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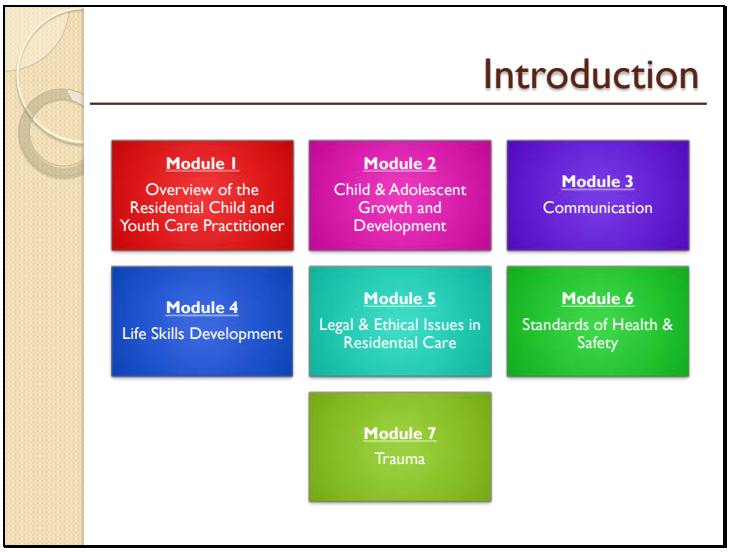

Introduction

Welcome to the Residential Child and Youth Care Practitioner online certification training program. This webinar is made up of seven modules.

Module 1: Overview of the Residential Child and Youth Care Practitioner
Module 2: Child and Adolescent Growth and Development
Module 3: Communication
Module 4: Life Skills Development
Module 5: Legal and Ethical Issues in Residential Care
Module 6: Standards of Health and Safety
Module 7: Trauma

For each of these modules there will be a pre-test and post-test. Before we begin, let's go over some terminology. For the purposes of this training, children and youth are referred to in several ways: youth, youths, clients, adolescents, teens, residents, kids, and children. Regarding the Residential Child and Youth Care Practitioners, they are referred to as RCYCPs, practitioners, and professionals. And finally, when the term "you" is used in these modules, the speaker is referring to you the practitioner.

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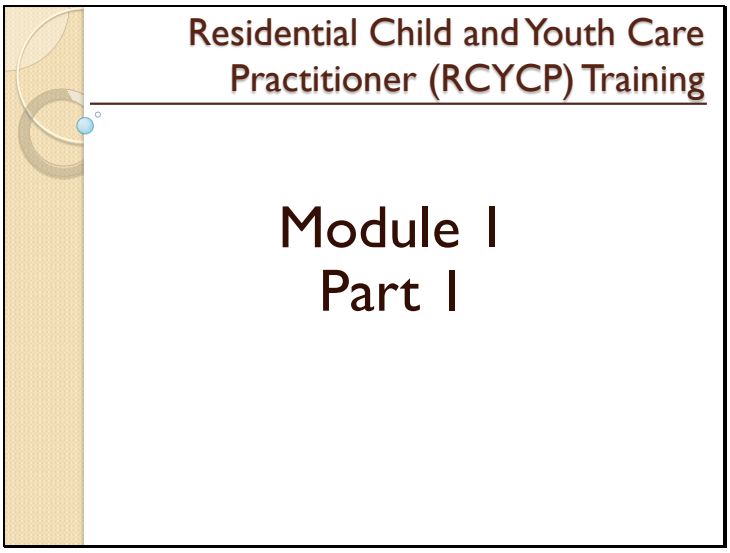

Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 1, Part 1 Overview of the Residential Child and Youth Care Practitioner Training.

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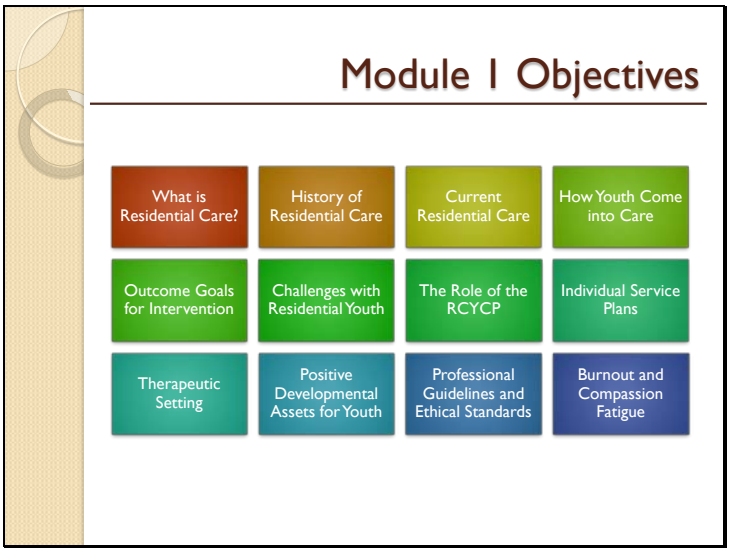

Module 1 Objectives

This module covers material about the residential care profession. Specifically, you will learn:

1. What is residential care.
2. The history of residential care.
3. What residential care looks like currently.
4. How youth come into care.
5. Outcome goals for intervention.
6. Challenges to working with residential youth.
7. The role of the residential child and youth care practitioner, hereafter referred to as RCYCP.
8. What Individual Service Plans are.
9. Components of a therapeutic setting.
10. Positive developmental assets for youth.
11. Professional guidelines and ethical standards.
12. What burnout and compassion fatigue are as well as strategies for avoiding them.

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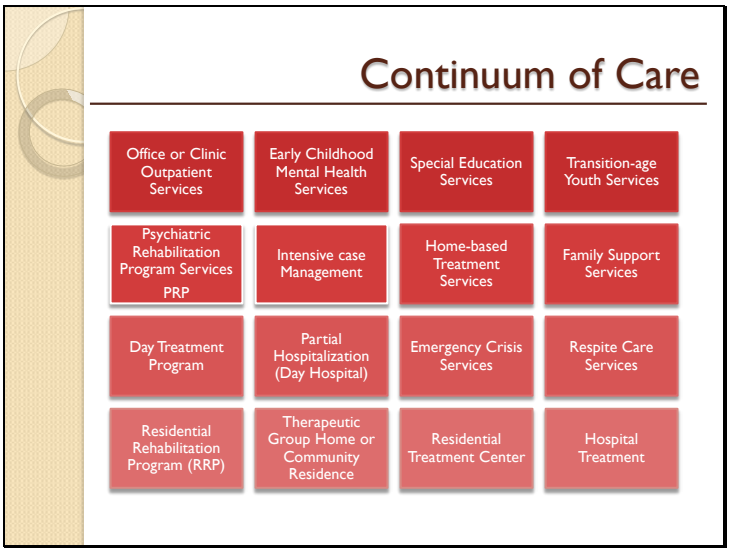

Continuum of Care

Before we talk about residential care, let's first discuss how communities provide care to their children and adolescents with mental health needs. The complete range of programs and services is referred to as the "continuum of care" and refers to the type and intensity of care that is needed, from least intensive to most intensive. Some services are targeted at youth of a specific age, while others are geared toward the youth's developmental or situational need. Not all programs are available in all communities.

Click on each service or program to hear a brief description of it.
(From Maryland's Coalition of Families for Children's Mental Health)

Office or Clinic Outpatient services: Visits are usually 20–50 minutes. A mental health professional may do an assessment and make a diagnosis. Based on the diagnosis, ongoing individual, group, or family therapy may be recommended. If medication has been prescribed, medication is monitored during outpatient office visits. The number of visits per month depends on the child's needs.

Early childhood mental health services: Mental health and or behavioural services are provided for young children ages birth to five years old by therapeutic preschool programs or infant and toddler programs through the local school system. Additionally, mental health consultation is

available for day-care providers who may request assistance with caring for a child with mental health or behavioural needs.

Special Education Services: Children and youth who have been determined to be “emotionally disabled” by their school system may receive intensive counselling and behavioural services in school through special education. The Individualized Education Plan (IEP) may include counselling as part of the child’s educational services.

Transition-age Youth Services: Services such as supported employment or supported education assist youth and young adults ages 16 to 24 with mental health needs to gain independence and transition to adulthood.

Psychiatric Rehabilitation Program Services (PRP): PRP is a range of services that reduce behavioural problems while promoting strength-based , age-appropriate social skills and integration of the child into the community.

Intensive Case Management: A case manager assists families in gaining access to the full range of mental health services, as well as any additional necessary medical, social, financial assistance, counselling, educational, housing, and other supports.

Home-based Treatment Services: A team of specially trained staff goes into a home and develops a treatment program to help the child and family.

Family Support Services: Services to help families care for their child, such as peer support, parent training, and/or parent support group.

Day Treatment Program: Intensive treatment that provides psychiatric services along with special education. The child usually attends five days per week.

Partial Hospitalization (Day Hospital): Provides all the services of a psychiatric hospital, but the patients go home each evening.

Emergency Crisis Services: 24-hour-per-day services for emergencies (for example, hospital emergency room, or mobile crisis team).

Respite Care Services: A child or youth with mental health or behavioural needs stays briefly away from home with specially trained individuals, or someone comes into the home to give the caregivers a break and provide the child with enhanced support.

Residential Rehabilitation Program (RRP): Supported living in the community for transition-age youth.

Therapeutic Group Home or Community Residence: This therapeutic program usually includes 6 to 10 children or adolescents per home, and may be linked with a day treatment program or specialized educational program.

Residential Treatment Center: Children or youth with serious and complex mental health needs receive intensive and comprehensive psychiatric treatment in a campus-like setting 24 hours per day on a longer-term basis.

Hospital Treatment: Children or youth receive comprehensive psychiatric treatment in a hospital. Treatment programs should be specifically designed for either children or adolescents. Length of stay is usually three to seven days. On discharge, children may attend a partial hospitalization program.

Let’s turn now to an in-depth discussion of residential care:

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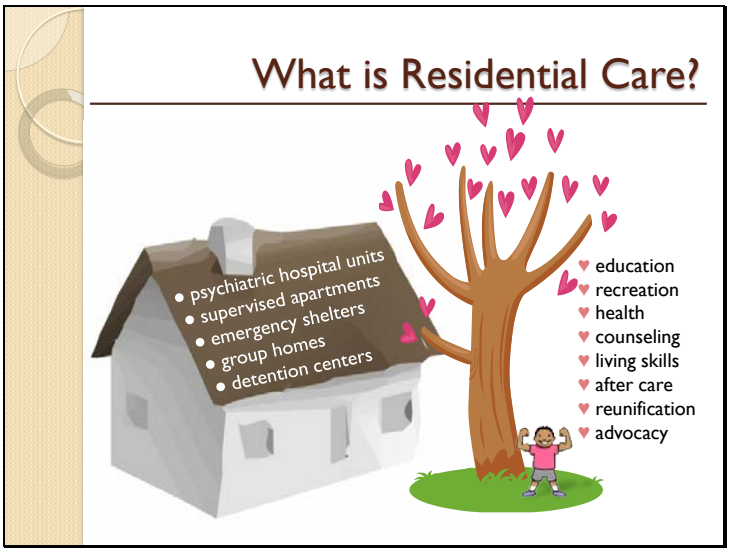

What is Residential Care?

Residential care involves placing children and youth in out-of-home settings when their needs are not being met within the family setting. This is usually a temporary placement, although it can vary in length from short-term to long-term. Care is provided for children 24 hours per day. The term “residential care” can be applied to a variety of settings, for example, psychiatric hospital units, supervised/staffed apartments, emergency shelters, group homes, and detention centers. Within residential settings children and families are offered a variety of services, including but not limited to – education, recreation, health and nutrition, counseling and therapy, daily and pre-independent living skills, after care, reunification services, and advocacy. Residential care programs usually serve high-risk youth and are often considered to be “last resort” placements for youth who have been unsuccessful in other, less restrictive community settings.

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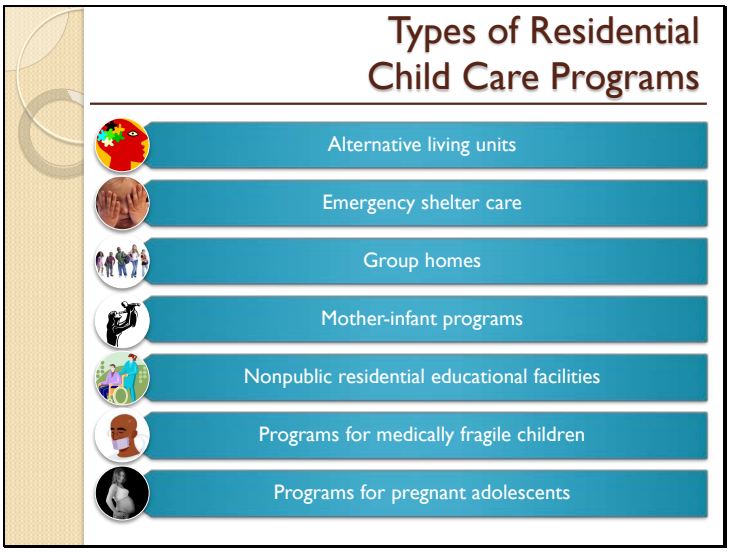

Types of Residential Child Care Programs

Let's look at the different types of residential child care programs.

Click on each type of program to hear more about it.

Alternative living units: provide residential services for children who, because of developmental disability, require specialized living arrangements. It has 3 or fewer children and provides 24 hours of supervision

Emergency shelter care: provide immediate temporary placement of a child in a residential child care program. Stays are less than 60 days.

Group homes: are residential facilities where youths live as a group and receive care, diagnosis, training, education, and rehabilitation

Mother-infant programs: are residential child care programs that provide special services and residential care to children (anyone under the age of 21) who are mothers and their infants

Nonpublic residential educational facilities: residential facility of a nonpublic school program for the placement of students with disabilities

Programs for medically fragile children: programs for children with complex medical needs who are dependent upon medical devices, for example, mechanical ventilation or IV administration of nutrition

Programs for pregnant adolescents: a residential program that provides comprehensive prenatal care, dental care, delivery services, pediatric services, and day care arrangements for pregnant minors

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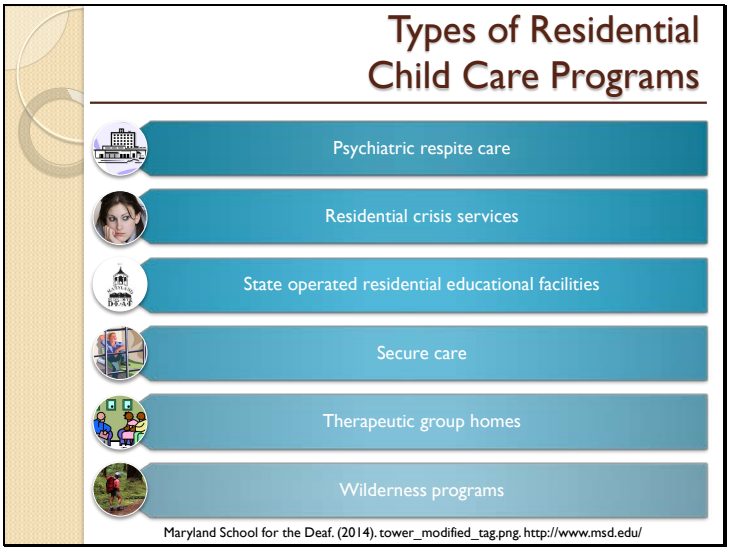

Psychiatric respite care: residential programs on hospital grounds in which children discharged from inpatient psychiatric hospitalizations receive transition services in anticipation of placement in a residential treatment or community-based setting

Residential crisis services: intensive mental health and support services that are provided to a child with a mental illness who is expecting, or is at risk of, a psychiatric crisis that would impair the child's ability to function in the community. They are designed to prevent a psychiatric inpatient admission of the child, provide an alternative to the psychiatric inpatient admission, or shorten the length of an inpatient stay

State-operated residential educational facilities: refers to the Maryland School for the Deaf and the Maryland School for the Blind

Secure care: a program that employs locked doors or other physical means to prevent escape by alleged or adjudicated delinquent children

Therapeutic group homes: small, private group homes that provide residential child care, as well as access to a range of diagnostic and therapeutic mental health services for children and adolescents who have mental health disorders.

Wilderness programs: programs in which facilities and activities are related to nature as much as possible in a site that is left essentially in its natural state, and where living and program quarters and activities are integrated into the natural environment.

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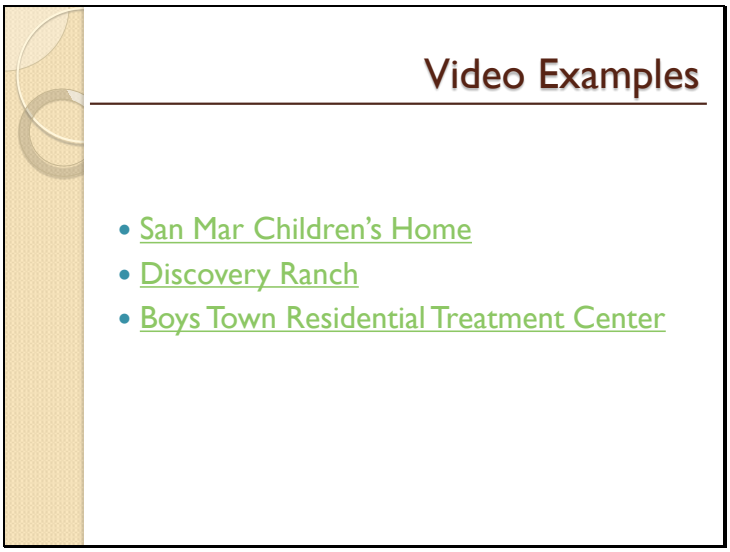

Video Examples

Let's take a look at some examples of residential child care programs. Click on the links to watch some short video clips.

- San Mar Children's Home
http://www.youtube.com/watch?v=5lQ8HN5Lr9Y
- Discovery Ranch
http://www.youtube.com/watch?v=HNY1U14wjDE
- Boys Town Residential Treatment Center
http://www.youtube.com/watch?v=OpTrE1bYLDg

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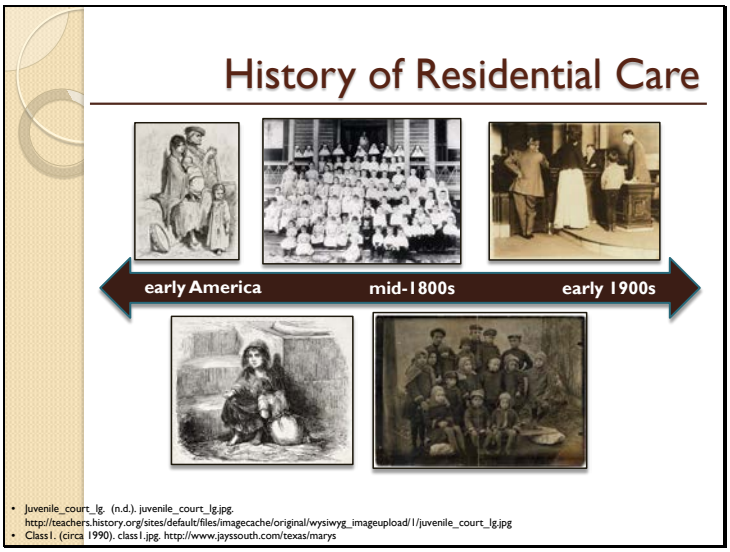

History of Residential Care

In early America children with special needs were dealt with in a manner similar to the poor. They were put in poor houses, workhouses, or sent to live with other families. Such children usually ended up in the care of individuals who were not really able to manage them. As the population of dependent children grew, new solutions were needed to address the problems.

In the early to mid-1800s, just as children were starting to be viewed as different and more fragile than adults, “orphan asylums” became the main form of residential care for children and youths. Such asylums were seen first and foremost as providing shelter, food, and clothing for dependent children. Secondarily, they were seen as a way to raise “decent, educated, and God-fearing citizens” which included teaching them obedience, respect for authority, and good morals The quality of care in the orphan asylums varied and could even be harsh. So, while these children might have been better off in terms of shelter, food, and clothing, they seldom received the kind of love and affection that children also need..

In the late 1800s and early 1900s, residential care underwent big change, in part due to the children’s rights movement led by Jane Addams and others. On April 9, 1912 President Taft signed the U.S. Children’s Bureau into law, an organization responsible for investigating, reporting, and lobbying for children at the national, state, and local levels. Among the changes that came out of this movement was the formation of juvenile court. Rather than sending troubled youths through the adult courts, they were sent to juvenile courts where they could be

rehabilitated. Similarly, residential care of children shifted from merely providing housing to addressing their mental health and focusing on the whole person, including their social background, family history, leisure interests, and ability to function in the community.

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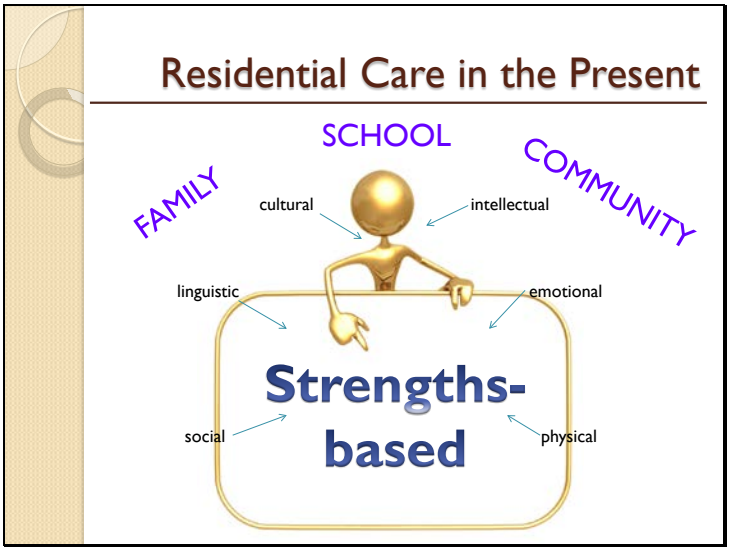

Residential Care in the Present

Nowadays residential care aims to resocialize youth through providing positive social experiences, to reeducate them through relearning, and to redirect negative behavior through counseling, helping the youth to move to a higher level of functioning.

Current residential care approaches emphasize a strengths-based approach, where treatment recognizes the importance of family, school, and community, as well as addresses the social, linguistic, cultural, intellectual, emotional, and physical needs of every child and youth. Thus, through coordinated care at these different levels, the goal is to improve functioning at home, in school, and in the community.

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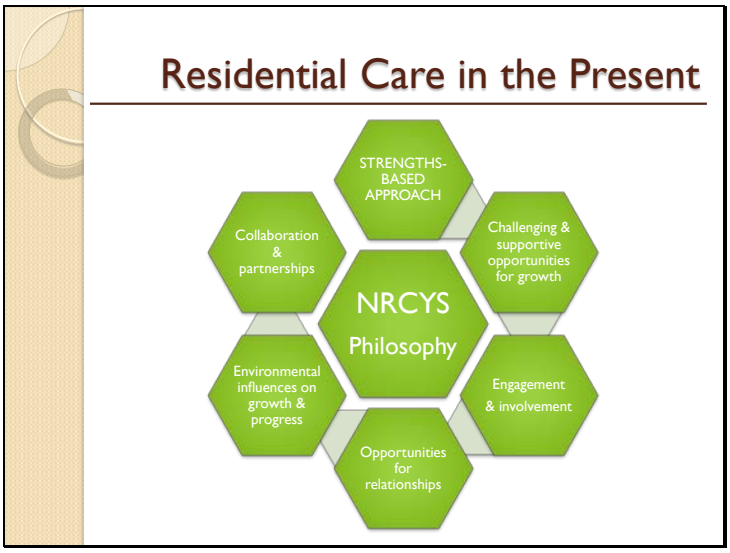

The following five elements highlighted by the National Resource Center for Youth Services (NRCYS), provide the basic foundation and philosophy of a strengths-based approach to residential care for children and youth;

First, children and youth in residential care must receive services that do more than focus on problems or deficits. They need a wide range of appropriately challenging and supportive opportunities to explore, learn, and grow as individuals

Second, children and youth in residential care and their families must be engaged and actively involved in all aspects of the services they receive. This includes assessment, goal setting, case planning, activities, program design, and program evaluation.

Third, children and youth in residential care must have opportunities to establish caring relationships in their lives. Their growth and progress occurs within the context of their relationships with staff, peers, family members, and other caring adults.

Fourth, children and youth in residential care must be served in programs that take into account environmental influences on growth and progress. Environments include physical, cultural, philosophical, and social dimensions.

Lastly, children and youth in residential care must be served in programs that collaborate and form partnerships with a number of resources. Those resources include the youth, their families, staff, other service providers, and the community.

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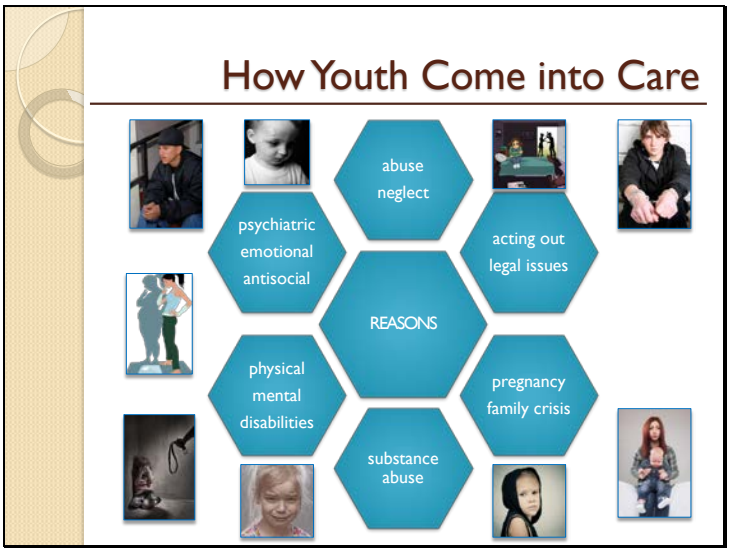

How Youth Come into Care

The most common reasons for residential care placement include abuse, neglect, behavioral acting out, trouble with the law (e.g., underage drinking), pregnancy, family crisis, and substance abuse. Placement may also be needed due to physical and/or mental disabilities, to attention deficit disorder, to attention deficit hyperactivity disorder, or to mental illnesses such as depression, conduct disorder, anorexia nervosa, bulimia, anxiety disorders, schizophrenia, and psychosis.

Children and youth who enter residential care vary greatly in many ways and may have a complex range of needs, problems, strengths, and weaknesses, as well as function at different developmental levels. Most adolescents in residential care have psychiatric, emotional, or antisocial symptoms, and many of those youth have limited verbal skills, some intellectual deficits, minimal successes in previous activities, and a history of acting out (or extreme withdrawal). They can also be very impulsive, attention-seeking, and easily influenced by others. Many youth entering residential care come from difficult home situations with high levels of risk, including those where there may be poverty, substance abuse, mental illness, domestic violence, criminal involvement, and frequent changes in where the family lives. In module 7 you will learn more about how such traumatic family situations can impact the development of children and youth.

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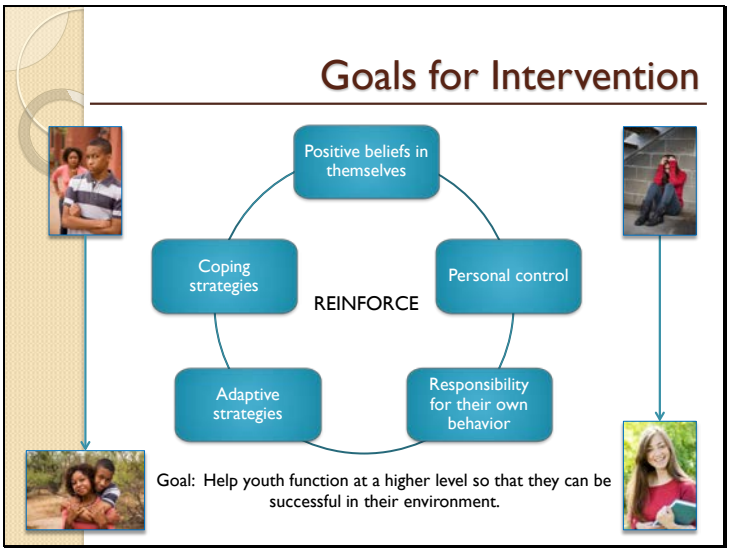

Goals for Intervention

Broadly speaking, the goal of residential treatment is to help each youth to function at a higher level. This includes reinforcing children's positive beliefs in themselves, their personal control, their responsibility for their own behavior, and their strategies to adapt and cope with difficult situations so that when they return to the family they can be successful in the environment and experience trust and commitment in relationships with others.

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Challenges

As an RCYCP, you will face challenges in working with residents. Oftentimes the youth who come into residential care do not want to be there at all. This can create a number of different challenges for the residential counselors and other staff members trying to help them. You may see many of the following types of behaviors:

- Lack of motivation (to change, or even to just accomplish day to day activities).
- Defiance (this might be seen in refusal to participate in activities, and unwillingness to follow rules or guidelines might be some of the ways that youth act defiant).
- Oppositional behaviors (such as passiveness, denial, constant complaining, hyperactivity, destructiveness, boisterousness, refusal to cooperate, inability to deal with give and take of relationships, and aggression).
- Overreaction to controls and expectations because they haven't had consistent experiences with structural limits.
- And defensiveness.

They may also:
- Find RCYCPs unfair, stupid, intrusive, or threatening.
- They may feel like rules are too difficult; that they will fail and be punished – so it paralyzes them or they decide to fail and get it over with.

- They may act out physically or experience physical symptoms (e.g., stomach aches, headaches…).

Many youth have given up on themselves and so begin to look for things to confirm their own sense of worthlessness.
Because many youth come from environments where they have experienced rejection by adults, humiliation by their peers, and negative labels like “failure,” “crazy,” and “not good enough”, they may fear that staff will see them in a negative way as well. Many have been physically and/or emotionally traumatized. Often they have painful feelings about themselves, believing that they are defective, inferior, and unable to change.

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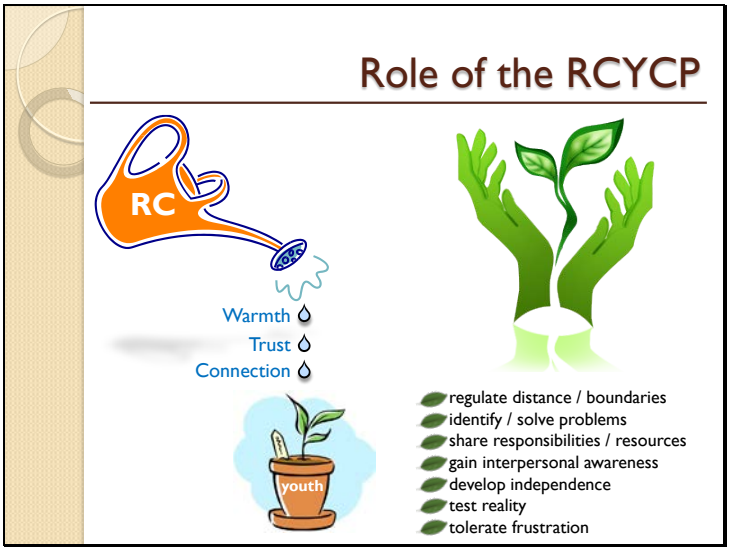

Role of the RCYCP

The role of the residential child and youth care practitioner is so very important. An RCYCP's knowledge, skills, compassion, and determination help to create relationships and an environment where positive change can take place for the children, youth, and their families. The residential environment becomes their new home and family, creating a new opportunity to establish healthy relationships that likely didn't exist before. In this new environment youth can experience warmth, trust, and connection with others, thereby promoting psychological growth. It also allows interactions that teach youth how to regulate distance and closeness, understand boundaries, identify and solve problems, share responsibilities, develop interpersonal awareness and skills, share resources and turn taking, develop independence, and improve their ability to test reality and tolerate frustration.

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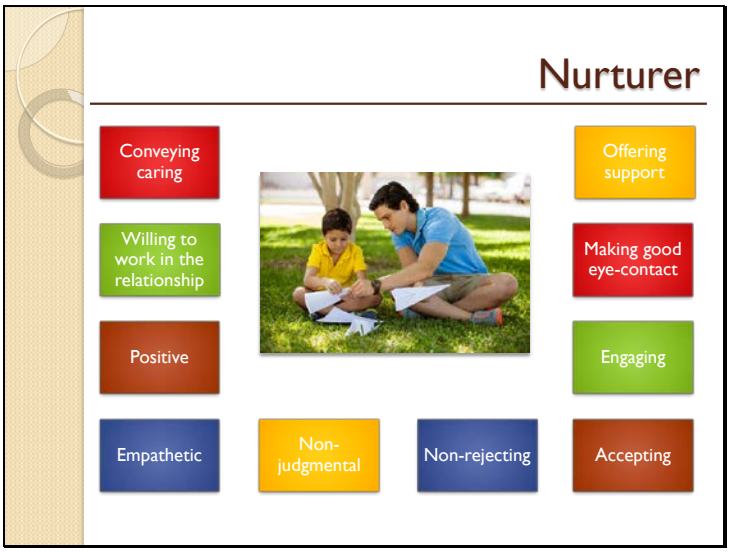

Nurturer

The effectiveness of residential treatment is first and foremost the direct result of positive connections between the staff and the youth. When these connections exist the youth develop a sense of trust and security that allows them to open themselves up for positive change. These connections are built by RCYCPs through:
Conveying caring and a willingness to work hard in the relationship especially when the youth is not making progress or is being defiant. Being positive, empathic, non-judgmental, and non-rejecting; Helping the youth to believe that they are being accepted unconditionally – whatever traits, characteristics, and values the youth has are to be respected and regarded as valuable (even if their behavior is not); Being available for the good and the bad; Engaging in discussions – not only about their challenges, but about their strengths as well – conversations that focus on things both related to their current situations as well as things that are un-related (like hobbies); Establishing good eye contact – this lets youth know that you are giving your full attention to them, as well as modeling healthy communication.

Our attitudes, values, and beliefs about young people significantly influence our interaction and therefore our success with them. By identifying strengths, providing opportunities, and giving support to them you are making a positive difference in their lives

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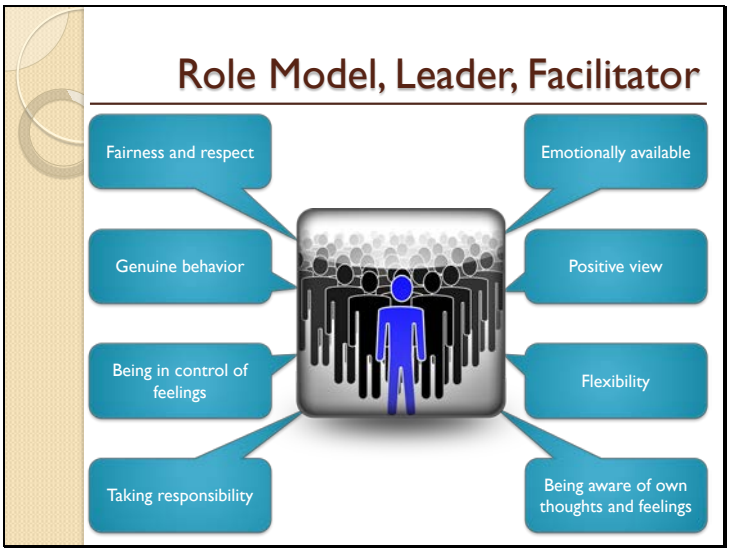

Role Model, Leader, Facilitator

Through engagement in activities and dialog, RCYCPs have the opportunity to model healthy skills for children in care, showing them how to function in a healthy and positive way. RCYCPs can model fairness and respect in interactions with all others (such as family members, staff, and other residents). RCYCPs can model "genuine behavior" interactions with others. That means that if you, the RC, are frustrated, or angry, or sad, you express those emotions, but it in healthy way that provides an opportunity to feel a genuine, caring relationship. RCYCPs can model being in control of feelings and taking responsibility for one's own behavior. That means that even when faced with negative behavior you must remain emotionally available and reassuring rather than angry, distant, punitive, offended, or holding a grudge. Finally, RCYCPs can model how to develop a positive view, how to be flexible, and how to become more aware of your own thoughts and feelings as well as those of others.

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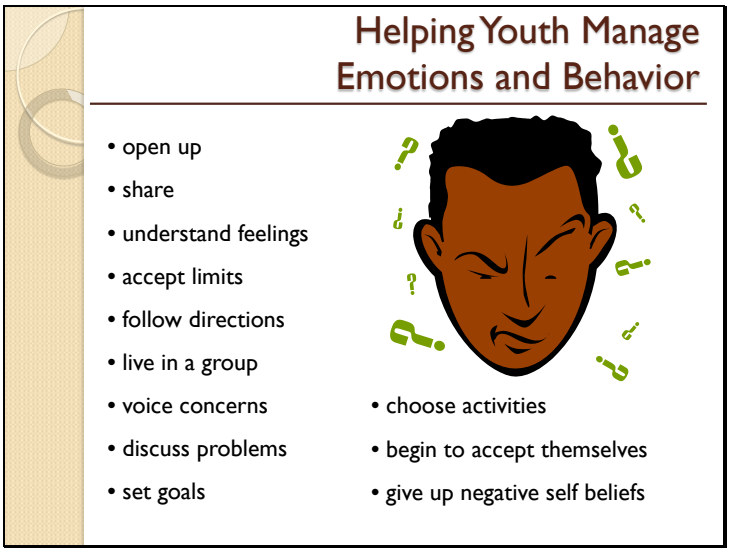

Helping Youth Manage Emotions and Behavior

Most youth in residential placement have not developed the ability to understand their own or other's thinking processes, and have trouble respecting the boundaries of others. These problems make the development of healthy relationships challenging. Nevertheless, most youngsters can be taught the skills that are important. With the guidance of caring RCYCPs, the youth have the ability to learn to open up, share, understand feelings, accept limits, follow directions, and live successfully in a social group such as a residential facility.

In order to help children and youth work through feelings, RCYCPs work to encourage youngsters to voice their concerns, to discuss problems, to set goals, to choose activities, and so forth.

- Other ways that residential counselors can help youth to learn how to manage feelings, behaviors, and socialization is by:
- Helping to resolve conflicts when they arise (this can mean between residents, or residents and staff, or residents and others in the community).
- Teaching respect and fairness.
- Helping youth understand the consequences of behavior, not just after the behavior has occurred (like after breaking rules) but potential consequences of actions before they actually engage in those actions.

- Providing supportive confrontations, feedback, acknowledgement, and/or praise. These will help improve youth's self-understanding, communication skills, and interactions.
- Also, redirecting negative or reactive behaviors to become strengths. For example, when a youth experiences and acts out in anger, is the youth using that as a self-protection mechanism? If so, RCYCPs can empathize with youth wanting to protect themselves, and then help the youth find out how that self-protection can be accomplished in a productive and healthy way.

Assisting youth in beginning to accept themselves and give up negative self beliefs.
One of the most important tasks an RCYCP can do to help shape behavior is to emphasize strengths in the youth, particularly any positive and adaptive behaviors they see the youth engage in.

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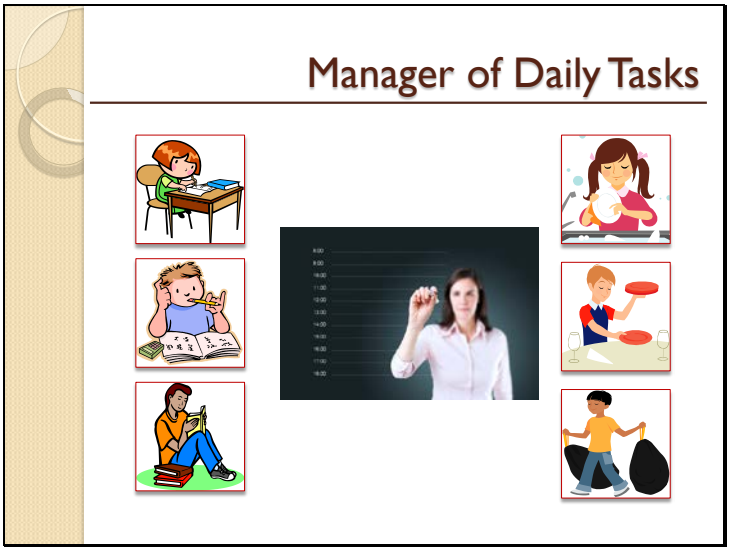

Manager of Daily Tasks

Residential counselors are the managers of everyday tasks, like doing homework or chores. This allows the youth to learn to function as a contributing member of the group, as well as of society. By managing these tasks, the RCYCP is lending importance to the process, as well as creating rituals and opportunities for positive events to happen.

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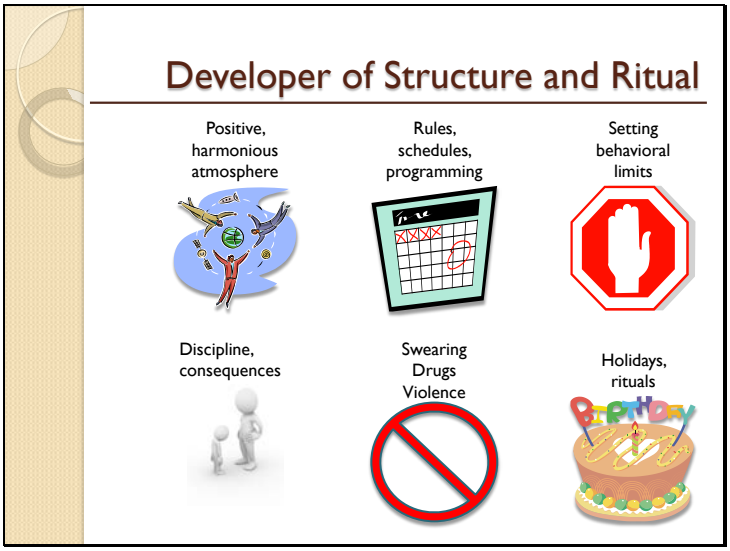


Developer of Structure and Ritual

The RCYCP's job is to help promote and reinforce the structure of everyday life at the center. Remember that most of the residents have come from unhealthy and unstructured environments where they have not been able to meet their potential. Providing a stable, nurturing, and healthy living environment, where things are consistent and the youth know what to expect, is so important because it allows the residents to feel reassured and safe and to take positive risks, thereby having an opportunity to grow and experience positive change.

Additionally, RCYCPs develop structure and ritual by:

- Maintaining a positive and harmonious atmosphere that provides for resident's physical well-being and emotional needs.
- Enforcing and helping youth to conform to rules, schedule, programming, and transitions.
- Setting behavioral limits which provide structure to the youth and help youth understand the consequences of their behavior.
- Using discipline and consequences judiciously as a way to shape behavior and strengthen, rather than weaken attachment bonds between RCYCP and youths.
- Actively working to diminish negativity, foul language, and glorification of violence, drugs, coercive interactions, and bullying.
- Structuring the environment so that meaningful exchanges among RCYCPs, staff, and residents can exist.

- Consistently reinforcing rules and limits so that youth know what to expect and have a sense of predictability.
- And developing rituals that strengthen social bonds and mark the importance of life transitions, such as birthdays, holidays, special events, as well as the coming and going of residents.

Slide 30

Advocate

As an RCYCP, you are an advocate as well, especially early on in a resident's stay. Initially it may be your responsibility as an RCYCP to act as the voice for the young people with others (other group members, staff, peers, family, community, school) to ensure their needs are understood and being met, so that eventually you can assist them as they speak for themselves.

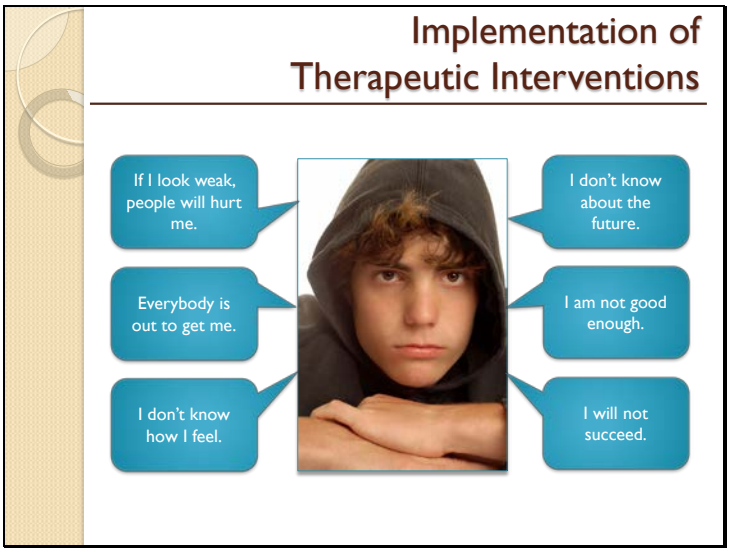
Slide 31

Engagement of Child as Partner

RCYCPs involve youths in the decision-making and treatment plan goals. This process of including the youths is beneficial because it:

- Empowers the youngsters
- Allows youngsters to take responsibility for their successes
- And helps to avoid power struggles over their treatment.

Slide 32

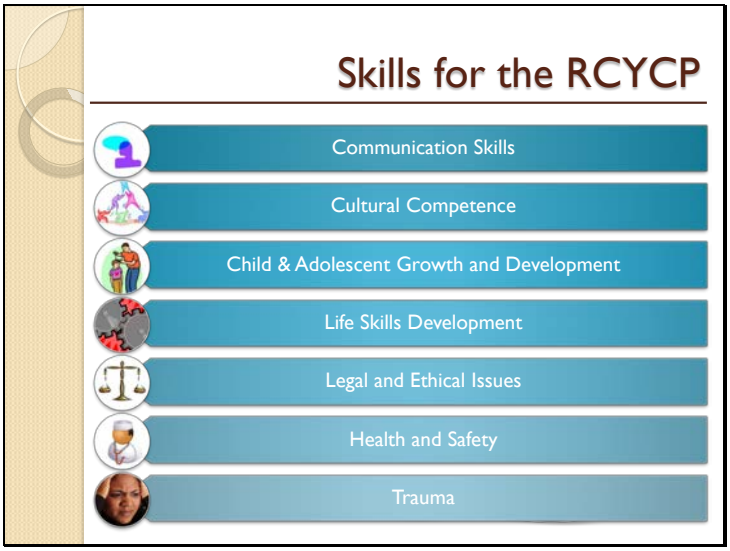


Implementation of Therapeutic Interventions

As a residential counselor, your job is important and varied. Within the broader context of daily activities, RCYCPs' duties will include, among many other things, the following:

- Re-directing youths' negative behaviors
- Helping to enhance youths' strengths while minimizing their weaknesses
- Correcting youths' distorted thinking (for example, "If I open up to people and show them vulnerability they will hurt me.")
- Modifying youths' maladaptive behaviors (for example, helping youth stand up for themselves in a socially competent and healthy way while minimizing aggression)
- Identifying thoughts and feelings and how those influence behavior (for example, the thought "everybody is out to get me" causes anger, anxiety, and feelings of hopelessness and in turn withdrawal behaviors like not wanting to participate)
- Helping youth to process their feelings (for example, helping them to figure out what they are thinking and feeling)
- Helping youth think about their past, present, and future
- Eliminating negative thoughts (for example, "I am not good enough," and "I will not succeed")
- And following the service plans set up for the youth in care, including making documentation (daily notes) on each youngster's behaviors as they relate to the plan.

Slide 33



Skills for the RCYCP

In the following modules you will learn content in the following related areas

Click on the following skills to hear their descriptions:

Communication Skills: In order for RCYCPs to be effective with children and youth it is necessary to have strong communication skills. Specifically, RCYCPs must have good verbal skills, be able to use language effectively, and be able to understanding the feelings and meanings behind others' language in order to be effective problem solvers.

Cultural Competence: It is important for RCYCPs to respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, sexual orientation, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities, and protects and preserves the dignity of each.

Child and Adolescent Growth and Development: RCYCPs need to understand the physical, emotional, cognitive, and social changes that occur at the different developmental levels of the youth they are working with, as well as moral and spiritual development. This understanding is key to creating treatment plans that are appropriate to the developmental level of each youth.

Life Skills Development: This is one of the most important learning areas for residential youth. RCYCPs need to know how to help youth with independent living skills, activities of daily living, job attainment skills, developmentally appropriate activities and recreation, as well motivation techniques and discipline.

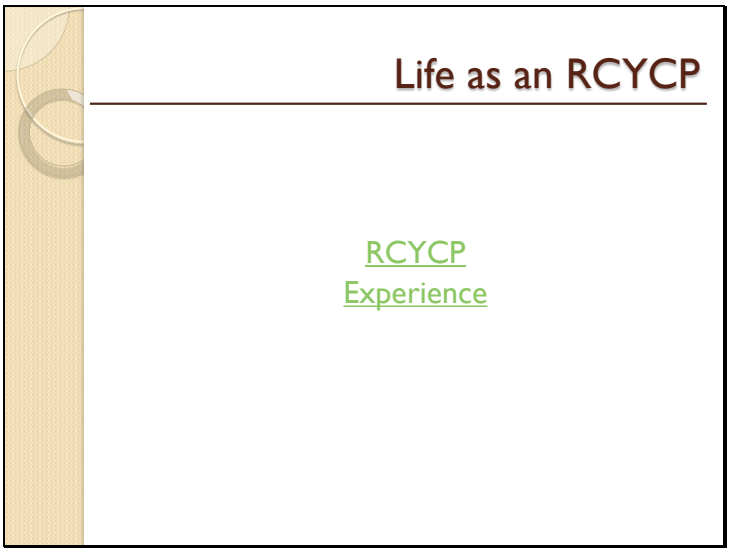
Legal and Ethical Issues: It is critical for RCYCPs to know about child abuse and neglect: recognizing it, reporting requirements, and issues of confidentiality

Health and Safety: As an RCYCP you will need to know universal precautions and infection control procedures, health and safety issues including disaster safety, fire drills, life threatening situations, house cleaning methods, healthy food preparation, childhood illnesses, medications, and crisis management.

