stomach and fasten the tabs to secure the diaper on his/ her waist.
  9. Replace any clothing over the new diaper.

- **SHARE** that some diaper brands have a yellow line on the front of the diaper that will turn blue when the diaper is wet. This can help parents and caregivers know when to change the diaper.

- **SHARE** that changing boys can, sometimes, be a challenge and laying a wipe on top of their penis can be helpful.

- **ACTIVITY** - Diapering practice. Provide the participant with a doll, diaper, and wipes and have them practice changing the baby's diaper. Provide additional instructions and feedback as needed.

- **SHARE** there are things that caretakers can do to prevent an infant from developing a diaper rash.
  - Check your infant's diaper often (every two hours) and change it promptly.
  - Clean your infant's diaper region thoroughly during changes.
  - Do not use scented wipes or soaps on your infant's diaper region.
  - Pat, do not scrub, a baby's bottom when drying your infant after a bath.
  - Avoid plastic pants and look out for skin marks, which, indicates the diaper is too tight.



- Call your pediatrician for rashes that don't seem to improve in a couple of days with over the counter ointments and diaper changes. Yeast diaper rashes are common in infants and tend to be bumpier and raised. These types of rashes tend to require antifungal medications.

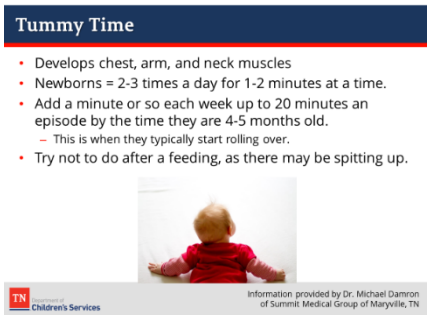
- **SHARE** that diaper rashes are very uncomfortable for little ones which is why appropriate diaper care is crucial.
- Infants only need to be bathed three to four times per week, as long as caregivers are cleaning their diaper region during changes. More frequent baths may result in dry skin.
- **CONDUCT** a brief discussion on the age children typically potty train and what assistance they might need when going to the bathroom.
  - Children are often ready to begin learning the concepts and skills of potty training around 18 months of age.

- Almost all children can be made ready for toilet training between 2-3 years of age.

- Refer participants to the Child Abuse Prevention Standard of Practice located in their participant guide. If children need assistance when using the toilet DCS staff should ensure that the door remains open while they are assisting the child.

- **TRANSITION** to the topic of tummy time by asking participants why tummy time for an infant is important. Tummy time is important for babies to develop the muscles in their upper chest, arms, and neck.

  - For newborns, you can do tummy time 2-3 times a day for 1-2 minutes at a time.
  - As babies get older and bigger, they typically can spend more time on their bellies. You may want to let them add a minute or so longer each week, up to about 20 minutes an episode by the time they are 4-5 months old. This is when they typically start rolling over.
  - Try not to do this after a feeding, as there may be more spitting up.



- **TRANSITION** by stating babies do not have regular sleep cycles until about 6 months of age. While newborns sleep about 16 to 17 hours per day, they may only sleep 1 or 2 hours at a time. As babies get older, they need less sleep. However, different babies have different sleep needs. It is normal for a 6-month-old to wake up during the night but go back to sleep after a few minutes.
- Practicing and reinforcing safe sleep for infants is a top priority. Sleep-related deaths for infants are preventable and this is a public health priority for the State of Tennessee. This class will offer a brief overview of the ABCs of Safe Sleep, but it is important for staff to complete the full Safe Sleep for Infants training.
- **EXPLAIN** children under the age of 12 months are at risk of SIDS and other sleep related deaths so it is important to practice safe sleep for every sleep including naptime and bedtime.

- The American Academy of Pediatrics makes several recommendations for Safe Sleep practices, including the ABCs of Safe Sleep.
- **ASK** what are the ABCs of Safe Sleep? Then show slide ABCs of Safe Sleep.