Trauma: As an RCYCP you will encounter many children and youth who have experienced abuse and neglect. In this training you will learn about the trauma associated with family violence and how it affects children and youth.

You will learn about all of these topics in the following modules.

Slide 35

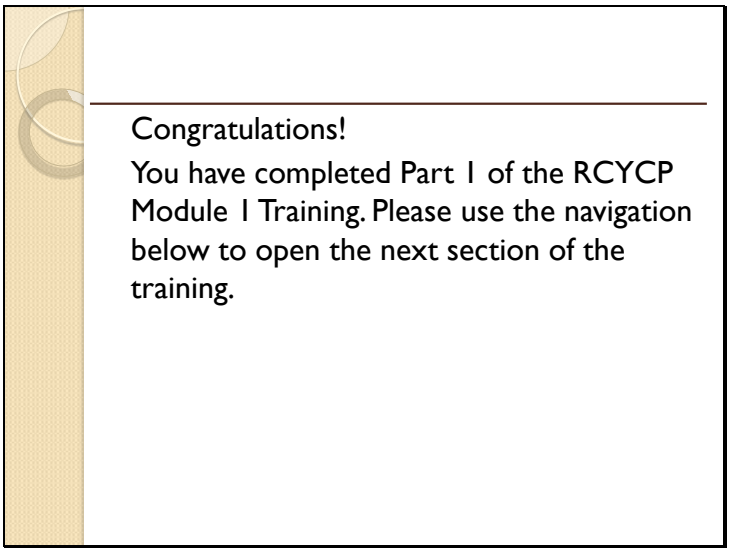


Life as an RCYCP

Now that you know a little about your role as an RCYCP, let's watch a short clip of a young woman discussing her experience as an RCYCP.

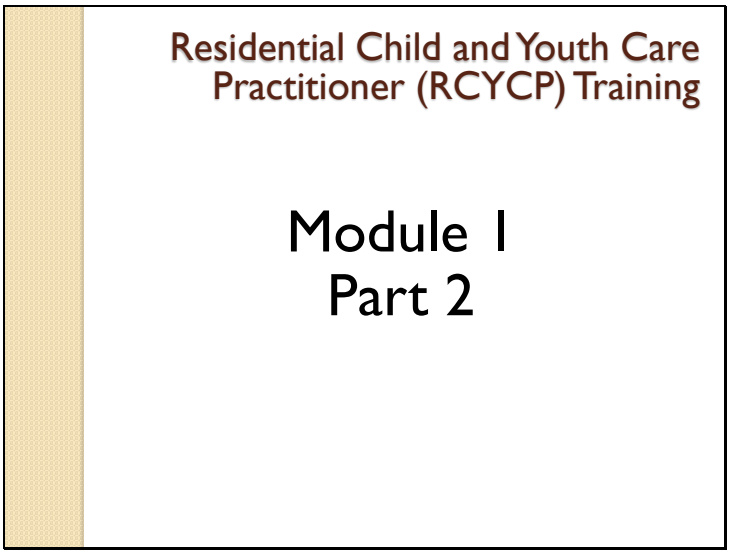
http://www.youtube.com/watch?v=cx8YTeTaR4E

Slide 36



Congratulations! You have completed Part 1 of the RCYCP Module 1 Training. Please use the navigation below to open the next section of the training.

Slide 2



Residential Child and Youth Care Practitioner Training

Welcome to Module 1, Part 2 of the Residential Child and Youth Care Practitioner Training.

Slide 3

Individual Service Plans/Treatment Plans

In residential care the Individual Service Plan (also sometimes referred to as the Treatment Plan) is essential to casework. The Individual Service Plan is typically based on assessment information of the youth and their family and is tailored to the individual and family specifically. This plan is completed within 30 days of admission and includes the following:

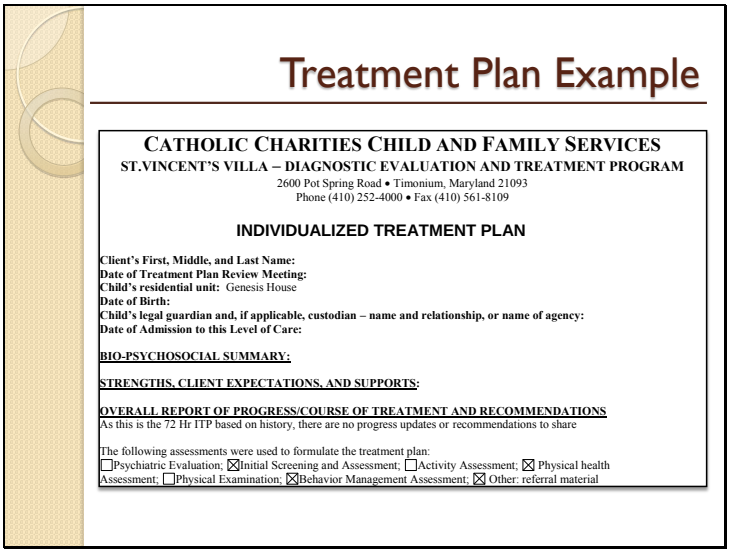
- An evaluation.
- A behavior plan if it is appropriate.
- Measurable outcomes with time frames for goal achievement.
- Implementation dates and strategies..
- The individual who will support, implement, and monitor
- Documentation indicating that the child, child's advocates, guardian, and family (when appropriate) have been involved in, informed of, and agree with the plan. (This is often referred to as "informed consent.").

The Individual Service plan also includes:

- A plan for education, including special education and related services.
- An identification of family relationships and the status of those relationships.
- A plan for health care, life skills development, personal, emotional, and social development.
- A plan for recreation, vocational training, and other areas that are seen as appropriate for the identified youth.

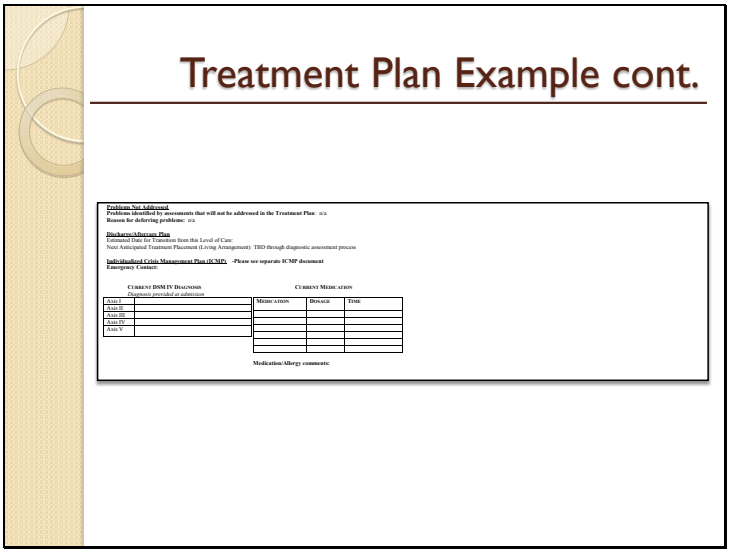
- The plan is reviewed and updated at least every 90 days. When circumstances change in some way that affects the youth or his/her plan, the plan is modified accordingly. As each youth makes progress toward the goals in his/her plan, that progress is documented in the Individual Service Plan, as well as an estimate about how long the individual is likely to need residential care.

Slide 4

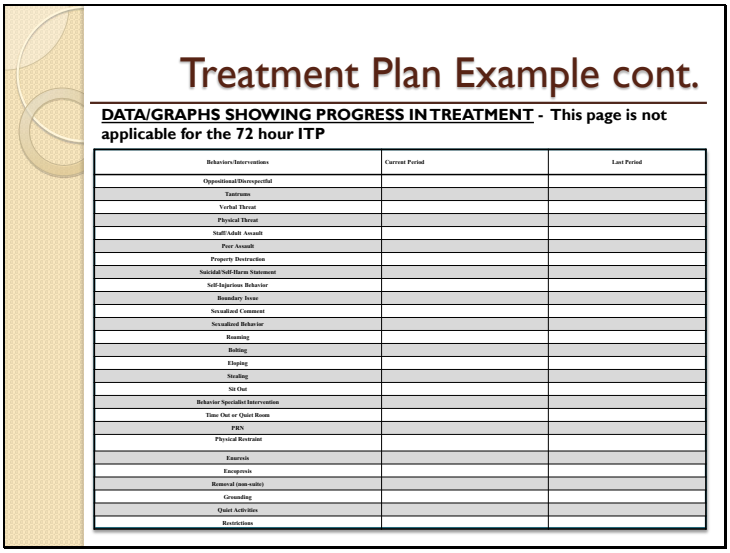


Treatment Plan Example

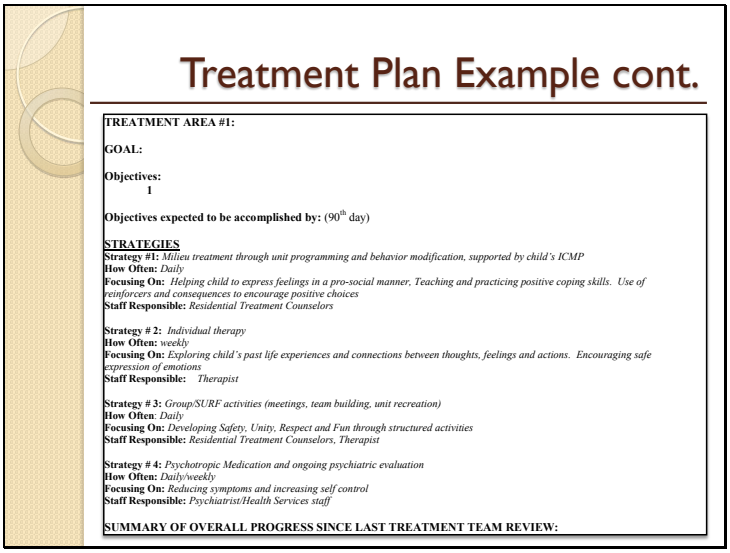
Slide 5


Treatment Plan Example cont.
Problems Not Addressed
Problems identified by assessments that will not be addressed in the Treatment Plan: n/a
Reason for deferring problems: n/a
Discharge/Aftercare Plan
Estimated Date for Transition from this Level of Care:
Next Anticipated Treatment Placement (Living Arrangement): TBD through diagnostic assessment process
Individualized Crisis Management Plan (ICMP) –Please see separate ICMP document
Emergency Contact:
Current DSM IV Diagnosis
Diagnosis provided at admission
Axis I
Axis II
Axis III
Axis IV
Axis V
Current Medication
Medication
Dosage
Time
Medication/Allergy comments:

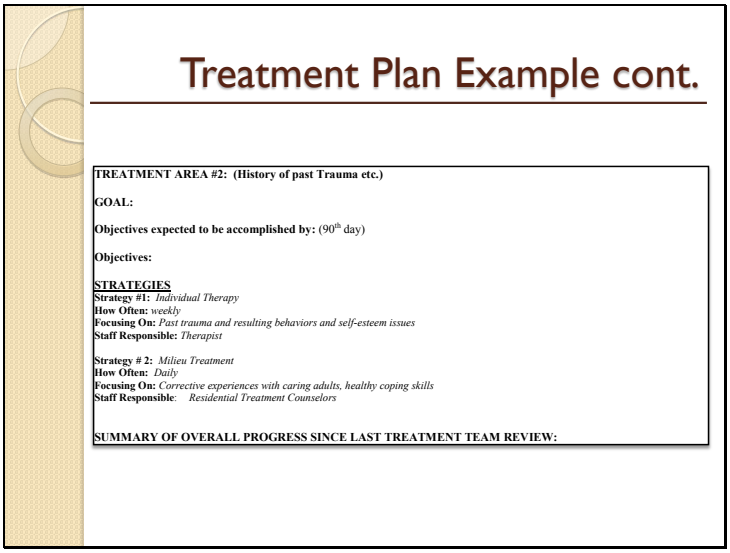
Slide 6


Treatment Plan Example cont.
DATA/GRAPHS SHOWING PROGRESS IN TREATMENT - This page is not applicable for the 72 hour ITP
Behaviors/Interventions
Current Period
Last Period
Oppositional/Disrespectful
Tantrums
Verbal Threat
Physical Threat
Staff/Adult Assault
Peer Assault
Property Destruction
Suicidal/Self-Harm Statement
Self-Injurious Behavior
Boundary Issue
Sexualized Comment
Sexualized Behavior
Running
Bolting
Eloping
Stealing
Sit Out
Behavior Specialist Intervention
Time Out or Quiet Room
PRN
Physical Restraint
Enuresis
Encopresis
Removal (non-suite)
Grounding
Quiet Activities
Restrictions

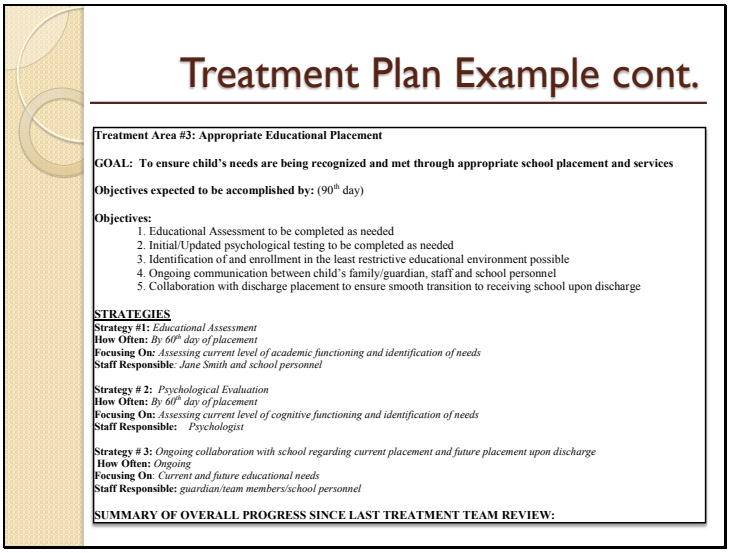
Slide 7


Treatment Plan Example cont.
TREATMENT AREA #1:
GOAL:
Objectives:
1
Objectives expected to be accomplished by: (90th day)
STRATEGIES
Strategy #1: Milieu treatment through unit programming and behavior modification, supported by child's ICMP
How Often: Daily
Focusing On: Helping child to express feelings in a pro-social manner, Teaching and practicing positive coping skills. Use of reinforcers and consequences to encourage positive choices
Staff Responsible: Residential Treatment Counselors
Strategy # 2: Individual therapy
How Often: weekly
Focusing On: Exploring child's past life experiences and connections between thoughts, feelings and actions. Encouraging safe expression of emotions
Staff Responsible: Therapist
Strategy # 3: Group/SURF activities (meetings, team building, unit recreation)
How Often: Daily
Focusing On: Developing Safety, Unity, Respect and Fun through structured activities
Staff Responsible: Residential Treatment Counselors, Therapist
Strategy # 4: Psychotropic Medication and ongoing psychiatric evaluation
How Often: Daily/weekly
Focusing On: Reducing symptoms and increasing self control
Staff Responsible: Psychiatrist/Health Services staff
SUMMARY OF OVERALL PROGRESS SINCE LAST TREATMENT TEAM REVIEW:

Slide 8


Treatment Plan Example cont.
TREATMENT AREA #2: (History of past Trauma etc.)
GOAL:
Objectives expected to be accomplished by: (90th day)
Objectives:
STRATEGIES
Strategy #1: Individual Therapy
How Often: weekly
Focusing On: Past trauma and resulting behaviors and self-esteem issues
Staff Responsible: Therapist
Strategy # 2: Milieu Treatment
How Often: Daily
Focusing On: Corrective experiences with caring adults, healthy coping skills
Staff Responsible: Residential Treatment Counselors
SUMMARY OF OVERALL PROGRESS SINCE LAST TREATMENT TEAM REVIEW:

Slide 9


Treatment Plan Example cont.
Treatment Area #3: Appropriate Educational Placement
GOAL: To ensure child's needs are being recognized and met through appropriate school placement and services
Objectives expected to be accomplished by: (90th day)
Objectives:
1. Educational Assessment to be completed as needed
2. Initial/Updated psychological testing to be completed as needed
3. Identification of and enrollment in the least restrictive educational environment possible
4. Ongoing communication between child's family/guardian, staff and school personnel
5. Collaboration with discharge placement to ensure smooth transition to receiving school upon discharge
STRATEGIES
Strategy #1: Educational Assessment
How Often: By 60th day of placement
Focusing On: Assessing current level of academic functioning and identification of needs
Staff Responsible: Jane Smith and school personnel
Strategy # 2: Psychological Evaluation
How Often: By 60th day of placement
Focusing On: Assessing current level of cognitive functioning and identification of needs
Staff Responsible: Psychologist
Strategy # 3: Ongoing collaboration with school regarding current placement and future placement upon discharge
How Often: Ongoing
Focusing On: Current and future educational needs
Staff Responsible: guardian/team members/school personnel
SUMMARY OF OVERALL PROGRESS SINCE LAST TREATMENT TEAM REVIEW:

Slide 10

Treatment Plan Example cont.

Treatment Area #4: Wellness

GOAL: To ensure opportunity for the child's further development of a healthy mind, body and spirit

Objectives expected to be accomplished by: (90th day)

Objectives:

1. Child will present with age/developmentally appropriate daily living skills including self-care/hygiene, healthy eating habits and regular physical activity
2. Identification of and engagement in activities child enjoys and shows potential for
3. Spiritual Development
4. Cultural awareness
5. Medical care/consultation

STRATEGIES

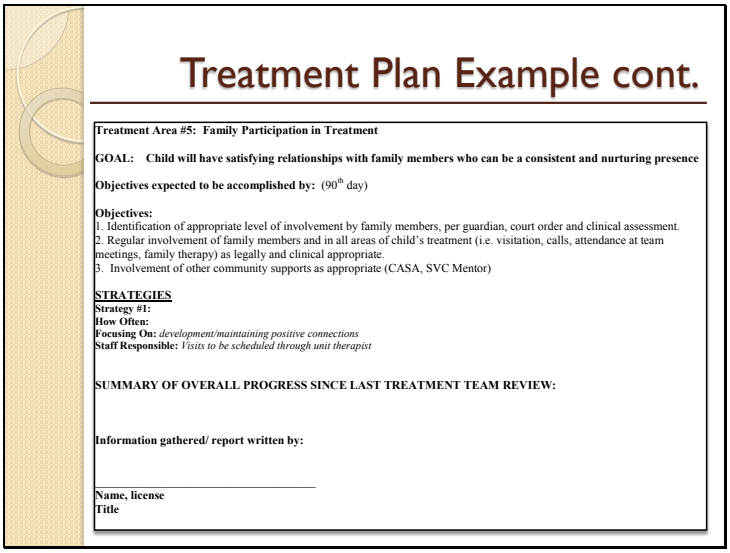
Strategy #1: *Milieu Treatment*
How Often: *Daily*
Focusing On: *Developing interest in skills for self care and recreational activities*
Staff Responsible: *Residential Treatment Counselors*

Strategy # 2: *Participation in Arts and Recreation activities, as well as Recreational Assessment*
How Often: *ongoing*
Focusing On: *identification and development of interests and skills*
Staff Responsible: *Trisha Ey, Mary Lee Saarbach, Residential Treatment Counselors*

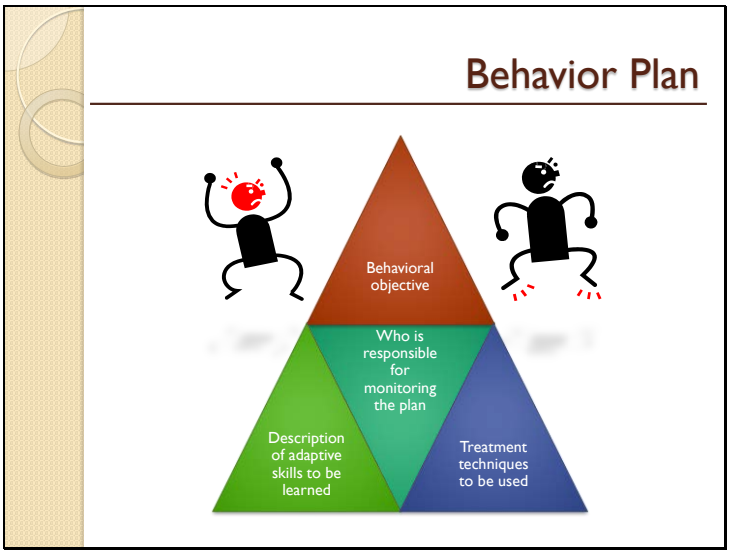
Strategy # 3: *Medical Care*
How Often: *on-going as needed*
Focusing On: *maintaining good health and resolving medical issues*
Staff Responsible: *pediatrician, nurses*

SUMMARY OF OVERALL PROGRESS SINCE LAST TREATMENT TEAM REVIEW:

Slide 11


Treatment Plan Example cont.
Treatment Area #5: Family Participation in Treatment
GOAL: Child will have satisfying relationships with family members who can be a consistent and nurturing presence
Objectives expected to be accomplished by: (90th day)
Objectives:
1. Identification of appropriate level of involvement by family members, per guardian, court order and clinical assessment.
2. Regular involvement of family members and in all areas of child's treatment (i.e. visitation, calls, attendance at team meetings, family therapy) as legally and clinical appropriate.
3. Involvement of other community supports as appropriate (CASA, SVC Mentor)
STRATEGIES
Strategy #1:
How Often:
Focusing On: development/maintaining positive connections
Staff Responsible: Visits to be scheduled through unit therapist
SUMMARY OF OVERALL PROGRESS SINCE LAST TREATMENT TEAM REVIEW:
Information gathered/ report written by:
Name, license
Title

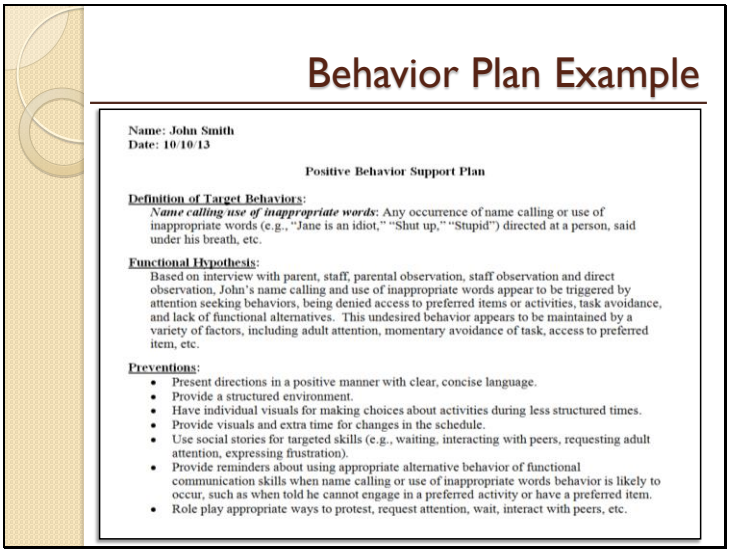
Slide 12



Behavior Plan

When a youth has behavioral challenges, a behavior plan is developed and included in the Individual Service Plan. It is developed by a team that may include doctors, human service professionals, or professional counselors and is based on an assessment of each challenging behavior that is identified for the youth in question. The behavior plan specifies the behavioral objective for the child, a description of the adaptive skills to be learned, who is responsible for monitoring the behavior plan, as well as the treatment techniques that will be used with the youth.

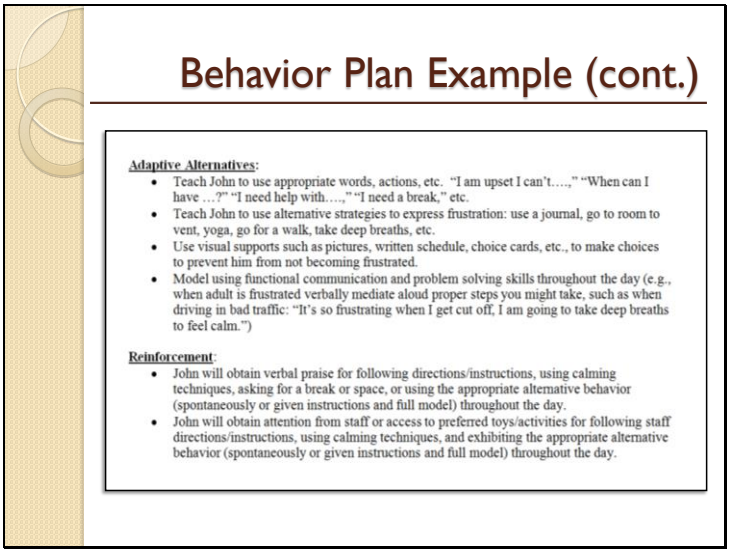
Slide 13



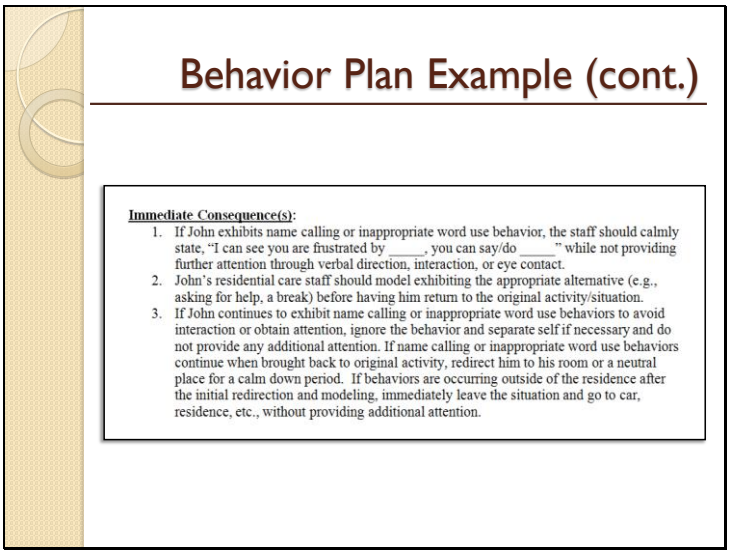
Behavior Plan Example

Let's take a look at an example of a behavior plan.

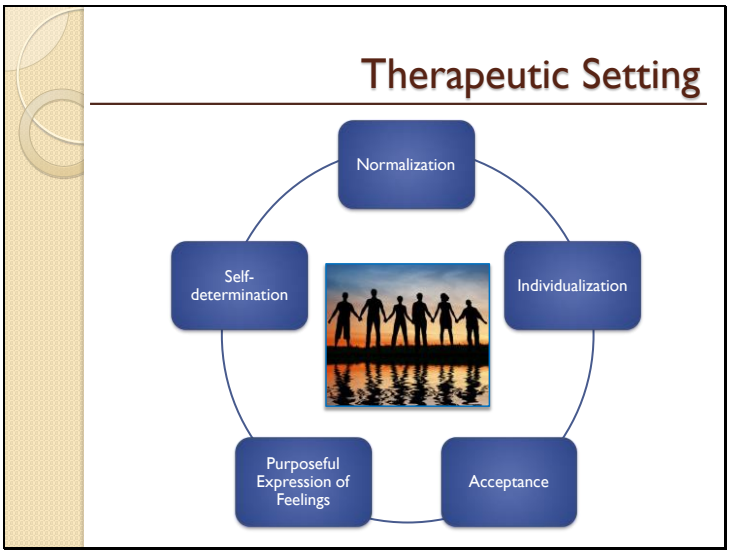
Slide 14


Behavior Plan Example (cont.)
Adaptive Alternatives:
Teach John to use appropriate words, actions, etc. "I am upset I can't…," "When can I have …?" "I need help with…," "I need a break," etc.
Teach John to use alternative strategies to express frustration: use a journal, go to room to vent, yoga, go for a walk, take deep breaths, etc.
Use visual supports such as pictures, written schedule, choice cards, etc., to make choices to prevent him from not becoming frustrated.
Model using functional communication and problem solving skills throughout the day (e.g., when adult is frustrated verbally mediate aloud proper steps you might take, such as when driving in bad traffic: "It's so frustrating when I get cut off, I am going to take deep breaths to feel calm.")
Reinforcement:
John will obtain verbal praise for following directions/instructions, using calming techniques, asking for a break or space, or using the appropriate alternative behavior (spontaneously or given instructions and full model) throughout the day.
John will obtain attention from staff or access to preferred toys/activities for following staff directions/instructions, using calming techniques, and exhibiting the appropriate alternative behavior (spontaneously or given instructions and full model) throughout the day.

Slide 15


Behavior Plan Example (cont.)
Immediate Consequence(s):
1. If John exhibits name calling or inappropriate word use behavior, the staff should calmly state, "I can see you are frustrated by _____, you can say/do _____" while not providing further attention through verbal direction, interaction, or eye contact.
2. John's residential care staff should model exhibiting the appropriate alternative (e.g., asking for help, a break) before having him return to the original activity/situation.
3. If John continues to exhibit name calling or inappropriate word use behaviors to avoid interaction or obtain attention, ignore the behavior and separate self if necessary and do not provide any additional attention. If name calling or inappropriate word use behaviors continue when brought back to original activity, redirect him to his room or a neutral place for a calm down period. If behaviors are occurring outside of the residence after the initial redirection and modeling, immediately leave the situation and go to car, residence, etc., without providing additional attention.

Slide 18



Therapeutic Setting

Residential child and youth care practitioners can contribute to providing a therapeutic environment for children and youth by following these basic principles and practices:

Click on each to hear a description.

Therapeutic Setting: making the patterns and conditions of everyday residential life as close as possible to those that are the normal patterns of mainstream society.

Individualization: taking into account the individualized needs of residents (psychological, physical, developmental, and so forth).

Acceptance: accepting and respecting the individuals as they are, complete with their strengths and their weaknesses.

Purposeful Expression of Feelings: recognition of a wide range of feelings, by the individuals, with opportunities to safely express those feelings.

Self-Determination: active participation of youth in the treatment plan process – including the right to make decisions.

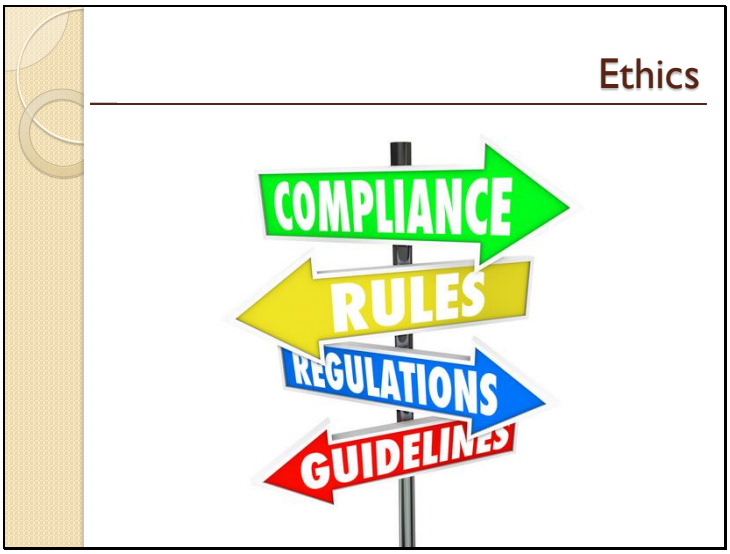
Slide 19

Positive Developmental Characteristics for Youth

By creating a therapeutic environment, RCYCPs are building skills that help young people make wise decisions, choose positive paths, and grow up as competent, caring, and responsible adults. In order to make this happen RCYCPs:

- Offer support: young people need to experience environments with support, care, and love from families and others.
- Empower youth: young people must feel safe, secure, and valued, and able to contribute to others and their community.
- Set boundaries and expectations: young people need to know what is expected of them, what is okay and not okay in terms of behavior.
- Teach constructive use of time: young people need constructive, enriching opportunities for growth in their lives, balanced with quality time at home.
- Foster commitment to learning: young people need a lifelong commitment to education and learning.
- Foster the development of positive values: youth need to develop strong values that guide their actions.
- Teach social competencies: young people need skills and knowledge to make positive choices, build strong relationships, and succeed in life.
- Facilitate the development of a positive identity: young people need a sense of their own power, purpose, worth, and promise.

Slide 20



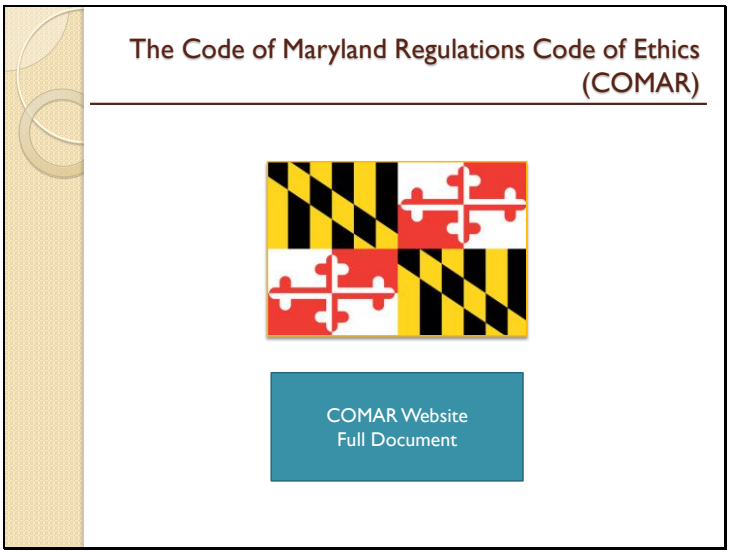
Ethics

Working with children and adolescents in residential care is both a privilege and a responsibility. It is a privilege because you have the opportunity to make a significant difference in the lives of these youth, and a responsibility because you are entrusted to safeguard the health and well-being of a unique and vulnerable group of kids. They have little power over their lives, and few skills for protecting and caring for themselves. As adults, you have the power to do great good, or in some unfortunate cases, great harm. Because of this power differential, and the complexity of the role of caregiver to this population, ethical guidelines are in place to protect both the youth, as well as you and the other professionals who care for them.

In following the ethical guidelines set out for you, you will know what is appropriate and expected behavior of you in your role as a residential child and youth care practitioner. You will also have an understanding of the values and beliefs that are considered worthwhile and important in the field of residential care.

We are going to discuss 2 sets of guidelines that you, as a residential counselor, need to know. The first is specific to Maryland regulations and your role as a residential child and youth care practitioner at your specific site. The second set of guidelines is broader and applies to the field of residential child and youth care in general.

Slide 21



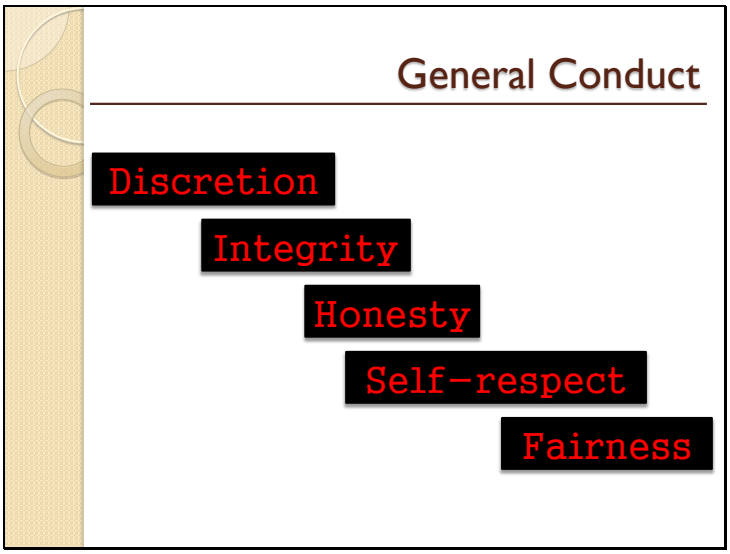
The Code of Maryland Regulations (COMAR) Code of Ethics

COMAR is the Code of Maryland Regulations and includes a code of ethics that applies to certified residential and child care program administrators, as well as certified residential child and youth care practitioners. As an RCYCP you are required to uphold this code of ethics, as well as report any violations of this code to the Board for Certification of Residential Child Care Program Professionals at 4201 Patterson Ave., Baltimore, MD 21215 - 2299 .

For the purposes of this training, you will receive a general overview and summary of the code, however, you may click on the website below to read the official document in its entirety.

http://www.dsd.state.md.us/comar/SubtitleSearch.aspx?search=10.57.05.*

Slide 22



General Conduct

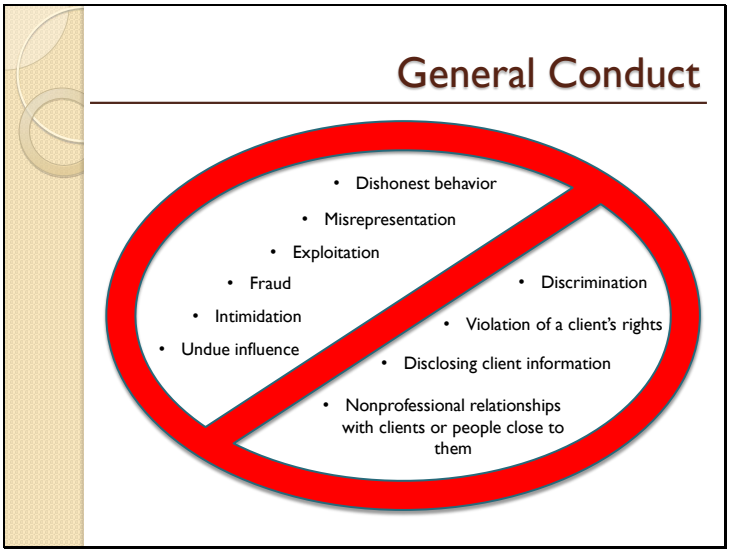
The following information is from the COMAR regulations:

The primary concern of the RCYCP should be the welfare of the children and youth that are in the residential program.

The RCYCP should:

- Function with discretion and integrity in relationships with other health professionals.
- Carry out all duties with honesty, integrity, self-respect, and fairness.
- Report any unethical conduct by another RCYCP or administrator to the Board.
- Inform the Board if someone is mis-representing him/herself as being certified when s/he is not.

Slide 23



General Conduct

The RCYCP may not:

- Participate in, or condone, dishonest behavior of any kind.
- Misrepresent his/her professional qualifications or experience.
- Exploit a relationship with a client for personal gain.
- Engage in solicitation that amounts to fraud, intimidation, or undue influence.
- Practice, condone, or facilitate discrimination on the basis of race, color, sex, sexual orientation, age, religion, national origin, marital status, political belief, disability, or other preference or personal characteristic, condition or status.
- Engage or participate in an action that violates or diminishes the civil or legal rights of a client.
- Share information given to you in confidence by a client without his/her express permission unless it involves danger to self or another individual, or for a compelling professional reason.
- Enter into a nonprofessional, social, or dual relationship with a client, or an individual that has a close personal relationship with a client.

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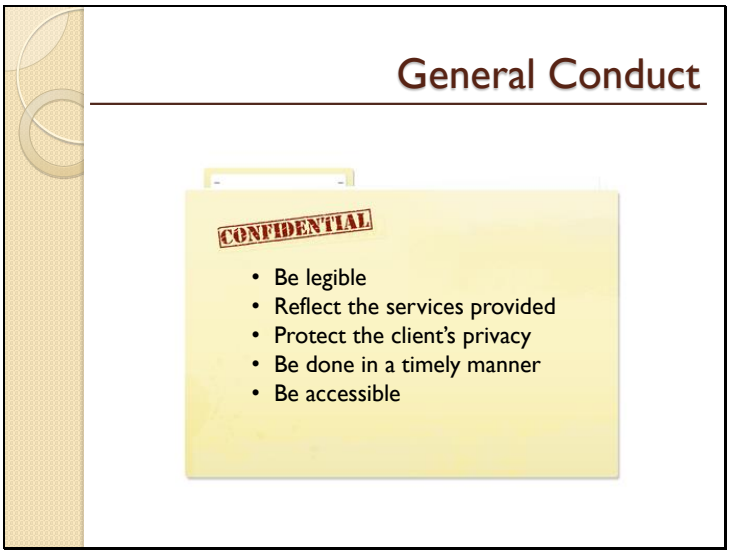

With regard to documentation in the client's record. It should:

- Be legible
- Reflect the services provided
- Protect the client's privacy
- Be done in a timely manner
- Be accessible in the manner necessary by the law

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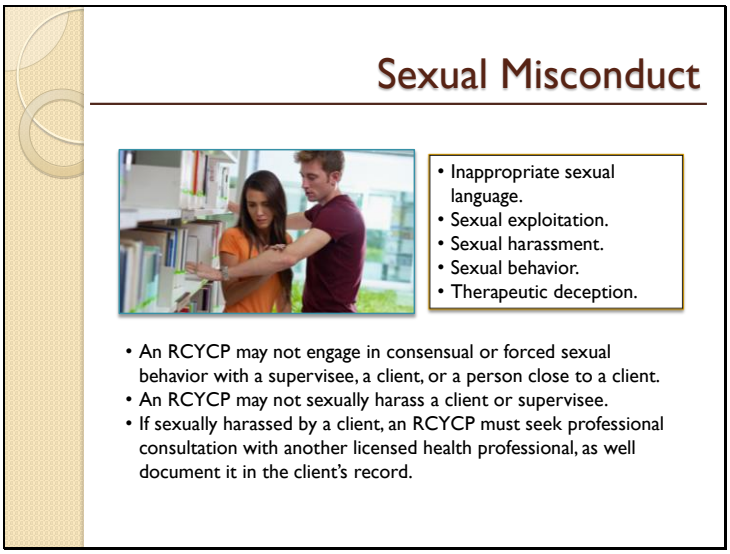

Sexual Misconduct

With regard to sexual misconduct the RCYCP may not engage in sexual misconduct with a client or a supervisee. Sexual misconduct includes, but is not limited to:

- Inappropriate sexual language.
- Sexual exploitation.
- Sexual harassment.
- Sexual behavior and.
- Therapeutic deception (suggesting that sexual contact, activity, or disclosure is part of the client's therapy or treatment).

The RCYP may not engage in either consensual or forced sexual behavior with:

- A client.
- A supervisee.
- An individual with whom the client has a close personal relationship if there is risk of exploitation or potential harm to the client.

With regard to sexual harassment, the RCYCP :

- May not sexually harass a client or supervisee.
- If sexually harassed by a client, the RCYCP must seek professional consultation with another licensed health professional, as well document it in the client's record.

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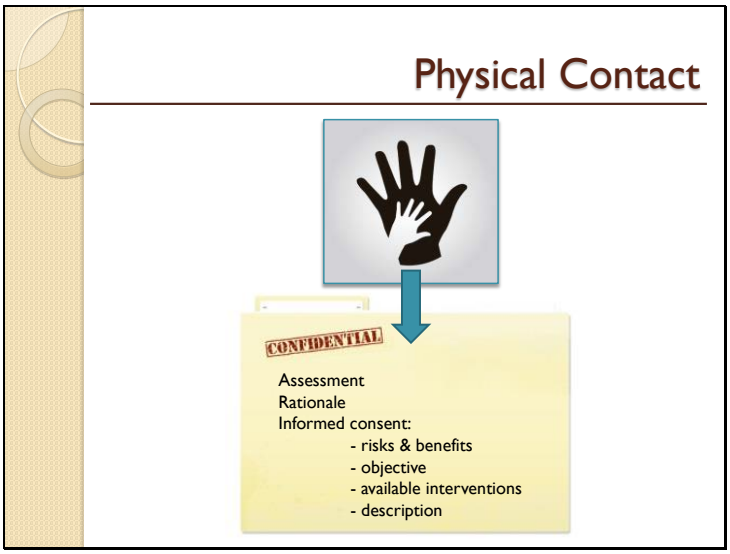

Physical Contact

If the RCYCP must have physical contact with a client as part of an accepted component of treatment, it must be documented in the client's record with the following:

- An assessment of the client.
- A written rationale for the use of the specific treatment for the client.
- A copy of the informed consent that is signed by the client and a licensed health care professional which addresses:
  - The risks and benefits of the treatment modality.
  - The objective or objectives and intended outcome or outcomes of the proposed treatment.
  - Available alternative interventions, and . . .
  - A description of the physical contact which may reasonably be anticipated by the client during the course of treatment.

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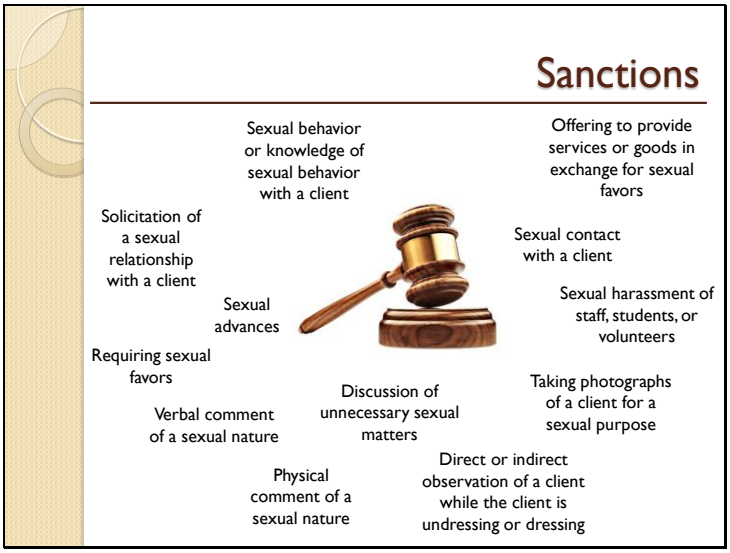

Sanctions

An RCYCP is subject to sanctions if s/he has engaged in sexual misconduct with a client or supervisee or has engaged in sexual behavior that would be considered unethical or unprofessional according to the professional standards of conduct, which include but are not limited to:

- Sexual behavior or knowledge of sexual behavior with a client.
- Solicitation of a sexual relationship with a client.
- Sexual advances, requesting sexual favors or both.
- A verbal comment of a sexual nature.
- Physical contact of a sexual nature.
- Discussion of unnecessary sexual matters.
- Direct or indirect observation of a client while the client is undressing or dressing.
- Taking photographs of a client for a sexual purpose.
- Sexual harassment of staff, students, or volunteers.
- Sexual contact with a client.

or

- Offering to provide services or goods in exchange for sexual favors.

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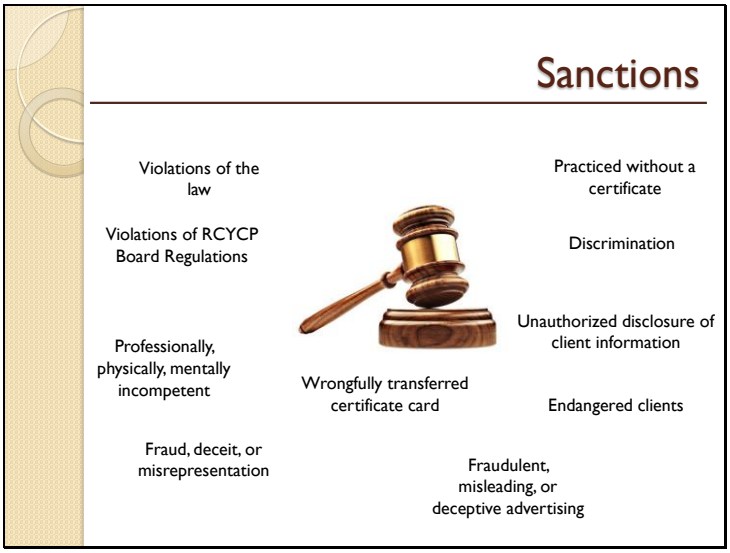

An RCYCP is also subject to sanctions for violating any provisions of the:

- Law pertaining to the profession of residential child and youth care.
- Regulations of the Board that pertain to RCYCPs.

Or if an RCYCP:

- Is professionally, physically, or mentally incompetent to act as an RCYCP.
- Has practiced fraud, deceit, or misrepresentation in the capacity of being an RCYCP.
- Has wrongfully transferred or surrendered his/her certificate card to any other individual.
- Has used fraudulent, misleading, or deceptive advertising.
- Has endangered or allowed the endangerment of the safety, health, and life of any client.
- Has willfully permitted unauthorized disclosure of information relating to a client's record.
- Has discriminated against clients, employees, or staff on the basis of race, religion, color, national origin, disability, gender, sexual orientation, or any other area that Board deems inappropriate or has practiced as an RCYCP without a certificate.
- For additional information on sanctions, re-hearings, and appeals, please visit the website and read through the COMAR regulations.

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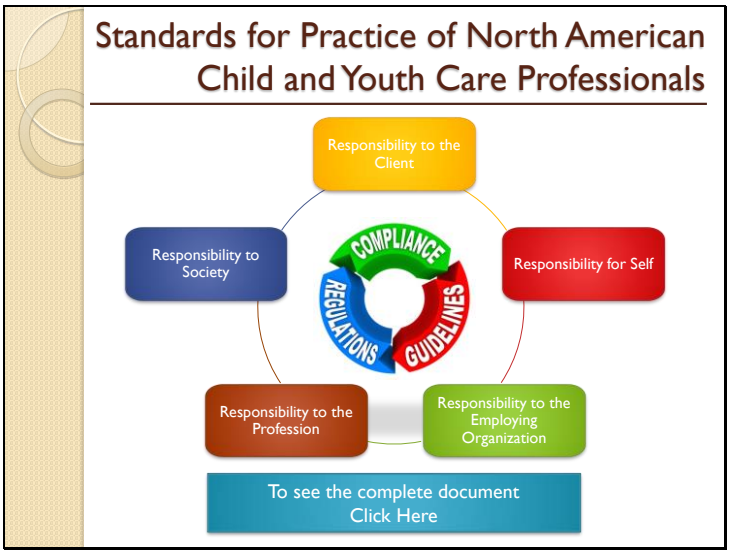

Standards for Practice of North American Child and Youth Care Professionals

“Everything you do as a youth care professional has the potential to be therapeutic or exploitive. How you wake residents up in the morning or assist them in getting to sleep at night, how you listen as they talk about their home visits, all have the potential to be helpful or hurtful” (NCJRS, p.24).

In addition to following the ethical guidelines that are specific to RCYCPs in Maryland, you should be familiar with the Standards for Practice of North American Child and Youth Care Professionals. This code was written by professionals in the field to convey the highest standards of care for children and young people.

In this webinar you will get an overview of these standards. You may click on the link below to see the complete document:

http://www.acycp.org/standards/CYC%20Ethics%20Code%20Rev%209.2009.pdf
Click on the boxes to hear the standards.

Responsibility to the client: Above all else, do not harm the child, youth, or family. That means not being disrespectful, degrading, dangerous, exploitive, intimidating, psychologically damaging or physically harmful to clients. This includes maintaining proper boundaries between yourself and your clients – a relationship that is professional, respectful, and appropriate. Sexual

intimacy with a client or the family member of a client is unethical. You respect the privacy of clients and keep information confidential unless otherwise specified. It also means ensuring that you are sensitive and non-discriminatory toward clients. Your professional responsibility is to the client and you should always be advocating for the client's best interest. Finally, in your responsibility toward clients and families, you must recognize and respect the differences in the life circumstances of clients and their families, as well as the differences in the needs of the clients and their families.

Responsibility for Self: As an RCYCP you are responsible for maintaining the highest standards of professional conduct. You take responsibility for your professional knowledge and abilities. That means that you maintain your competency – getting training, education, supervision, experience, and guidance as needed. You must be aware of your own values and their implication for practice. It also means that you maintain your physical and emotional well-being so that you are the best professional that you can be.

Responsibility to the Employing Organization: As an RCYCP you have made a commitment to help the youth with whom you work. You have also made a commitments to the organization that hired you, and as such, you must respect those commitments. As an employee you must treat colleagues with respect, courtesy, fairness, and good faith. And while your colleague's clients are not your own, it goes without saying that you must relate to the clients of colleagues with professional consideration as well.

Responsibility to the Profession: As an RCYCP your responsibility to the profession requires you to practice ethically, such that you are guided in your professional practice by these standards, as well as those set out by COMAR. In addition to your own professionalism, your responsibility to the profession means that you report ethical violations by others when you are aware of them. It also means collaborating with colleagues to provide the best possible outcomes for the youth with whom you work.

Responsibility to Society: As an RCYCP you have a responsibility to society on a broader level by promoting understanding and facilitating acceptance of diversity in society. You give back to society in other ways as well, for example, by demonstrating the standards of this Code with students and volunteers.

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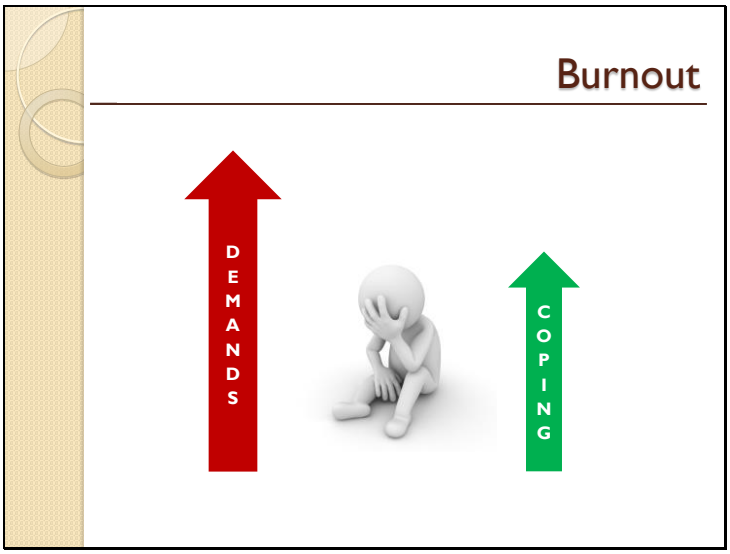

Burnout

Your job as an RCYCP can be extremely rewarding. Like all jobs, however, it can have its challenges as well. In particular, professionals in this field can experience what are known as Job Burnout and Compassion Fatigue. In order to take care of yourself, to keep your job as fulfilling as possible, and to continue to be a successful professional, it is important that you understand what these two conditions are, recognize their symptoms, and learn strategies to avoid or minimize their effects.

Job burnout can happen when someone experiences long-term emotional and interpersonal stress on the job. Burnout can lead to complete exhaustion that is physical, mental, and/or emotional. There are many causes of burnout, and they often occur in human service jobs where there are high emotional demands and a challenging work pace. Burnout is not considered a sign of personal weakness or bad attitude, but more due to the situation. The demands of this work are very high.

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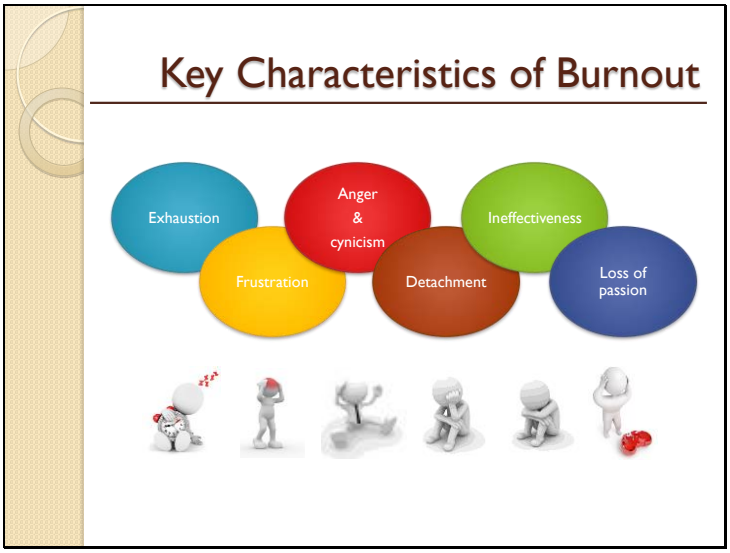

Key Characteristics of Burnout

The key characteristics of burnout include:

- Overwhelming exhaustion – feeling emotionally drained and used up, lacking energy to face another day or another person in need.
- Feelings of frustration, anger, and/or cynicism, along with negative or unusually detached response to other people
- Finally, burnout includes a sense of ineffectiveness and failure on the job, along with a loss of professional idealism and passion

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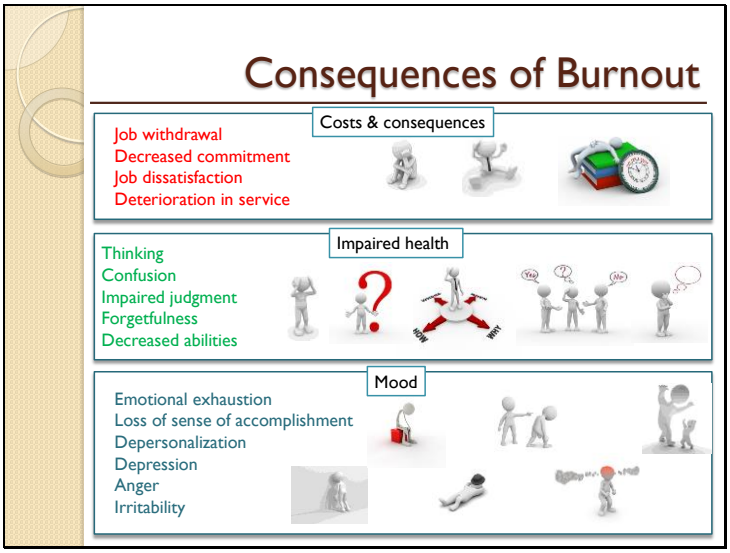

Consequences of Burnout

There are many costs and consequences of burnout. People with burnout experience job withdrawal, including decreased commitment, job dissatisfaction, turnover, and absenteeism. Understandably there is a deterioration in the quality of care and services provided to clients.

People with burnout also experience impaired health, including:

- Problems with thinking such as confusion, impaired judgment and decision-making, forgetfulness, decreased ability to identify alternatives, prioritize tasks, and evaluate one's own performance
- There are also problems with mood such as emotional exhaustion, loss of sense of personal accomplishment and merit, depersonalization and alienation, depression, and easy excitability, anger, and irritability

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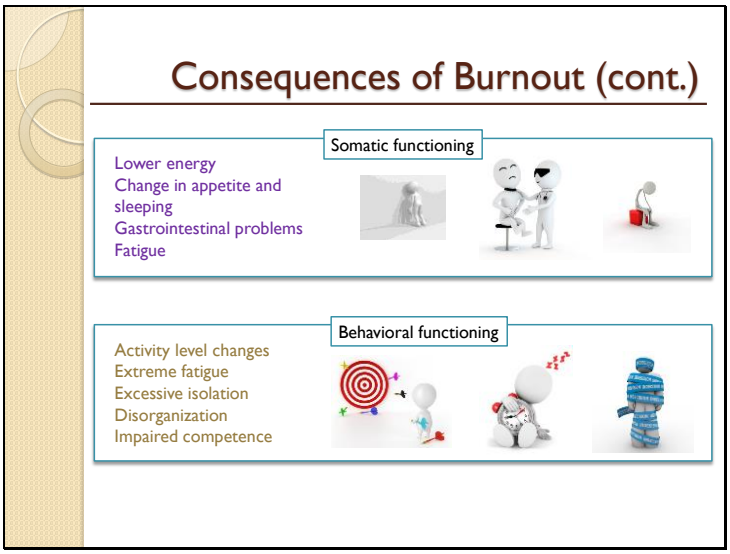

Other problems include:

- Problems with somatic functioning such as lower energy level, change in appetite and sleeping, gastrointestinal problems, imagined ailments, and fatigue
- And problems with behavioral functioning such as increased or decreased activity level, extreme fatigue, excessive isolation from co-workers, family, and clients; disorganization, misplacing of items, and impaired competence on the job

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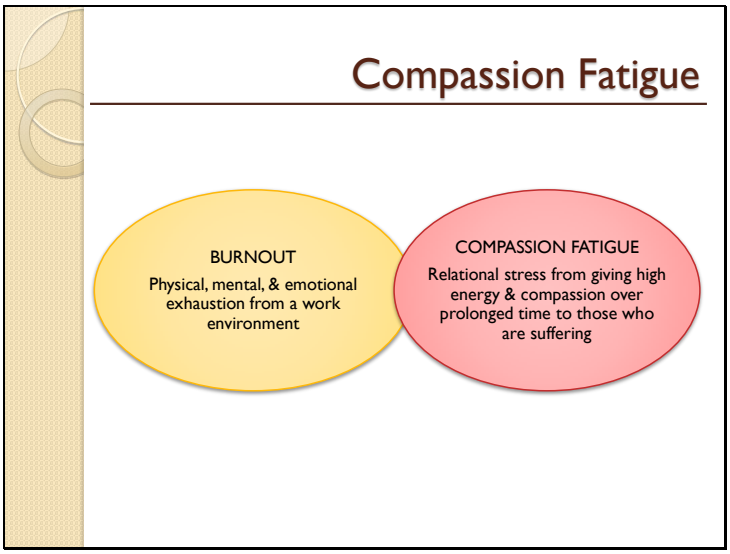

Compassion Fatigue

Burnout and Compassion Fatigue are closely related, but not the same. Burnout tends to reflect the physical, mental, and emotional exhaustion from work environment stressors. Compassion Fatigue, on the other hand, is more about relational stress, resulting from giving high levels of energy and compassion over a prolonged period of time to those who are suffering. When we have difficulty helping the suffering of others we feel guilt, hopelessness, distress, and those take a toll on us emotionally.

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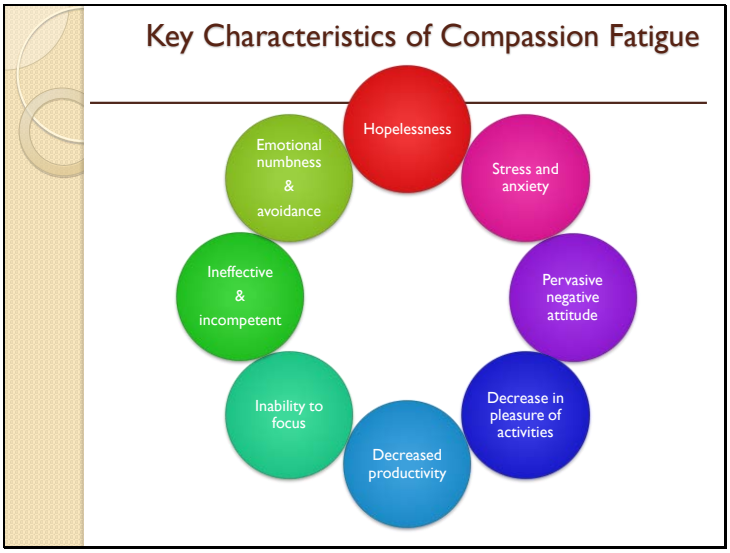

Key Characteristics of Compassion Fatigue

The key characteristics of compassion fatigue include:

- Feelings of hopelessness.
- Constant stress and anxiety.
- A pervasive negative attitude.
- Decrease in the pleasure of activities that one used to enjoy.
- Decreased productivity.
- Inability to focus.
- Feeling professionally ineffective and incompetent and . . .
- Emotional numbness or avoidance.

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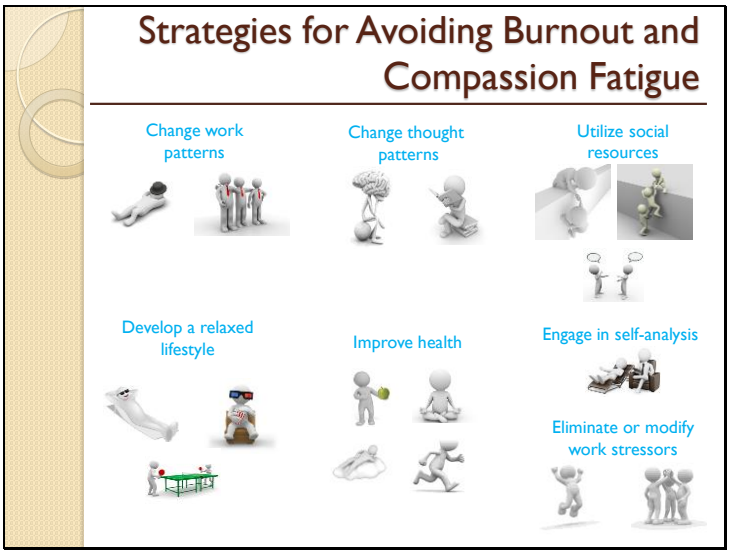

Strategies for Avoiding Burnout and Compassion Fatigue

So how do you avoid burnout and compassion fatigue? Here are some strategies to try:

Change your work patterns by:

- Slowing down your pace of work.
- Taking regular breaks from work.
- Avoiding overtime.
- Finding balance between work and life.

You can also develop preventive coping skills by:

- Learning to change thought patterns (for example, you can reduce expectations, reinterpret the meaning of people's behavior, clarify your values, imagine new goals and next steps) or by . . .
- Sharing or venting your emotional feelings.
- Managing your time, and resolving conflicts.
- Be sure to utilize social resources such as . . .
- Getting professional support from colleagues.
- Getting effective guidance and support from supervisors and . . .
- Getting personal support from family and friends.

You may also help to prevent burnout and compassion fatigue by developing a relaxed lifestyle. You can:

- Use relaxation techniques such as biofeedback, meditation, massages, hot baths, yoga.
- You can engage in hobbies and . . .
- Develop positive interests in non-work related activities.
- You can also make improvements in health through.
- Nutrition.
- Exercise and . . .
- Sleep.

You may also engage in self-analysis by:

- Developing a better understanding of your own personality, needs, and motives.
- Therapy can be very helpful for this.
- Or by reducing your internal stressors . . .
- Articulating your own spiritual-philosophical values and ethics and . . .
- Considering how your personal ideals and aspirations interact with job conditions in the workplace.

Finally, you can identify and eliminate or modify work stressors.

It is important that if you recognize signs or symptoms of either burnout or compassion fatigue in yourself, you use the resources that are available to you at work to help you deal with them appropriately.

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Code of Ethics (Standards for North American Child and Youth Care Professionals_

COMAR Regulations

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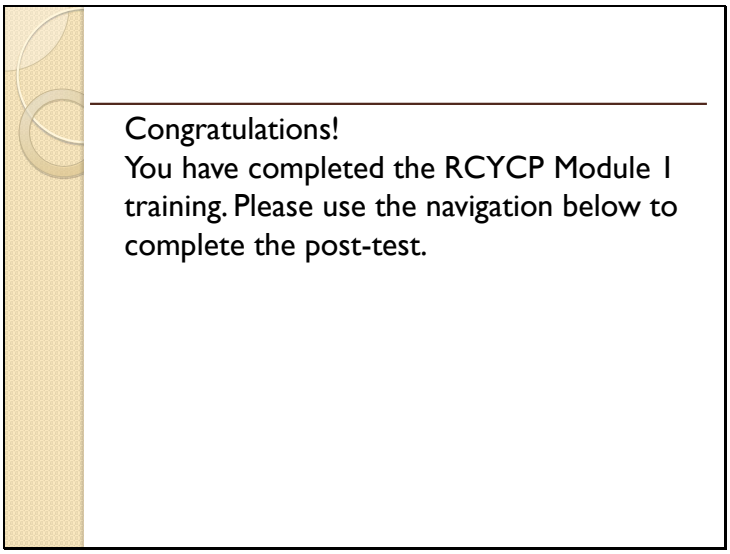

Congratulations! You have completed the RCYCP Module 1 training. Please use the navigation below to complete the post-test.

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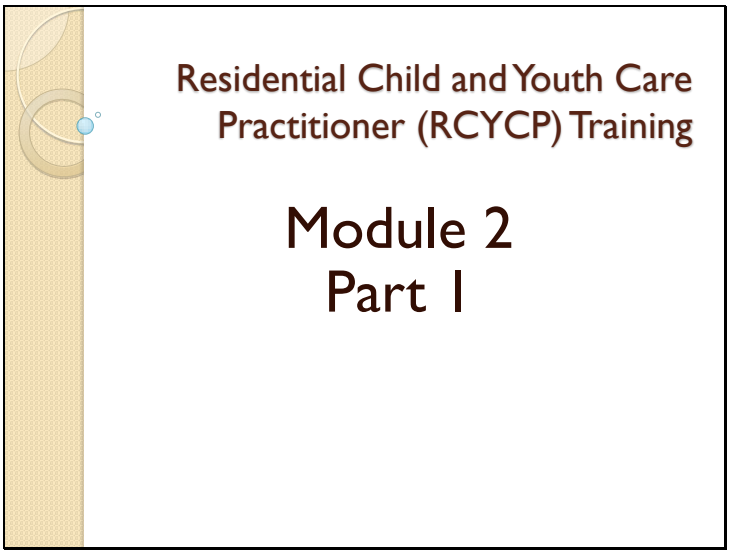

Residential Child and Youth Care Practitioner Training

Welcome to Module 2, Part 1 of the Residential Child and Youth Care Practitioner Training.

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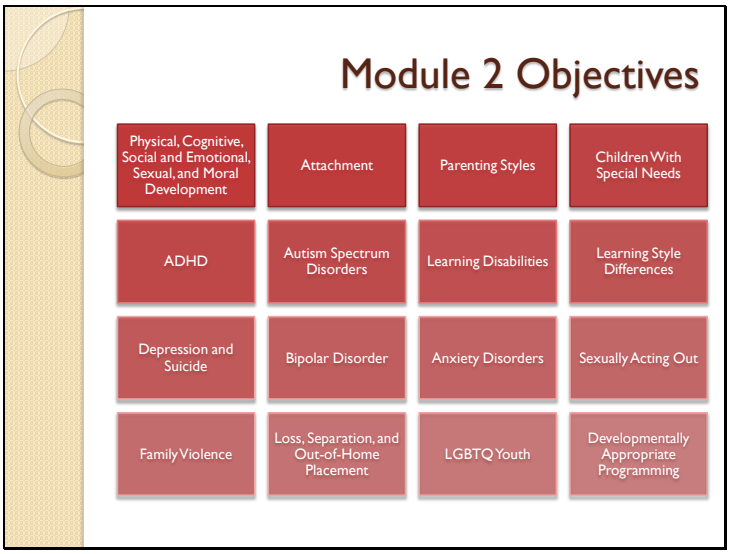

Module 2 Objectives

This module covers material about child and adolescent growth and development. Specifically, you will learn about:

1. Physical, cognitive, social and emotional, sexual, and moral development at all stages, beginning in infancy and continuing through adolescence. Additionally, you will learn about . . .
2. Attachment
3. Parenting styles
4. Children with special needs
5. Attention Deficit Hyperactivity Disorder, or ADHD
6. Autism Spectrum Disorders
7. Learning Disabilities
8. Learning Style Differences
9. Depression and suicide
10. Bipolar disorder
11. Anxiety disorders
12. Sexually acting out
13. Family violence
14. The impact of loss, separation, and out-of-home placement on youth
15. Lesbian, Gay, Bisexual, Transgender, and Questioning -- or LGBTQ -- youth, and
16. Developmentally appropriate programming for at-risk youth

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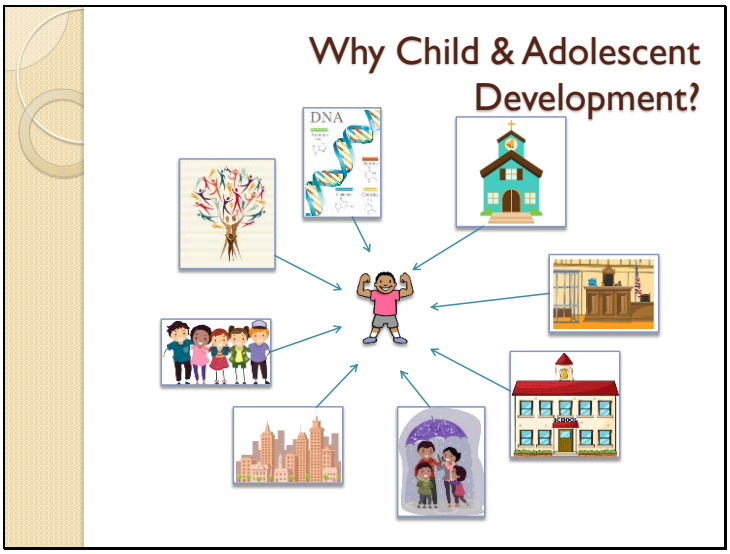

Why Child & Adolescent Development?

So why learn about child and adolescent development?

The answer is simple. Who we are as people is the result of our biology, as well as our relationships and our environment --- both nature and nurture. By understanding the developmental needs and important milestones in children's and adolescents' lives, you will be able to work with them more successfully and be better able to offer support and guidance to their families and communities.

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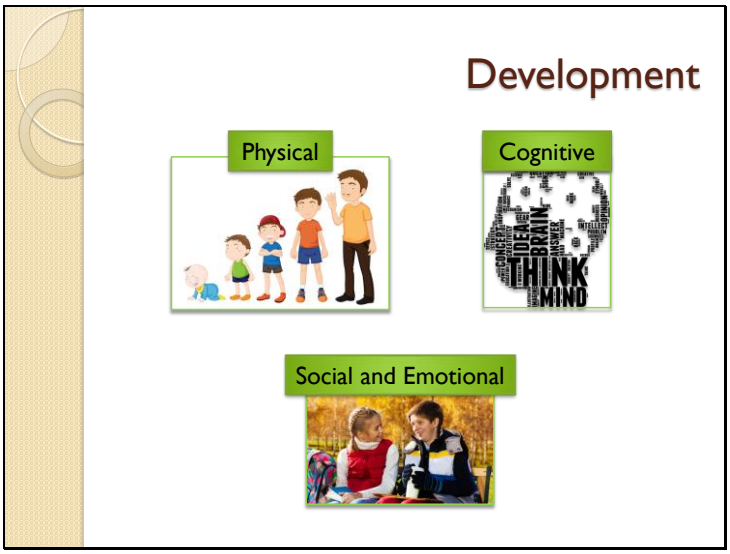

Development

Development is usually divided into 3 broad categories: physical development, cognitive development, and social and emotional development.

Physical development is concerned with children's bodies and how they change over time as a result of the normal process of maturing.

Cognitive development addresses children's mental process, including how they think and what they think about.

Social and emotional development pertains to how children manage relationships, including their ability to express needs, feelings, and desires within relationships.

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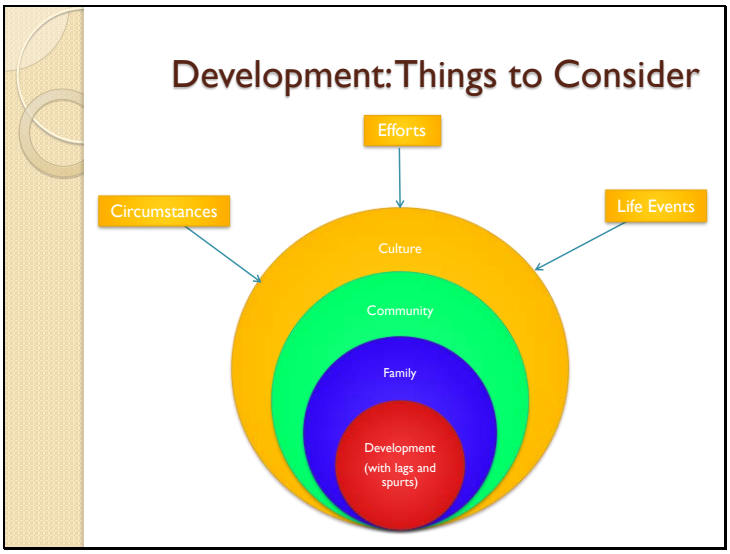

Development: Things to Consider

Some things to consider with regard to development include the following:

- Change is multi-directional. That is to say that change does not always occur in a straight line. It can have lags and spurts. A child might go through a period of quick change – for example, a growth spurt, plus learning to walk and learning to talk -- as well as a period where there is very little change for a while.
- Development occurs within multiple contexts, including one's family, one's community, and one's culture. For example, growing up in an abusive family environment has a significant impact on a child's social and emotional development.
- Human development is plastic in the sense that individuals can be molded through time by their circumstances, efforts, and unexpected events; at the same time, however, people maintain a certain amount of identity that is resistant to change.

In this section we will explore the developmental milestones for children and adolescents in the following domains: physical development (including sexual development), cognitive development (including moral development), and social and emotional development.

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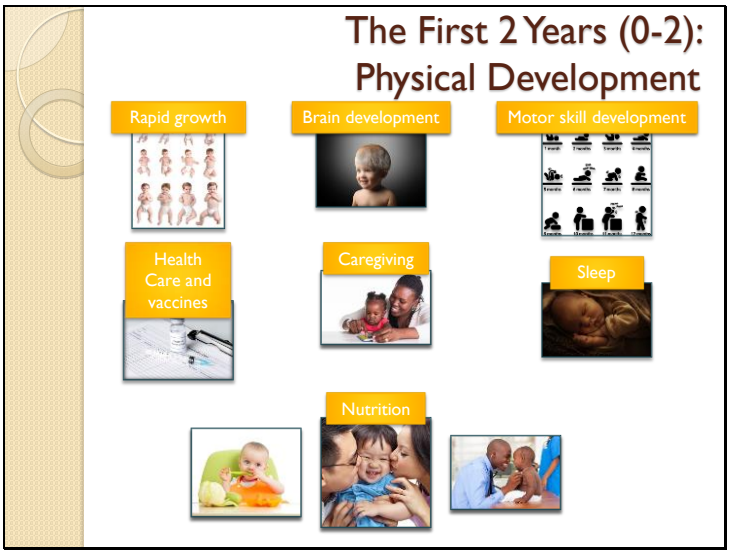

The First 2 Years (0-2): Physical Development

The first two years of a child's life are characterized by rapid growth in body, mind, and social relationships.

In terms of physical development, growth is rapid. For example, infants double their birth weight by 4 months and triple it by age one. Two year olds are approximately half of their adult height and about one fifth of their adult weight. Gains of weight and height are monitored closely by pediatricians.

Brain development is also rapid at this age. The brain increases dramatically in size and complexity. Experience and normal stimulation by parents and caregivers help to foster this very important brain development. For example, talking to babies, playing games like peek-a-boo, and singing all help brain development.

Infants gradually improve their motor skills as they begin to grow and the brain begins to mature.

Good physical health for infants is significantly influenced by health care and caregiving, proper nutrition, immunizations, and sleep. Throughout childhood, regular and ample sleep correlates with normal brain maturation, learning, emotional regulation, academic success, and

psychological adjustment. That is to say, getting enough good sleep is extremely important for proper development. On the other hand, lifelong sleep deprivation can lead to health problems.

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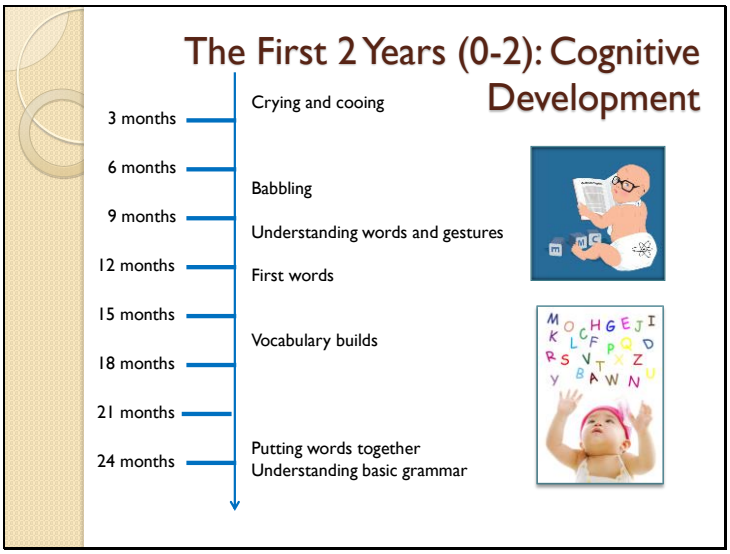

The First 2 Years (0-2): Cognitive Development

In terms of cognitive development, infants are smart and active learners, adapting to experience. They are like “little scientists.” Infants first react to their own bodies, then respond to other people and things. Eventually, infants become more goal-oriented, creative, and experimental. Infants gradually develop an understanding of objects. Researchers have found impressive intellectual capacities for infants by about 6 months of age.

Language learning might be the most impressive cognitive accomplishment of infants. Eager attempts to communicate are apparent in the first weeks and months of a baby’s life, through crying and cooing. Infants begin to babble at about 6 to 9 months, understand words and gestures by 10 months, and speak their first words at about one year. Vocabulary begins to build very slowly until the infant knows approximately 50 words. Toward the end of the second year, toddlers put words together, showing that they understand the basics of grammar.

Slide 9

The First 2 Years (0-2): Social and Emotional Development

In terms of social and emotional development, within the first two years of a child's life, babies progress from reactions primarily revolving around pain and pleasure to more complex patterns of social awareness and emotional responsiveness. Initially, newborns seem to have only two simple emotions: distress and contentment; either they are crying and fussing or peaceful. Soon, other emotions become recognizable, like social smiling, or smiling in reaction to interaction with others; laughter; and curiosity. By 4 to 8 months, infants start to express some additional negative emotions, such as anger in response to frustration (for example, when strapped into their car seats when they want to be exploring instead), and eventually, they start to express sadness and fear.

Slide 10

The First 2 Years (0-2): Social and Emotional Development

Infants in particular have two dominant types of fear: stranger wariness, which is fear in response to a stranger, and separation anxiety. Babies may begin to cry or act distressed, even exhibiting anger, if a familiar caregiver leaves.

Click on the video link at the bottom of the page to see what separation anxiety looks like: http://www.youtube.com/watch?v=Y6QtuU1L_A8 (separation anxiety video)

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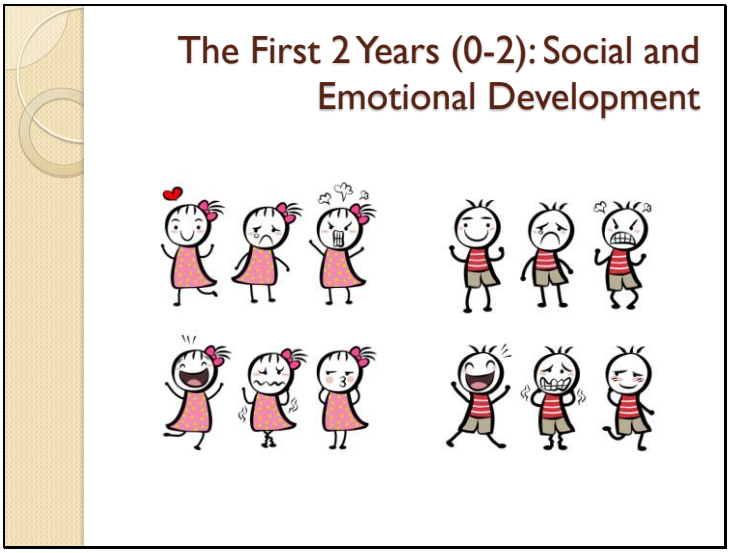

The First 2 Years (0-2): Social and Emotional Development

By their second year of life, toddlers have developed emotions that take on a new complexity and strength. There is more awareness of themselves and their interactions with others. Toddlers experience self-awareness, disgust, pride, shame, guilt, and embarrassment. Anger and fear become less frequent and more focused toward infuriating or terrifying experiences.

By age 2, children can display the entire spectrum of emotional reactions. They have been taught what is acceptable in their family and culture. For example, some cultures might encourage pride, while others might discourage pride and cultivate modesty and shame.

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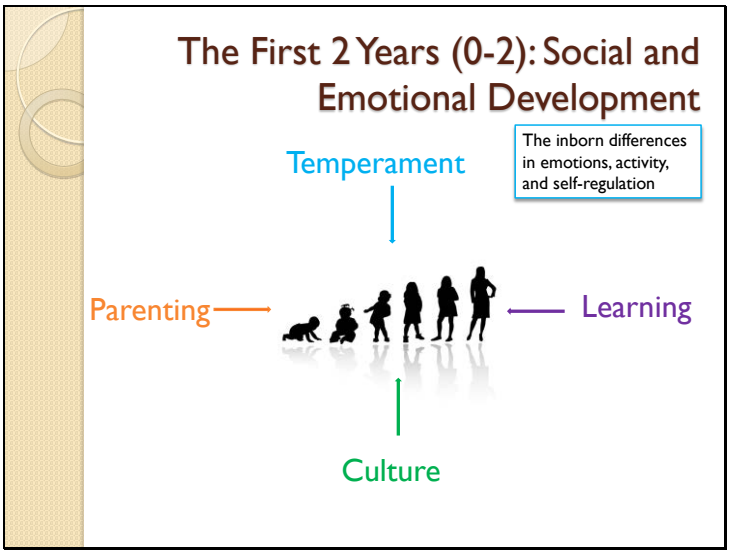
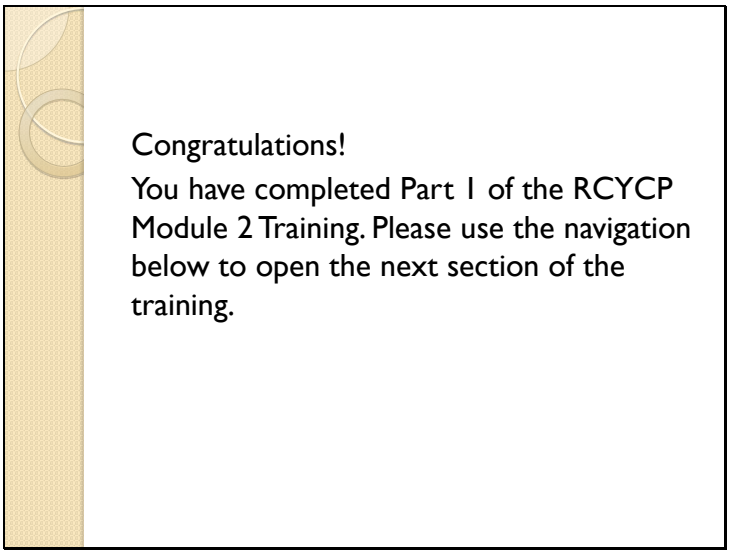


The First 2 Years (0-2): Social and Emotional Development

A child's temperament – that is, the inborn differences between one person and another in emotions, activity, and self-regulation – plays a role in emotional development as well. For example, traits such as shyness and aggression are generally thought to be part of one's temperament. Temperament is not the only component of a baby's emotional development, however. Personality traits such as honesty and humility, for example, are considered learned. Thus, babies grow into people whose genetic traits are shaped by their experiences – the result of parenting, culture, and learning.

Most important to the development of emotion is the relationship between parent and baby, or caregiver and baby. Let's turn now to a discussion of attachment.

Slide 16



Congratulations! You have completed Part 1 of the RCYCP Module 2 Training. Please use the navigation below to open the next section of the training.

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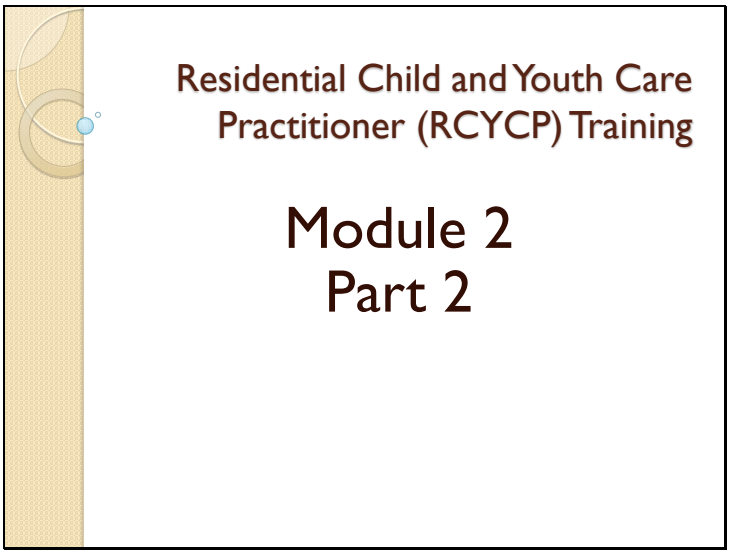

Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 2 of the Residential Child and Youth Care Practitioner Training.

Slide 3

Attachment

The concept of attachment is critical to understanding children – especially children who are mistreated or experience trauma. Attachment will be discussed here in module 2, but will be brought up again in module 7 when you learn about trauma.

Let's get started.

Attachment is a lasting bond between people. It begins before birth, solidifies by age 1, and influences relationships throughout life. Our attachment to our parents, formed when we were children, affects our behavior with our own children, as well as our relationship with our partners. Attachment is a universal trait that is important from an evolutionary standpoint to ensure the survival of the species. Historically, proximity-seeking - that is, staying near a caregiver - and contact-maintaining, or staying in physical contact with a caregiver, fostered the survival of the species by keeping toddlers near their caregivers and keeping caregivers constantly aware of potential outside danger.

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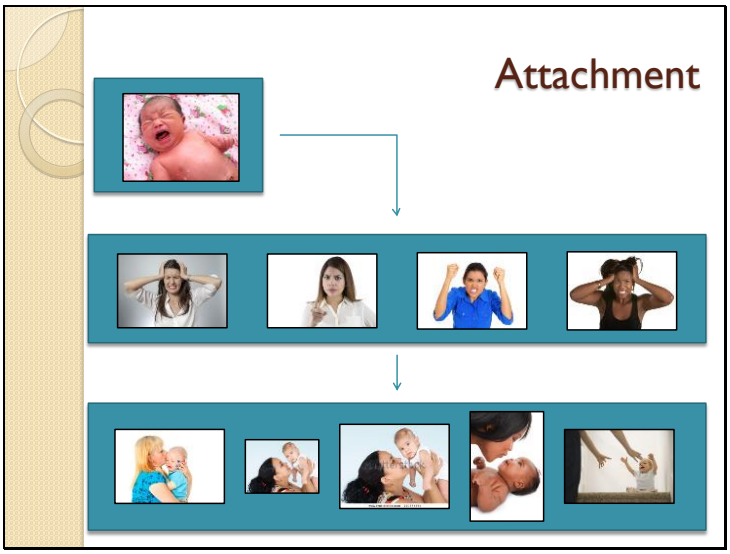

The quality of attachment that an infant develops with a specific caregiver is largely determined by the caregiver's response to the infant. By response, we are referring to how the caregiver reacts to and treats the infant when the infant's feelings of safety and security are threatened: for example, how the caregiver reacts when the infant is ill, physically hurt, emotionally upset, or frightened.

A pattern then develops: Baby is distressed, caregiver responds, baby reacts to caregiver. So by about 6 months of age, and based on these patterns, infants begin to anticipate their caregivers' responses to their distress, and their behavior adjusts accordingly. Let's look at how this works.

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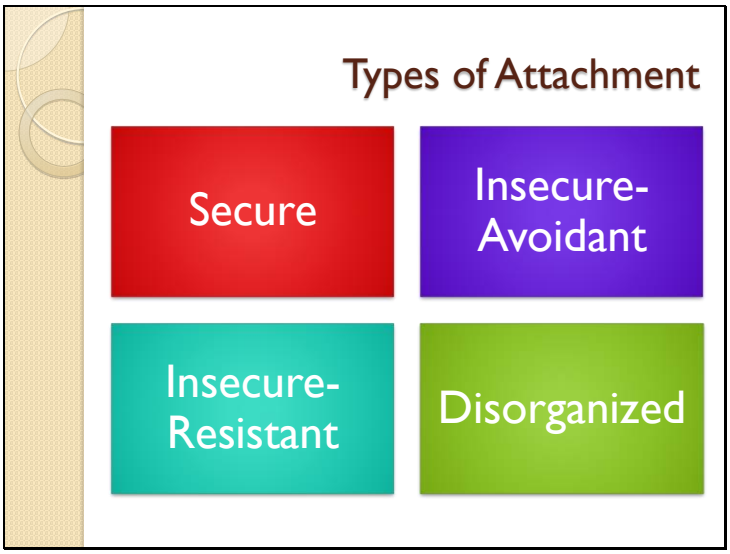

Types of Attachment

There are 4 types of infant-parent attachment: secure, insecure-avoidant, insecure-resistant, and disorganized.

Slide 6

Secure Attachment

When infants are distressed, caregivers who consistently respond in sensitive or “loving” ways, such as picking the infant up promptly and reassuring the infant, make infants feel secure in the knowledge that when they cry, they will then be comforted by their caregiver.

Slide 7

They also seek proximity, or physical closeness, to the caregiver, and maintain contact with the caregiver until they feel safe. These infants are "secure" in their attachment to their caregiver. For example: a toddler might scramble down from the caregiver's lap to play with an interesting toy, but occasionally look back, vocalize a few syllables, or return for a hug. Or, a caregiver's departure may cause distress, but the caregiver's return elicits a positive reaction, like smiling, hugging, and then more playing.

Securely attached infants will be concerned but not completely overwhelmed by a caregiver's leaving.

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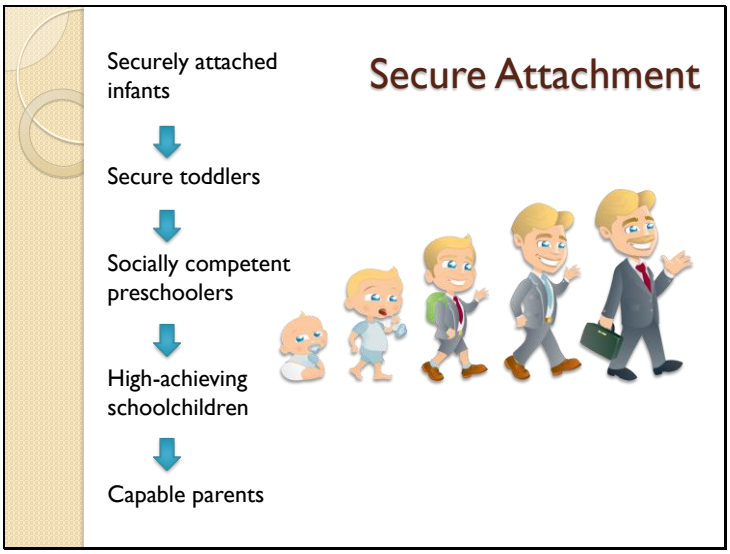

Research has shown that having a loving primary caregiver and developing a secure attachment to that primary caregiver help to protect children from social and emotional difficulties.

The attachment has a lifelong effect, too. Securely attached infants are more likely to become secure toddlers, socially competent preschoolers, high-achieving schoolchildren, and capable parents.

About two-thirds of infants are securely attached. The remaining one-third of infants fall into the insecure attachment categories that will be discussed next.

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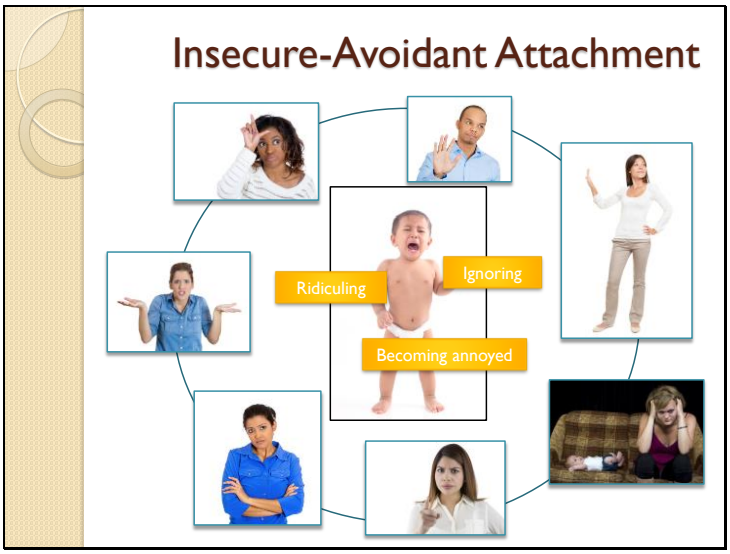

Insecure-Avoidant Attachment

When caregivers consistently respond to distress in insensitive or rejecting ways, such as ignoring, ridiculing, or becoming annoyed, infants develop a strategy for dealing with distress that is “insecure and avoidant.” Essentially, they avoid their caregiver when distressed and try not to show negative emotion in the presence of the caregiver, because they don’t want to be rejected. This happens even though there is still a deep desire to get the kind of comfort that securely attached infants receive from their caregivers. As you might guess, this avoidance strategy is a poor one and increases the risk for developing adjustment problems.

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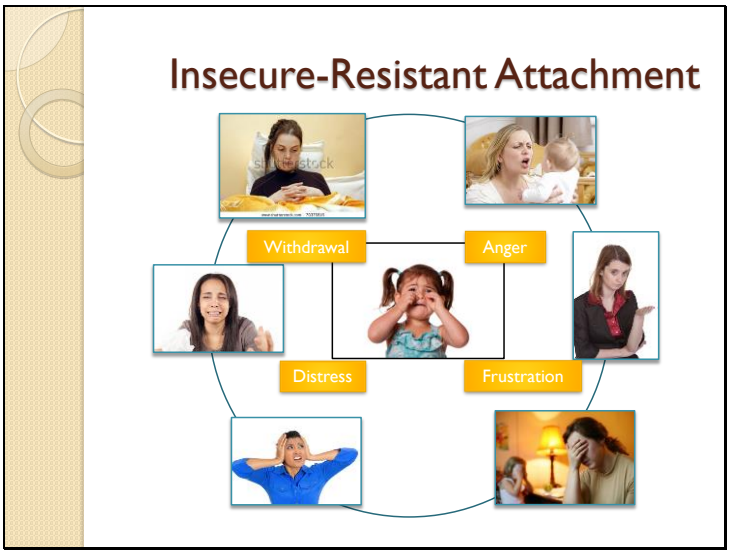

Insecure-Resistant Attachment

When infants have caregivers who respond in inconsistent, unpredictable, and/or 'involving' ways, such as expecting the infant to worry about the caregiver's own needs, or increasing the infant's distress, they develop a strategy that is "insecure and resistant." They tend to display extreme negative emotion to draw the attention of their inconsistently responsive caregiver. Essentially, by exaggerating anger and distress, they are hoping that they can elicit a response from the inconsistently responsive caregiver. This attachment style is also associated with an increase in the risk of developing social and emotional maladjustment.