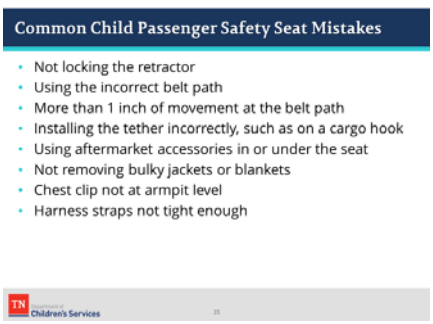
    - Alone- not co-sleeping with adults, other children, or animals
    - Back – not on their side or stomach
    - Crib- a bassinette or pack n play are other approved places for babies to sleep. Babies should never be placed on an adult bed, couch, chair, bouncy seat, swing, car seat, etc. to sleep. The crib should have only a fitted crib sheet, no toys, pillows or blankets in the sleeping area.
- **SHOW** an example of a sleep sack here and explain that not all babies like to be swaddled and a baby should stop being swaddled when they can roll over.
- Once baby can roll over on their own, it is safe for them to sleep in other positions; however, it is important to ensure the sleep surface is free from blankets, toys, pillows, or other items that could restrict the baby's breathing.
- **TRANSITION** by stating we are now going to discuss some basics about child passenger safety seats. This is a very brief overview and participants should attend the Child Passenger Safety Seat training and installation course for more information and to practice installation.
- **SHARE** the slide regarding Tennessee State Law for Child Passenger Safety Seats and highlight the following.

    - Children under one (1) year of age, or any child, weighing twenty (20) pounds or less, must be secured in a child passenger restraint system in a rear facing position, meeting federal motor vehicle safety standards, in a rear seat, if available, or according to the child safety restraint system or vehicle manufacturer's instructions. (Note: If the child safety seat has a higher rear-facing weight rating, usually 30 or 35 pounds, it may be continued to be used in a rear-facing position so long as the child's weight permits. Check the manufacturer's instructions accompanying the child safety seat for more information.) The American

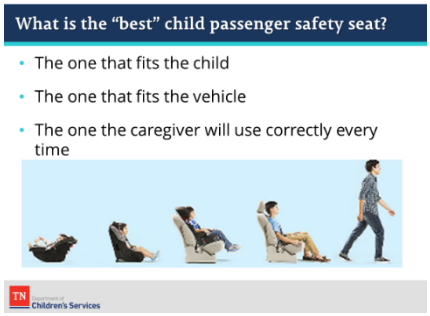
Academy of Pediatrics states it is best for children to ride rear-facing as long as possible to the highest weight and height allowed by the manufacturer of their convertible seat. When they have outgrown the seat rear-facing, they should use a forward-facing seat with a full harness as long as they fit.

- Children age one (1) through age three (3), and weighing more than twenty (20) pounds, must be secured in a child safety seat in a forward facing position in the rear seat, if available, or according to the child safety restraint system or vehicle manufacturer's instructions.
- Children age four (4) through age eight (8), and measuring less than four feet nine inches (4'9") in height, must be secured in a belt-positioning booster seat system, meeting federal motor vehicle safety standards in the rear seat, if available, or according to the child safety restraint system or vehicle manufacturer's instructions. (Note: If the child is not between age four (4) and age eight (8), but is less than four feet nine inches (4'9") in height, he/she must still use a seat belt system meeting federal motor vehicle safety standards.)
- Children age nine (9) through age twelve (12), or any child through twelve (12) years of age, measuring four feet nine inches (4'9") or more in height, must be secured in a seat belt system. It is recommended that any such child be placed in the rear seat, if available. (Note: If the child is not between age nine (9) and age twelve (12), but is four feet nine inches (4'9") or more in height, he/she must still use a seat belt system meeting federal motor vehicle safety standards.)
- Children age thirteen (13) through age seventeen (17) must be secured by using a passenger restraint system, including safety belts, meeting federal motor vehicle safety standards.

- **SHARE** common child passenger safety seat mistakes slide and discuss.
  - It is important to remove bulky jackets or clothing prior to buckling a child into a child passenger safety seat.



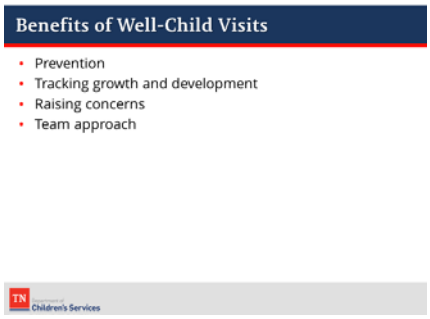
- Never place aftermarket accessories on or under the seat or child as they prohibit full functioning; such as seat covers, head positioners, toys on the seat.
- Once the child is properly restrained with the chest clip at armpit level and the harness straps tightened, a caregiver can place a blanket over the child for added warmth; however, it is important to ensure it does not restrict the child's airway.
- Never allow a child to sleep in a car seat when not traveling.
- Do not prop the child's bottle up in the car seat as this could present a choking hazard.
- Show slide What is the "best" child passenger safety seat? and share that parents and Caregivers often ask which child passenger safety seat is the best one. Then answer is the one that fits the child, fits the vehicle and they will use correctly every time.



- **ASK** if there are any questions about Child Passenger Safety Seat use and transition to the next topic on medical and dental services.

- **SHARE** DCS Policy 20.7 and the attached protocol outline the schedule in which children/youth in DCS custody must been seen at the Health Department for their early periodic screening diagnosis and treatment (EPSD & T).
- **SHOW** participants where to access this policy and protocol and highlight Section C of the policy.
- **REVIEW** slide that outlines the EPSD & T schedule for young children.

- **DISCUSS** the benefits of well-child visits and display slide.

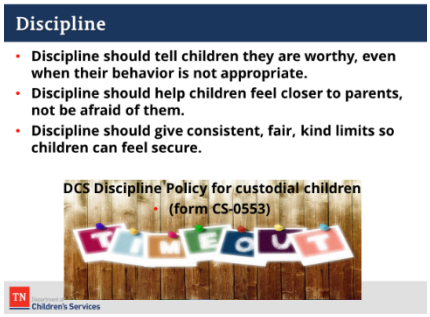


    - **Prevention**. Your child gets scheduled immunizations to prevent illness. You also can ask your pediatrician about nutrition and safety in the home and at school.
    - **Tracking growth and development**. See how much your child has grown in the time since your last visit, and talk with your doctor about your child's development. You can discuss your child's milestones, social behaviors and learning.
    - **Raising concerns**. Make a list of topics you want to talk about with your child's pediatrician such as development, behavior, sleep, eating or getting along with other family members. Bring your top three to five questions or concerns with you to talk with your pediatrician at the start of the visit.
    - **Team approach**. Regular visits create strong, trustworthy relationships among pediatrician, parent and child. The AAP recommends well-child visits as a way for pediatricians and parents to serve the needs of children. This team approach helps develop optimal physical, mental and social health of a child.

- You can call the doctor whenever you have a question about your child that you are unsure of the answer too.
- Most pediatrician offices have answering services after hours that can assist you when you have questions. During office hours, you can also ask to speak to a nurse to ask questions. The DCS health nurse is also a resource for health information.
- If you suspect a newborn may be sick, you can look for signs such as fever, poor feeding, vomiting, irritability, and difficulty breathing.
- Reasons you may take an older child straight to the hospital would be difficulty breathing, persistent vomiting, signs of dehydration, severe abdominal pain, or a high fever.