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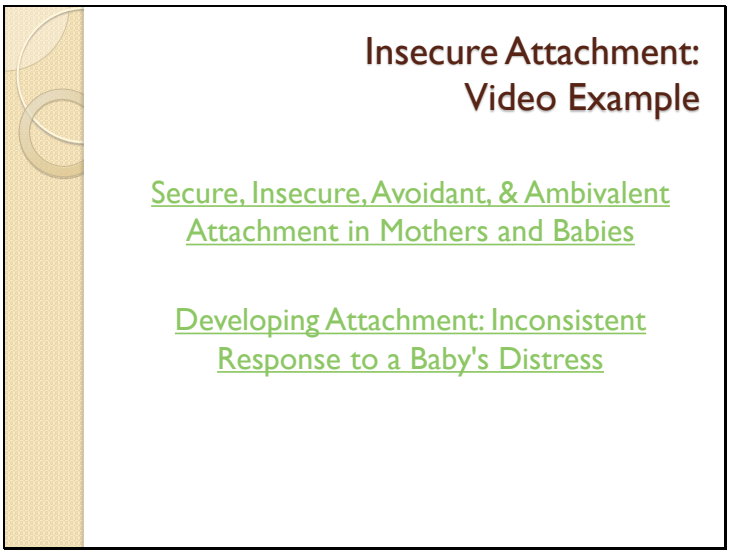

Insecure Attachment: Video Example

Click on the links to see some examples of insecure attachments:
Secure, Insecure, Avoidant, & Ambivalent Attachment in Mothers & Babies:
http://www.youtube.com/watch?v=DH1m_ZMO7GU

Developing Attachment: Inconsistent Response to a Baby's Distress:
http://www.youtube.com/watch?v=8BA8CcEUP84

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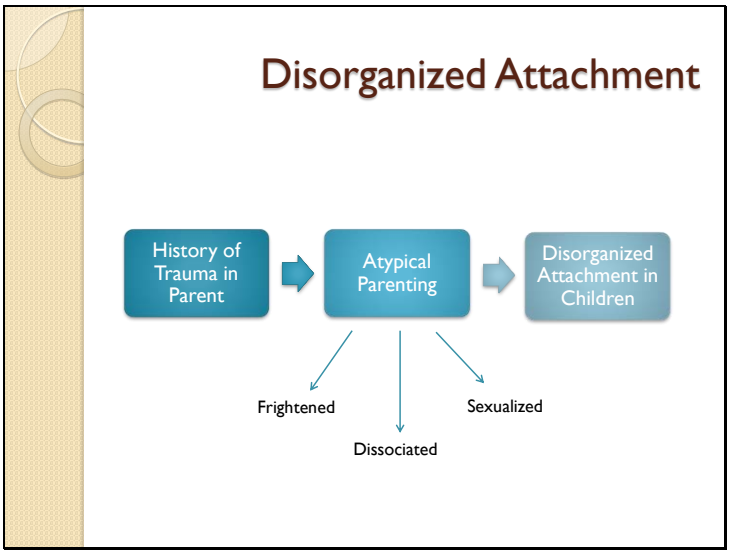

Disorganized Attachment

Finally, infants who are exposed to unusual parenting and to caregiver behaviors that are 'atypical,' such as frightening, frightened, dissociated, sexualized, or otherwise out of the ordinary behaviors, exhibit "disorganized" attachment. This type of attachment is also considered "insecure." Research suggests that caregivers who display atypical behaviors often have a history of unresolved mourning or unresolved emotional, physical, or sexual trauma, or are otherwise traumatized. So, for example, a mother who was traumatized as a child may inadvertently display unusual or unhealthy parenting behaviors that create a disorganized attachment in her children.

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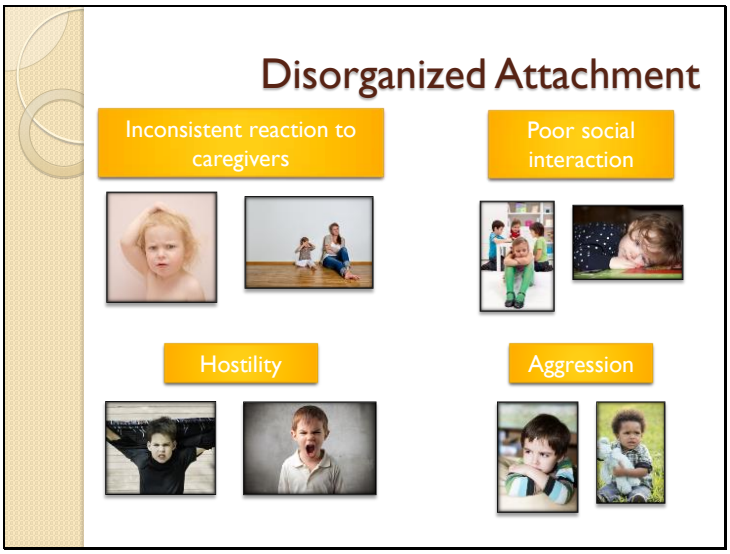

Infants who have a disorganized attachment react to their caregivers in inconsistent ways, like shifting from distress to anger to avoidance within a single interaction. For example, such toddlers might shift from hitting to kissing their mothers, from staring blankly to crying hysterically, or from pinching themselves to freezing in place.

Disorganization prevents them from developing a strategy for social interaction (even an avoidant or resistant one). Sometimes they become hostile and aggressive, and difficult for anyone to relate to.

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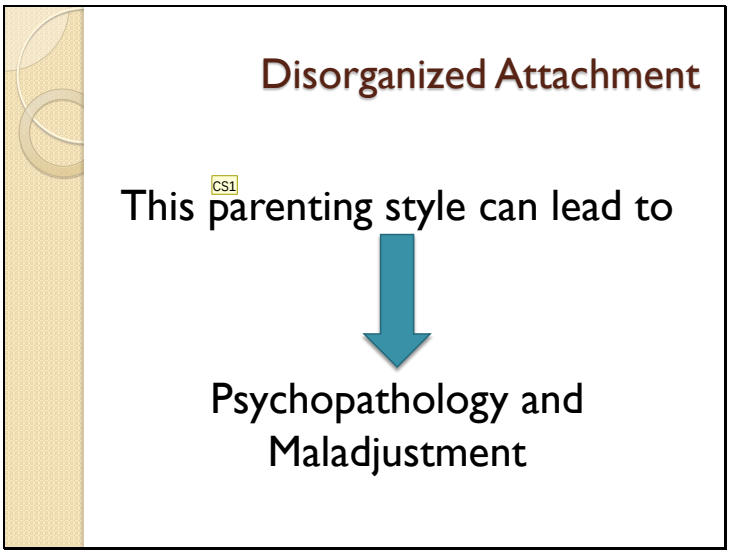

This attachment style is recognized as a significant predictor for serious psychopathology – or psychological and behavioral dysfunction -- and maladjustment in children.

They are more vulnerable to stress, have problems regulating and controlling their emotions, and display oppositional, hostile, and aggressive behaviors, and coercive styles of interaction.

This type of attachment style is over-represented in groups of children with clinical problems, and those who are victims of maltreatment. So, for example, in the general population, about 5-10% of infants are this type, but nearly 80% of maltreated infants have a disorganized attachment.

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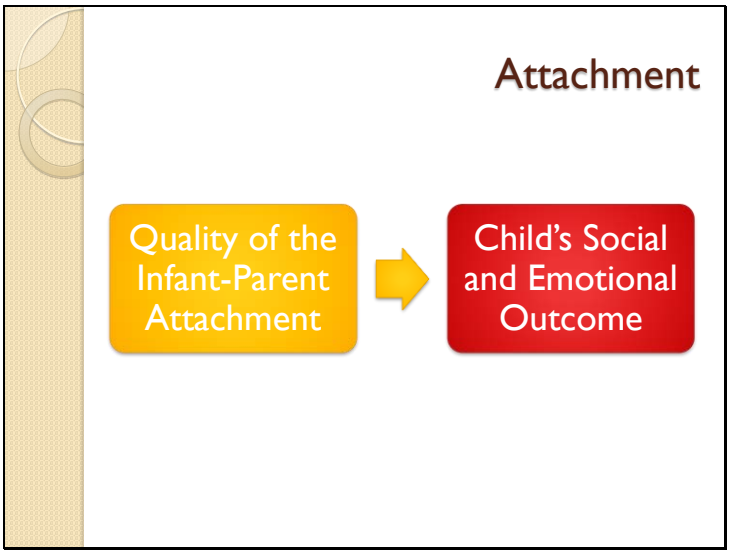

Attachment

As we have shown, the quality of the infant-parent attachment is a powerful predictor of a child's later social and emotional outcome.

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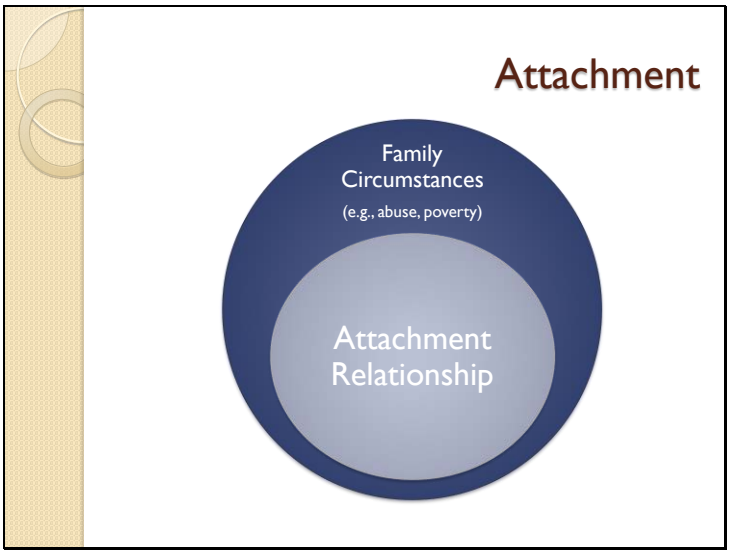

One thing to note, however, is that attachment status may shift with family circumstances. For example, abuse or the stress of poverty can make secure attachment less likely. While it may seem strange, children develop attachment relationships with even the most abusive and neglectful caregivers. The question is never, 'is there an attachment between this parent and child?' but rather, 'what is the quality of the attachment relationship between this parent and child?' Attachment as it relates to abuse and neglect will be discussed in more detail later.

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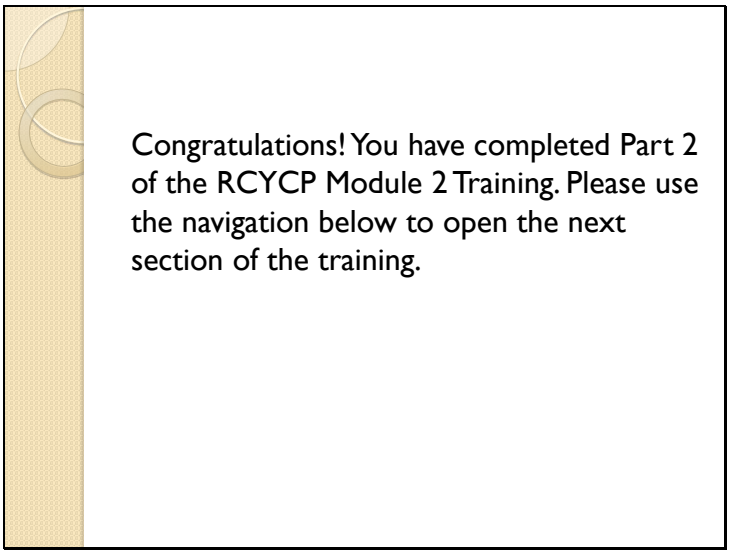

Congratulations! You have completed Part 2 of the RCYCP Module 2 Training. Please use the navigation below to open the next section of the training.

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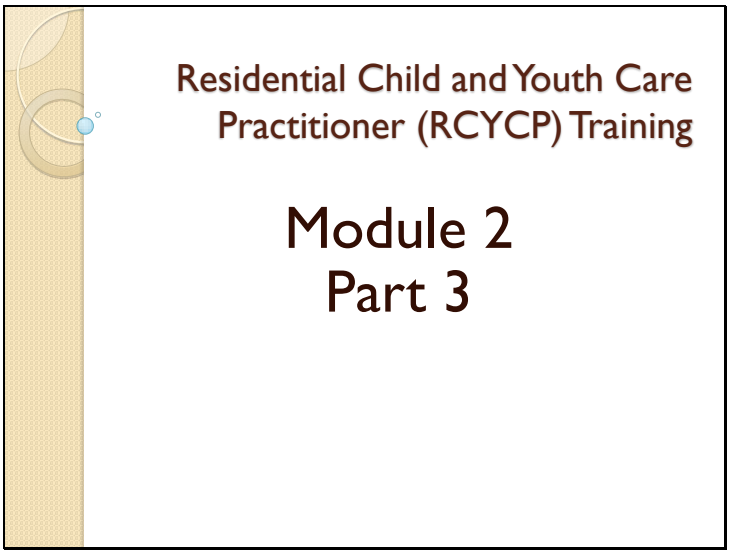
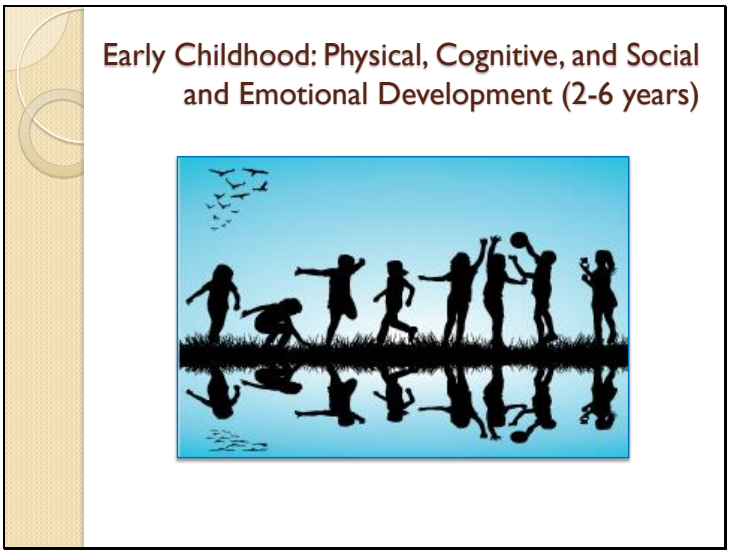


Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 2, Part 3 of the Residential Child and Youth Care Practitioner Training.

Slide 3



Early Childhood: Physical, Cognitive, and Social and Emotional Development (2-6 years)

Also known as the “preschool years” and sometimes the “play years”, early childhood is a period of extraordinary growth in every domain. Children this age spend most of their waking hours discovering, creating, laughing, chasing, and attempting new challenges with their developing bodies. They play with sounds, words, and ideas, and engage in creative and dramatic play, both by themselves and with others.

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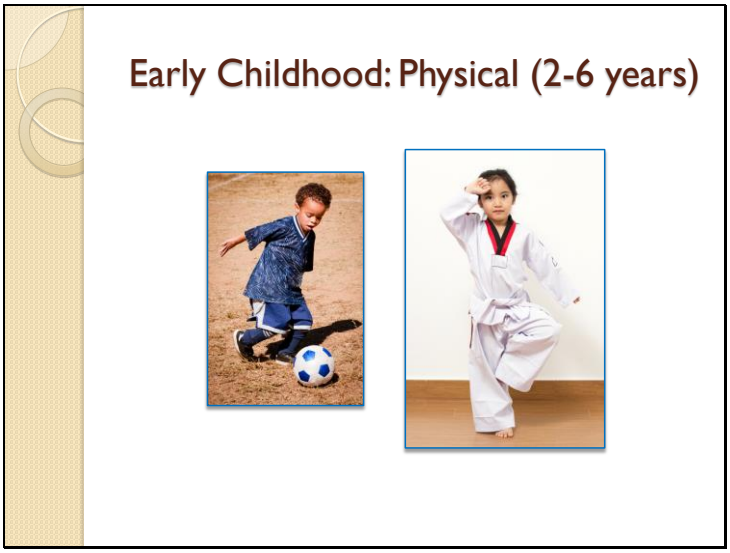

Early Childhood: Physical (2-6 years)

In terms of physical development at this stage, children continue to gain weight, grow taller, and slim down. Their lower body lengthens and their fat is replaced by muscle.

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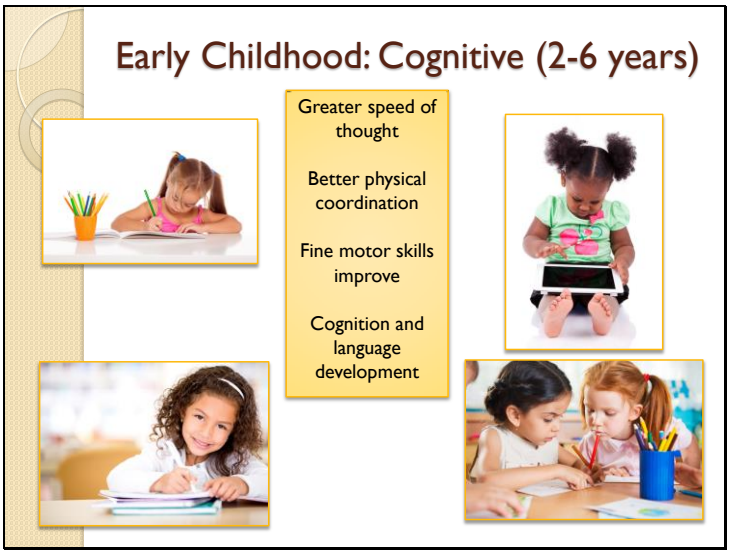

Early Childhood: Cognitive (2-6 years)

Most of the brain is functioning by age 2. There is a greater speed of thought – essentially more efficient information processing. These changes allow for children to think before they act and be less impulsive.

The maturation of the brain allows for better physical coordination, such as improved speed and grace. Fine motor skills such as writing significantly improve at this age as well.

Cognition develops rapidly from age 2-6, as does language. Today, many 3- to 6-year-olds are in school. Research suggests that there is rapid development and great learning potential in the early years, which makes preschool a valuable resource.

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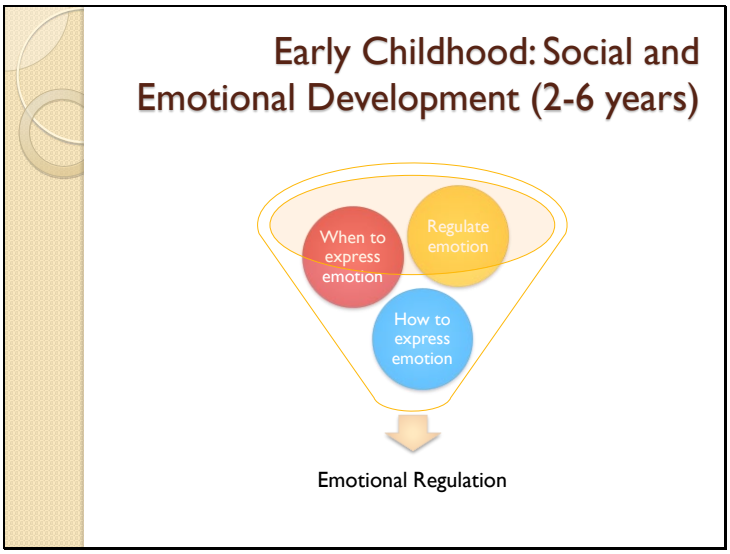

Early Childhood: Social and Emotional Development (2-6 years)

With regard to social and emotional development, during early childhood children learn to regulate and control emotions. They learn when and how to express emotions in a controlled manner. For example, they learn how to be angry without becoming explosive, how to be scared, but not terrified, and how to be sad, but not inconsolable.

Emotional regulation becomes possible as a result of brain maturation.

Slide 7

Children who have difficulty with emotional regulation may develop internalizing or externalizing problems.
Internalizing problems: Involves turning one's emotional distress inward, such as by feeling excessively guilty, ashamed, or worthless.
Externalizing problems: Involves expressing powerful feelings through uncontrolled physical or verbal outbursts, such as by lashing out at other people or breaking things.

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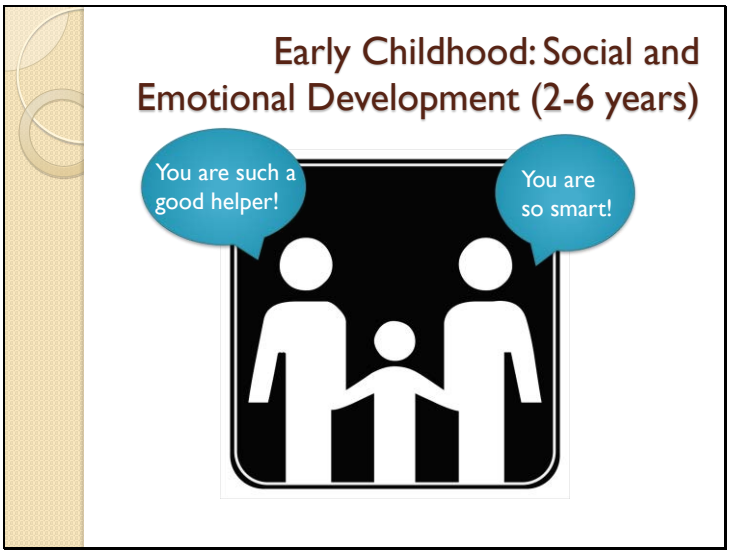

Children's beliefs about their worth are connected to parental confirmation. Parents confirm children's worth through comments such as "you are such a good helper," and remind them of their positive accomplishments. Throughout this process, children form their self-concept, which is their understanding of themselves with regard to their self-esteem, appearance, personality, and various other traits. Self-esteem tends to be high during early childhood.

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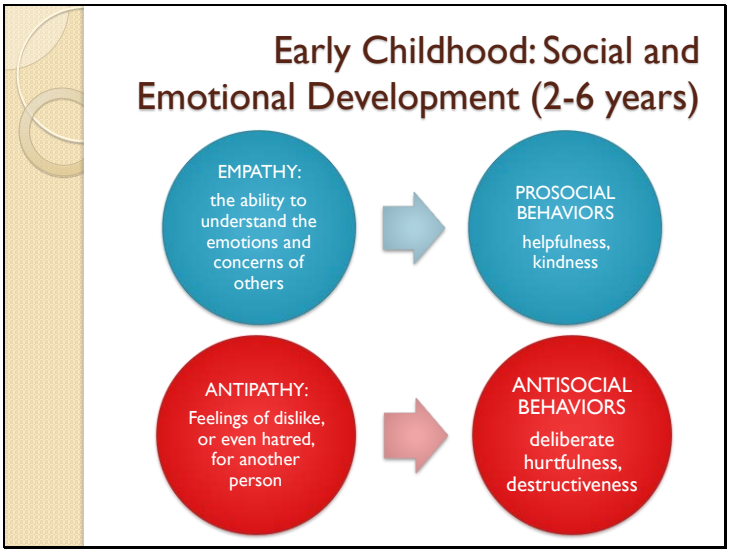

During early childhood children develop emotions of empathy and antipathy.

Empathy: the ability to understand the emotions and concerns of another person – especially when they differ from one's own.

Antipathy: feelings of dislike or even hatred for another person.

Empathy leads to prosocial behaviors, such as helpfulness and kindness, without any benefit to oneself. For example, a child experiencing empathy might express concern or offer to share food or a toy. On the other hand, antipathy can lead to antisocial behavior such as deliberate hurtfulness or destructiveness aimed at another person, including people who have not actually harmed the antisocial person. This can be seen in verbal insults, social exclusion, and physical assaults.

By age 4 and 5 most children can be deliberately prosocial or antisocial.

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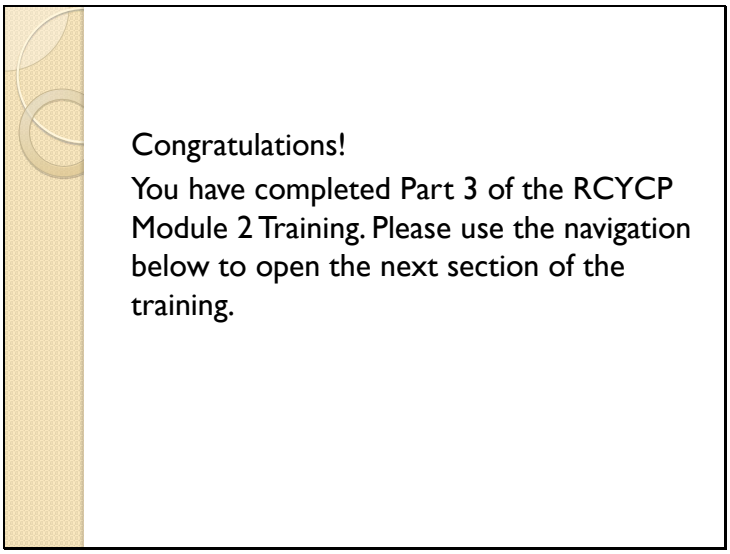

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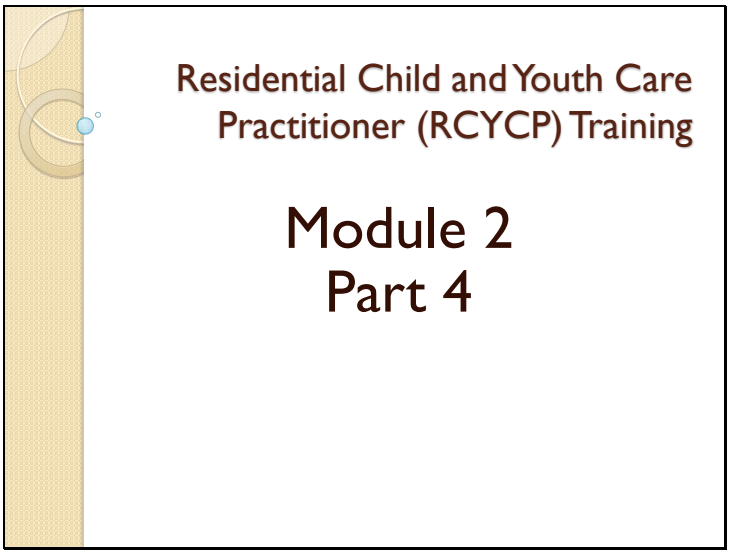

Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 2, Part 4 of the Residential Child and Youth Care Practitioner Training.

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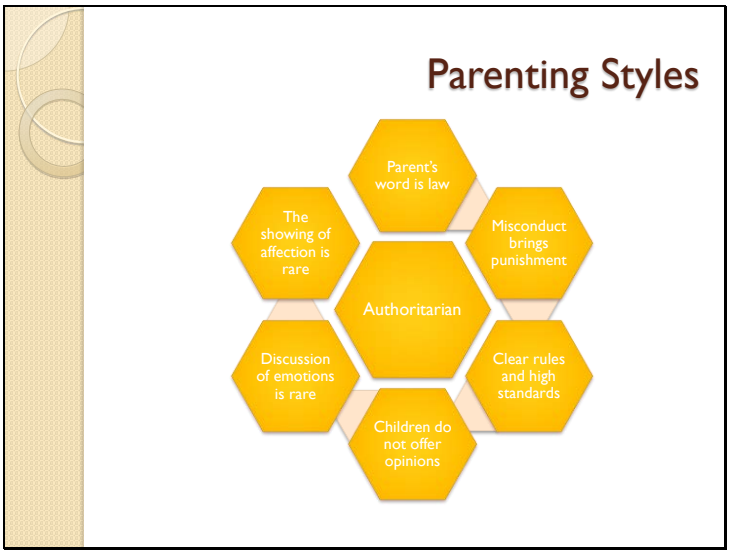

Parenting Styles

There are 3 major styles of parenting that differ on the dimensions of expressions of warmth, strategies for discipline, communication, and expectations for maturity. Let's talk about each one separately:

1. In "authoritarian" parenting:
   a. The parent's word is law. It should not to be questioned.
   b. Misconduct brings strict punishment (usually physical, but not so harsh as to be considered abusive).
   c. Parents set down clear rules and hold high standards.
   d. They do not expect children to offer opinions.
   e. Discussion about emotions is especially rare.
   f. Finally, authoritarian parents love their children, but they often appear aloof and rarely showing affection.

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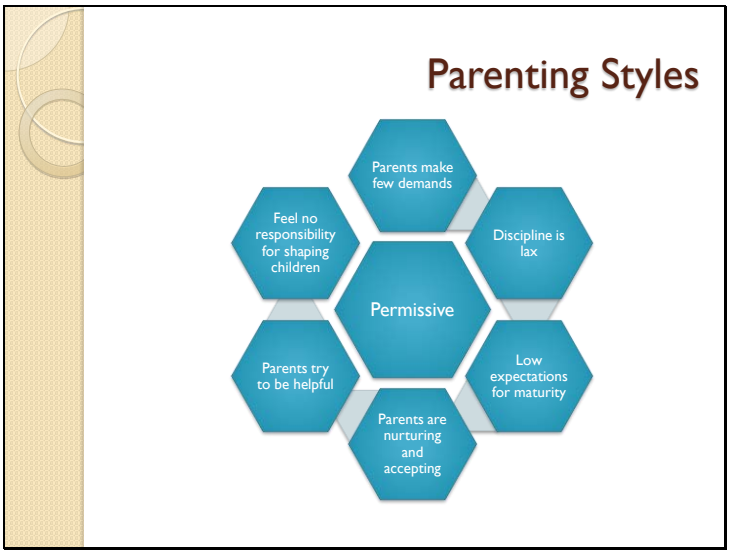
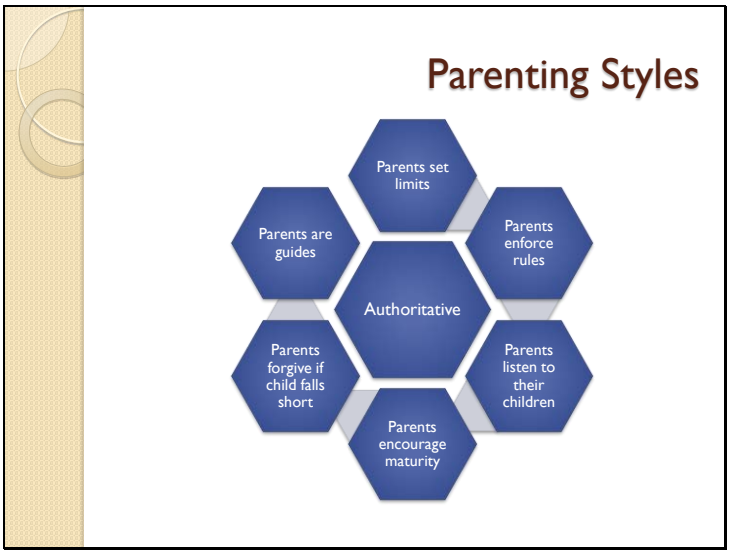


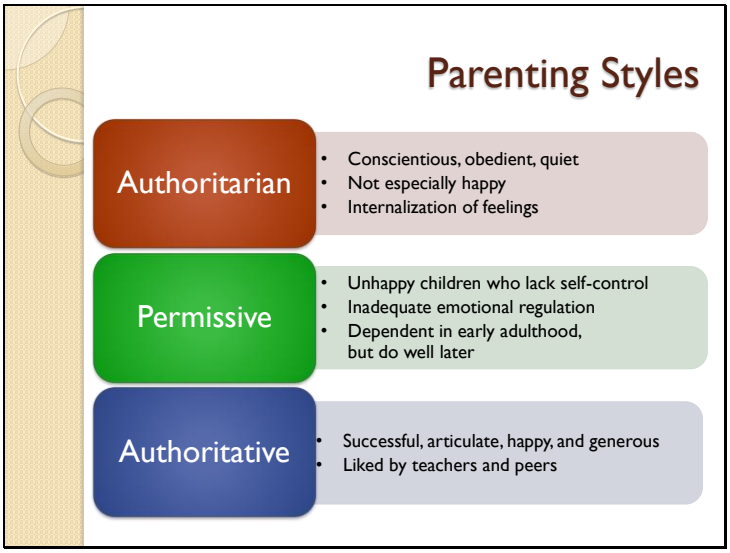
2. The second style is called “permissive” parenting (also called “indulgent”). In this style:
   a. Parents make few demands, hiding any impatience they feel.
   b. Discipline is lax.
   c. Parents have low expectations for maturity.
   d. Parents are nurturing and accepting, listening to whatever their children say.
   e. Parents try to be helpful.
   f. And finally, permissive parents do not feel responsible for shaping their children.

Slide 5



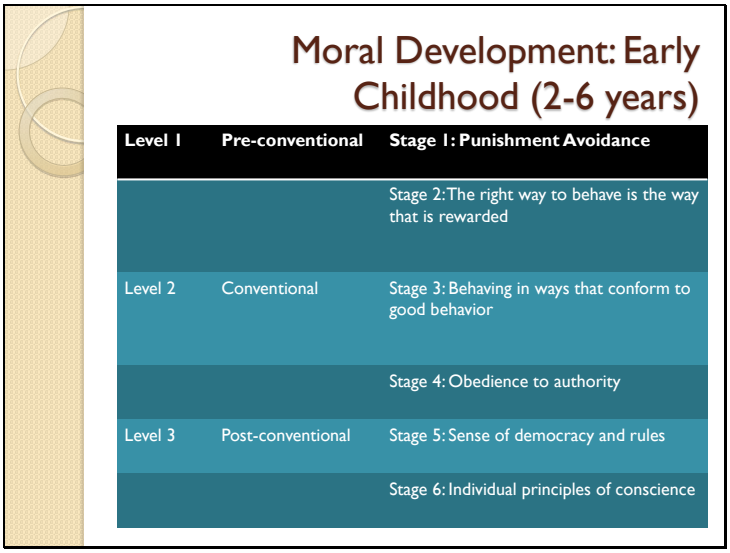
3. The third style of parenting is “authoritative” parenting. In this style,
   a. Parents set limits and enforce rules, yet also listen to their children.
   b. Parents encourage maturity, but they usually forgive (not punish) if the child falls short.
   c. Finally, authoritative parents consider themselves guides, not authorities and not friends.

Slide 6



- The long-term effects of parenting styles are the following:
- Authoritarian parents raise children who are likely to become conscientious, obedient, and quiet, but not especially happy. Such children tend to feel guilty or depressed, internalizing their frustrations and blaming themselves when things don't go well. As adolescents, they sometimes rebel, leaving home before age 20.
- Permissive parents raise unhappy children who lack self-control, especially in the give-and-take of peer relationships. Inadequate emotional regulation makes them immature and impedes friendships, which are the main reason for their unhappiness. They tend to continue to live at home, still dependent, in early adulthood. In middle and late adulthood, they fare quite well.
- Authoritative parents raise children who are successful, articulate, happy with themselves, and generous with others. These children are usually liked by teachers and peers, especially in the United States and other societies in which individual initiative is valued.

Slide 11



Moral Development: Early Childhood (2-6 years)

Let's talk about moral development in children now.

According to Lawrence Kohlberg, the leading theorist in moral development, people progress in their moral reasoning through a series of six identifiable stages, beginning as children. He classified these 6 stages into 3 levels (pre-conventional, conventional, and post-conventional). Kohlberg believed that individuals could only progress through these stages one at a time and in order. That is to say that people cannot jump around the stages, nor can they skip stages. At 2-6 years, children are at Level 1: the pre-conventional level.

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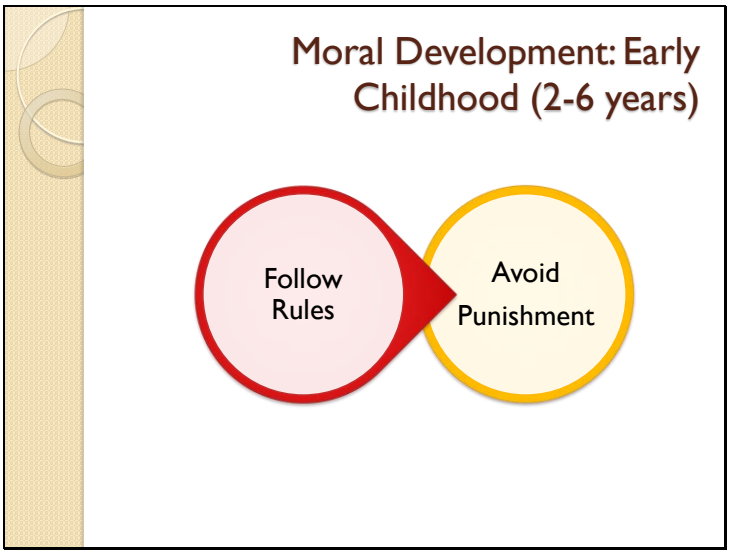
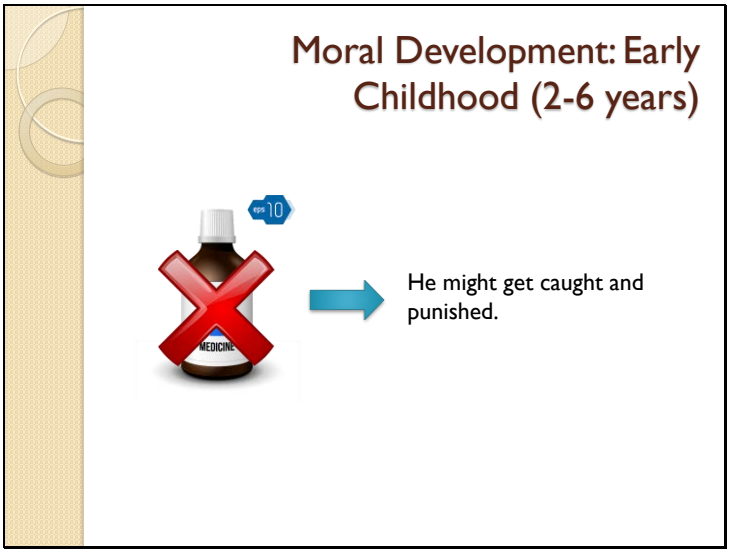


Children ages 2-6 are focused on the notions of punishment and obedience. Right and wrong is based solely on the idea that whatever leads to punishment is wrong. They see rules as fixed and absolute, needing to be obeyed to avoid punishment. An answer to an ethical question at this stage illustrates a belief that if you are going to get in trouble by doing something, then it is wrong to do it. Take Kohlberg's classic ethical dilemma, the Heinz Dilemma.

Heinz's wife was near death, and her only hope was a drug that had been discovered by a pharmacist who was selling it for a lot more money than it cost to make. Heinz could only raise a small amount of money and insurance wouldn't cover the rest. Heinz offers to pay what he has and continue paying more money later. The pharmacist refuses. In desperation Heinz considers stealing the drug. Would it be wrong for him to do that?

Slide 13



Children at this developmental stage would say that Heinz should not steal the drug because he might get caught and punished.

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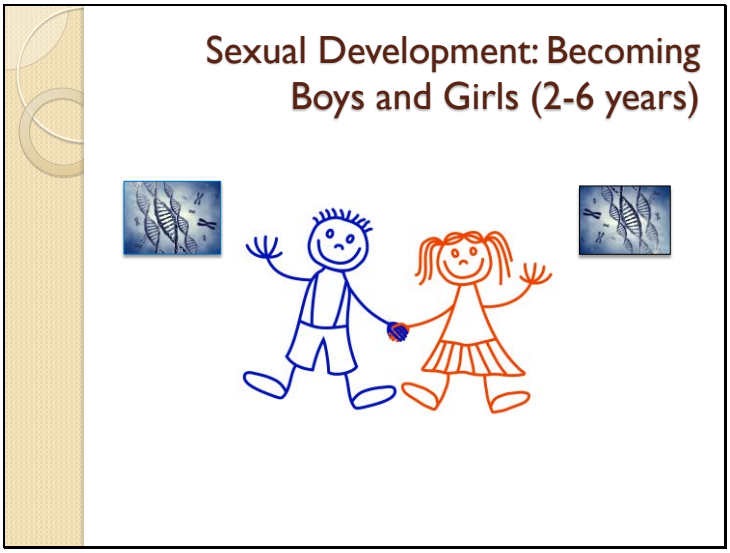
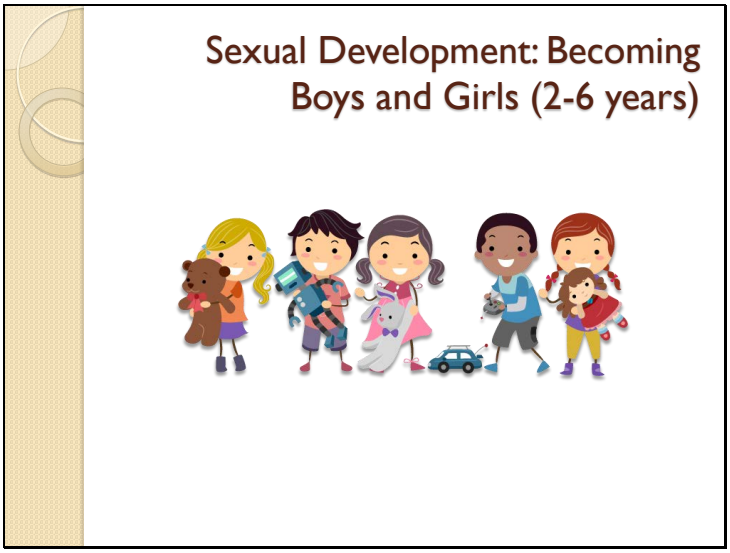


Sexual Development: Becoming Boys and Girls (2-6 years)

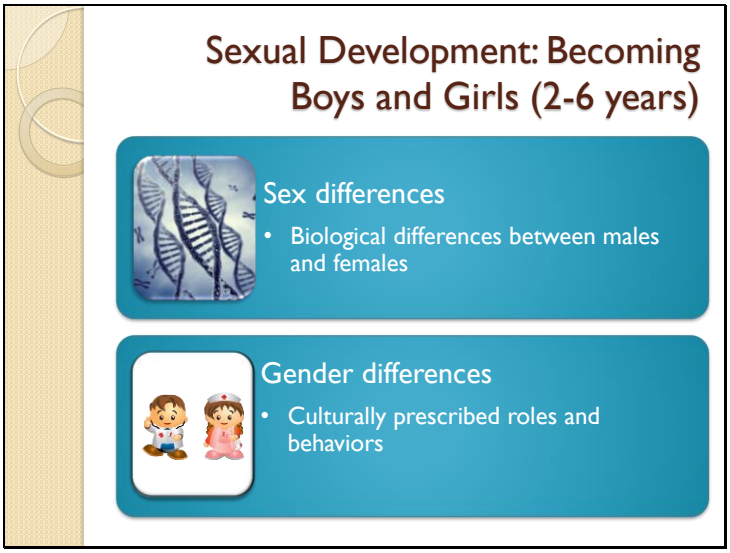
Biology determines whether a person is male or female, depending on their chromosomal makeup. Male and female bodies produce sex-specific hormones that exert control over the brain, body, and behavior.
Sexual identity is more than biology, however, and it is during early childhood that patterns and preferences become apparent.

Slide 15



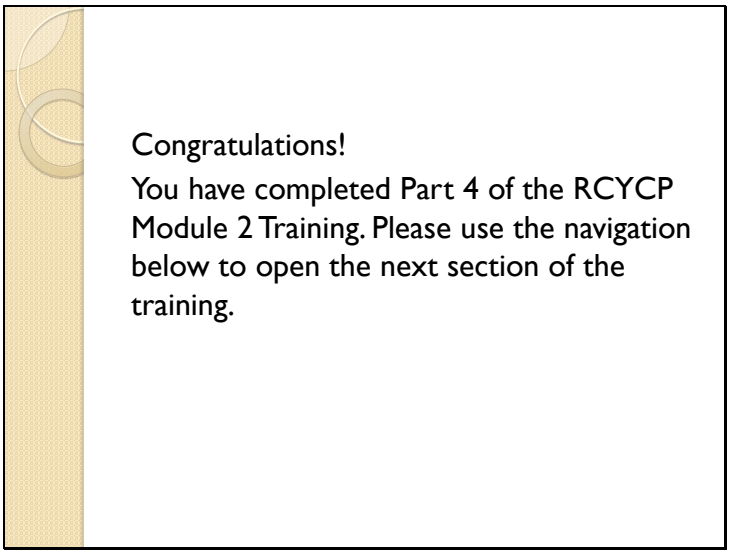
Children are more conscious of gender with every year of childhood. Even 2-year-olds consistently apply gender labels like lady, man, Mr. and Mrs. By age 4, children are convinced that certain toys are appropriate for one sex but not the other, such as dolls and trucks, and that certain roles -- like nurse, teacher, and police officer -- are best for one sex over another.

Slide 16



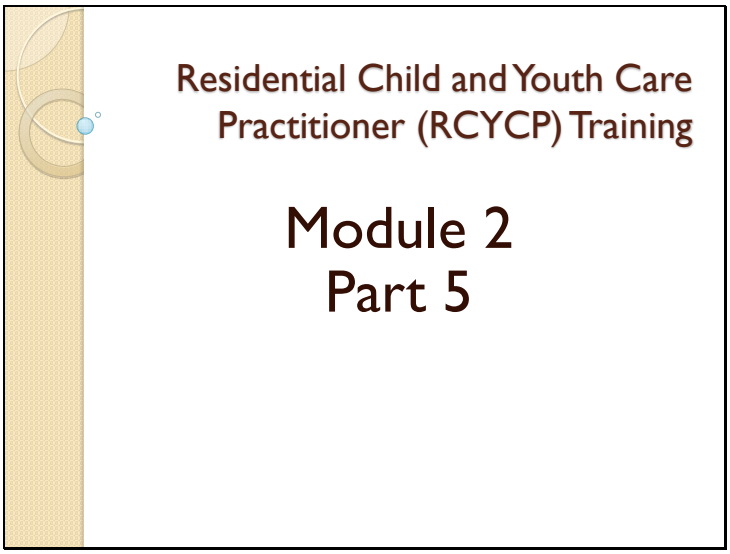
Sex versus Gender:
Scientists make a distinction between sex differences and gender differences. Sex differences are biological differences between males and females. Gender differences are culturally prescribed roles and behaviors. At around 5 years of age, many children become rigid in their ideas of sex and gender. Boys might argue against playing with dolls because they believe “dolls are for girls.” Gender stereotypes are the strongest at about age 6.

Slide 17



Congratulations! You have completed Part 4 of the RCYCP Module 2 Training. Please use the navigation below to open the next section of the training.

Slide 2



Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 2, Part 5 of the Residential Child and Youth Care Practitioner Training.

Slide 3

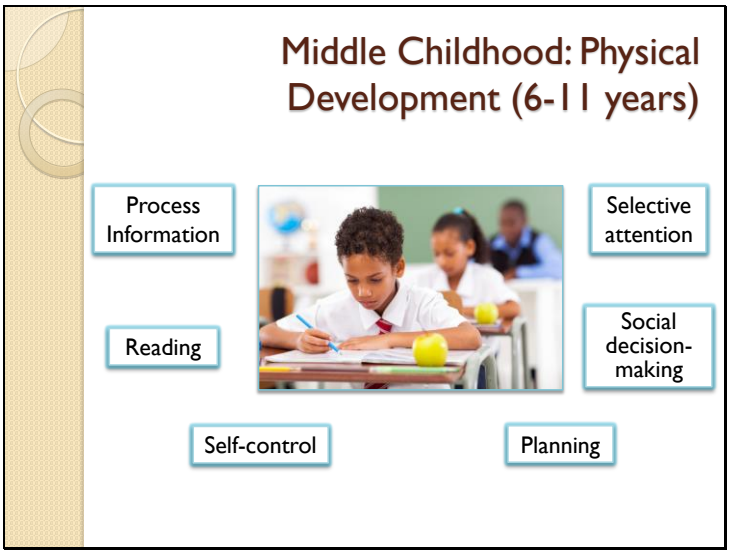
Middle Childhood: Physical Development (6-11 years)

Middle childhood spans the ages of 6 to 11, and for most children is marked by good health, steady growth, the mastery of new athletic skills, language advancement, and less dependency on families.

In terms of physical development, middle childhood is a time of steady growth and few serious illnesses. School-age children's growth is slow and steady, and they are able to care for themselves more independently – brushing their teeth, getting dressed, making their own lunch, and walking to school. Muscles become stronger, and athletic skills become more advanced. Because children this age can now play organized games with rules, physical games such as tag become age-appropriate and enjoyable.

Physical activity is beneficial for this group in many ways: better overall health, less obesity, appreciation for cooperation and fair play, improved problem-solving abilities, and respect for teammates and opponents of many ethnicities and nationalities. At this age, there are hazards as well, like loss of self-esteem as a result of criticism from teammates or coaches, sports-related injuries, and reinforcement of prejudices -- for example, reinforced stereotypes of the opposite sex.

Slide 4



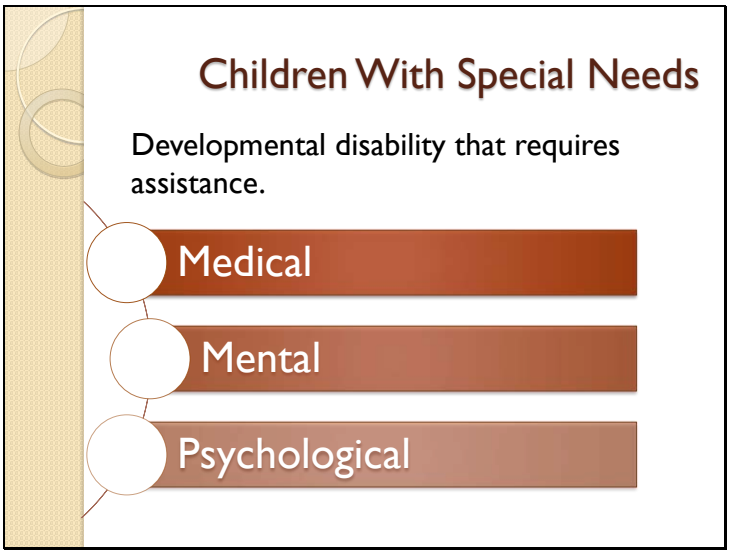
Middle Childhood: Physical Development (6-11 years)

In terms of brain development, the brain works faster now and is better coordinated. Children at this stage of development can quickly process information, as well as pay special attention to the most important elements of their environment. By age 7, they are significantly better able to concentrate on some stimuli while ignoring others, termed “selective attention,” which is helpful in both school and play. So, for example, a child in this stage should be able to pay attention to a teacher while ignoring a disruptive student.