- **SHARE** DCS Policy 20.12 outlines dental services for children in custody. According to the policy, children over the age of 12 months should be seen by a dentist every six months.
  - Teething usually starts between four to seven months and most babies will develop their first tooth between ages 6 months to 12 months.
  - Parents/caregivers can help ease teething pain by massaging their baby's gums with clean fingers, offering solid, not liquid-filled, teething rings, or a clean frozen or wet washcloth. If you offer a teething biscuit, make sure to watch your baby while he or she is eating it.
  - Stay away from teething tablets that contain the plant poison belladonna and gels with benzocaine. Both are marketed to numb your child's pain, but the FDA has issued warnings against both due to potential side effects.
  - In addition, amber teething necklaces are not recommended. Necklaces placed around an infant's neck can pose a strangulation risk or be a potential choking hazard. There is also no research to support the necklace's effectiveness.
  - Caregivers should brush the child's teeth with a smear of fluoride toothpaste, the size of a grain of rice, once their first tooth appears.
  - Teething is another area that cultural considerations should be taken into consideration. When in doubt, discuss your concerns with your supervisor.

- **SHARE** the DCS Discipline Policy for custodial children (form CS-0553). This policy must be followed by all foster parents and by all individuals caring for a custodial child. While this policy is geared toward custodial children, the concepts discussed in the policy about discipline can be implemented by all caregivers and should be encouraged by DCS Staff.



- **EXPLAIN** that discipline is a teaching process that is initiated by a trauma informed caregiver who is able to identify the underlying need of a child. It is through this process that a child develops the self-control, self-reliance,

resiliency, and appropriate life skills necessary to assume responsibilities, make daily living decisions, and live according to accepted levels of social behavior.

- Discipline should:
  - tell children they are worthy, even when their behavior is not appropriate
  - help children feel closer to parents, not be afraid of them
  - give consistent, fair, kind limits so children can feel secure
- The following forms of punishment must not be used for ANY custodial child:
  - Corporal Punishment such as slapping, spanking, or hitting with any object,
  - Excessive exercising (particularly of a military nature), running laps, repetitive sit-ups, etc.
  - Cruel and unusual punishment,
  - Assignment of excessive or inappropriate work,
  - Denial of meals and daily needs,
  - Verbal abuse, ridicule or humiliation,
  - Permitting a child to punish another child,
  - Chemical or mechanical restraints ex; use of psychotropic medications as a restraint,
  - Denial of planned visits, telephone calls, or mail contact with birth family, attorney, siblings, Family Service Worker, pre-adoptive family, or attorney,
  - Seclusion as a punishment,
  - Threat of removal from the foster home, or
  - Any discipline that occurs more than 24 hours after the incident.
- An appropriate form of discipline that is effective for children ages 2-12 is time out. Have the child sit down in a boring, safe place and set a timer for 1 minute for each year of the child's life. Do not give your child attention during the time-out period.

Lesson 4: Strengthening Development through Interaction

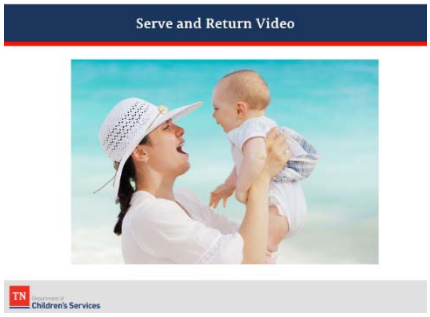
Estimated Time: 30 minutes

Supporting Materials:

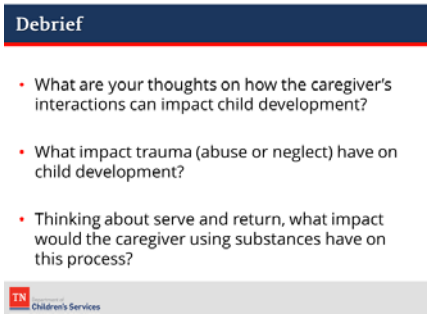
- PowerPoint
- Projector
- Flipchart & Markers

Talking Points/Facilitator Instructions

- Infants develop through the "Serve and Return" process. Here is a video that explains how the brain develops with these interactions. It also demonstrates how a child may have difficulty with attachment if they have missed these milestone interactions.
- **PLAY** Serve and return video https://www.youtube.com/watch?v=m_5u8-QSh6A (1 minute, 42 seconds)



- **DEBRIEF** the video by asking participants their thoughts on how the caregiver's interactions can impact child development.
- **ASK** What impact trauma (abuse or neglect) have on child development? Thinking about serve and return, what impact would the caregiver using substances have on this process?