This brain development also allows for important accomplishments such as reading, social decision-making, and mental control processes that enable self-control and planning for the future.

While some children develop without any challenges, others have special learning needs that are the result of problems in the development of their brains. Let’s take a few moments and discuss children with special needs.

Slide 6

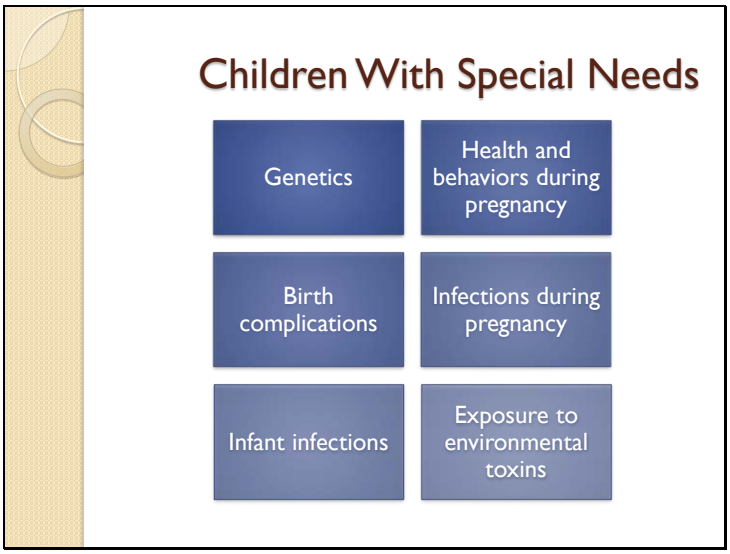


Children with Special Needs

In the United States, the term "special needs" is used to describe individuals with a developmental disability -- an impairment that may be medical, mental, or psychological and that requires assistance. For example, children with autism, bipolar disorder, Down syndrome, dyslexia, blindness, or cystic fibrosis may be considered to have special needs.

Developmental disabilities affect all racial, ethnic, and socioeconomic groups. In the U.S., about 1 in 6 children have a developmental disability.

Slide 7



Children With Special Needs

Developmental disabilities begin anytime during the developmental period and usually last throughout a person's lifetime. Most developmental disabilities begin before a baby is born, but some can happen after birth because of injury, infection, or other factors (CDC).
Most developmental disabilities are thought to be caused by a complex mix of factors, including:

- Genetics;
- Parental health and behaviors during pregnancy (e.g., smoking and drinking);
- Complications during birth;
- Infections the mother might have during pregnancy;
- Infections the baby might have early in life;
- Exposure of the mother or child to high levels of environmental toxins such as lead

For some developmental disabilities such as Fetal Alcohol Syndrome, which is caused by drinking during pregnancy, the cause of the disability is known. For most, like autism for example, the cause is unknown.

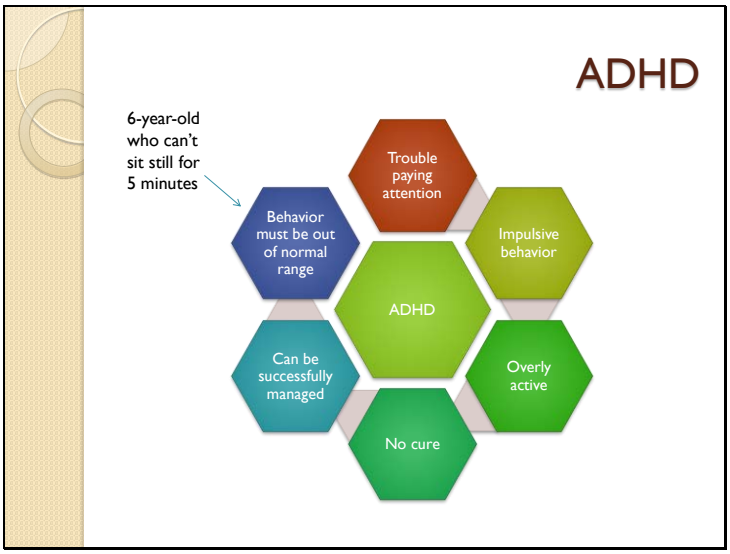
Slide 8

Children With Special Needs

Developmental disabilities are particularly relevant in middle childhood because children are grouped by age and expected to learn on schedule in school. In the United States, schoolchildren who are below average in achievement are given special intervention. Professionals use a battery of tests to diagnose and develop recommendations. If a child has been identified as having special needs, an Individualized Education Plan, or IEP, is established in a partnership between school and family to specify educational goals for the child. About 13 percent of all school-age children in the United States receive special-education services.

Let's talk about some of the disorders that you, as an RCYCP, might encounter in children with whom you work.

Slide 9



ADHD

People with attention-deficit hyperactivity disorder, or ADHD, may have trouble paying attention or controlling impulsive behaviors – where they may act without thinking about what the result will be -- or they may be overly active. Although ADHD can't be cured, it can be successfully managed, and some symptoms may improve as the child ages. In order for these problems to be diagnosed, they must be out of the normal range for a child's age and development. For example, you can expect that a 2-year-old will have trouble sitting and paying attention for long periods of time. That is considered normal. However, if a 6-year-old cannot sit still and pay attention for five minutes, we would consider that out of the normal range of development.

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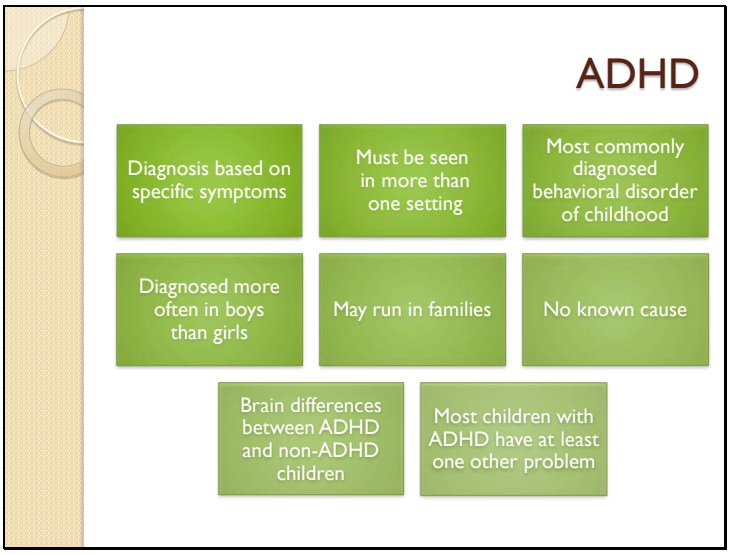

The diagnosis is based on very specific symptoms and must be seen in more than one setting -- for example, at home and in school.

ADHD is the most commonly diagnosed behavioral disorder of childhood. Nearly 1 in 10 children has an ADHD diagnosis. ADHD is diagnosed much more often in boys than girls.

ADHD may run in families, but there is no known cause. Brain imaging studies suggest that the brains of children with ADHD are different from those of other children.

Most children with ADHD have at least one other developmental, psychiatric, or behavioral problem.

Let's talk about symptoms now.

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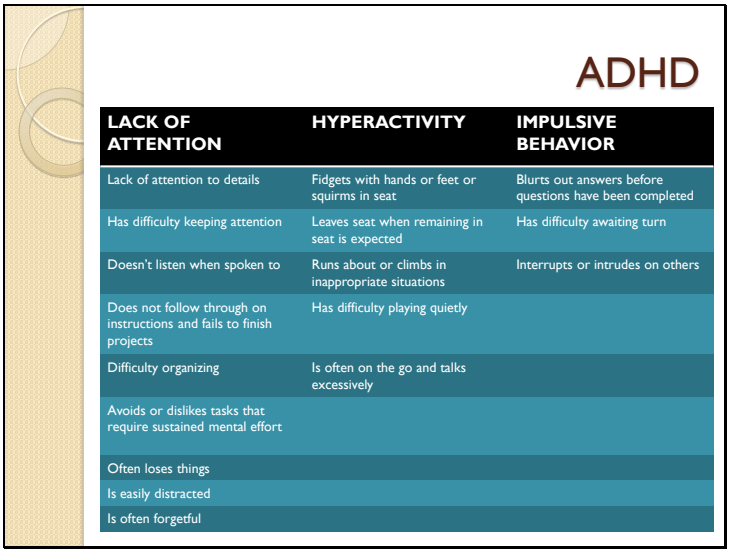

Symptoms of ADHD fall into 3 groups:
- Lack of attention, or inattentiveness
- Hyperactivity
- Impulsive behavior, or impulsivity

Some children's symptoms primarily fall into the first category; these children display attention-deficit disorder, or ADD, and tend to be less disruptive.

A child displaying "inattentive" symptoms:
- Fails to give close attention to details or makes careless mistakes in schoolwork;
- Has difficulty paying attention during tasks or play;
- Does not seem to listen when spoken to directly;
- Does not follow through on instructions and fails to finish school work or chores;
- Has difficulty organizing tasks and activities;
- Avoids or dislikes tasks that require sustained mental effort (such as schoolwork);
- Often loses toys, assignments, pencils, books, or tools needed for tasks or activities;
- Is easily distracted;
- And finally, is often forgetful in daily activities.

A child showing "hyperactivity" symptoms:
- Fidgets with hands or feet, or squirms in their seat;
- Leaves their seat when remaining seated is expected;

- Runs about or climbs in inappropriate situations;
- Has difficulty playing quietly;
- And is often “on the go,” and talks excessively.

Finally, a child with “impulsivity” symptoms:
- Blurts out answers before questions have been completed;
- Has difficulty awaiting their turn;
- Interrupts or intrudes on others.

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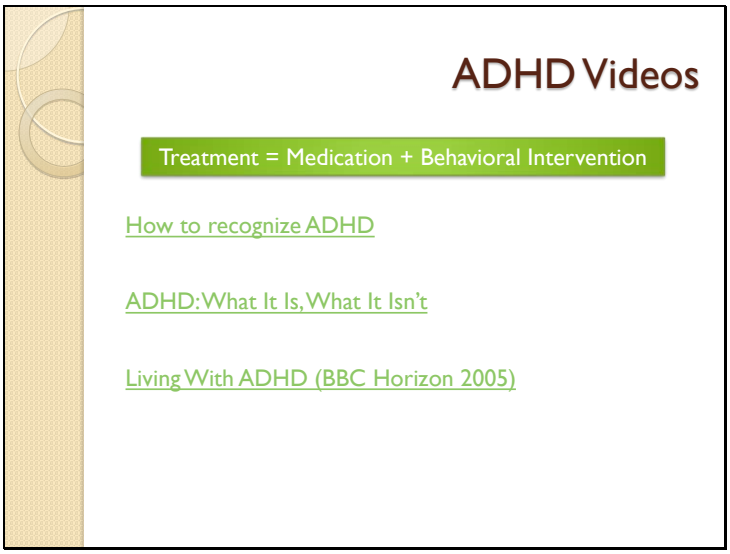

ADHD Videos

ADHD is a chronic and long-term condition. Without intervention ADHD may lead to drug and alcohol abuse, school failure, difficulty with job stability, and trouble with the law. Treatment includes both medication and behavioral intervention. Although it is not curable, with early intervention and treatment, ADHD can be successfully managed.

Click on the links to see some videos about ADHD

How to Recognize ADHD:
http://www.youtube.com/watch?v=IbEPgoS-zSA

ADHD: What It Is, What It Isn't -- Keeping Kids Healthy:
http://www.youtube.com/watch?v=t9ZKdXDTUww

10/10/2010 14:09 BBC Horizon 2005 Living With ADHD(1):
http://www.youtube.com/watch?v=-a9qIiaPhRg

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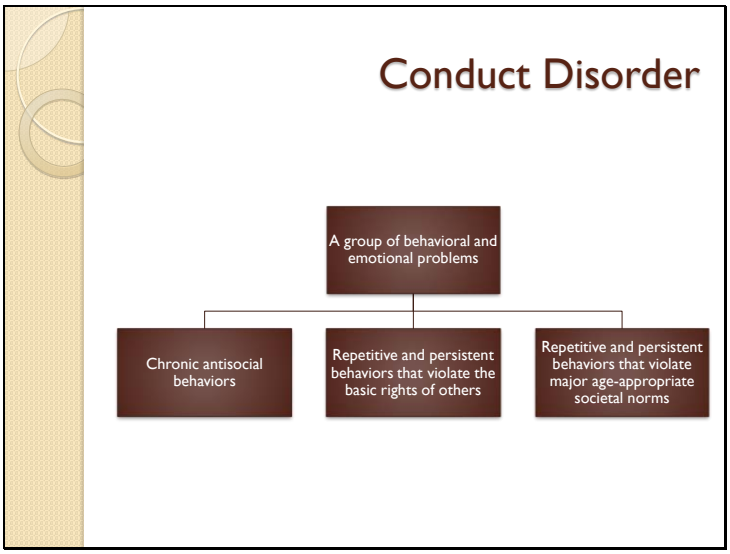

Conduct Disorder

Another common psychiatric disorder of childhood and adolescence, and one you will likely see as an RCYCP, is conduct disorder.

Conduct disorder is a group of behavioral and emotional problems in which children and youth have significant difficulty following rules and behaving in a socially acceptable way. You may say to yourself, “Well, a lot of kids are like this.” What makes conduct disorder different from run-of-the-mill behavior issues is that it is characterized by a variety of chronic antisocial behaviors. With conduct disorder, there is a repetitive and persistent pattern of behavior that violates the basic rights of others, major age-appropriate societal norms, or both.

Slide 15

Conduct disorder may include some of the following behaviors:

1. Aggression to people and animals wherein someone
- bullies, threatens or intimidates others;
- often initiates physical fights;
- has used a weapon that could cause serious physical harm to others (such as a bat, brick, broken bottle, knife, or gun);
- is physically cruel to people or animals;
- steals from a victim while confronting them (for example, assault);
- and/or forces someone into sexual activity.

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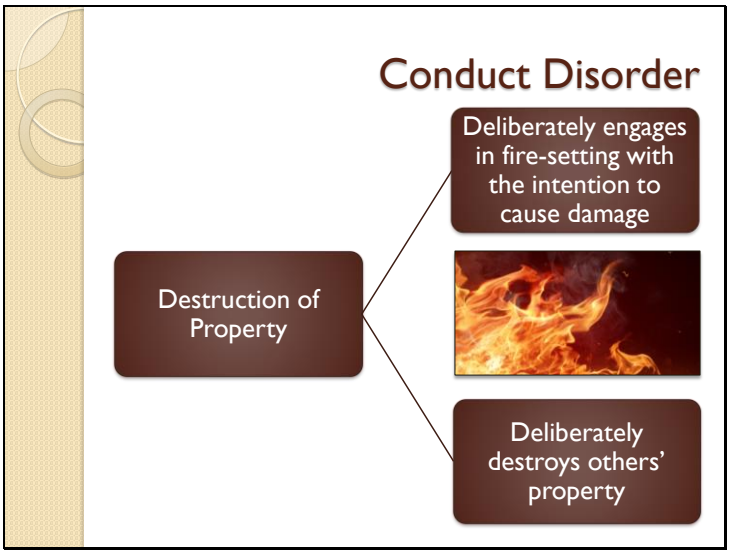

2. Destruction of property, wherein someone
- deliberately engages in fire-setting with the intention to cause damage;
- and/or deliberately destroys others' property.

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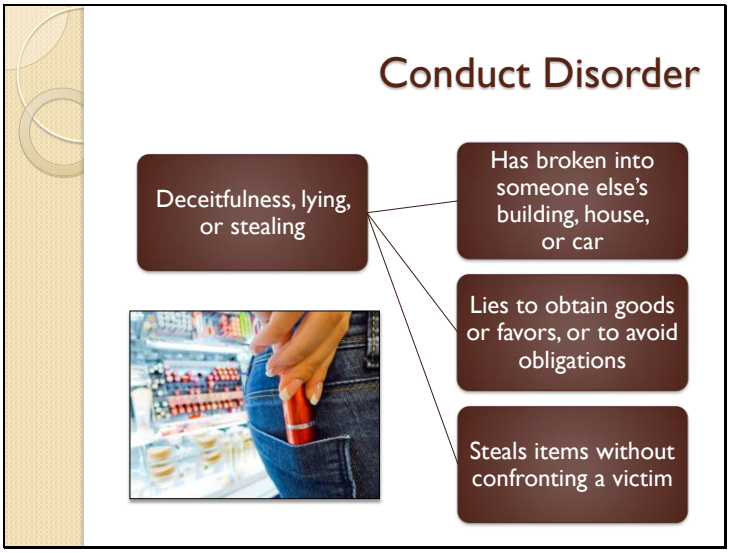

3. Deceitfulness, lying, or stealing, wherein someone

- has broken into someone else's building, house, or car;
- lies to obtain goods or favors, or to avoid obligations;
- and/or steals items without confronting a victim (such as shoplifting, but without breaking and entering).

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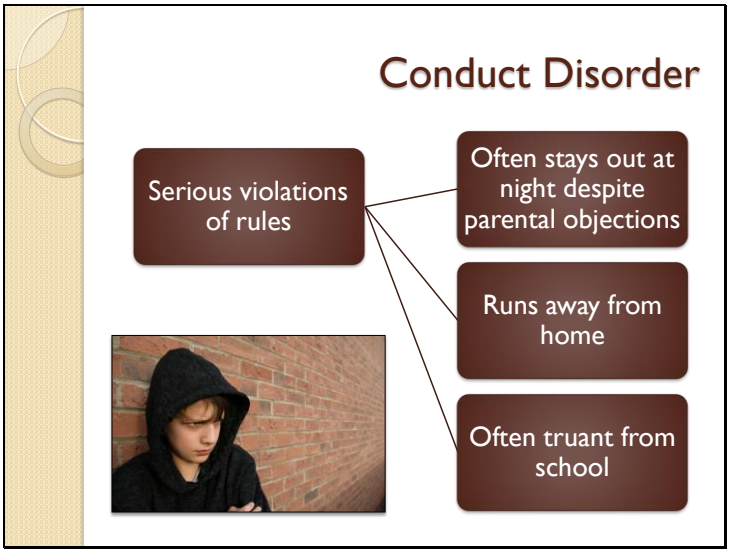

And finally,

4. Serious violations of rules, wherein someone
- often stays out at night despite parental objections;
- runs away from home;
- and/or is often truant from school.

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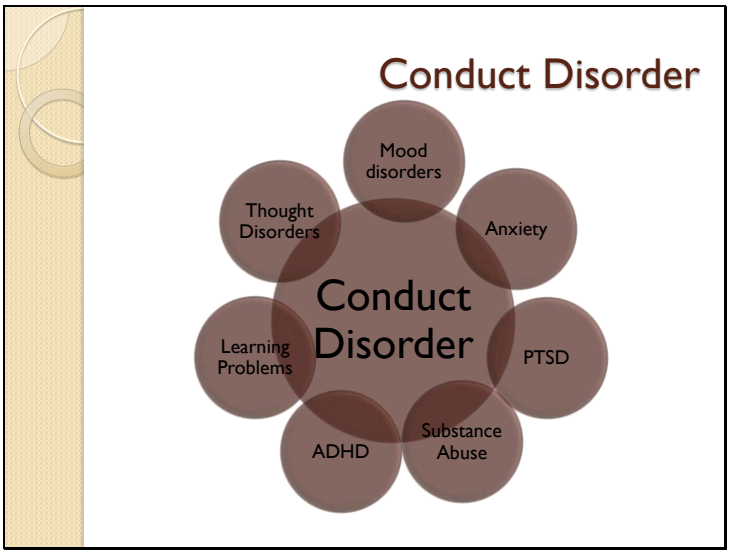

Many children with a conduct disorder have other conditions such as mood disorders, anxiety, PTSD, substance abuse, ADHD, learning problems, or thought disorders.

It is critical for children and youth with conduct disorder to receive treatment. Research shows that youngsters with conduct disorder are likely to have ongoing problems if they, and their families, do not receive early and comprehensive treatment. Without treatment, many youngsters with conduct disorder are unable to adapt to the demands of adulthood and continue to have problems with relationships and holding a job. They often break laws or behave in an antisocial manner.

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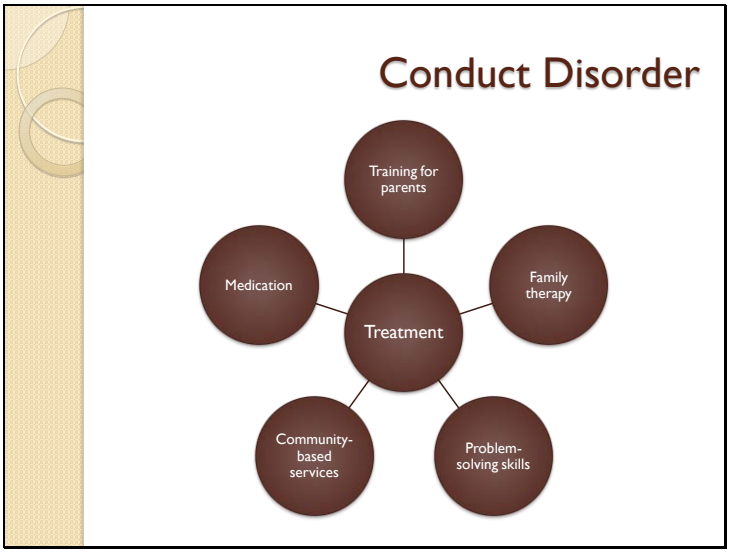
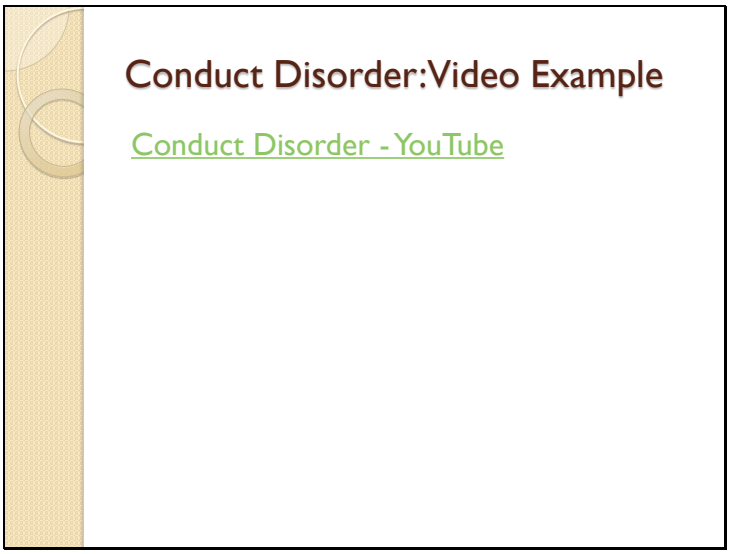


Treatment for conduct disorder includes:

1. Training for parents on how to handle child or adolescent behavior;
2. Family therapy;
3. Training in problem-solving skills;
4. Community-based services that focus on the young person within the context of the family and community influences, and
5. Possible use of medication for those with: difficulty paying attention, impulse problems, or depression.

Slide 21

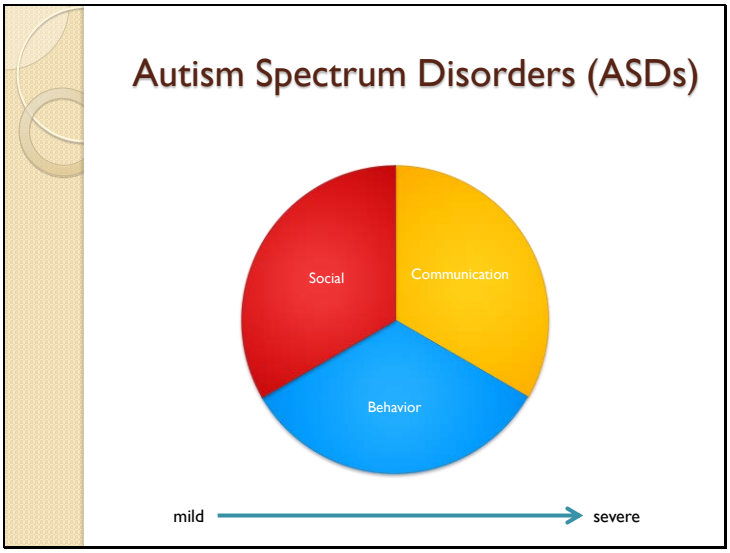


Conduct Disorder: Video Example

Click on the link to see a short clip of a family struggling with children with conduct disorder.

Conduct Disorder
http://www.youtube.com/watch?v=THsIP7pM9Oc

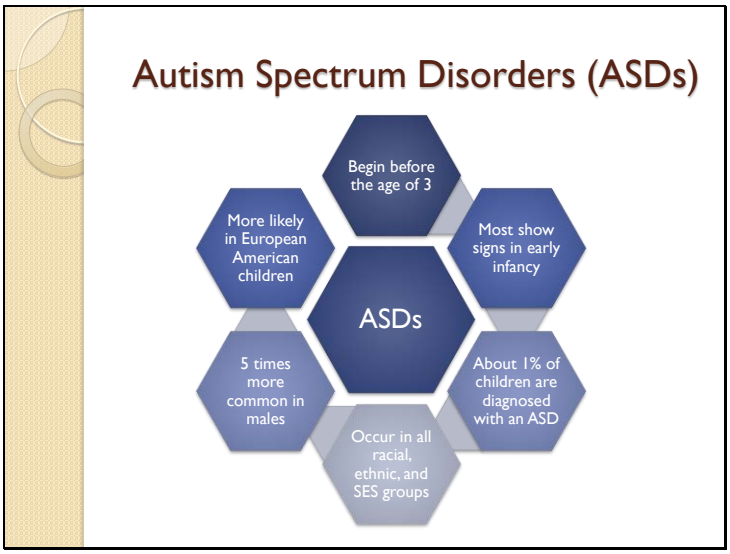
Slide 22



Autism Spectrum Disorders (ASDs)

Autism spectrum disorders, or ASDs, are a group of developmental disabilities marked by significant social, communication, and behavioral challenges. Autism spectrum disorders affect each person in different ways and can range from very mild to severe.

Slide 23



Autism spectrum disorders begin before the age of 3, with most children showing signs in early infancy. For some children, however, symptoms might not show up until 24 months or later, so that the children appear to develop typically and then stop gaining new skills or lose the skills they had.

Currently, 1 in 110 children (or about 1%) are diagnosed with an ASD. ASDs occur in all racial, ethnic, and socioeconomic groups, but are five times more common in males than females. Also, there are more European American children with ASDs than Latino, Asian, or African American.

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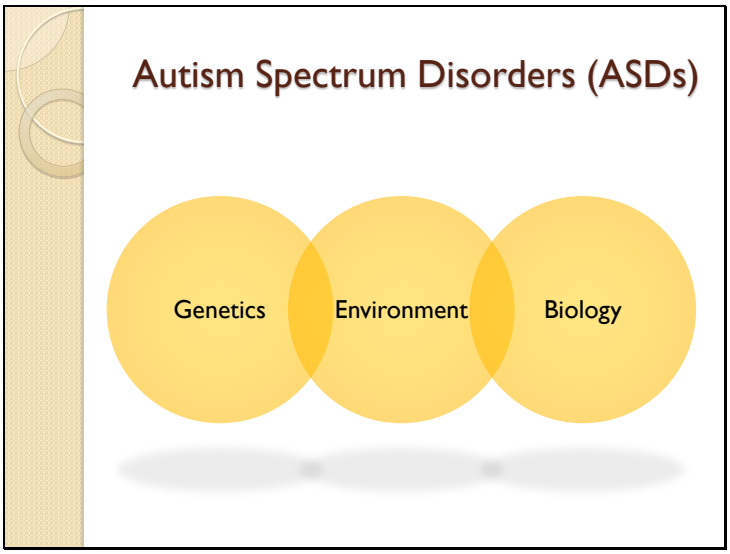
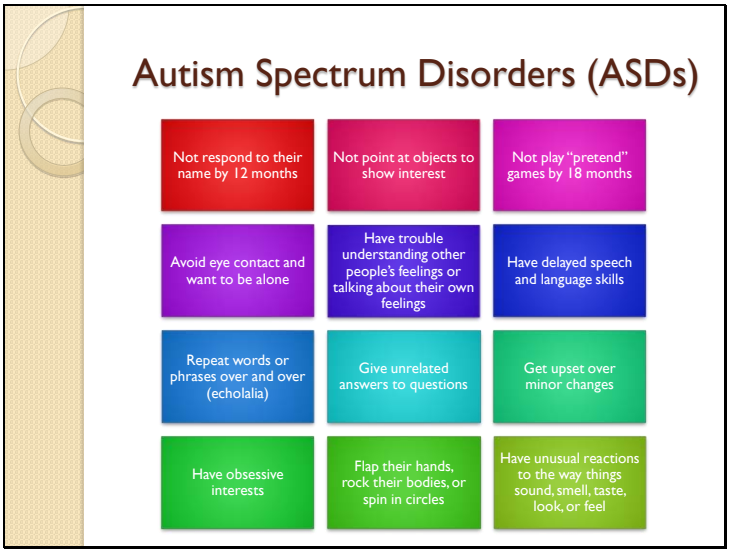


Most scientists agree that there is a genetic link to autism. Children who have a sibling or parent with an ASD are at significantly higher risk of having an ASD themselves; however, it is likely that many different factors make a child more likely to have an ASD, including environmental and biological factors. For example, the prescription drugs valproic acid and thalidomide have been linked to a higher risk of ASDs in cases where they were taken during pregnancy.

Let's talk about some signs and symptoms of ASDs.

Slide 25

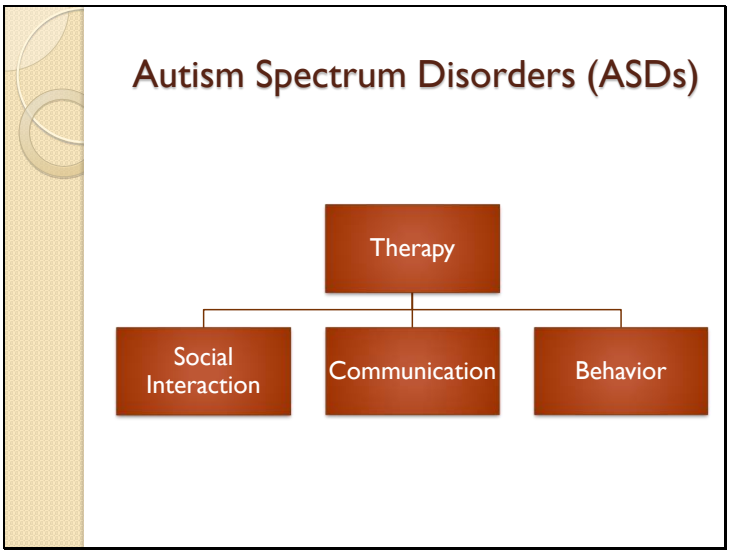


A person with ASD might:

- Not respond to their name by 12 months
- Not point at objects to show interest
- Not play “pretend” games by 18 months
- Avoid eye contact and want to be alone
- Have trouble understanding other people’s feelings or talking about their own feelings
- Have delayed speech and language skills
- Repeat words or phrases over and over, known as echolalia
- Give unrelated answers to questions
- Get upset over minor changes
- Have obsessive interests
- Flap their hands, rock their bodies, or spin in circles
- Have unusual reactions to the way things sound, smell, taste, look, or feel

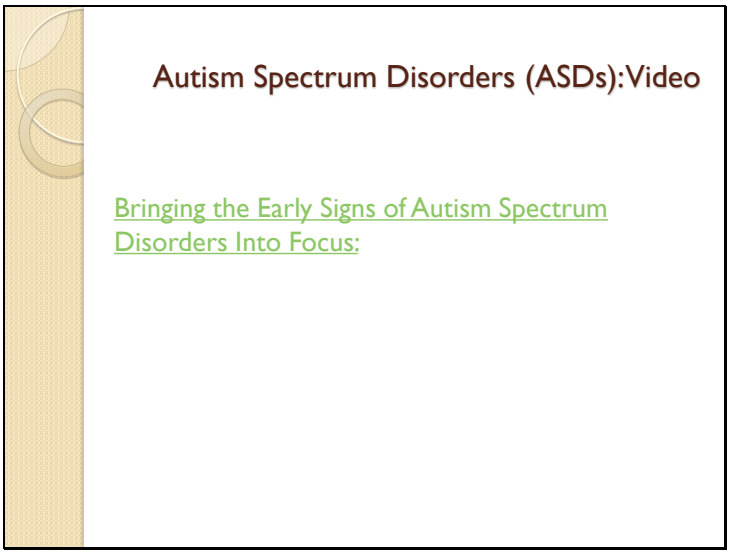
Some children never speak, rarely smile, and often play for hours with one object (such as a spinning top or a toy train).

Slide 26



Currently, there is no known cure for ASDs; however, research indicates that early intervention services can greatly improve a child's development. Typical services include therapy to assist with social interaction and communication, and behavioral interventions.

Slide 27

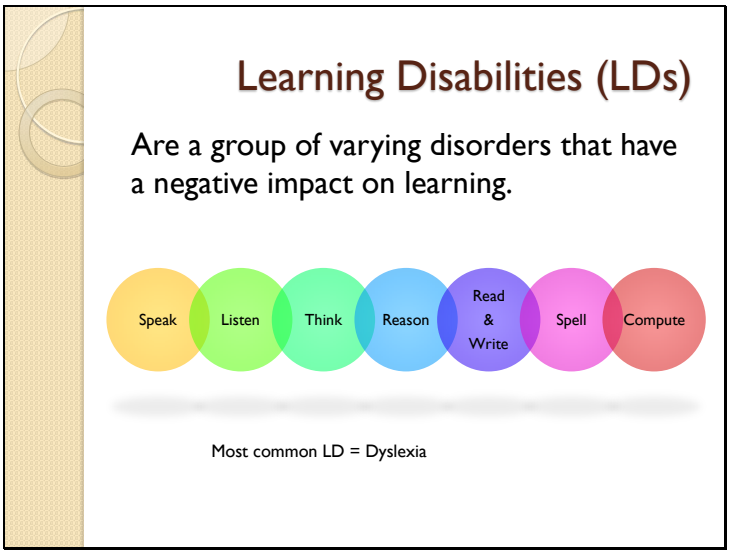


Autism Spectrum Disorders (ASDs): Video

Click on the link to see a short video about the early signs of Autism Spectrum Disorder

Bringing the Early Signs of Autism Spectrum Disorders Into Focus:
http://www.youtube.com/watch?v=YtvP5A5OHpU

Slide 29



Learning Disabilities (LDs)

As an RCYCP, you will likely encounter youth with learning disabilities. So what do we mean by the term “learning disabilities”?

Learning disabilities, or LDs, are a group of varying disorders that have a negative impact on learning. They may affect one’s ability to speak, listen, think, reason, read, write, spell, or compute. LDs are a group of disorders, not a single disorder. You may be familiar with some LDs; the most common is in the area of reading, known as dyslexia.

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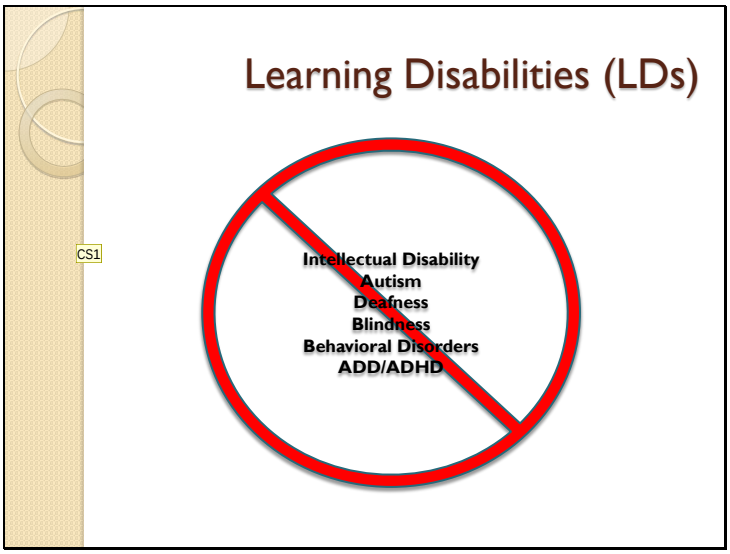
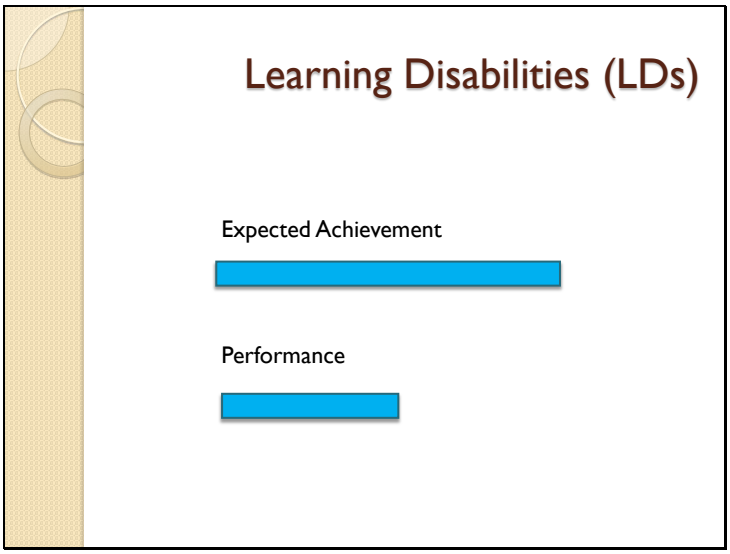


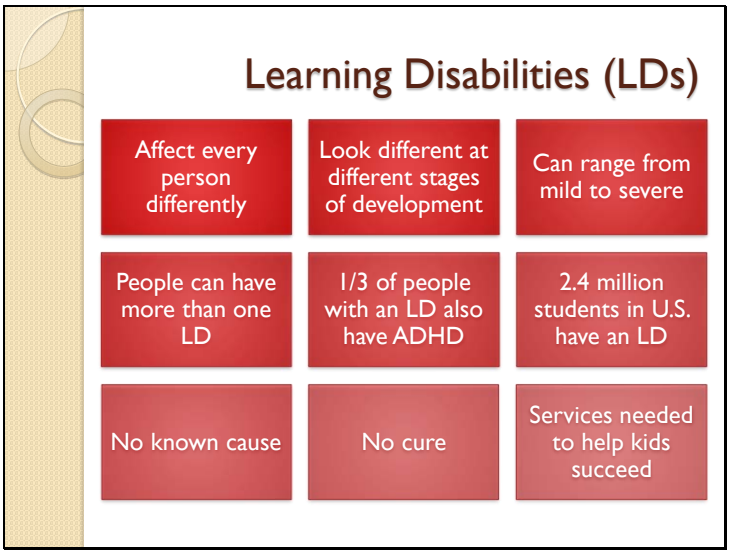
Intellectual disability (once referred to as “mental retardation”), autism, deafness, blindness, behavioral disorders, and ADD/ADHD are not learning disabilities, though often these conditions are confused with LD. Additionally, LD is often mistaken as laziness, or associated with disorders of emotion and behavior. In fact, people with LDs are often of average or above-average intelligence but still struggle to acquire that impact their performance in school, at home, in the community, and in the workplace.

Slide 31



According to the National Center for Learning Disabilities, the hallmark sign of a learning disability is “a distinct and unexplained gap between a person’s level of expected achievement and their performance.” That means, for example, that you might see a youth who is clearly smart, but is not earning the grades that you would expect him or her to earn.

Slide 32



Learning disabilities affect every person differently, and they look different at various stages of development. They can range from mild to severe, and it is not uncommon for people to have more than one learning disability. In addition, about one-third of individuals with an LD also have ADHD.

Currently 2.4 million students in the United States are diagnosed with LD and receive special education services in our schools.

There is no known cause of learning disabilities and there is no cure for learning disabilities. They are lifelong. People with LD need services in order to succeed at school and in social situations.

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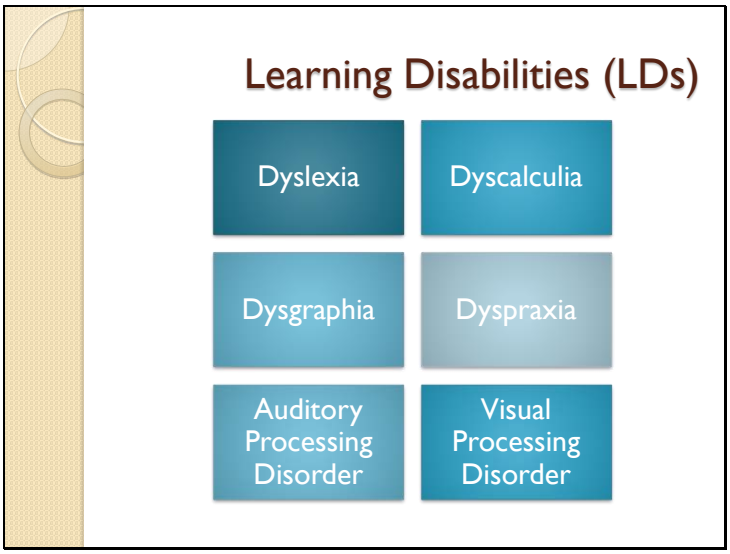

Let's look at some of the most common learning disabilities.

Slide 34

Learning Disabilities (LDs): Video

Click on the link to hear more about learning disabilities.

Learning Disabilities, What Are the Different Types?:
http://www.ncld.org/learning-disability-resources/videos/video-learning-disabilities-what-are-the-different-types

National Center for Learning Disabilities. Learning Disability Fast Facts. Available:
http://www.ncld.org/types-learning-disabilities/what-is-ld/learning-disability-fast-facts

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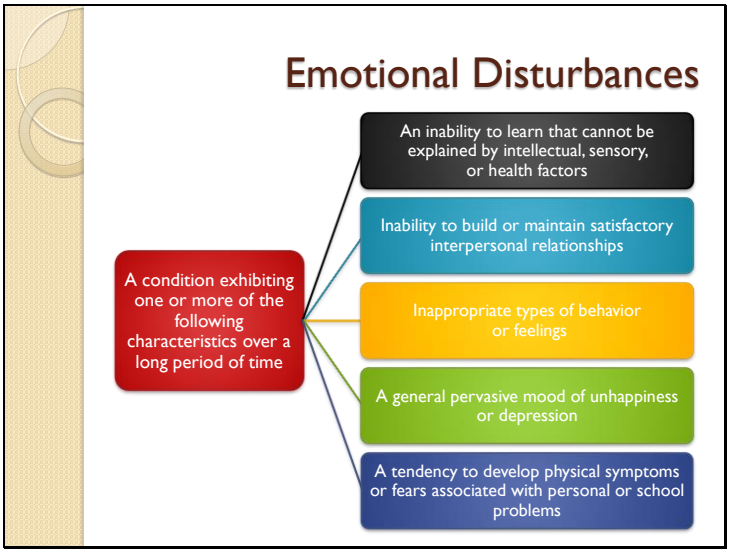


Emotional Disturbances

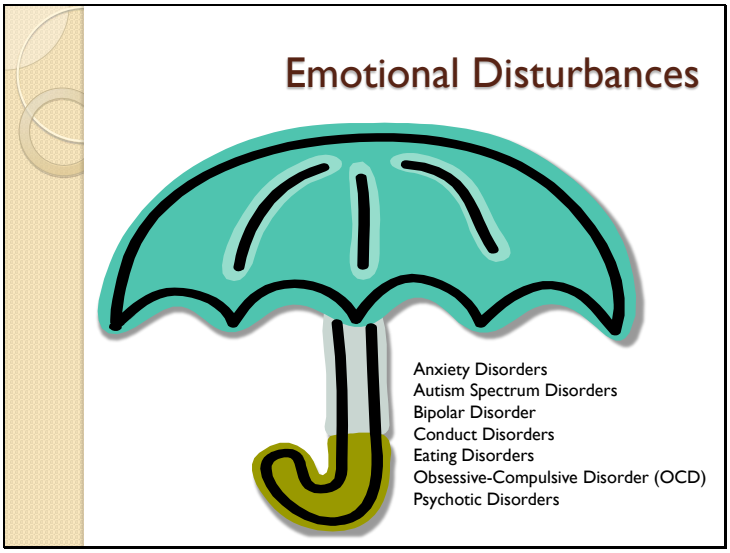
As an RCYCP, you might work with children that are labeled as having an “emotional disturbance” or “ED”. Emotional disturbances is a category of disability that is defined as:

A condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child’s educational performance:

- An inability to learn that cannot be explained by intellectual, sensory, or health factors;
- An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
- Inappropriate types of behavior or feelings under normal circumstances;
- A general pervasive mood of unhappiness or depression, and/or
- A tendency to develop physical symptoms or fears associated with personal or school problems.

You can see that emotional disturbances can affect not only an individual’s emotional state, but their physical, social, and cognitive (or thinking) skills as well.

Slide 39

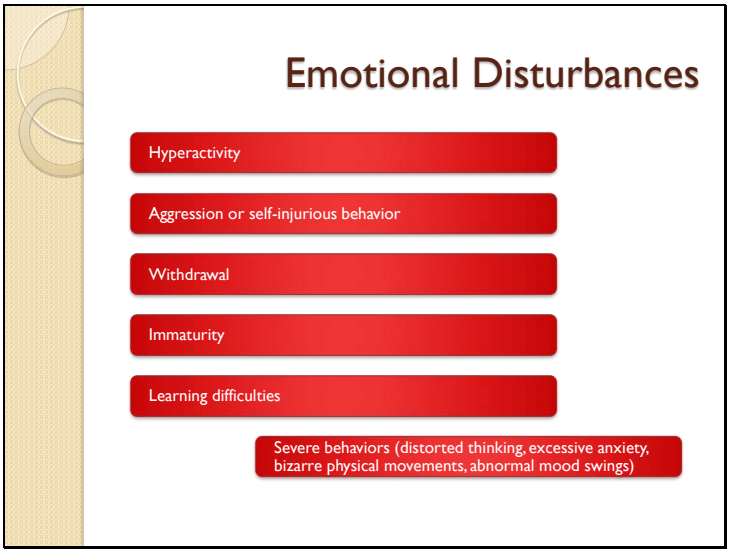


You can think of Emotional Disturbances as an umbrella term for a wide range of conditions. These include, but are not limited to:

- Anxiety Disorders
- Autism Spectrum Disorders
- Bipolar Disorder
- Conduct Disorders
- Eating Disorders
- Obsessive-Compulsive Disorder (OCD) and
- Psychotic Disorders

You will learn about many kinds of Emotional Disturbances in this module.

Slide 40



Some of the characteristics and behaviors that you might see in a child who has an emotional disturbance include:

- Hyperactivity, including short attention span or impulsiveness;
- Aggression or self-injurious behavior, such as acting out or fighting;
- Withdrawal -- not interacting socially with others due to excessive fear or anxiety;
- Immaturity, which can be characterized by inappropriate crying, temper tantrums, and poor coping skills, and
- Learning difficulties, characterized by academically performing below grade level.

Children with the most serious emotional disturbances may have more severe behaviors, such as distorted thinking, excessive anxiety, bizarre physical movements, and abnormal mood swings.

There are many children who do not have an emotional disturbance but still display some of these behaviors at various times during their development. That is normal. What separates children with emotional disturbances is that these behaviors continue over long periods of time.

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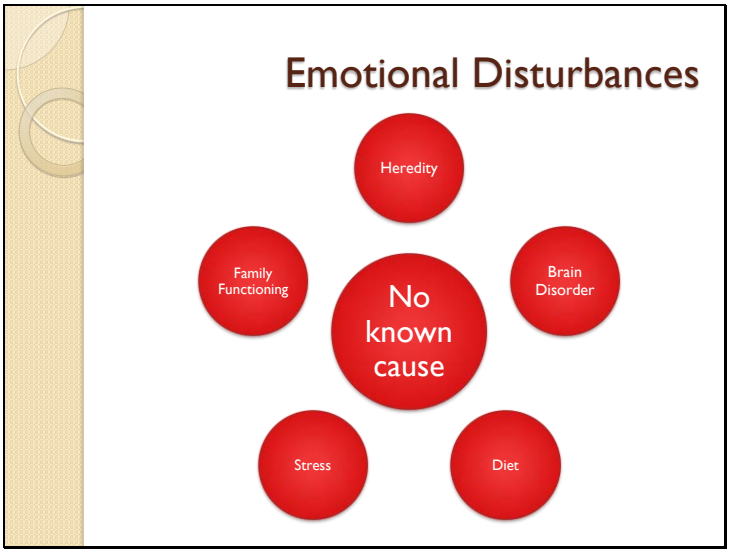

As with many other developmental issues, there is no known cause for emotional disturbances, although several factors may contribute to the problem, including heredity, brain disorder, diet, stress, and family functioning.

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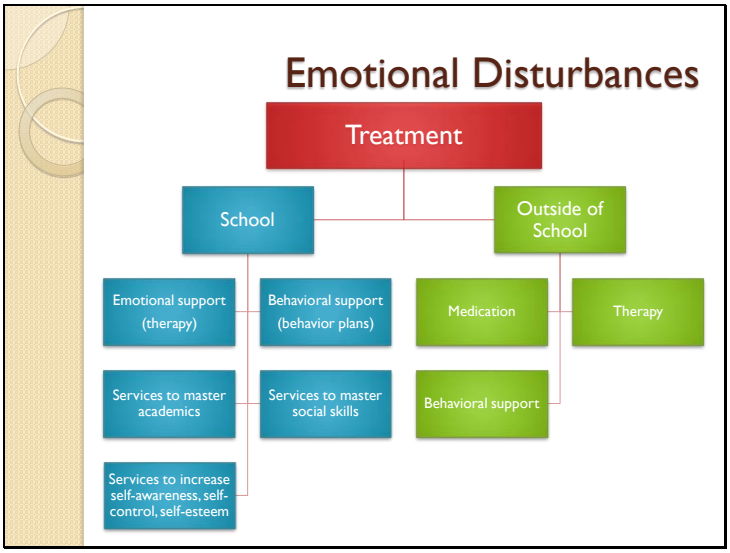
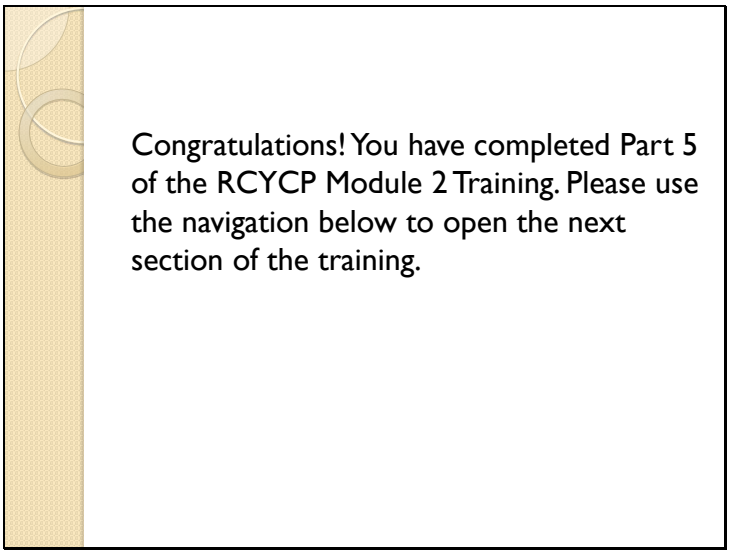


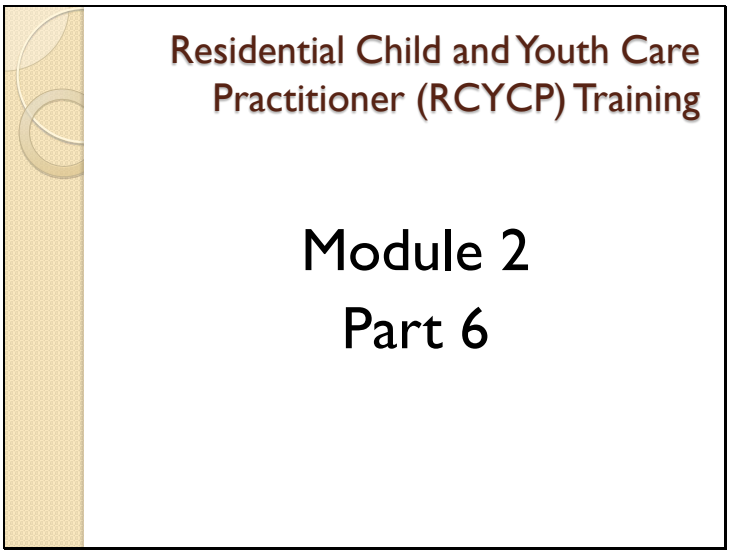
Children with ED often have special education and related services in the school setting that are designed to deal with their emotional needs. Typically these programs include providing emotional and behavioral support (such as therapy and behavior plans), as well as services to help them master academics, develop social skills, and increase self-awareness, self-control, and self-esteem. Treatment outside of the school setting is similar, and may include medication, therapy, and behavioral support.

Slide 43



Congratulations! You have completed Part 5 of the RCYCP Module 2 Training. Please use the navigation below to open the next section of the training.

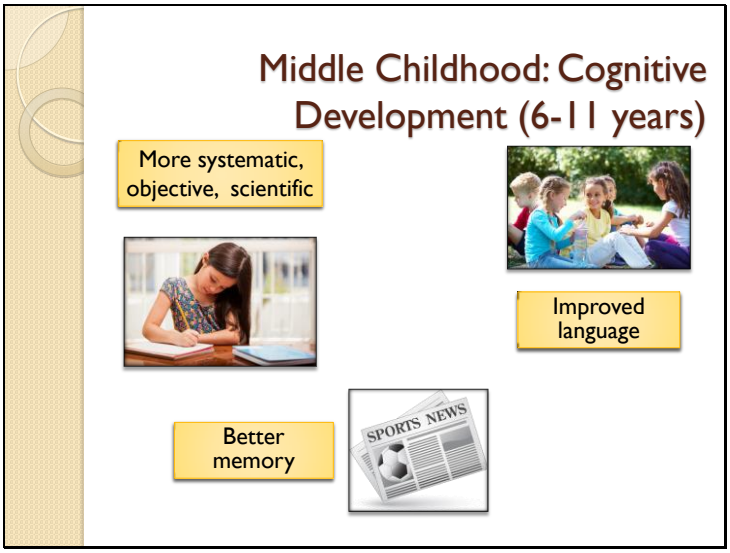
Slide 2



Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 2, Part 6 of the Residential Child and Youth Care Practitioner Training.

Slide 3

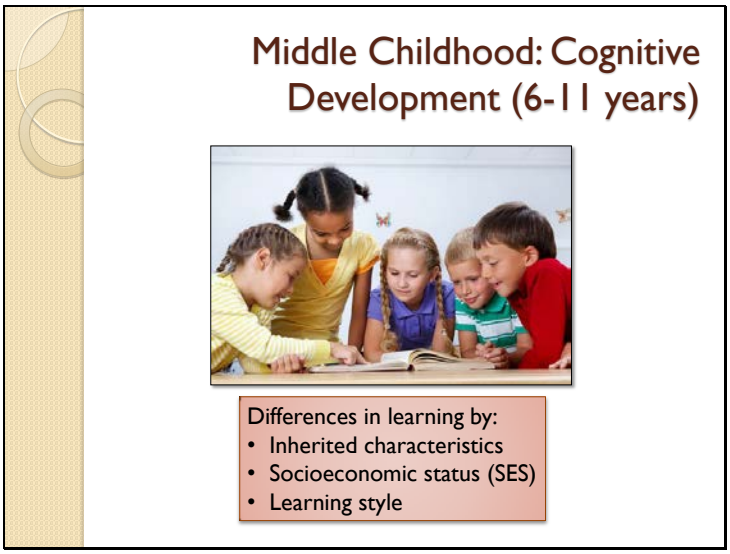


Middle Childhood: Cognitive Development (6-11 years)

In terms of cognitive development in middle childhood, school-age children become more systematic, objective, and scientific, which makes them great learners.

They also have better memories. They can recall things faster and more efficiently, especially when they are interested. For example, a child might memorize all facts about football history if he or she likes football, but can't memorize math facts. Their language improves as well. They are more knowledgeable, and are better able to understand the meaning of new words, as well as understand jokes and metaphors. They also adapt their language to the people they are with, for example, speaking one way with friends and another way with adults.

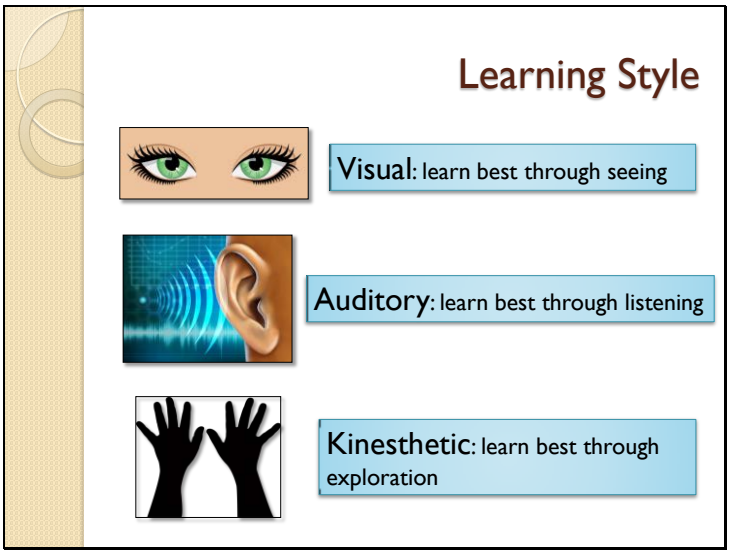
Slide 4



Children differ in their success with learning to speak, read, and write. Some differences may be genetic; however, researchers agree that social context matters. There is a strong link between socioeconomic status, or SES, and language. Children from families with a low SES (that is, more impoverished) tend to have smaller vocabularies, simpler grammar, shorter sentences, and tend to fall behind peers in talking, reading, and other subjects.

There are also differences in learning style. That is to say, not everyone learns effectively in the same way.

Slide 5

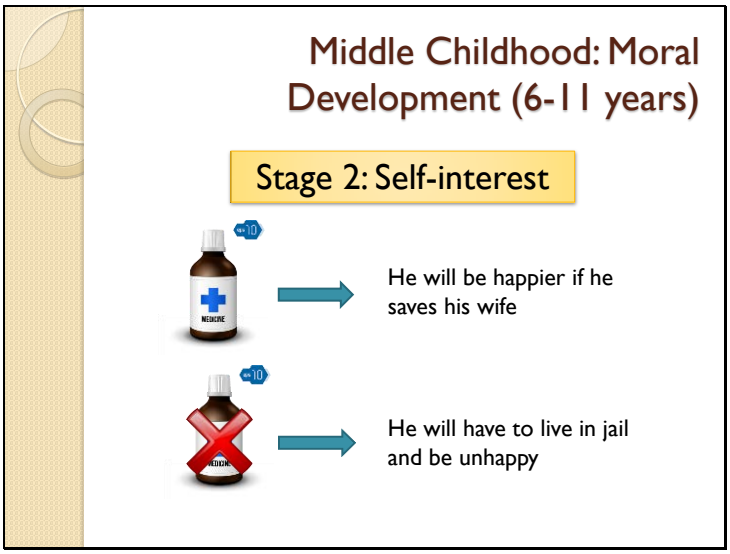


Learning Style

There are three types of learners:

- Visual learners have a preference for acquiring knowledge through seeing. They think in pictures or images. They benefit greatly from slides, diagrams, handouts, and the like.
- Auditory learners obtain knowledge best through listening. They learn by reading aloud and remember things by verbalizing lessons to themselves or having discussions with others. They benefit greatly from lectures, discussion, audio recordings, and the like.
- Finally, Kinesthetic learners or tactile learners prefer to learn through experience and active exploration. They are "hands-on" learners. For example, kinesthetic learners enjoy experiments, activities, field trips, and so forth.

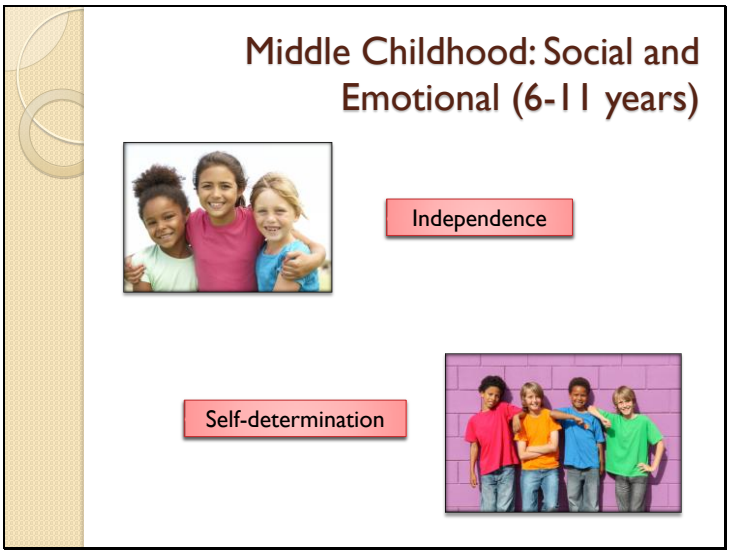
Slide 7



Development

With regard to moral development in middle childhood, as children grow older, they begin to see that there is not just one right view. They begin to think more about themselves and their own self-interest, thus leading them to the next stage of moral development – self-interest. Essentially, they think about "what's in it for me?" The answer to the Heinz dilemma at stage two, then, is along the lines of, "Heinz should steal the medicine because he will be happier if he saves his wife," or "Heinz should not steal the medicine since he will have to live in jail, and then he would be unhappy." It is not the question of whether or not Heinz should steal the medicine that illustrates the morality, but the reasoning that is given for the answer – in this case, driven by self-interest.

Slide 8



Middle Childhood: Social and Emotional (6-11 years)

In middle childhood kids make some significant advances in social and emotional development. In particular, there is an increase in independence and self-determination. Children at this stage are increasingly able to manage themselves, take responsibility, and exercise self-control.

Sexual impulses are quiet at this developmental stage. Children at this stage typically choose to be with others of the same sex.

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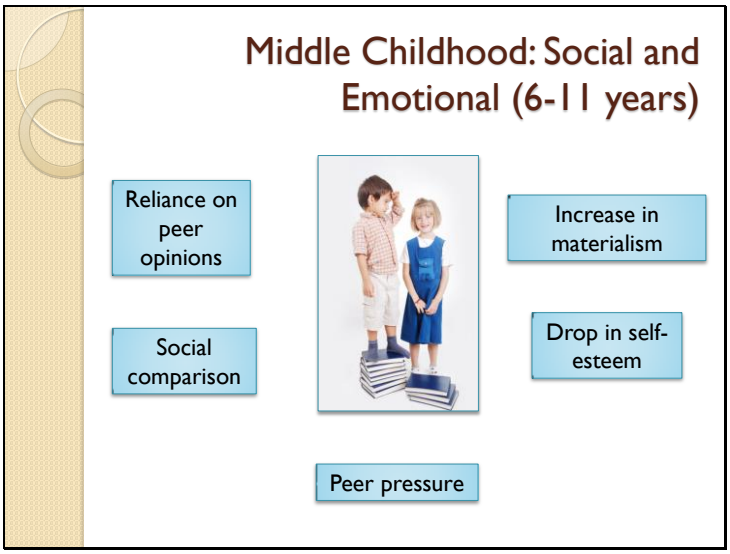

Most children in middle childhood are happy with themselves and have friends who appreciate them. In terms of self-concept, schoolchildren begin to rely on peers' opinions of themselves rather than their parents'. They care more about what others think about them and do a lot of comparing of themselves to others – "Is he better at sports than I am?" "Does she have more friends than I do?" This is also the stage when peer pressure can become an issue.

Because there is more of an emphasis in this stage about the opinions of peers, it is not surprising that kids have a drop in self-esteem. They are now vulnerable to the opinion of others – even other children whom they don't know.

Also, materialism increases and attributes that adults might find superficial become important – which makes self-esteem more fragile (for example, kids may want the latest toys, shoes, clothes, video games, etc.).

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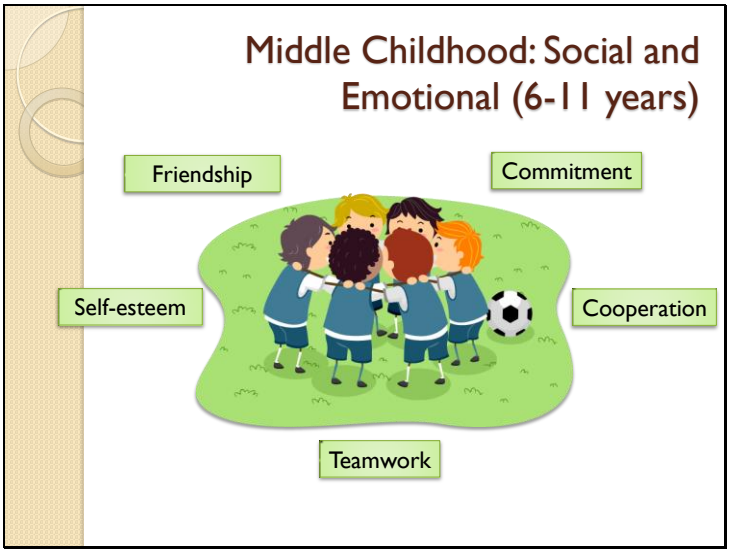

After-school activities, especially sports, can be very valuable at this stage because it helps kids with a foundation for friendship and realistic self-esteem. It also helps with building teamwork, cooperation, and commitment.

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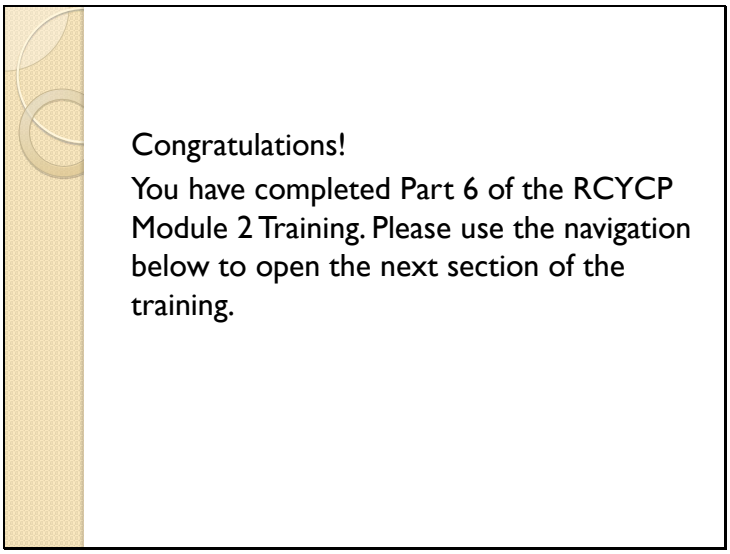

Congratulations! You have completed Part 6 of the RCYCP Module 2 Training. Please use the navigation below to open the next section of the training.

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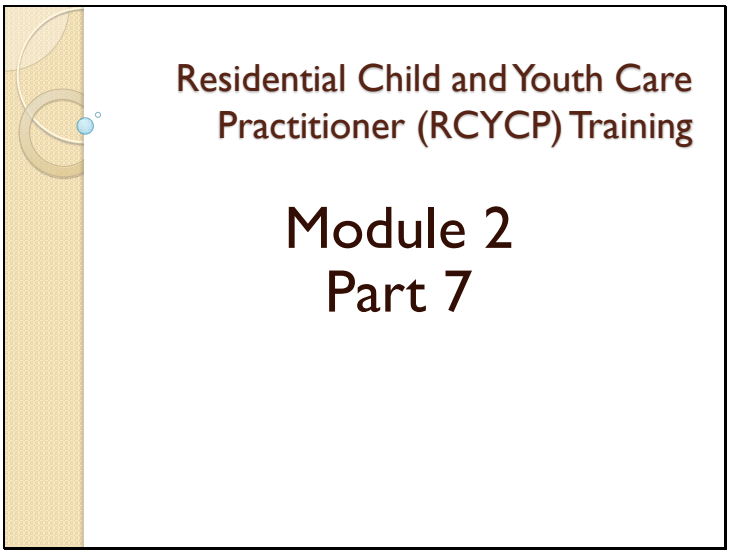
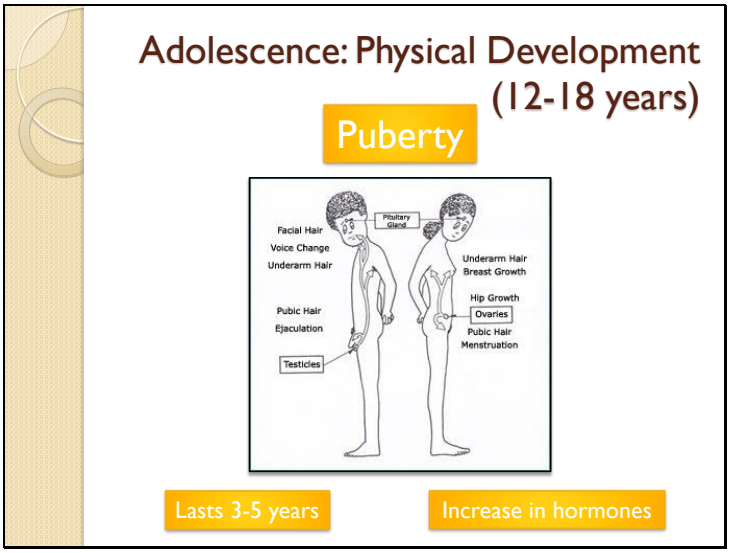


Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 2, Part 7 of the Residential Child and Youth Care Practitioner Training.

Slide 3



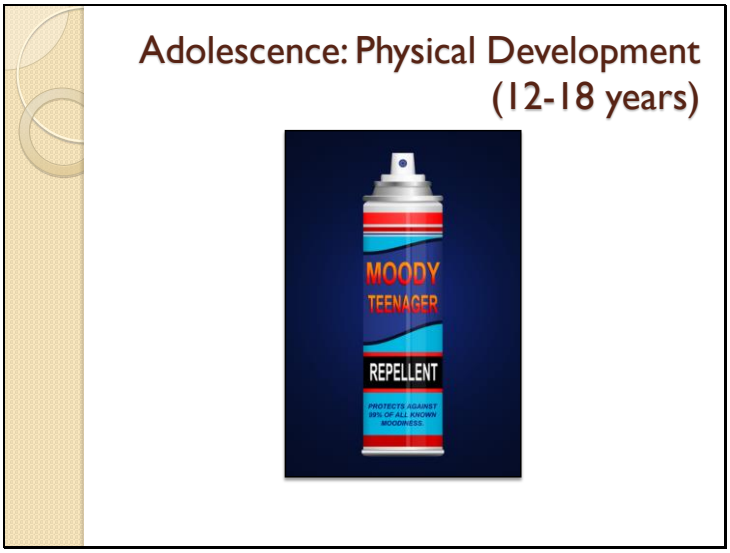
Adolescence: Physical Development (12-18 years)

Adolescence begins with puberty. Puberty refers to the years of rapid growth and sexual maturation that complete the transition from child to adult in terms of size, shape, and sexuality. It usually lasts three to five years and is marked by an increase in hormones for both males and females. Girls get their periods and their bodies begin to change, for example with breast maturation, pubic-hair growth, and widening of the hips.

For boys, puberty means that boys will undergo physical changes as well. Boys will develop pubic hair and facial hair. They will have a growth spurt that includes growth of penis and testicles. Their voices will deepen and they will experience spermarche, which is the first ejaculation of sperm – either by a wet dream or physical stimulation.

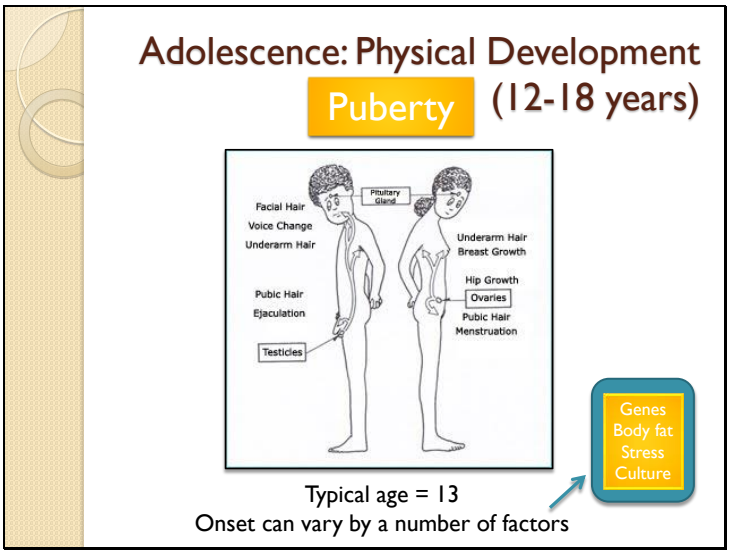
Picture source: http://mrclay10sci2.wikispaces.com/puberty

Slide 4



The increase in hormones has an effect on mood as well. Adolescent outbursts of sudden anger, sadness, and lust are caused by hormones combined with reactions from other people to the young person's changing body.

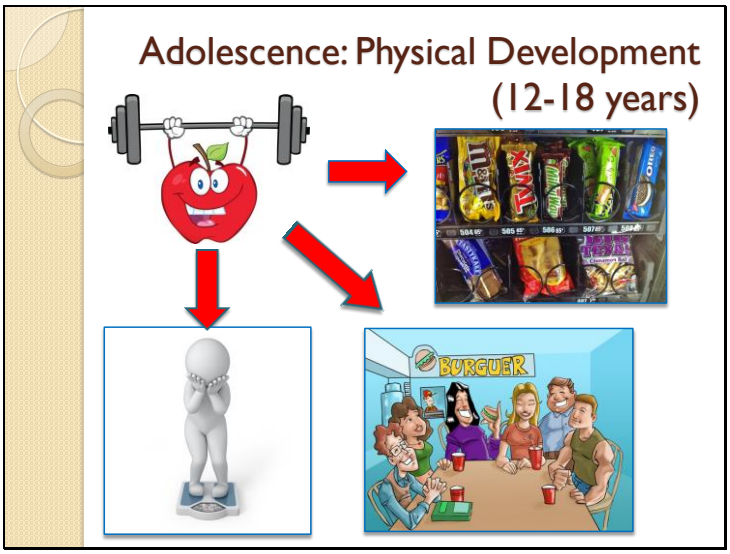
Slide 5



The typical age of puberty for males and females is just under 13 years of age, although it can vary. Many factors affect the onset of puberty, especially among girls. Such factors include genes, body fat, and stress.

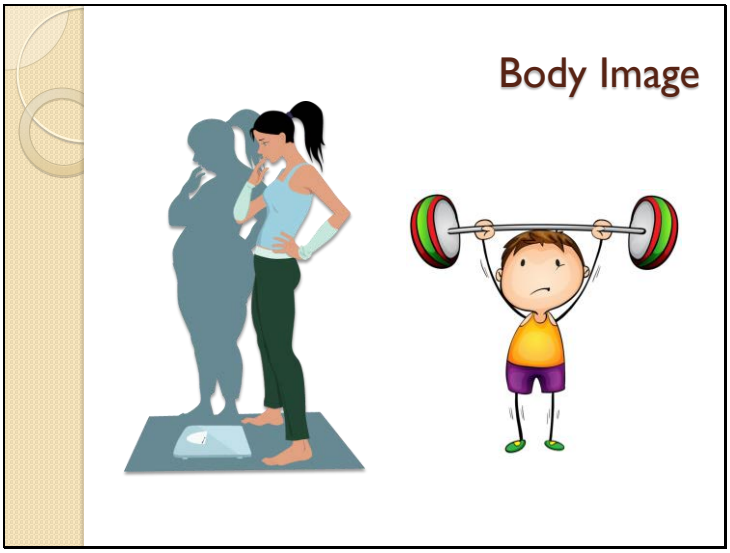
There are cultural variations as well. Well-nourished Africans tend to experience puberty a few months earlier than Europeans, and Asians a few months later than Europeans. Urban children tend to experience puberty earlier than rural children, most likely as a result of less physical activity and higher fat levels.

Slide 6



Proper adolescent nutrition is important to the physical changes that occur during this time period, but may be complicated by a desire to eat junk food, as well as by peer culture, and body image issues.

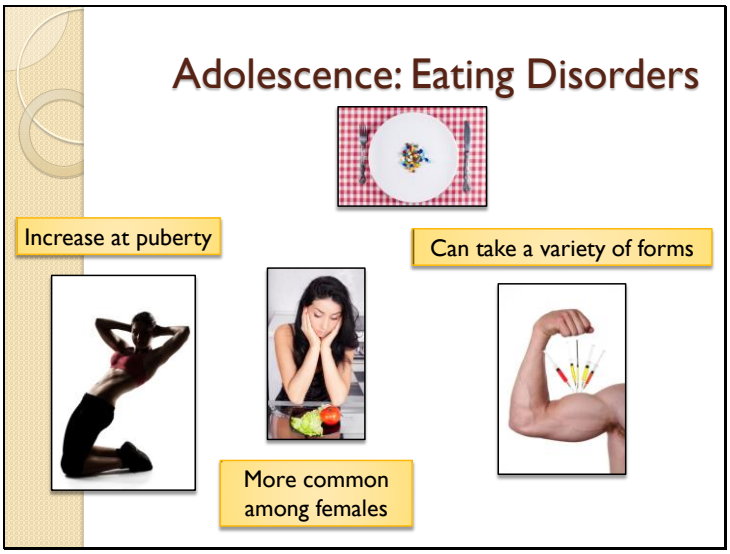
Slide 7



Body Image

Let's talk about body image issues for a moment. By "body image issues," we are referring to the concerns that adolescents have about their changing bodies. Body image issues may arise during this time period. Adolescents tend to focus on, and exaggerate, imperfections in their body, as well as compare themselves to others. Girls may want to be thinner, whereas boys tend to want to look taller and stronger.

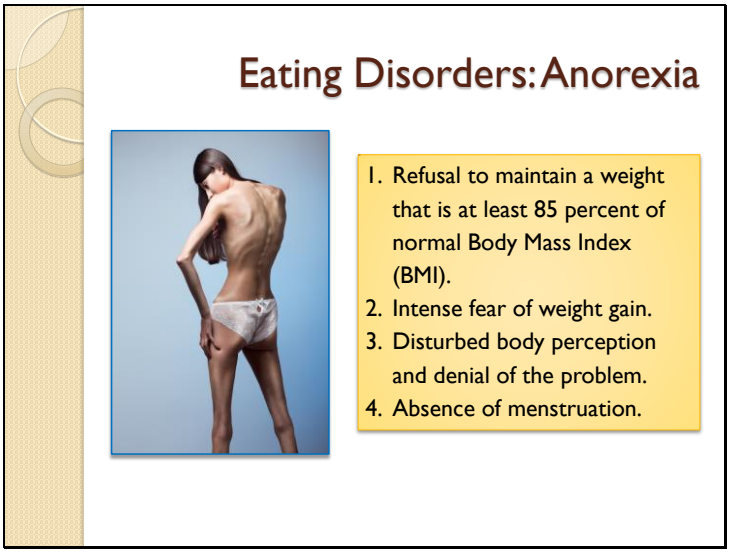
Slide 8



Adolescence: Eating Disorders

Body image issues can put adolescents at risk for eating disorders. Eating disorders, while rare in childhood, increase dramatically at puberty. They are more common among females, but occur with males as well. They can take a variety of forms, such as eating erratically, ingesting diet pills, taking steroids to increase muscle mass, or over-exercising. Two eating disorders that are common in adolescence are Anorexia Nervosa and Bulimia Nervosa.

Slide 9



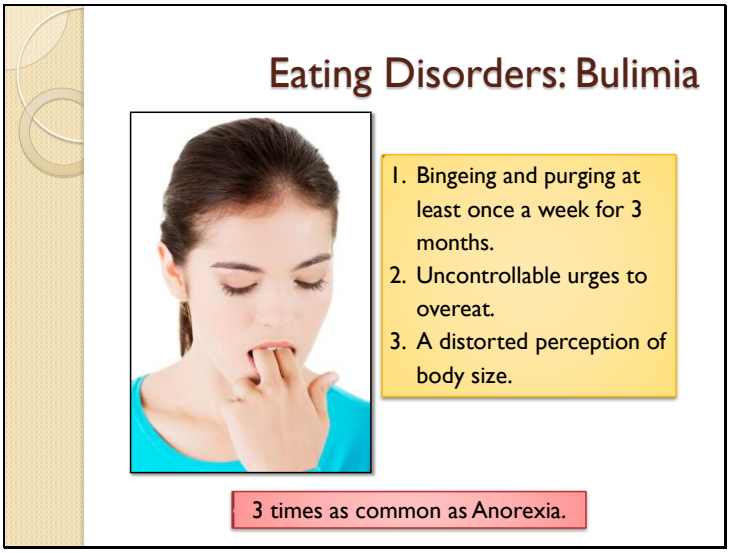
Eating Disorders: Anorexia

Anorexia Nervosa is a disorder characterized by voluntary starvation – that is, a disorder where someone essentially starves himself or herself.

The 4 symptoms of anorexia are:

1. Refusal to maintain a weight that is at least 85 percent of normal Body Mass Index (BMI).
2. Intense fear of weight gain.
3. Disturbed body perception and denial of the problem; and,
4. Absence of menstruation in adolescent and adult females.

Slide 10



Eating Disorders: Bulimia

The second common eating disorder in adolescence is Bulimia.
The 3 symptoms of bulimia include:
1. Bingeing (or overeating) and purging at least once a week for 3 months.
2. Uncontrollable urges to overeat.
3. A distorted perception of body size.

Bulimia is three times as common as anorexia.

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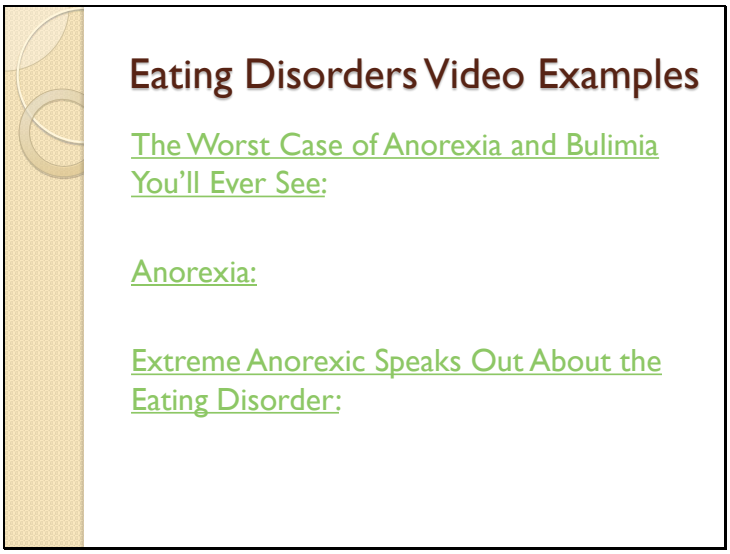

Eating Disorders Video Examples

Click on the links to see some videos about the devastation of eating disorders.

The Worst Case of Anorexia and Bulimia You'll Ever See:
http://www.youtube.com/watch?v=iy_RPP2eIfk

Anorexia: http://vimeo.com/22689975

Extreme Anorexic Speaks Out About the Eating Disorder:
http://www.youtube.com/watch?v=sz-nPMTXduo

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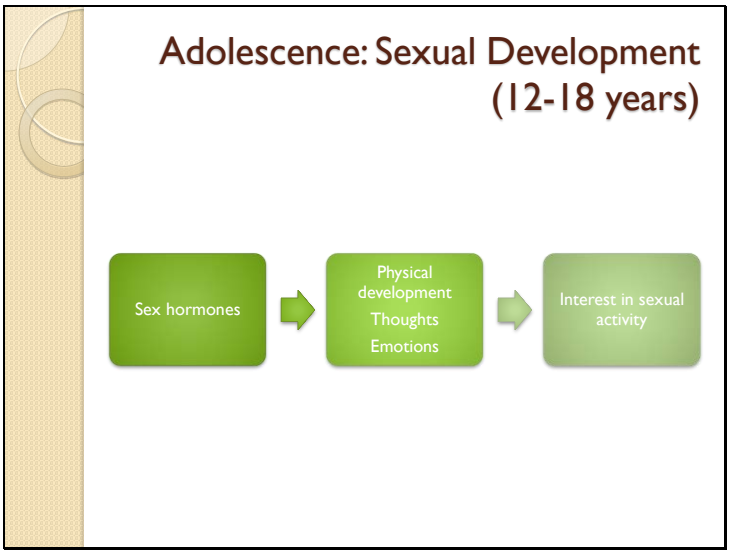
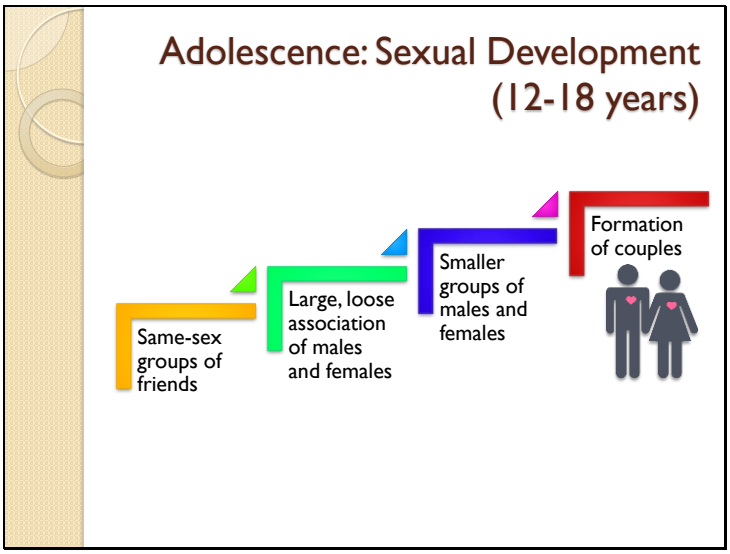


Adolescence: Sexual Development (12-18 years)

During puberty, sex hormones are responsible for the physical development of males and females, and for other changes as well. In particular, sex hormones trigger thoughts and emotions so that adolescents become more interested in sexual activity.

Romances often begin in adolescence, and about half of all U.S. teens become sexually active.

Slide 15



Typically, children and then adolescents progress through relationships in the following way:

1. First, adolescents have groups of friends that are typically of their own gender.
2. Eventually, there is a loose association of girls and boys, mainly interacting within a crowd.
3. Next, small mixed-sex groups of the advanced members of the crowd begin to form.
4. Finally, adolescents begin to form couples, with relationships becoming more private and less group-focused.

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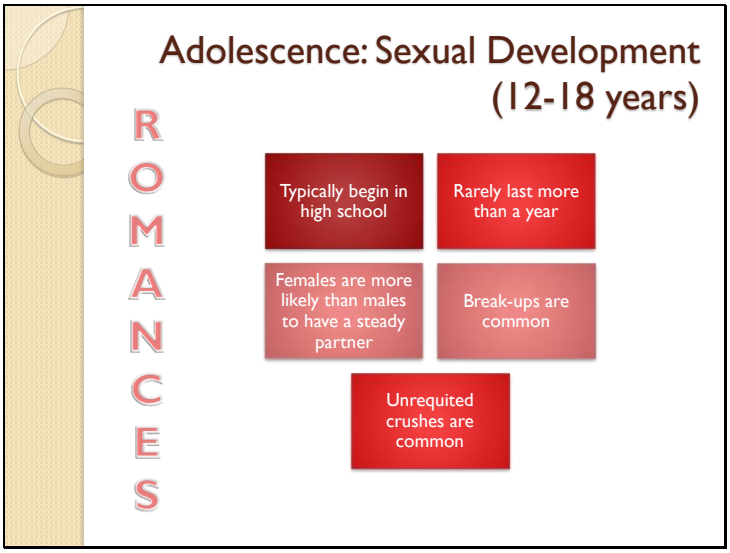
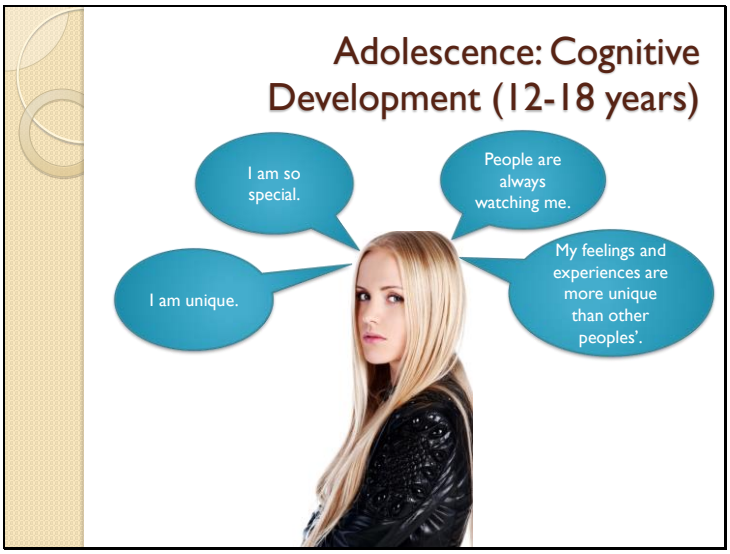


First romances typically begin in high school and rarely last more than a year. Females are more likely than males to have a steady partner. Breakups are common, as are unrequited crushes, and are typically on display to the high school peer group. Adolescents tend to react strongly to rejection, in severe cases even contemplating revenge or suicide. Peer group support is helpful for such romantic ups and downs.

Slide 18



Adolescence: Cognitive Development (12-18 years)

In terms of cognitive development, it is typical for young adolescents to think intensely about themselves and about what others think of them. This is termed "egocentrism." Egocentrism is common in early adolescence among both males and females and every ethnic group. This leads adolescents to think of themselves as unique, special, and much more socially significant (that is, noticed by everyone) than they actually are. That means that they believe what they observe in others must be directly related to them. For example, a teacher's frown must surely be about the adolescent doing or looking a certain way rather than about something entirely unrelated to them. This belief that others are always watching and evaluating them can lead to feelings of self-consciousness.

Additionally, they believe that their thoughts, feelings, and experiences are more unique and more wonderful or awful than everyone else's. Their egocentrism also lends itself to feelings of invincibility – they cannot be harmed by the things that would defeat a normal mortal. For example, "Texting and driving may kill people, but it won't kill me."

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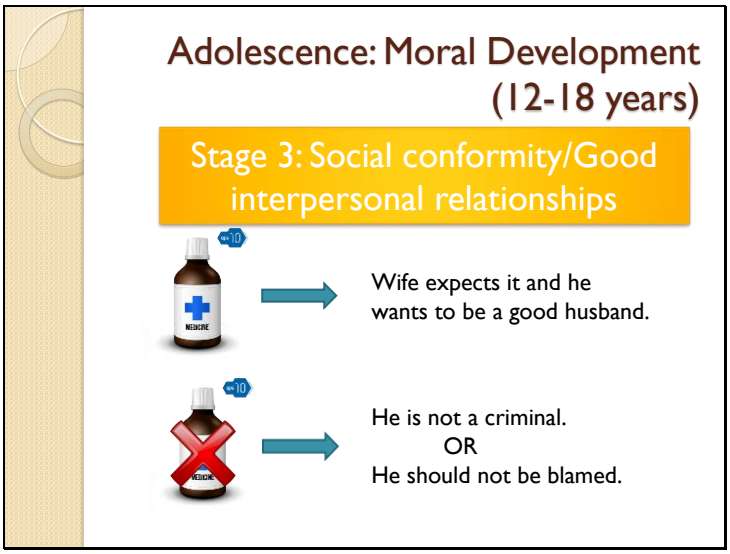

Adolescence: Moral Development (12-18 years)

By adolescence most youth have moved into stage 3 of Kohlberg's moral development, which centers on social conformity and good interpersonal relationships. In this stage kids have a sense of what "good boys" and "good girls" do and that they should live up to social expectations of the family and community. There is also a certain need for approval by others at this stage.

With regard to the Heinz dilemma, adolescents may suggest that Heinz should steal the medicine because his wife expects it, or he wants to be a good husband. Or, adolescents might suggest that Heinz should not steal the drug because stealing is bad and he is not a criminal, and that he has tried all that he can do without breaking the law so he should not be blamed.

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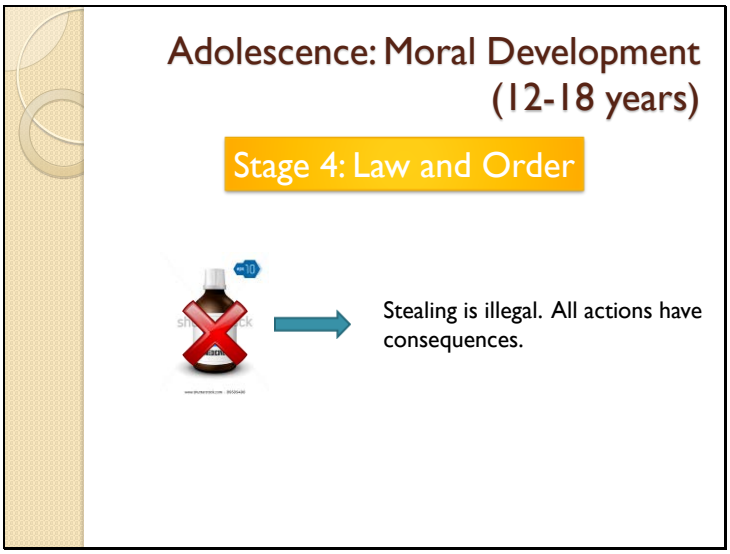

Eventually, as adolescents near adulthood, they will shift into stage 4 of moral development with a focus on law and order for maintaining the social order. In this stage, there is a focus on respecting authority. In response to the Heinz dilemma, older adolescents might respond that Heinz should not steal the medicine because the law prohibits stealing; it is illegal, and all actions have consequences.

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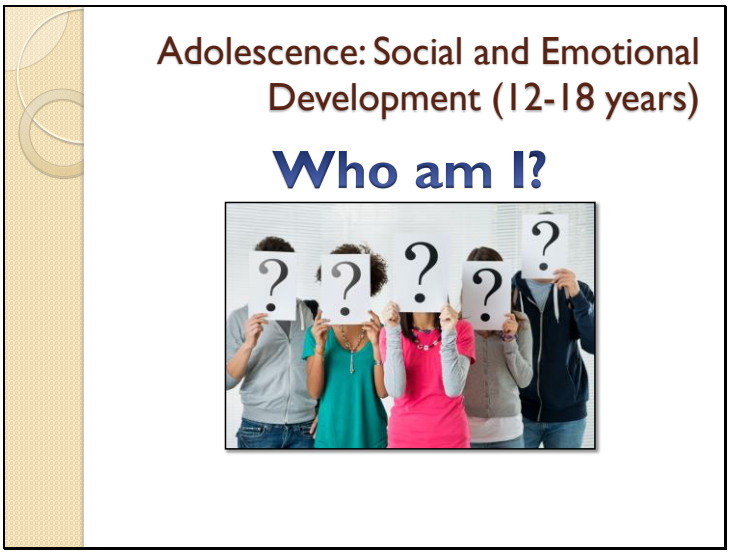

Adolescence: Social and Emotional Development (12-18 years)

Adolescence is a period marked by a search for identity and a time for self-discovery. Self-expression and self-concept become increasingly important. Adolescents try to answer the question “who am I?” especially with regard to religion, politics, vocation, and sexuality. In their search for identity, adolescents will evaluate the goals and values of their parents and culture, keeping pieces that make sense to them and discarding others.

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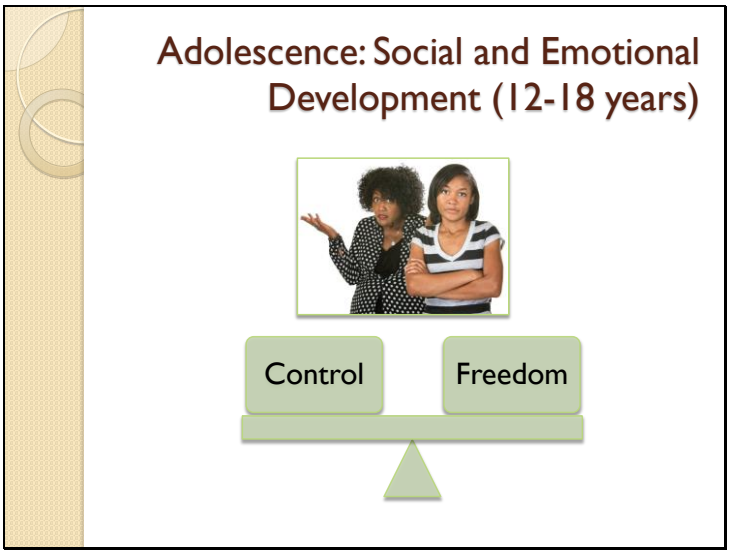

Relationships with families are important during this stage. Families continue to be influential, although not surprisingly, there is an increase in rebellion and bickering. Adolescents seek independence and freedom, but also rely on parental support. The most successful families have good communication and warmth, while allowing adolescents to develop independence. Too much control can interfere with the developing adolescent, while too much freedom can be problematic as well.

Slide 24

Other relationships are important during this stage as well. Adults who are not parents (for example, grandparents or coaches) can be positive role models and offer support. Friends and peers of both sexes are increasingly important during this stage.

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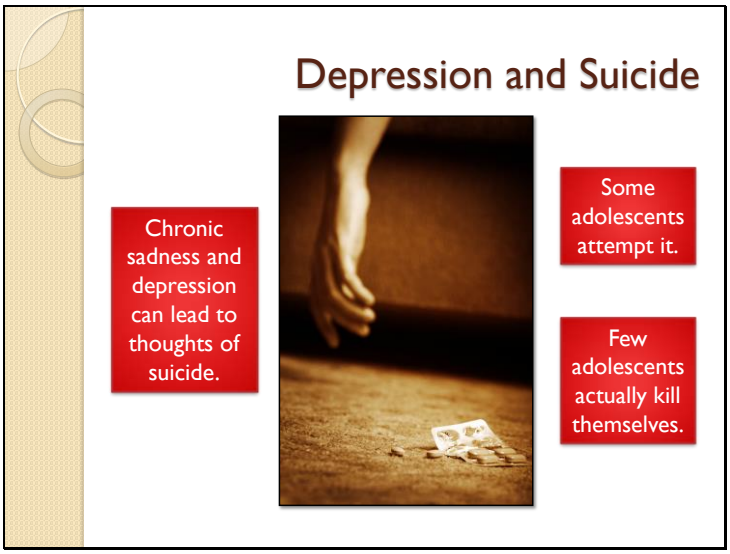

Depression and Suicide

As we talked about, nearly all adolescents become self-conscious and self-critical. A few become chronically sad and depressed. Some adolescents have suicide thoughts; some attempt it. Few adolescents actually kill themselves.