- Refer participants to Child Welfare Trauma Toolkit and Building Strong Brains trainings that are offered by their regional trainers. They are encouraged to attend these trainings to further their understanding of the impact trauma has on children and our role in reducing the impact.
- **SHARE** support for growth and development comes from caregivers. Although the capacity for development is biological, children need the support, protection, and involvement of the adults in their lives in order to reach that capacity. The most important source of support for growth comes from the child's caregivers. Mastering a new developmental stage is not a complete, all-

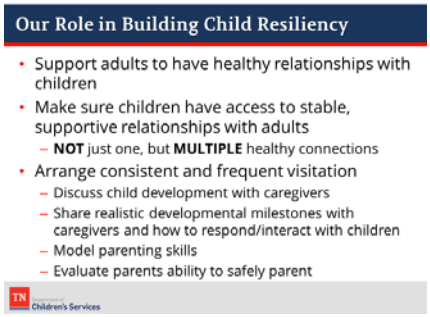
at-once transformation, and there are frustrations and regressions to previous behaviors at every transition stage.

- An example of this is “potty training.” A child may appeared to be “potty trained,” then get sick, go visit grandma, or go on a long trip and regress back to soiling and wetting. Once the family is back home in familiar surroundings and the child is back in his or her typical routine, the child is once again toileting herself or himself. Behaviors that occur when a child transitions from one stage to another are not very pleasant for the adult caregiver. It is important that the child’s caregiver and other adults in the child’s life understand these behaviors as normal and temporary and understand how to support the child in growth to the next stage.

- We know that the children we work with in the child welfare system have experienced trauma. Despite the negative experiences they have had and the delays in their development that may occur, we know that the brain and other biological systems are most adaptable early in life. Recovery and resiliency are possible.

- The single most common factor for children who develop resilience is at least one stable and committed relationship with a supportive parent, caregiver, or other adult.
  - These relationships provide the child with the responsiveness and protection they need to recover from any disruptions in their development.
- Research indicates that supportive, responsive relationships with caring adults as early in life as possible can prevent or reverse the damaging effects of trauma.
- Children aren’t born with the skills to be resilient and cope with adversity—they are born with the potential to develop them. If children do not get what they need from their relationships with adults and the conditions in their environments—or (worse) if those influences are sources of toxic stress—, their skill development can be seriously delayed or impaired.
- The support that children need to build these skills is one of our most important responsibilities. Growth-promoting environments provide children with “scaffolding” that helps them practice necessary skills before they must perform them alone.

- Caregivers can facilitate the development of a child's skills by establishing routines, modeling social behavior, and creating and maintaining supportive, reliable relationships.
- When we support adults to have healthy relationships with children, we have the opportunity to change children's trajectories by stacking the scale and creating resilience.
- We can assist in this process by making sure vulnerable children have access to stable, supportive relationships with adults—as early and as consistently as possible. We can also make sure those caring for children are given the support and services to ensure their own development as parents.