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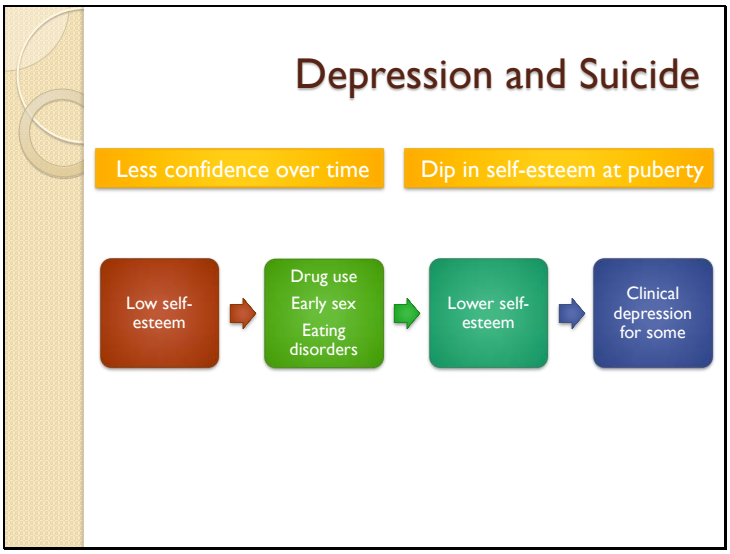

The general emotional trend from late childhood through adolescence is toward less confidence. There is a dip in self-esteem at puberty for children of every ethnicity and gender. Both parents and peers have an effect on an adolescent's self-esteem. Often, young adolescents with very low self-esteem turn to drug use, early sex, and disordered eating which further reduces self-esteem. Some adolescents sink into clinical depression.

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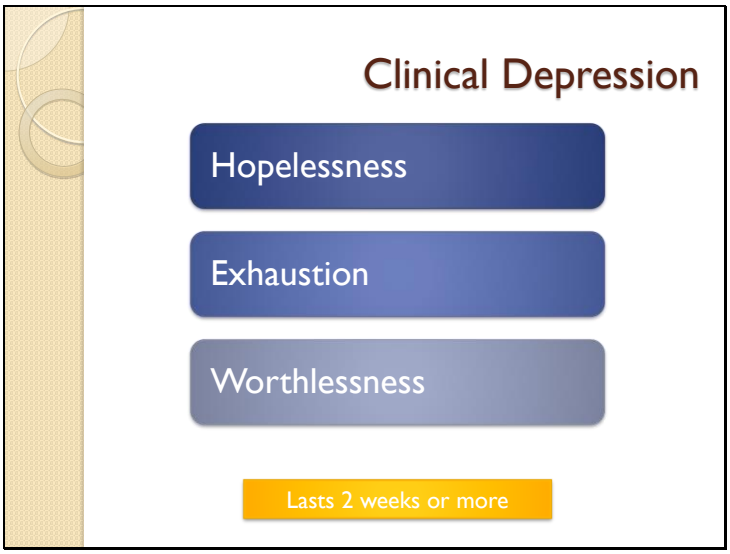

Clinical Depression

What do we mean by clinical depression? Clinical depression refers to feelings of hopelessness, exhaustion, and worthlessness that last two weeks or more.

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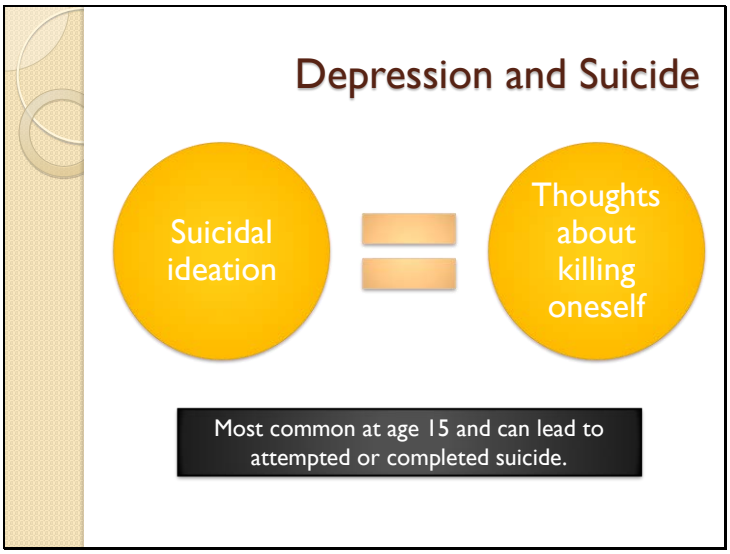

Depression and Suicide

Depression puts adolescents at risk for suicidal ideation. Suicidal ideation is serious and distressing thoughts about killing oneself. Suicidal ideation is most common at about age 15 and can lead to attempted suicide (a potentially lethal action against the self that does not result in death), or a completed suicide (a lethal action against the self that does result in death).

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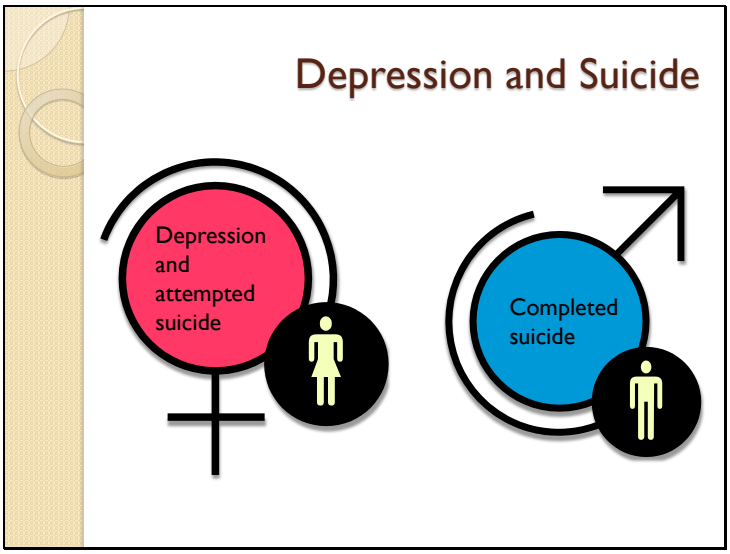

Depression and attempted suicide are more common among females than males, but completed suicide is higher for males. Males tend to use more lethal methods of suicide than females do.

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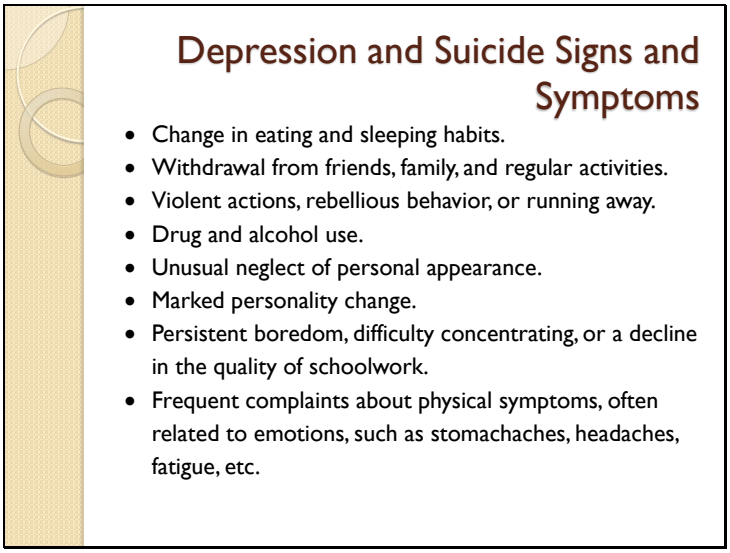

Depression and Suicide Signs and Symptoms

Many of the signs and symptoms of suicidal feelings are similar to those of depression. Let's look at them now:

- Change in eating and sleeping habits.
- Withdrawal from friends, family, and regular activities.
- Violent actions, rebellious behavior, or running away.
- Drug and alcohol use.
- Unusual neglect of personal appearance.
- Marked personality change.
- Persistent boredom, difficulty concentrating, or a decline in the quality of schoolwork.
- Frequent complaints about physical symptoms, often related to emotions, such as stomachaches, headaches, fatigue, etc.

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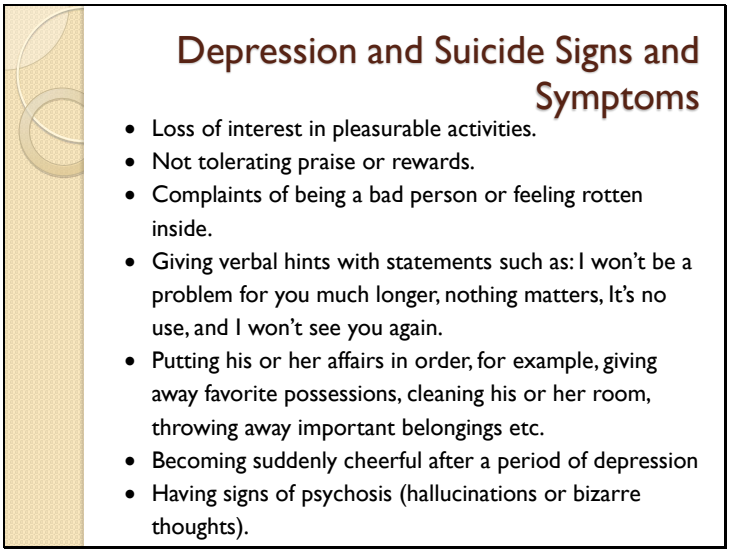

- Loss of interest in pleasurable activities
- Not tolerating praise or rewards
- Complaints of being a bad person or feeling rotten inside
- Giving verbal hints with statements such as: I won't be a problem for you much longer, nothing matters, It's no use, and I won't see you again
- Putting his or her affairs in order, for example, giving away favorite possessions, cleaning his or her room, throwing away important belongings etc.
- Becoming suddenly cheerful after a period of depression
- Having signs of psychosis (hallucinations or bizarre thoughts)

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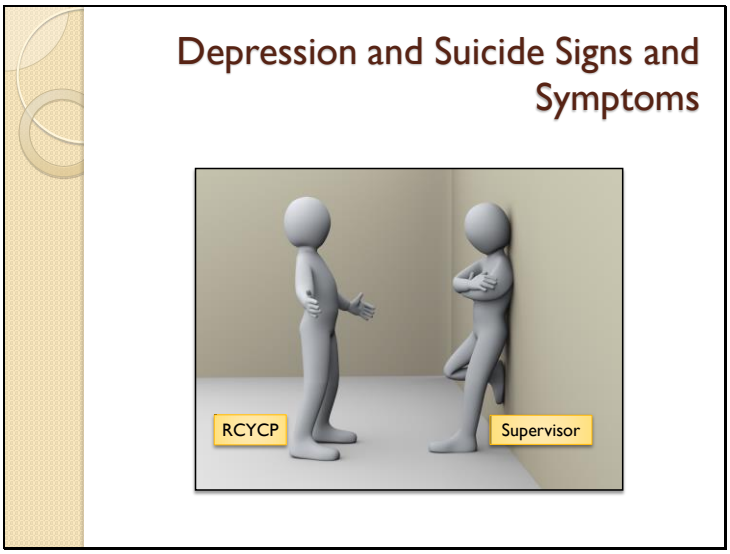

Depression and suicidal feelings are treatable mental disorders. With the help of mental health professionals who can diagnose and establish treatment plans, young people can be helped. Caregivers who have concerns about the emotional state of a child or adolescent should seek professional help from a physician or a qualified mental health professional. You, as an RCYCP, should share any concerns you might have about a youth with your supervisor.

Let's discuss now some other mental illnesses that can affect youth.

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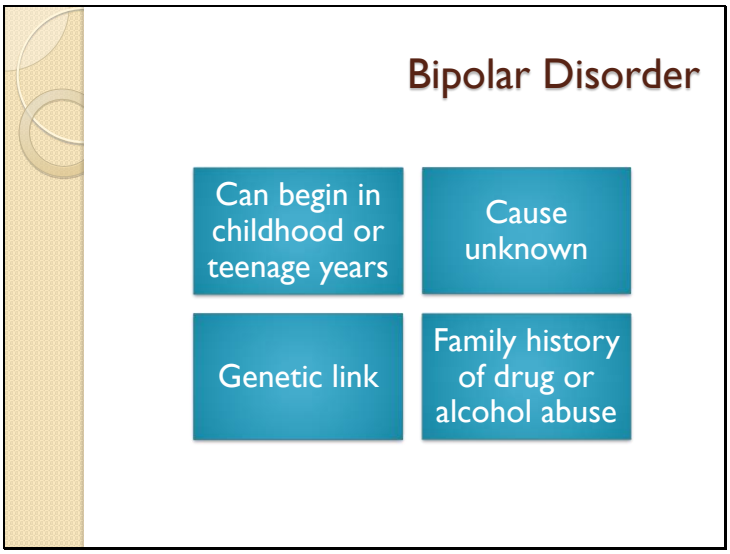

Bipolar Disorder

Bipolar disorder can begin in childhood and during the teenage years, although it is usually diagnosed in adult life. The cause of bipolar disorder is unknown although there is a genetic link. It occurs more often in relatives of people with bipolar disorder. If one or both parents have bipolar disorder the chances are greater that their children will develop the disorder. Family history of drug or alcohol abuse also may be associated with greater risk for bipolar disorder.

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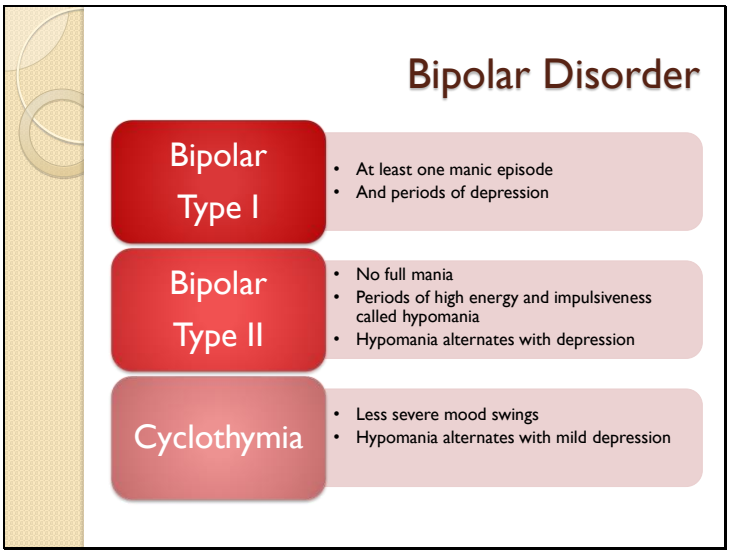

There are 3 different types of bipolar disorder:
1. The first is Bipolar Disorder Type I: people with this type have had at least one manic episode and periods of major depression.
2. The second type is Bipolar Disorder Type II: people with this type have never had full mania. Instead they experience periods of high energy levels and impulsiveness that are not as extreme as mania as described earlier. This form of mania is referred to as hypomania. These periods of hypomania alternate with episodes of depression.
3. The third type is a mild form of bipolar disorder called cyclothymia. Cyclothymia involves less severe mood swings. People with this form of bipolar disorder alternate between hypomania and mild depression. Occasionally people with bipolar disorder type II and Cyclothymia are misdiagnosed with depression.

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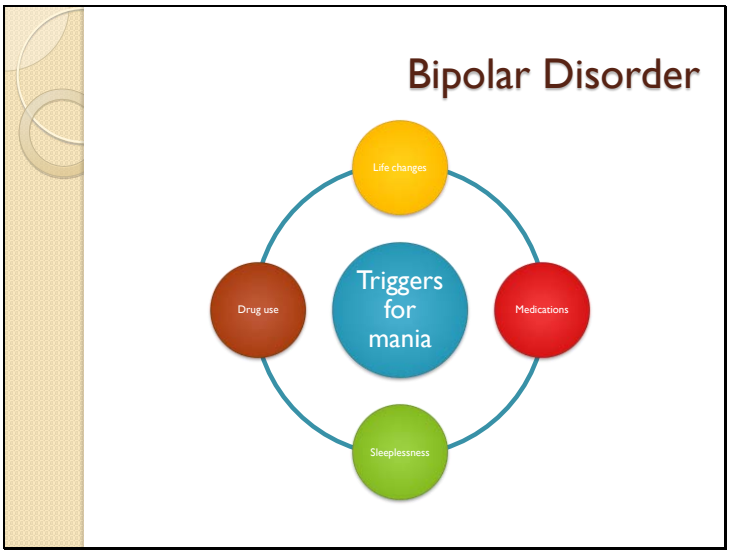

In the majority of people with bipolar disorder, there is no clear cause for the manic or depressive episodes. The following, however, may trigger a manic episode in people with bipolar disorder:

- Life changes such as childbirth.
- Medications such as antidepressants or steroids.
- Periods of sleeplessness.
- Recreational drug use.

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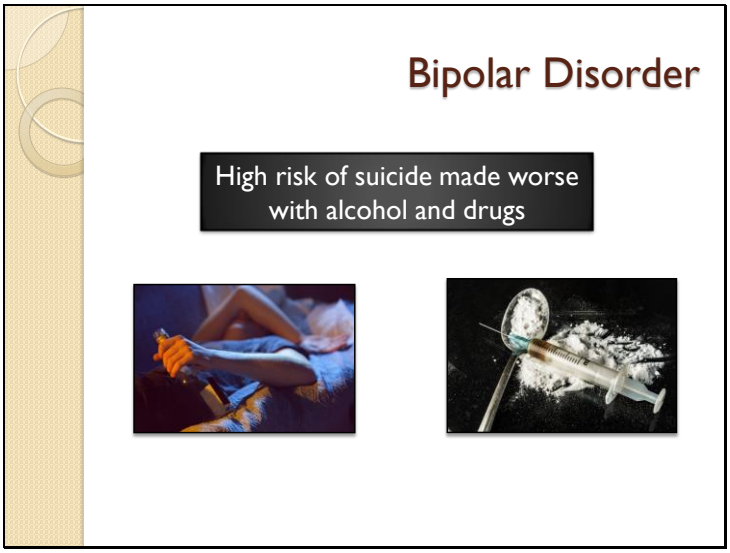

There is a high risk of suicide with bipolar disorder, and behavior that may accompany the disorder, such as alcohol abuse or drug use, can make symptoms worse and increase the suicide risk.

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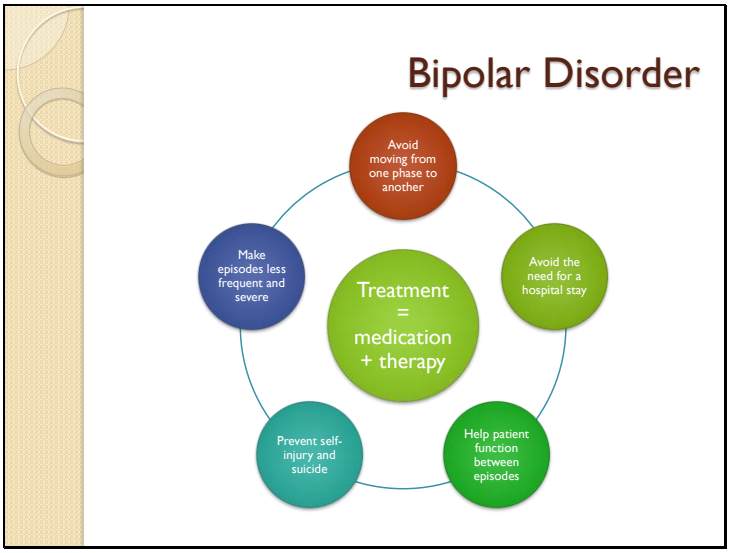

Bipolar disorder is extremely difficult to treat. Treatment includes mood stabilizing medication, and other forms of therapy. Because periods of depression or mania return in most patients, even with treatment, the main goals of treatment are to:

- Avoid moving from one phase to another.
- Avoid the need for a hospital stay.
- Help the patient function as well as possible between episodes.
- Prevent self-injury and suicide.
- Make the episodes less frequent and severe.

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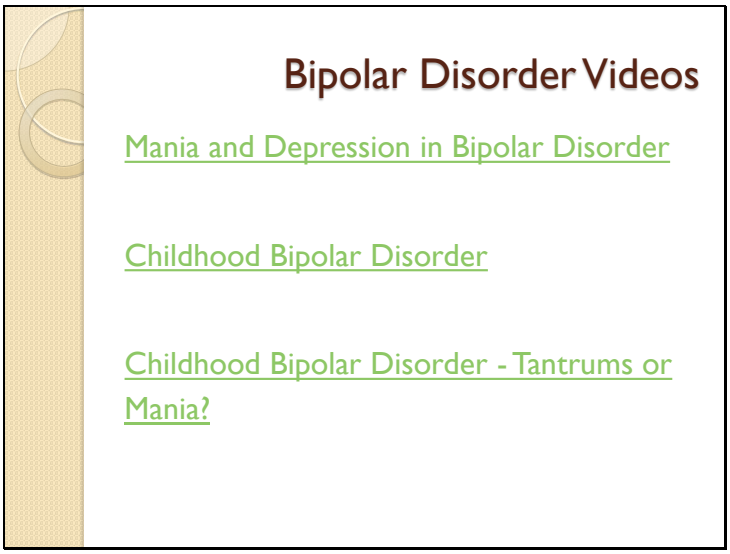

Let's look at some videos on childhood bipolar disorder. Click on the links to watch. (Ellen Leibenluft)

Mania and Depression in Bipolar Disorder:
http://www.youtube.com/watch?v=1U9tD2dquOA&list=PL6DC4C789ACF50063

Childhood Bipolar Disorder:
http://www.youtube.com/watch?v=ri0LTG7gL1k&list=PL6DC4C789ACF50063

Childhood Bipolar Disorder - Tantrums or Mania?:
http://www.youtube.com/watch?v=04FgLeODwbI&list=PL6DC4C789ACF50063

http://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml

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Anxiety Disorders

Let's now turn to a discussion of anxiety disorders.

Anxiety in children is both expected and normal at specific times in development. For example, young children experience distress and anxiety in response to separation from a parent or caregiver. Some children's distress may be intense. As mentioned earlier in this module, this is referred to as "separation anxiety".

Young children also experience developmentally typical (that is to say, normal) fears, for example, fear of the dark, storms, animals, or strangers. At some point, however, anxiety is developmentally atypical (that is to say, not normal), and begins to get in the way of daily life. When this happens, there is a need for some type of therapeutic intervention.

There are different types of anxiety. Let's talk about these.

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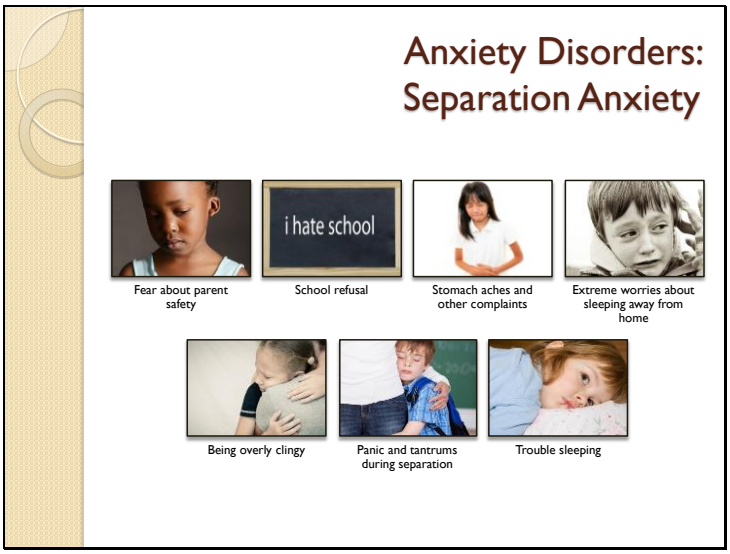

Anxiety Disorders: Separation Anxiety

Separation anxiety: is intense distress and anxiety at times of separation from parents or other persons with whom they are close. Symptoms of separation anxiety include the following:

- Constant thoughts and intense fears about the safety of parents and caretakers.
- Refusing to go to school.
- Frequent stomachaches and other physical complaints.
- Extreme worries about sleeping away from home.
- Being overly clingy.
- Panic or tantrums at times of separation from parents.
- Trouble sleeping or nightmares.

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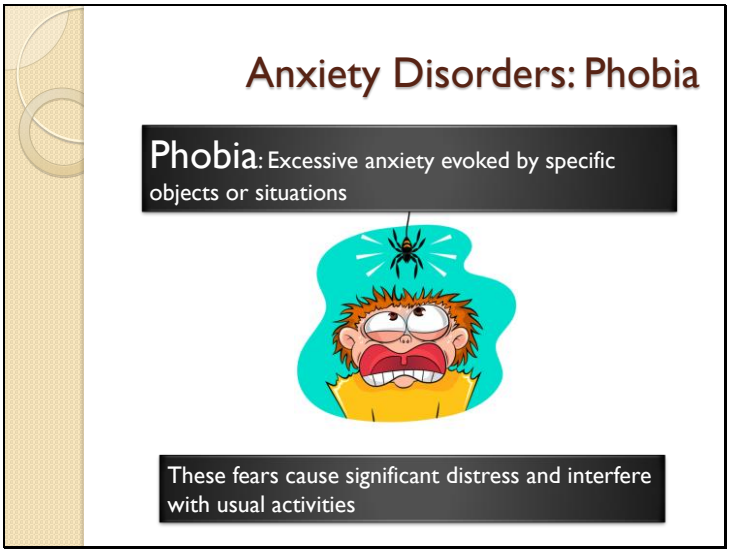

Anxiety Disorders: Phobia

Another type of anxiety is Phobia. Phobia is excessive anxiety evoked by specific objects or situations. Symptoms of phobia include the following:

- Extreme fear about a specific thing or situation (e.g., spiders, dogs, needles).
- The fears cause significant distress and interfere with usual activities.

So for example, you have probably heard of ”arachnophobia”, which is the fear of spiders.

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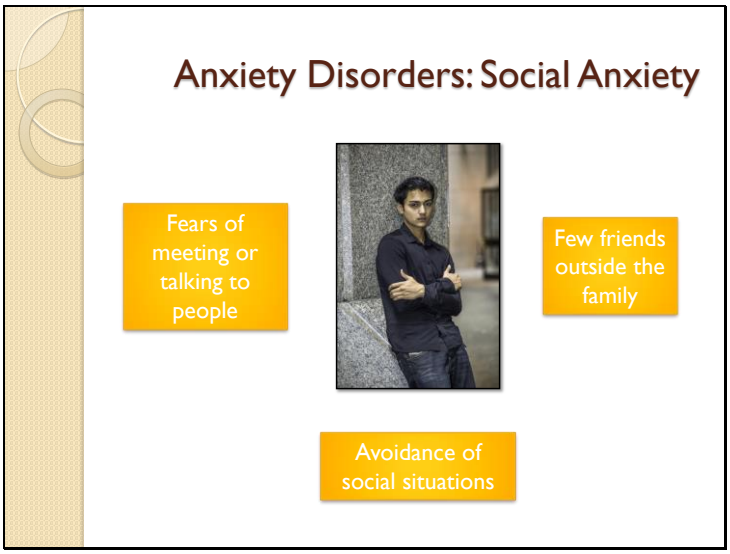

Anxiety Disorders: Social Anxiety

A third type of anxiety is Social anxiety which is fear of social situations and interaction with other people. People who have social anxiety worry, in part, that others are scrutinizing or judging them. Symptoms of social anxiety include the following:

- Fears of meeting or talking to people.
- Avoidance of social situations.
- Few friends outside the family.

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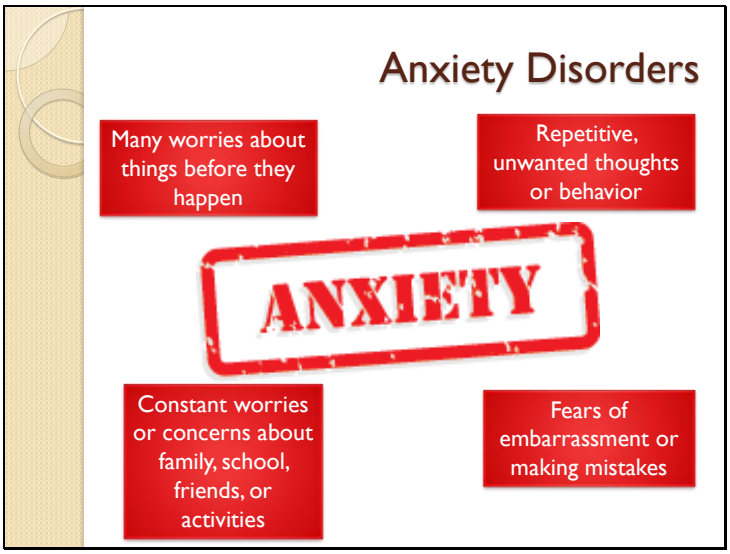

Anxiety Disorders

Other symptoms of anxiety include:

- Many worries about things before they happen.
- Constant worries or concerns about family, school, friends, or activities.
- Repetitive, unwanted thoughts or behaviors and,
- Fears of embarrassment or making mistakes.

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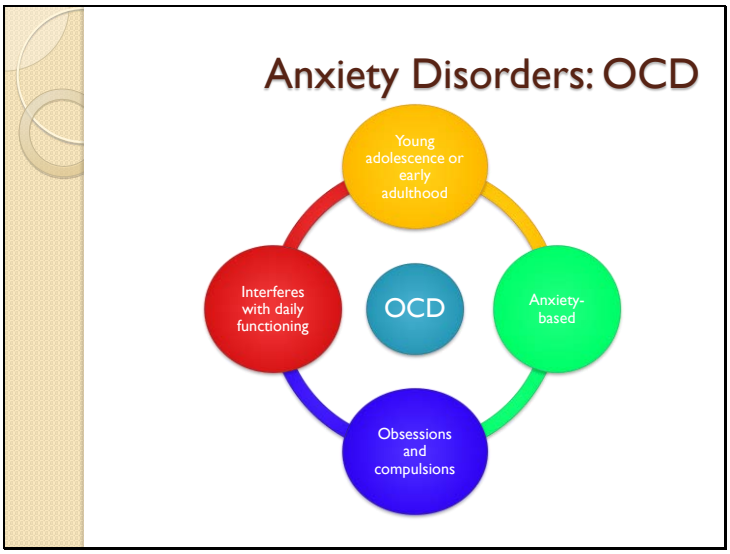
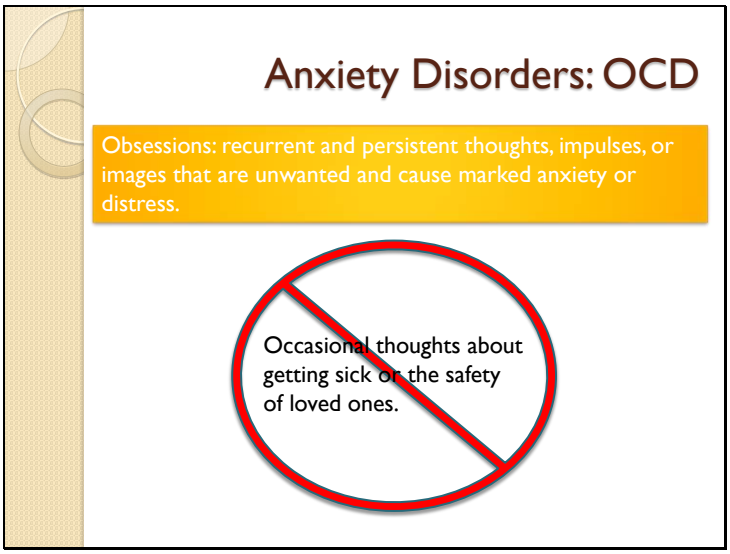


Anxiety Disorders: OCD

One of the most recognized anxiety-based disorders is Obsessive Compulsive Disorder (known as OCD).

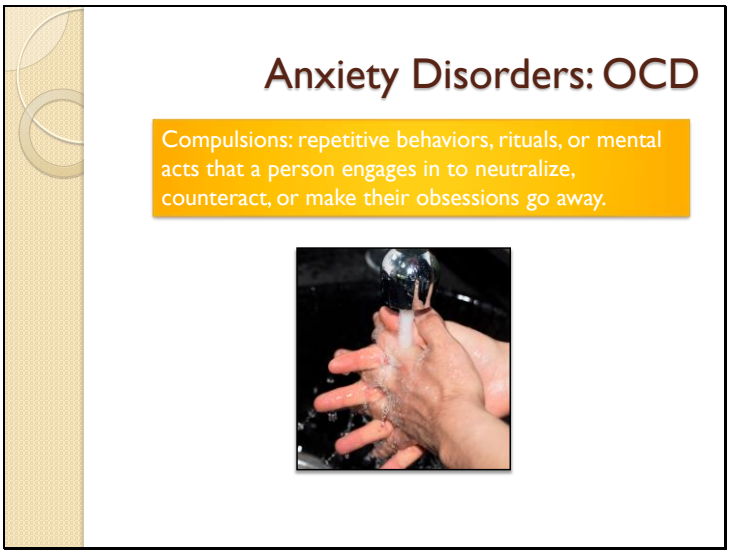
OCD typically begins in young adolescence or early adulthood and is seen in as many as 1 in 200 children and adolescents. OCD is an anxiety-based disorder that is characterized by recurrent intense obsessions and/or compulsions that cause severe discomfort and interfere with daily functioning.

Slide 52



So what are obsessions? Obsessions are: recurrent and persistent thoughts, impulses, or images that are unwanted and cause marked anxiety or distress. Oftentimes, these obsessions are unrealistic or irrational rather than simply excessive worries about real-life problems or preoccupations. So for example, adolescents might worry about being gay, even when they are sure they are not. Such obsessions consume these persons' thoughts (they can't stop thinking about it or get it out of their heads). Obsessions are NOT occasional thoughts about getting sick or about the safety of loved ones. Obsessions may then lead to compulsive behavior.

Slide 53



So what are compulsions? Compulsions are repetitive behaviors, rituals, or mental acts that a person engages in to neutralize, counteract, or make their obsessions go away. So for example, a youth might have an obsessive thought that harm will come to a loved one if they don't go up the stairs correctly (remember, the obsession is not rational); so to protect their loved ones they may go up the stairs several times to make sure they have done it right, and may even walk down the stairs backwards in an effort to "undo" any "damage" they believe they have done by not going up the stairs correctly. Sometimes the compulsions are linked to the obsessions. For example, a person might have a strong fear of germs and contamination that will cause harm (an obsession) and the response might be a compulsion to wash their hands such that they are constantly washing their hands. Sometimes, however, the obsession and compulsion are unrelated. For example, a youth might worry that they will lose control of themselves and hurt others and deals with that obsession compulsively by repeating activities in multiples, for example, in 3's because 3 is a "good" or "safe" number.

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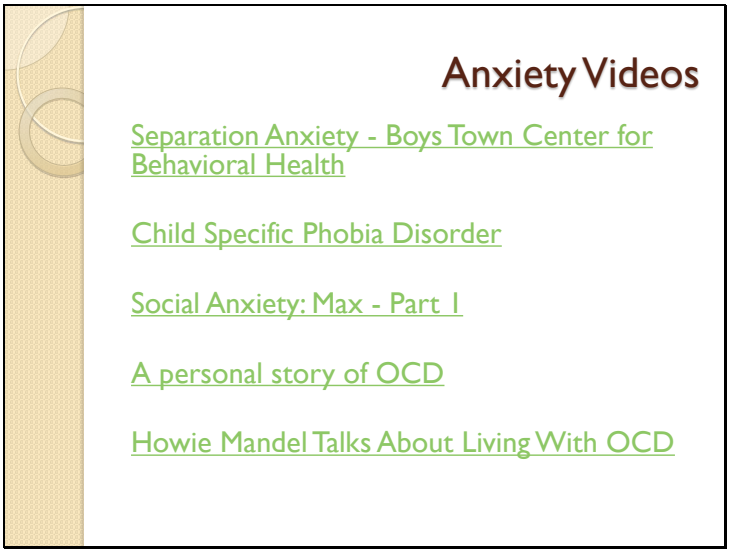

Anxiety Videos

Click on the links to view some videos about anxiety disorders.

Separation Anxiety - Boys Town Center for Behavioral Health:
https://www.youtube.com/watch?v=7CfIE0vZeDo

Child Specific Phobia Disorder:
http://www.youtube.com/watch?v=ht3Hy4RZzLs&list=PLehGvMkd5jMakBQcMMrA2l2z02xeThVv1

Social Anxiety: Max - Part 1:
http://www.youtube.com/watch?v=HKORi449_4E

A personal story of OCD:
http://www.youtube.com/watch?v=x4sadYeLHKU

Howie Mandel Talks About Living With OCD:
http://www.youtube.com/watch?v=dSZNnz9SM4g

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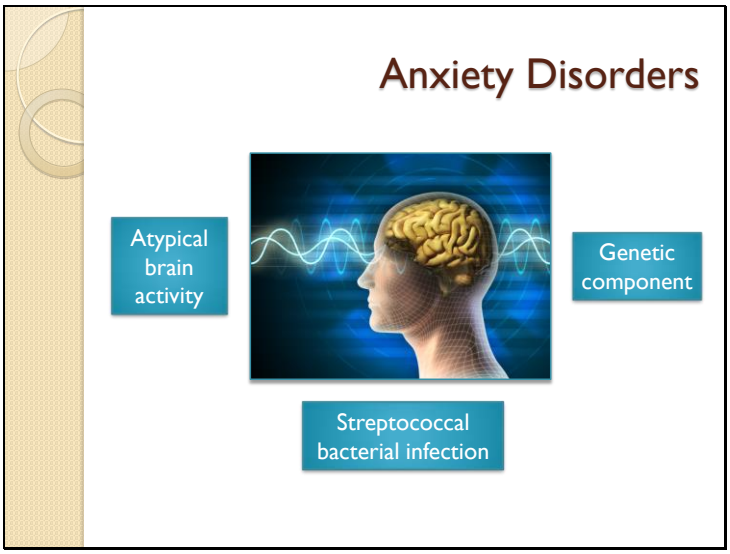

Anxiety Disorders

Anxiety disorders such as those just described are thought to involve atypical activity in the brain. There is also a genetic component to anxiety disorders such that parents with anxiety disorders are more likely to have children with anxiety disorders as well, although children may also develop anxiety with no previous family history. OCD in particular, may also develop or worsen after a streptococcal bacterial infection.

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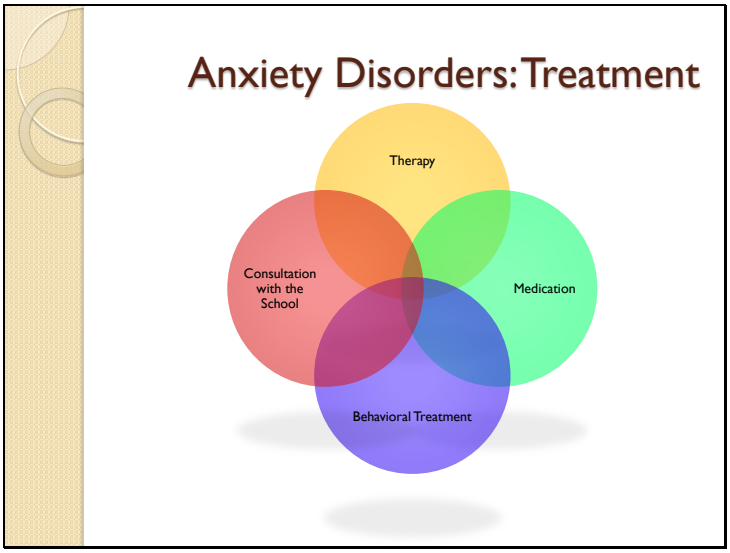

Anxiety Disorders: Treatment

Anxiety disorders in children and adolescents are highly treatable. That is to say, with treatment many children and adolescents can improve significantly. Treatment typically involves therapy, medication, behavioral treatments, and consultation with the school.

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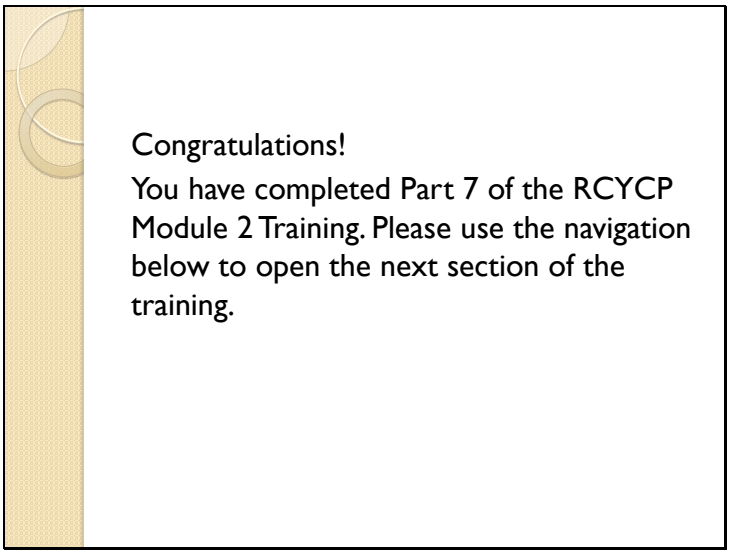
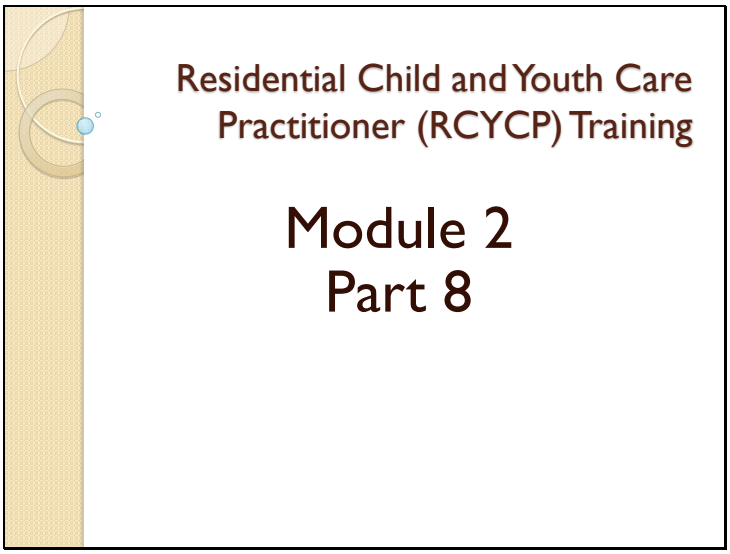


Congratulations! You have completed Part 7 of the RCYCP Module 2 Training. Please use the navigation below to open the next section of the training.

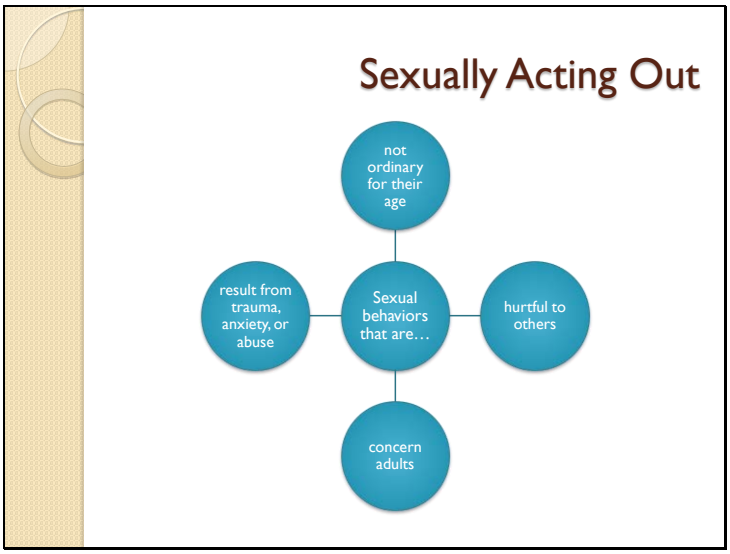
Slide 2



Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 2, Part 8 of the Residential Child and Youth Care Practitioner Training.

Slide 3



Sexually Acting Out

In addition to being able to identify and understand some of the mental health challenges faced by children and adolescents it is important to also look at some behaviors that could indicate non-normative (that is to say not normal) developmental issues. In particular, let us talk about sexual acting out.

It is important to know that some sexual behavior or exploration is normal for children. Children who show normal sexual behavior or exploration associated with expected development are not considered to be acting out. Rather, sexually acting out refers to children who engage in sexual behaviors that are not ordinary for their age, or that are hurtful to others, or that concern adults. Sexually acting out also refers to sexual behaviors that result from trauma, anxiety, or abuse of the child. So what do we mean by sexually acting out?

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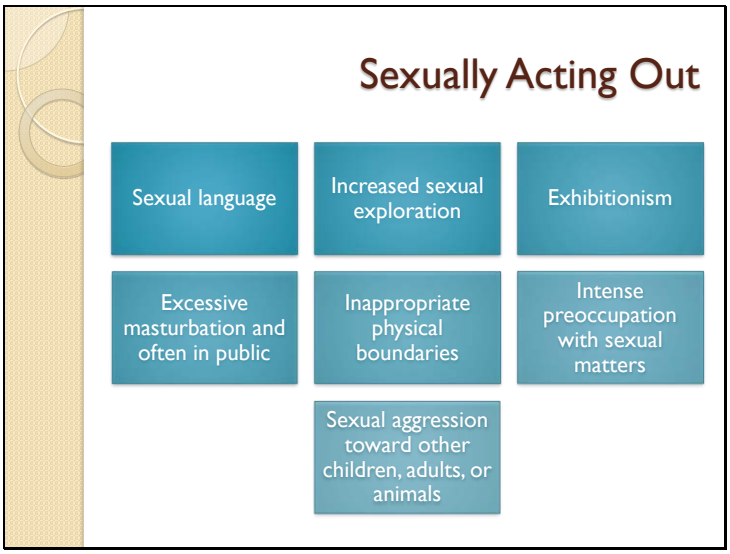

Sexually acting out may include:

- Sexual language (e.g., direct and inadvertent statements).
- Increased sexual exploration.
- Exhibitionism.
- Excessive masturbation, and often in public.
- Inappropriate physical boundaries.
- Intense preoccupation with sexual matters.
- Sexual aggression toward other children, adults, or animals.

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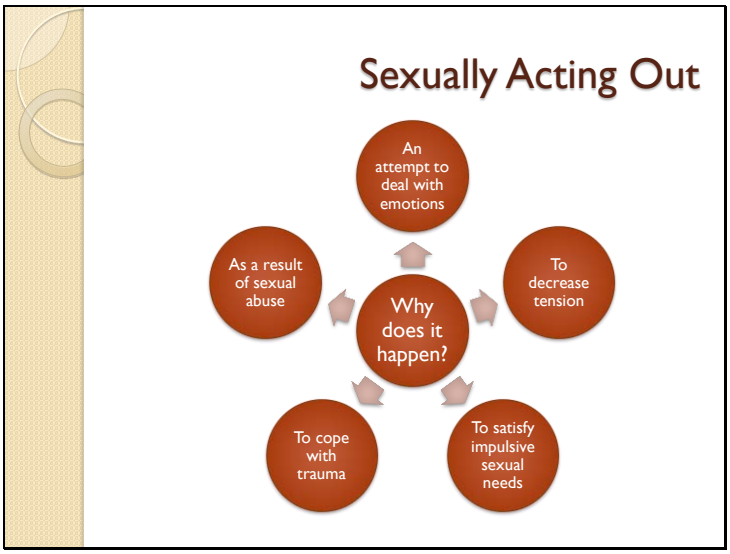

Why does sexually acting out happen?

Children sexually act out for many different reasons. It can be:

1. As an attempt to deal with difficult emotions (sadness, anxiety, fear, abandonment)
2. Or to decrease tension
3. Or to satisfy impulsive sexual needs,
4. Or to cope with intrusive, trauma-related memories
5. Or as a result of sexual abuse

A majority of kids (though not all) who act out sexually have been sexually abused. Also, not all children who have been sexually abused show sexual behaviors, but many do. Some children do not engage in sexually acting out behaviors until years after their initial abuse.