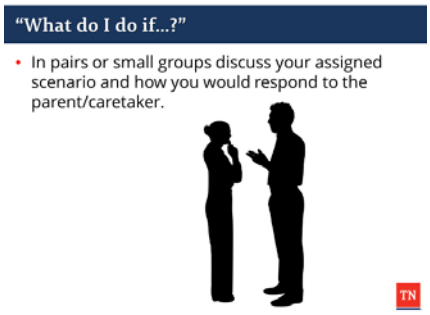


- Children are more resilient when they have multiple healthy connections or attachments, and that RESILIENCY is the key to surviving trauma.
- Arranging consistent and frequent visitation between caregivers and children who are placed out of home, maintains and supports the parent-child relationship necessary for successful reunifications and also has life-long significance for the child.
- When used effectively, visitation can minimize some of the effects of trauma that a child experiences, as a result of being removed from their family.
- **EXPLAIN** that we as Caseworkers should regularly be discussing healthy development of children with caregivers. This is especially important when we are observing parent child interactions during visitation.
- Sharing milestones with parents can also help them have realistic exceptions and better understand their child's behavior. If parents do not know when a child should have a certain skill, they may worry unnecessarily or have higher expectations of the child. Children who have experienced trauma may be developmentally behind their chronological age and caregivers may have to alter their interaction to meet that child's developmental need.
    - For example, a 1-year old child that was not talked to as an infant may need cooing and babbling from a caregiver similar to what a 6-month infant might need.

- The primary purpose of visits is to meet the child's developmental need for maintaining and enhancing relationships with family members and to reduce their sense of loss due to removal.
- The secondary purposes of visits are for Caseworkers to:
  - Teach parenting skills
  - Evaluate the parent's ability to safely parent in order to determine the service and visiting plans and the final permanency plan.
- Included in your participant guide are some resources to assist you when you are observing visitation and observing children with their caretakers.
  - Have participants look at the *Milestones Checklist* created by the CDC. This resource summarizes some of the social/emotional, language, cognitive and physical development milestones that occur at each age and outlines some activities caretakers can do with their infants/children to assist in development.

  - This is information that Caseworkers can share with parents/caregivers in preparation for visitation so parents/caregivers can engage their children in developmentally appropriate activities during visitation.
  - This information can also assist Caseworkers during home visits when observing children to determine if they are developmentally on track or if they may be experiencing delays.
  - Have participants look at the *Tips for Talking with Parents about Developmental Concerns* resource created by the CDC. When observing parents/caregivers interact with children sometimes we notice that the parent might not be engaging the child in a developmentally appropriate way and could be jeopardizing the safety of the child. It's important that we as Caseworkers address these concerns with the parent and help them understand their child's developmental level.
  - The next training in this series, Meaningful Parent/ Child Visitation, goes into more detail about thoughtfully planning visitation between children and parents and giving feedback to parents about visitation.
- **Activity - Visitation Scenarios**

- **EXPLAIN** to participants that we will now be practicing how we can talk to parents/caregivers and intervene by providing feedback during visitation when we notice concerns.
- **DIVIDE** participants into small groups of 2-3 people. Assign them one of the scenarios in the participant guide and have them answer the questions. Give them about 5 minutes to work on this.



- **DEBRIEF** as a large group by asking each group to share how they would provide feedback and/or model/coach the parent/caregiver when observing visits between parents and their children.
- Lastly, between now and when you participate in the next training in this series regarding thoughtful visitation and providing feedback, we ask that you utilize the *Milestones Checklist* when you are observing children and their interaction with caregivers. We also ask that you utilize the *Interaction Observations by age range* resource to assist you in assessing parental knowledge regarding child developmental and how to best provide feedback and modeling for the parent/caregiver. We will be utilizing this information during the next training.

Lesson 6: Wrap Up

Estimated Time: 15 minutes

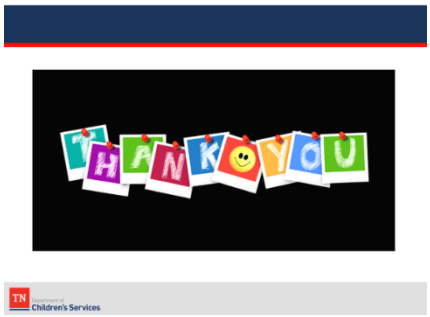
Supporting Materials:

- PowerPoint
- Projector
- Speakers

Talking Points/Facilitator Instructions

- **ASK** participants to share one thing they are going to implement in the field as a result of this training.

- **THANK** participants for their time and their commitment to gain knowledge and understanding of child development and to provide feedback and modeling for parents/caregivers.
- **REQUEST** participants to complete the course reaction survey.



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