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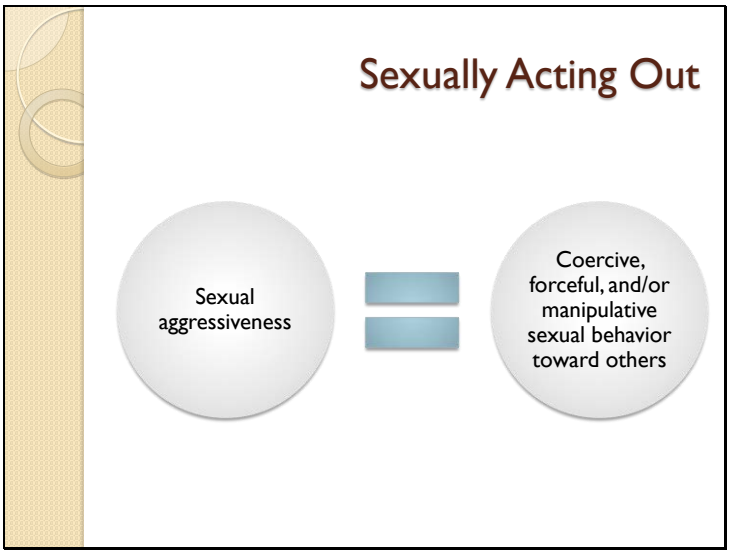
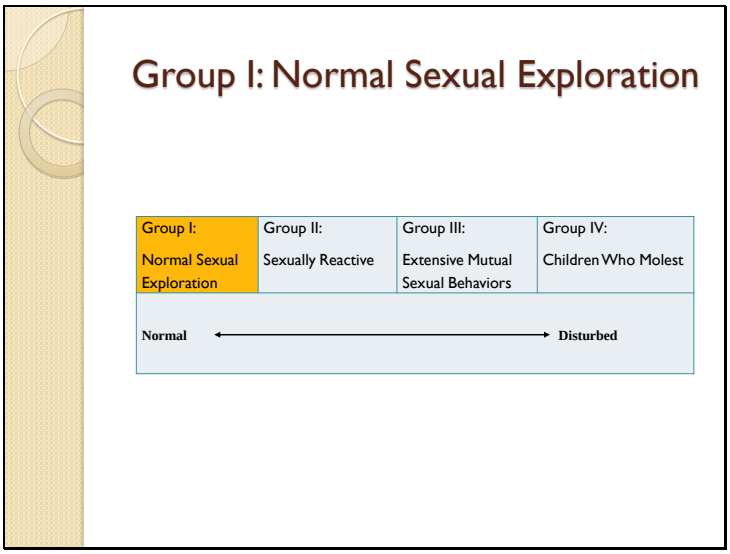


Sexual aggressiveness is a form of sexually acting out that includes coercive, forceful, and/or manipulative sexual behavior towards others. Every act of sexualized behavior has the potential for increasing the probability of future acts.

Slide 7



Group I: Normal Sexual Exploration

To help you get a better understanding of sexually acting out, let's first look at normal sexual exploration. Then we will look at some other categories on the continuum of sexual behavior. As we progress through each category you will see that the behaviors are considered out of the range of normal and become more disturbed.

So let's start begin now with Group 1: Normal Sexual Exploration.

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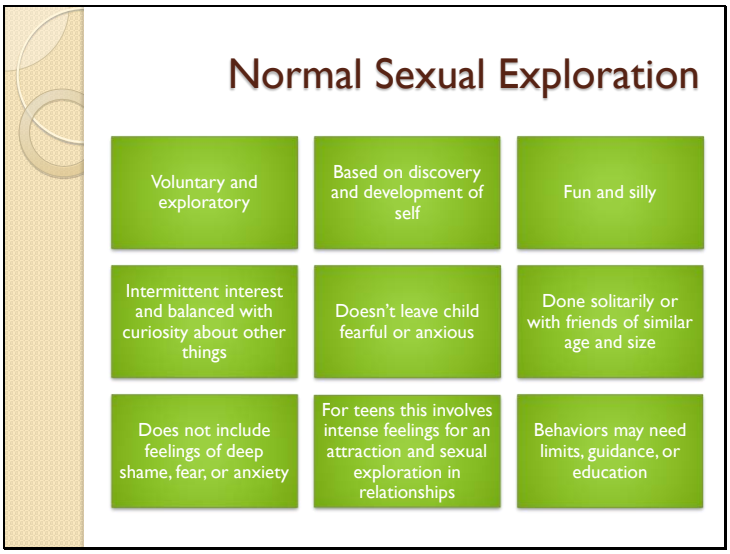

Normal Sexual Exploration

- Is voluntarily and exploratory in nature.
- Is sexual behavior based on the discovery and development of their physical and sexual selves.
- Is characterized by spontaneity and lightheartedness (fun and silly).
- It includes an interest in sex that is intermittent and balanced with curiosity about all things.
- In normal sexual exploration, sexual behavior may leave the child feeling embarrassed but not fearful or anxious.
- It is done solitarily or with friends of similar age and size; less often with siblings.
- It usually does not include feelings of deep shame, fear or anxiety.
- For teens this often involves intense feelings for someone they are attracted to and involves sexual exploration in relationships.
- These behaviors may need limits, guidance or education, but are not considered abnormal or pathological.

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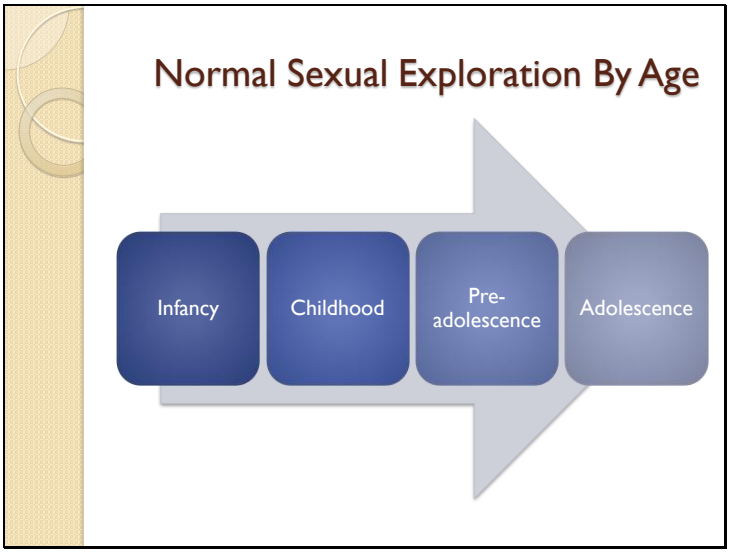

Let's look at what is normal sexual exploration by age. Click on each developmental level to hear what is considered normal.

Infancy:
- Children begin to explore their bodies, including their genitals.
- Skin touch is the primary method infants have available for learning about their bodies, other's bodies, and their sexuality.
- Other people's response to that body exploration is one of the earliest forms of social learning.

Childhood:
- Half of all adults report having participated in sex play as children.
- Children express interest in feelings aroused by touching their genitalia in the same way they express interest in the light of the moon, or a flower blooming. Children express general interest in others' bodies and may touch. Adult reactions teach shame or that privacy is important for certain behaviors.
- Masturbation occurs naturally in boys and girls, and begins in infancy. By the age of two or three years, most children have learned that masturbation in front of others is likely to get them in trouble.

Pre-Adolescence :
- A strong interest in viewing other people's bodies via photographs, films, videos, etc.

• Very few children become sexually active in pre-adolescence. When they do, adults usually initiate it.
• Sexual activity or play during this age usually represents the use of sex for non-sexual goals and purposes.

Adolescence:
• Adolescence itself is generally marked by the societal acknowledgment of sexual capacity. The way other people react to a teen's physical sexual characteristics (body hair, formation of breasts, deepening of the voice, beginning of menses) have a profound effect on both the young person's sense of self-esteem and the development of his/her social skills.
• The adolescent develops a growing awareness of being a sexual person, and of the place and value of sex in one's life, including such options as celibacy.
• The adolescent may work toward significant resolution of confusion and conflict about sexual orientation.
It is during this time that individuals are able to join together the physical and social aspects of sex and sexuality.
• Most adolescents practice some types of interactive sexual behaviors with others, such as fondling, open-mouth kissing, and simulated intercourse.

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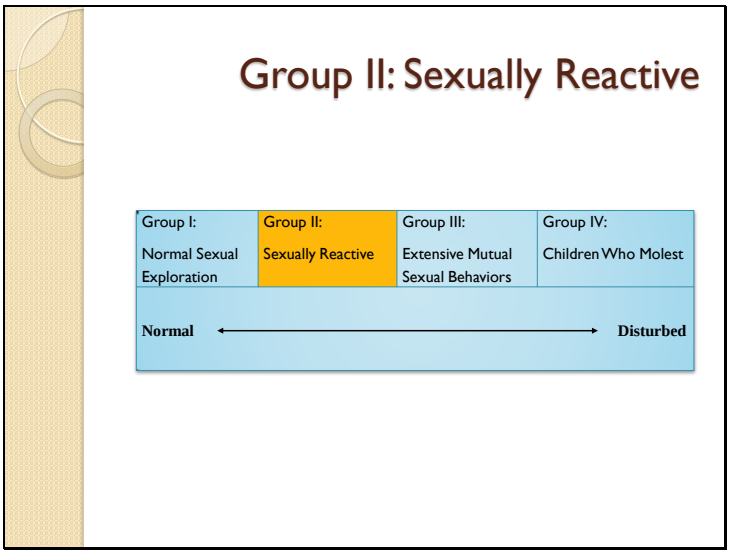

Group II: Sexually Reactive

Now that you know about normal sexual exploration, let's look at some other categories on the continuum of sexual behavior. We will begin a discussion of the non-normative behaviors with Group II: Sexually Reactive.

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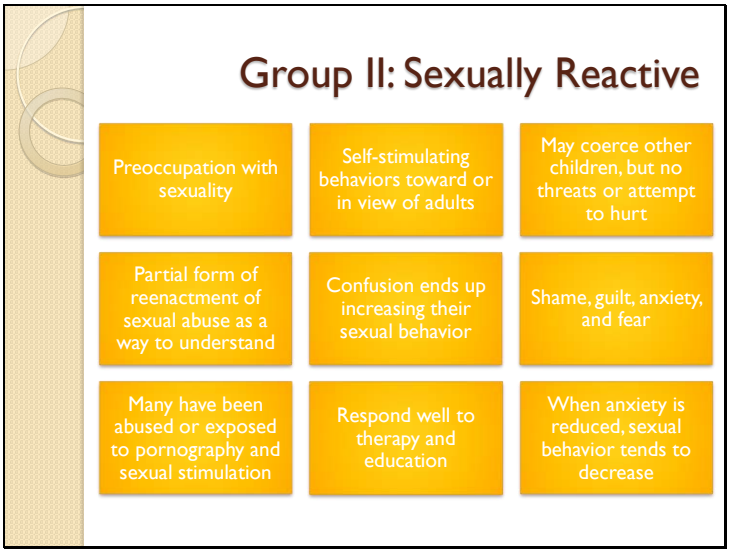

For children and adolescents who fall into the sexually reactive category:

- Sexual behaviors may be frequent, with their sexuality being out of balance compared to their peer group. These youth exhibit more sexual behaviors than Group I and have a preoccupation with sexuality.
- Many of the behaviors for youth in this group are self-stimulating (done to physically stimulate themselves) but may be directed toward and/or done in view of adults.
- Youth in this group may coerce other children, though the other children may dislike or be bothered by the behavior; there are no threats and no attempt to hurt. The difference in age is usually not great and force is not usually involved.
- Sexual behavior in this group often represents a partial form of reenactment of sexual abuse the child has experienced and may be the child's way of trying to understand.
- Youth in this group have trouble making sense of such stimulation and so their confusion ends up increasing their sexual behavior.
- Sexually reactive youth often feel shame, guilt, anxiety, and fear related to the having or doing the sexual behaviors.
- Many of these youth have been abused or exposed to pornography and sexual stimulation.
- Youth in this group respond well to therapy and education.
- For these youth, when the anxiety is reduced or more age appropriate and less sexually stimulating environments are encouraged, the level of sexual behavior tends to decrease.

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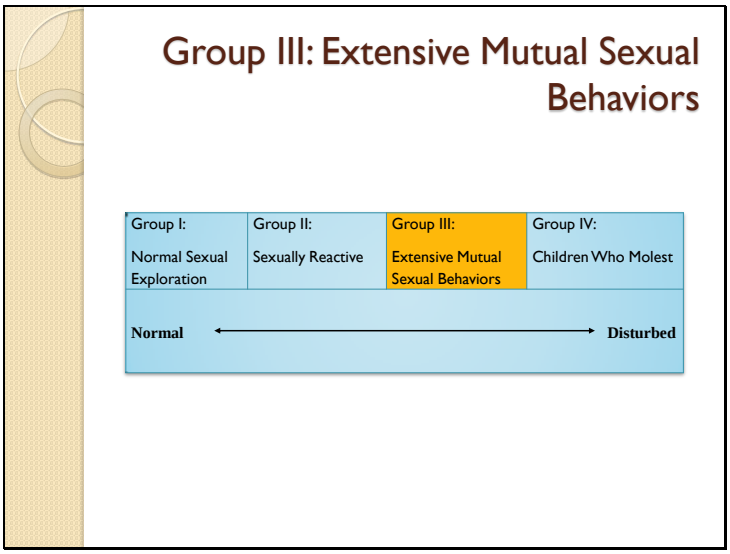

Group III: Extensive Mutual Sexual Behaviors

So as we move along the continuum we get to Group III – the Extensive Mutual Sexual Behaviors group.

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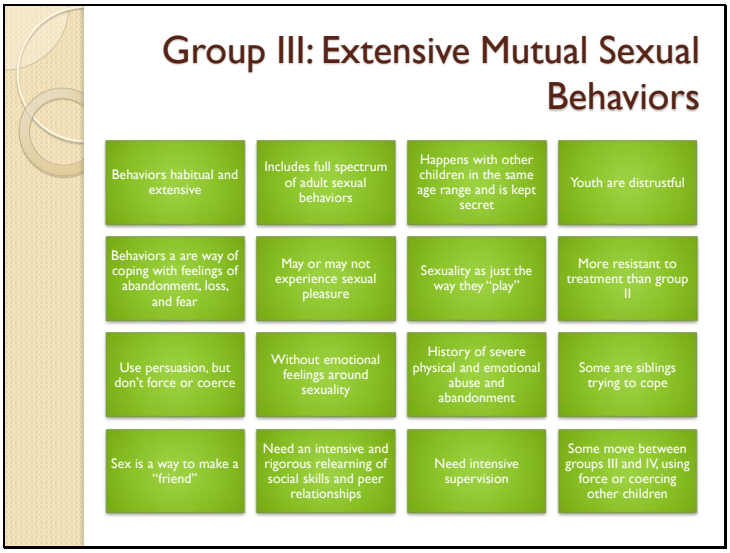
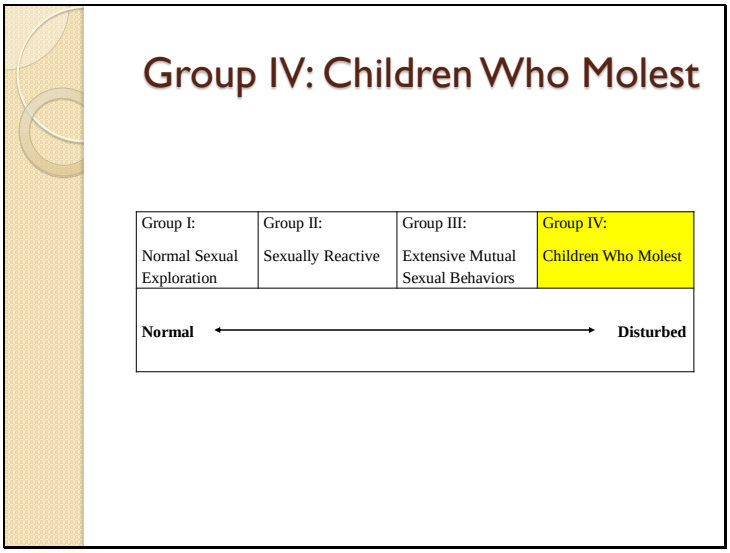


- For youth in this group, sexual behaviors are often habitual and extensive, with the child participating in the full spectrum of adult sexual behaviors.
- Generally this happens with other children in the same age range, and the youth conspire to keep the behaviors secret.
- These youth are often distrustful; they are chronically hurt and abandoned by adults; and they relate best to other children. Sexual behaviors are a way of coping with their feelings of abandonment, loss, and fear.
- Youth in this category may or may not experience sexual pleasure.
- They often approach sexuality as just the way they “play”.
- These youth are usually more resistant to treatment than Group Two
- They use persuasion, but don’t usually force or coerce other children into participating in sexual acts.
- Characteristically they are without emotional feelings around sexuality – they don’t have the lighthearted spontaneity of normal children, nor the shame and guilt of the sexually reactive children.
- Often they have a history of severe physical and emotional abuse and abandonment.
- Some are siblings who mutually engage in extensive sexual behaviors as a way of coping in a highly dysfunctional family life.
- Sex is a way for them to relate to their peers and a way to make a “friend”.
- These children need an intensive and rigorous relearning of social skills and peer relationships.
- They need intensive supervision in the home setting and around other children.

- Some kids move between groups III and IV, forcing or coercing another child into sexual behaviors of their choices.

Slide 14



Group IV: Children Who Molest

Now we are on the end of the continuum of sexual behavior with the fourth group: Children who molest.

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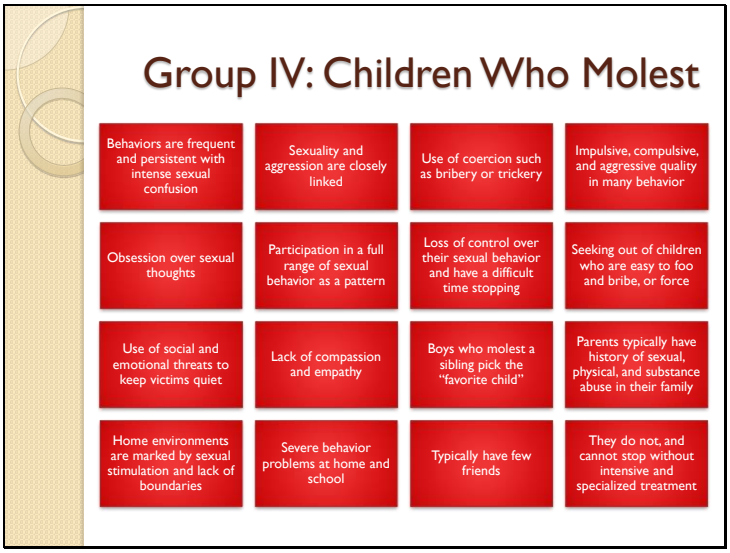

Children in this group have the most severe problems with sexually acting out. They are children who become offenders themselves. For these youth:

- Sexual behaviors are frequent and persistent with intense sexual confusion.
- Sexuality and aggression are closely linked so that when they act out sexually it often is with feelings of anger, rage, loneliness, or fear.
- They use some kind of coercion to gain participation such as bribery or trickery.
- There is an impulsive, compulsive, and aggressive quality in many of their behaviors - not just sexual behaviors.
- They obsess over sexual thoughts and participate in a full range of sexual behavior which becomes a pattern, rather than isolated incidents.
- They lose control over their sexual behavior and have a very difficult time not repeating actions, even when punished or when trying to stop.
- These youth seek out children who are easy to fool and bribe, or force them into sexual activity.
- They frequently use social and emotional threats to keep their victims quiet.
- They lack compassion and empathy with their victims and feel regret in getting caught, their regret is not with hurting another child.
- When boys in this group molest a sibling, the victim is typically the favorite child of the parents.
- Most parents also have sexual, physical and substance abuse in their family history.
- The home environments of these children are marked by sexual stimulation and lack of boundaries. For example, parents might watch pornography at home in front of their children.

- These youth have severe behavior problems at home and school and typically have few friends.
- They do not, and cannot stop without intensive and specialized treatment.
- Often this includes therapy, strong intervention, and medication to control their impulses.

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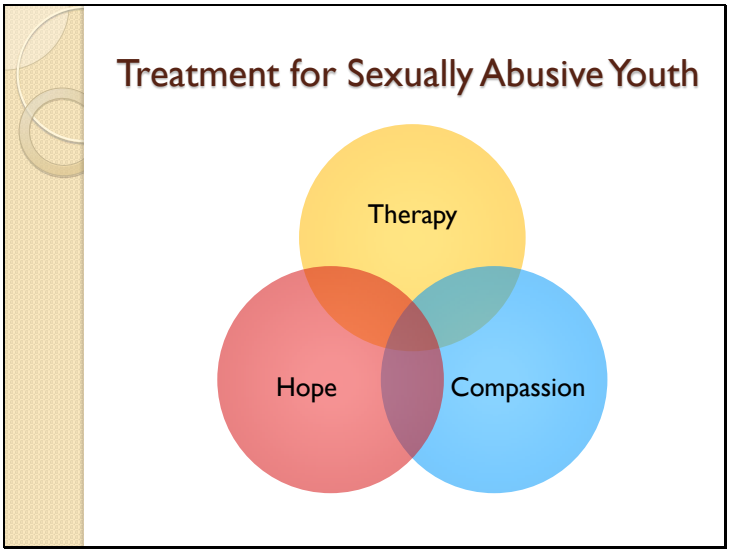

Treatment for Sexually Abusive Youth

The majority of sexually abusive youth are responsive to, and can benefit from, treatment. Sexually acting out children, despite their acts, need to be viewed compassionately and with a hopeful attitude toward recovery. These children are often victims of maltreatment themselves and deserve a chance to heal and live a healthy life.

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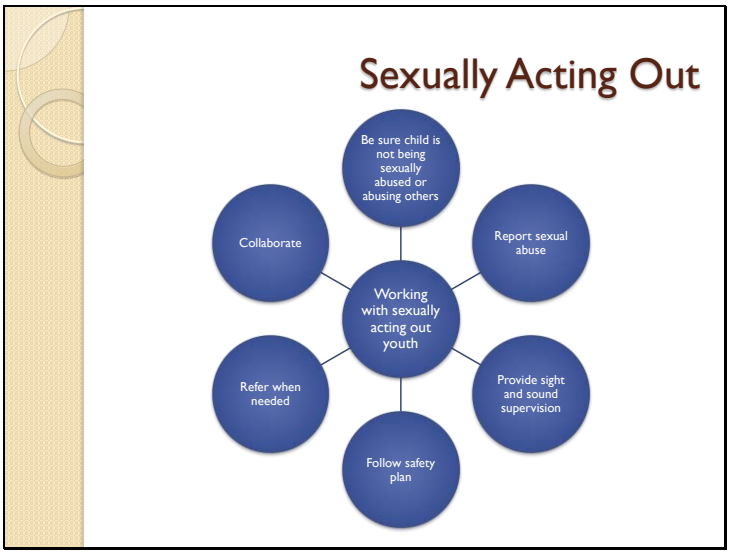

Sexually Acting Out

While you as an RCYCP will follow the guidelines set up at your work site, in general, the immediate goals for working with sexually acting out children include the following:

1. Be sure the child is not being sexually abused or abusing others.
2. Report any/all incidents of sexual abuse to all parties involved.
3. Provide "sight and sound supervision" at all times (that means being able to both see and hear what is going on).
4. Follow a written safety plan at all times.
5. Refer children for psychiatric and/or medical evaluations when needed.
6. Collaborate with school, daycare, or after school personnel.

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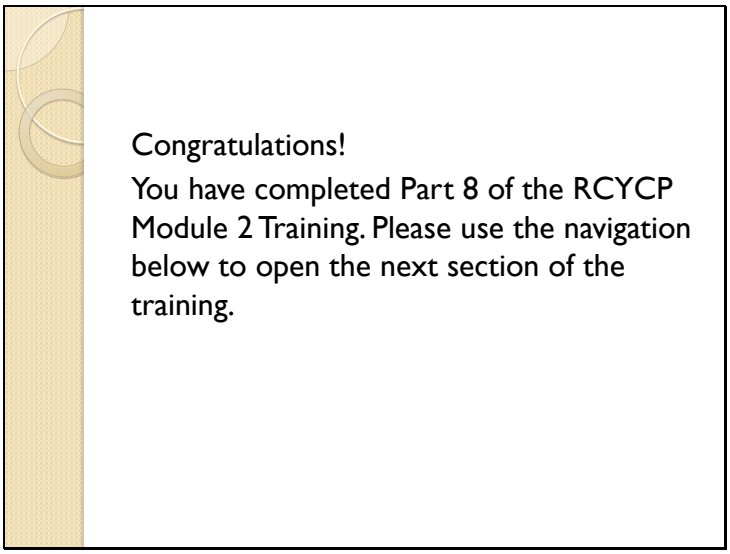

Congratulations! You have completed Part 8 of the RCYCP Module 2 Training. Please use the navigation below to open the next section of the training.

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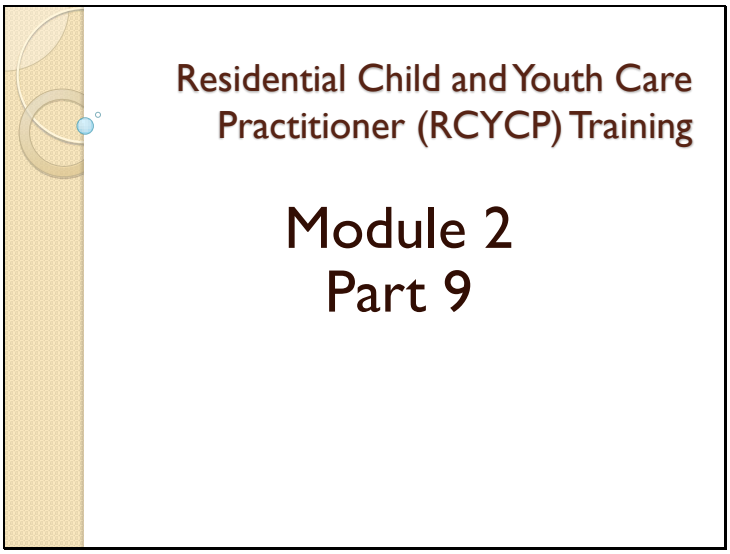

Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 2, Part 9 of the Residential Child and Youth Care Practitioner Training.

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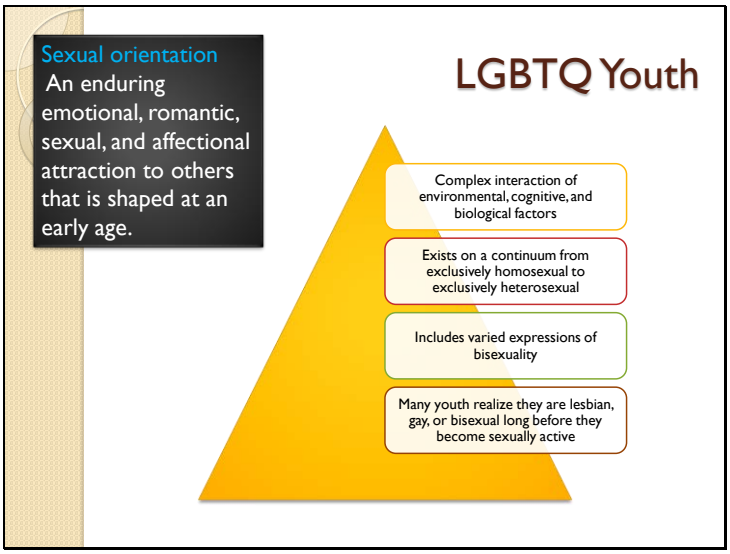

LGBTQ Youth

During the past decade, lesbian, gay, bisexual, and transgender adolescents have become increasingly visible in our families, communities, and systems of care. A significant number of these youth are in residential care and require understanding and care that is specific to their unique needs and development. We are going to discuss those issues now. Let's start with an overview of terminology.

Sexual orientation: is an enduring emotional, romantic, sexual, and affectional attraction to others that is shaped at an early age. Although there are many theories about the origin of sexual orientation, most scientists agree that it is probably the result of a complex interaction of environmental, cognitive, and biological factors. Sexual orientation exists on a continuum from exclusively homosexual (attraction to same-sex people) to exclusively heterosexual (attraction to opposite-sex people), and includes varied expressions of bisexuality (attraction to same-sex and opposite-sex people).

Many youth realize that they are lesbian, gay, or bisexual long before they become sexually active, some by age 5.

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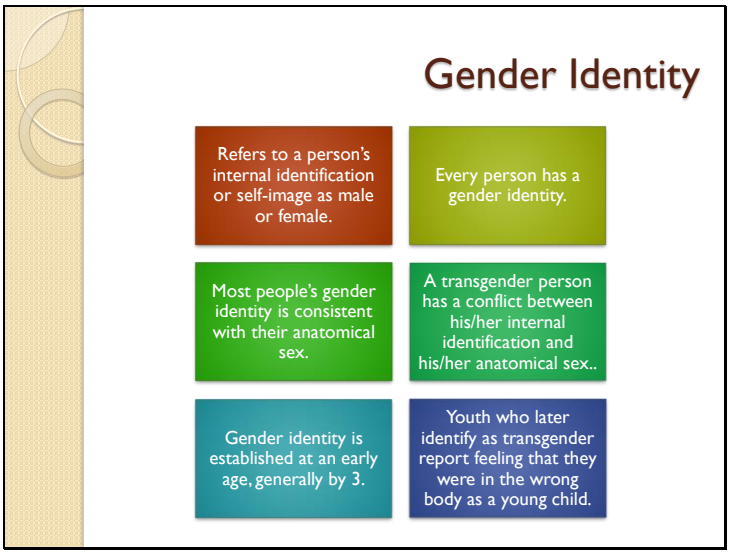
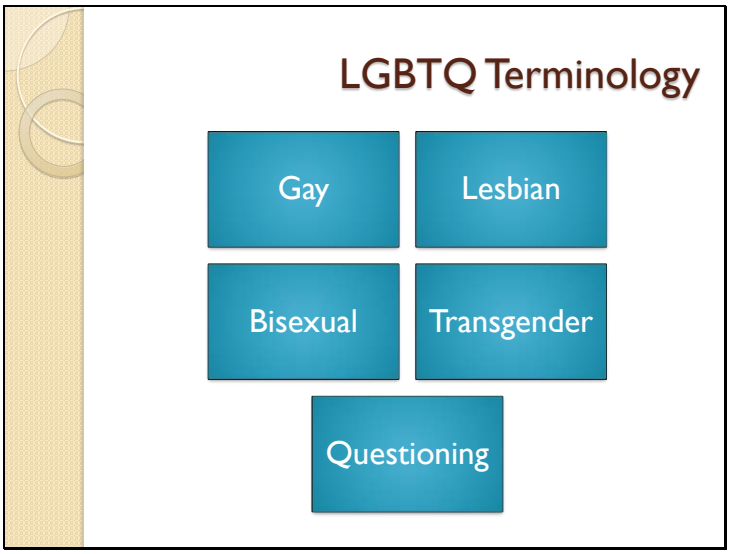


Gender Identity

As mentioned previously in this module, gender identity is distinct from sexual orientation and refers to a person's internal identification or self-image as male or female. Every person has a gender identity. Most people's gender identity (their understanding of themselves as male or female) is consistent with their anatomical sex. For a transgender person, however, there is a conflict between the two; the individual's internal identification as male or female differs from his or her anatomical sex.

Gender identity is also established at an early age, generally by age 3. Increasingly, young people who identify as transgender do so during adolescence. Many youth who later identify as transgender report feeling that they were in the wrong body as a young child.

Slide 5



LGBTQ Terminology

Click on the links to hear the different definitions of other terms you need to know.

Gay: Which refers to homosexual men who partner with men (although it is also used as an overarching term).
Lesbian: Refers to homosexual women who partner with women.
Bisexual: Refers to individuals who partner with both genders.
Transgender: Refers to gender identity that is different than birth assigned gender.
Questioning: You might also hear the term “Questioning” which refers to not yet being certain of one’s sexual orientation.

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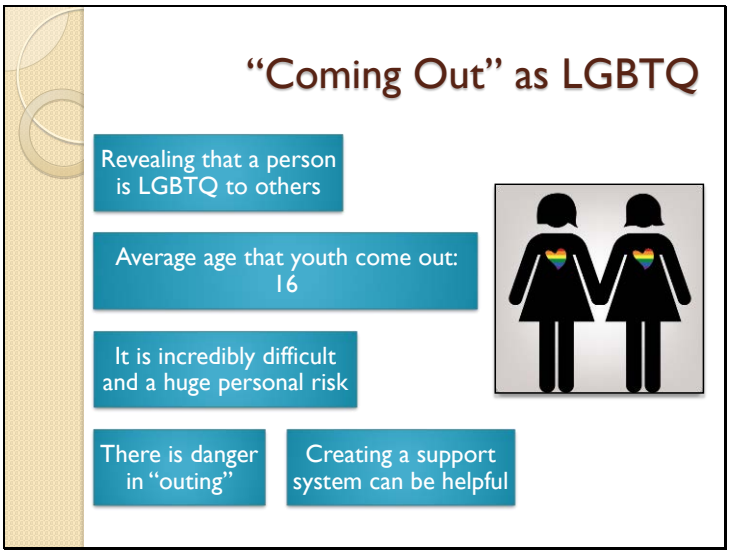
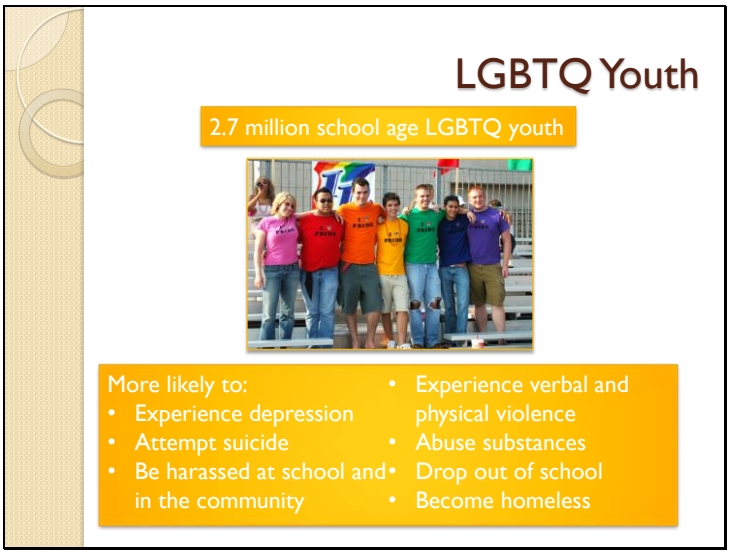


"Coming Out" as LGBTQ

Finally, you will hear the phrase "coming out." So what does that mean?

- Coming out means revealing that a person is LGBTQ to others. The average age that youth come out is now 16. It is incredibly difficult and a huge personal risk. Many youth are rejected by loved ones for coming out. There is also a danger in "outing."
  - Over 30% of LGBTQ youth reported suffering physical violence at the hands of a family member after coming out
  - Creating a support system of people can help many to feel a sense of pride and understanding of who they are.

Slide 7

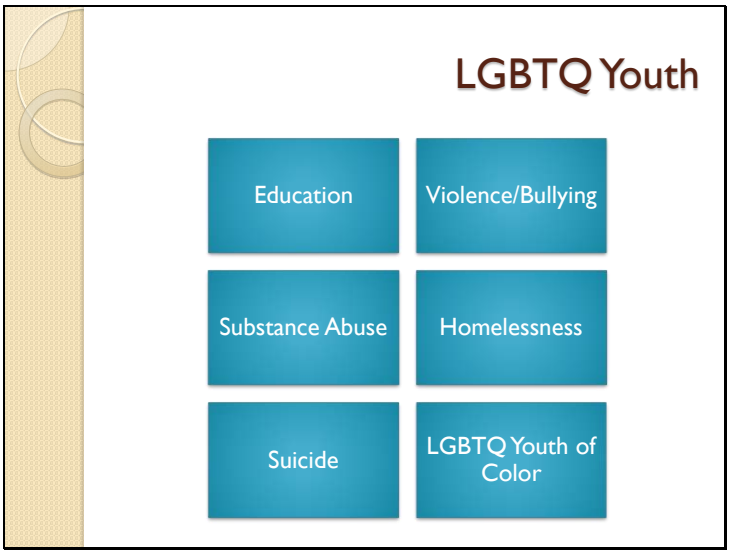


LGBTQ Youth

So what do we know about LGBTQ youth?

- There are an estimated 2.7 million school age LGBTQ youth in the United States, and they are a vulnerable population.
- LGBTQ youth are more likely than their heterosexual peers to:
  - Experience depression.
  - Attempt suicide.
  - Be harassed at school and in the community.
  - Experience verbal and physical violence.
  - Abuse substances.
  - Drop out of school.
  - Become homeless.

Slide 8



Click on the links to hear some startling statistics about LGBTQ youth.

With regard to education:
- 31% of LGBTQ youth reported skipping school each month because of fear for their own safety (4.5 times more than heterosexual peers).
- 28% of LGBTQ youth dropped out of school due to peer harassment (3 times the national average).
- 97% of all students report hearing anti-gay remarks in school.
- 18.8% have heard anti-gay remarks from faculty.
- 82.9% reported that staff never or only sometimes intervened.
- In one study of LGBTQ adolescents, half said homosexuality was discussed in their classes. 50% of the females and 37% of the males said it was handled negatively.

With regard to Violence/Bullying:
- 84% had been verbally harassed at school.
- 65.3% had been sexually harassed.
- 55% of transgender youth reported physical attacks.
- 100% of LGBTQ youth in New York City group homes reported verbal harassment while at their group home and 70% reported physical violence due to their sexual orientation or gender identity.
- Over 39% of all gay, lesbian, and bisexual youth reported being punched, kicked, or injured with a weapon at school because of their sexual orientation.

• 77.9% of LGBTQ youth reported sometimes or frequently hearing anti-gay remarks. They reported hearing slurs such as “homo,” “faggot,” and “sissy” about 26 times a day or once every 14 minutes.

With regard to Substance Abuse:
• Youth who are harassed because of their real or perceived sexual orientation are more likely than non-harassed youth to use crack cocaine, cocaine, anabolic steroids, and inhalants.
• 68% of teen gay males and 83% of teen lesbians use alcohol.
• 46% of teen gay males and 56% of teen lesbians use other drugs.

With regard to Homelessness:
• Between 20-40% of homeless youth are LGBTQ.
• Homelessness increases the likelihood of engaging in prostitution and alcohol and drug abuse, violence, suicide, and HIV and other STDs.
• 26% of LGBTQ youth who “come out” to their families are thrown out of their homes because of conflicts with moral and religious values.
• 78% of the LGBTQ youth were removed or ran away from their foster placements as a result of hostility toward their sexual orientation or gender identity.

With regard to Suicide:
• 33% of LGBTQ high school students reported attempting suicide in the previous year, compared to 8% of their heterosexual peers.
• LGBTQ youth are 4 times more likely to attempt suicide.
• 16% required medical attention as a result of an attempt compared to 3% of heterosexual peers.

With regard to LGBTQ Youth of Color:
• Stigma creates even greater risk for substance use, violence, and risky sexual behaviors.
• Youth of color often don’t identify as “gay” which may mean they will not seek services or hear messages designed for the White LGBTQ community.
• LGBTQ youth of color may not receive their community’s support regarding sexual orientation or transgender identity
• LGBTQ Native American youth have increased risk for substance abuse, mental illness, and HIV infection due to racial/ethnic discrimination and to homophobia within native cultures.

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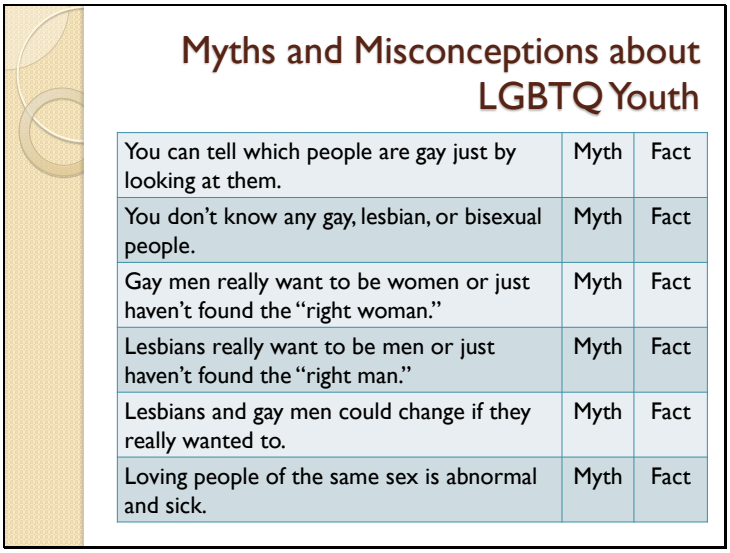

Myths and Misconceptions about LGBTQ Youth

Do you know what are myths and facts about LGBTQ youth? Let's look at some.

Answer the question by clicking on the True or False

Myth: You can tell which people are gay just by looking at them.
Fact: Society and the media have perpetuated stereotypes of gay and lesbians for so long that people believe that the only way to identify a gay or lesbian is to look for the stereotype. There is a great deal of diversity in the gay and lesbian community.

Myth: I don't know any gay, lesbian, or bisexual people.
Fact: Statistics show that one in ten people are gay or lesbian. Given this figure, you probably do know someone who is gay, lesbian or bisexual; they probably are just not "out" to you.

Myth: Gay men really want to be women or just haven't found the "right woman."
Fact: Most gay men do not want to be women. Their sexual, affectional, and emotional orientation is towards men. A significant number of gay men have been married.

Myth: Gay women really want to be men or just haven't found the "right man."
Fact: Most gay women have no desire to be men. Their sexual, affectional, and emotional orientation is towards women. A significant number of lesbians have been married.

Myth: Lesbians and gay men could change if they really wanted to.
Fact: Most studies indicate that those who are highly motivated to change their sexual orientation may change their behavior, but not their underlying desires. In fact, it is often societal homophobia that forces people to attempt to change. Therefore, energy should be focused on dismantling homophobia so that people will feel comfortable with their orientation, whatever that may be. Another fact is that most gay or lesbian people would not want to change, even if there was a way.

Myth: Loving people of the same sex is abnormal and sick.
Fact: According to the American Psychological Association as of 1972, “It is no more abnormal or sick to be homosexual than to be left-handed.” Isolation, fear from hiding, and alienation as a result of homophobia is what causes mental illness, not the orientation itself. Therefore, homophobia is what should be cured.

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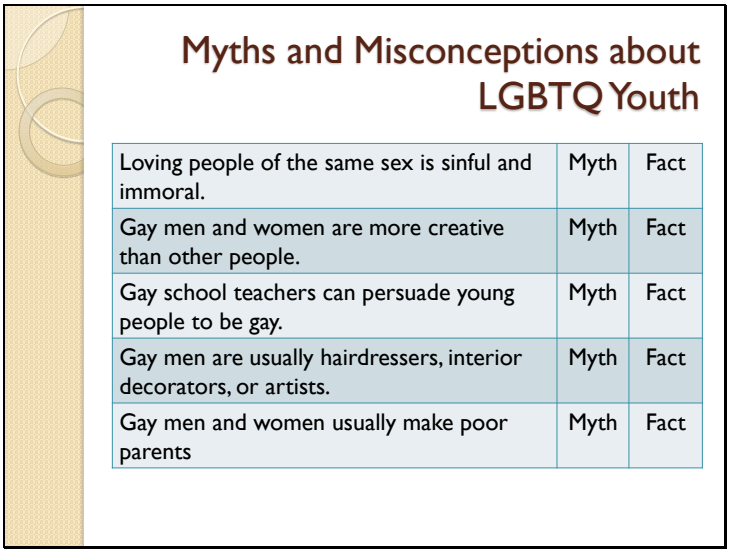

Myth: Loving people of the same sex is sinful and immoral.
Fact: While some religious denominations believe this, many do not. What is universally preached is that intolerance and hatred is wrong.

Myth: Gay men and women are more creative than other people.
Fact: While many gay men and lesbians are creative people who have challenged the roles which society has tried to pigeon-hole them into, they are no more creative than their heterosexual counterparts.

Myth: Gay school teachers can persuade young people to be gay.
Fact: Gay and lesbian people do not have a desire or a need to recruit. No one can be persuaded to be gay or lesbian. Gay and lesbians may encourage those in the closet to “Come Out,” but there is no desire to change heterosexuals into homosexuals.

Myth: Gay men are usually hairdressers, interior decorators, or artists.
Fact: Some gay men are hairdressers, interior decorators, and artists, but so are some straight men. This is a stereotype perpetuated by the media.

Myth: Gay men and women usually make poor parents.
Fact: One out of four families has a lesbian or gay man in its immediate family; heterosexual parents are not found to be consistently more loving or caring than their lesbian, gay or bisexual counterparts.

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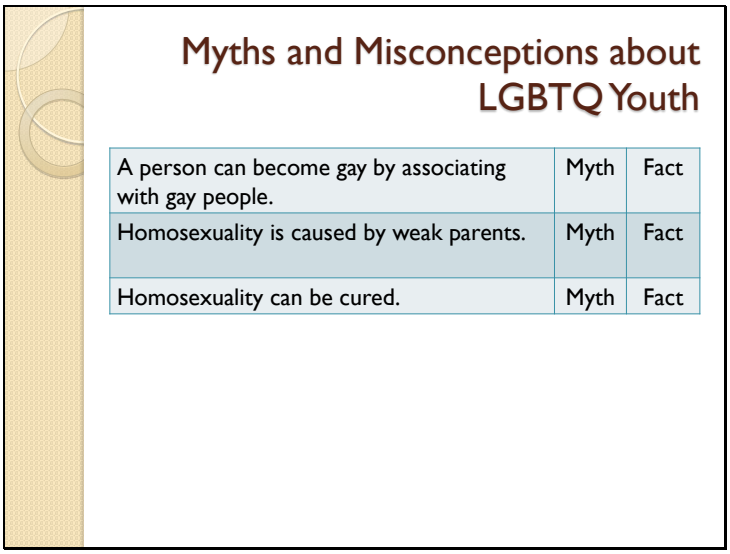

Myth: A person can become gay by associating with gay people.
Fact: A person cannot be made to be gay by association any more than a Caucasian could be made African-American by association.

Myth: Homosexuality is caused by weak parents.
Fact: There is no evidence that homosexuality is caused by weak or strong parents. There is no real consensus on what causes homosexuality. Most gay or lesbian teenagers sense that they are “different” during their early adolescent years.

Myth: Homosexuality can be cured.
Fact: Homosexuality is not a disease or an illness or an affliction and therefore, there is no need to cure.

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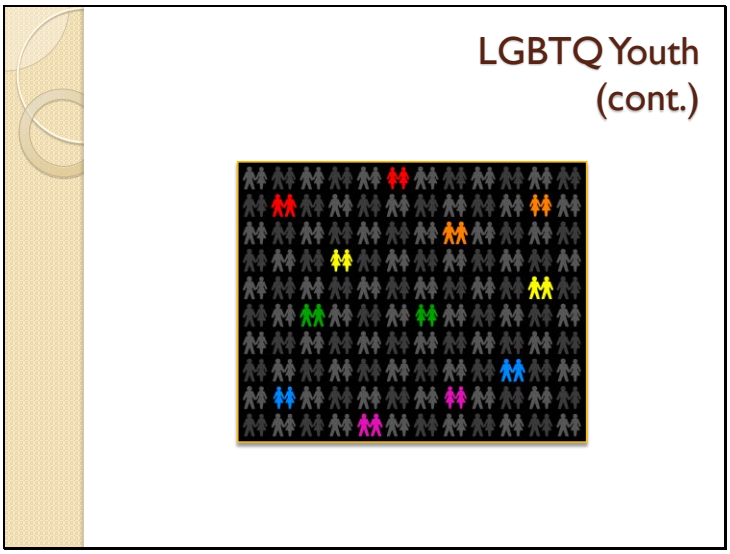
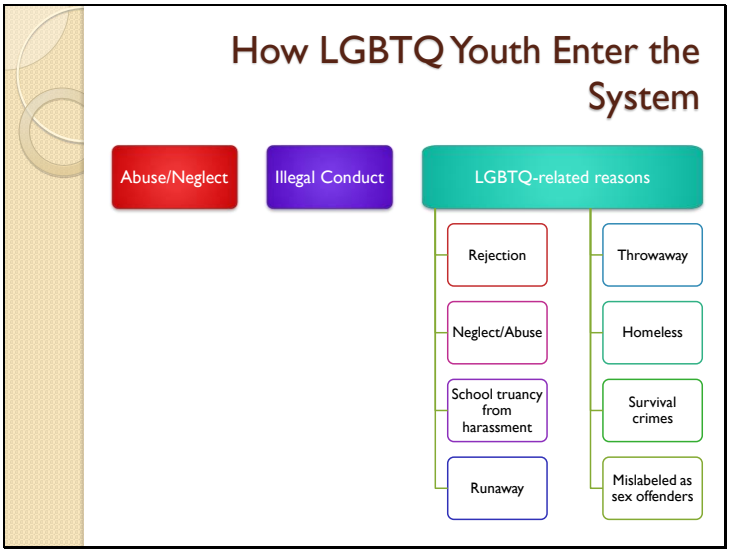


So how many youth in residential care are LGBTQ? That is difficult to answer because many of these youth hide their sexual orientation and gender identity from anyone whom they perceive as rejecting or unsupportive. Also, LGBTQ youth who come into care are often in various stages of awareness and comfort with their sexual orientation and gender identity, and they may not have resolved these issues for themselves. Even if the youth internally identifies as lesbian, gay, bisexual, or transgender, he or she may still choose not to reveal this information to agency personnel. Although there are no reliable statistics, providers and other individuals who work in child welfare and juvenile justice systems consistently report that LGBTQ youth are disproportionately represented among youth in out-of-home care. That is to say that there is a higher percentage of LGBTQ people in out-of-home care than one would expect based on the percentage of LGBTQ in the entire population.

Slide 13



How LGBTQ Youth Enter the System

So how do LGBTQ youth typically enter the system? For some, they enter the same way that other non-LGBTQ youth enter the system, for example, from families with abuse or neglect, or because they have been charged with illegal conduct.

A large proportion of LGBTQ youth enter these systems, however, for reasons either directly or indirectly related to their sexual orientation or gender identity. This includes youth who, because of their sexual orientation or gender identity, have been rejected, neglected, or abused by their birth families; youth who have stopped attending school because of anti-LGBTQ abuse or harassment, runaway, “throwaway,” and homeless youth, some of whom engage in survival crimes, and youth who have been mislabeled as sex offenders simply because of their sexual orientation or gender identity.

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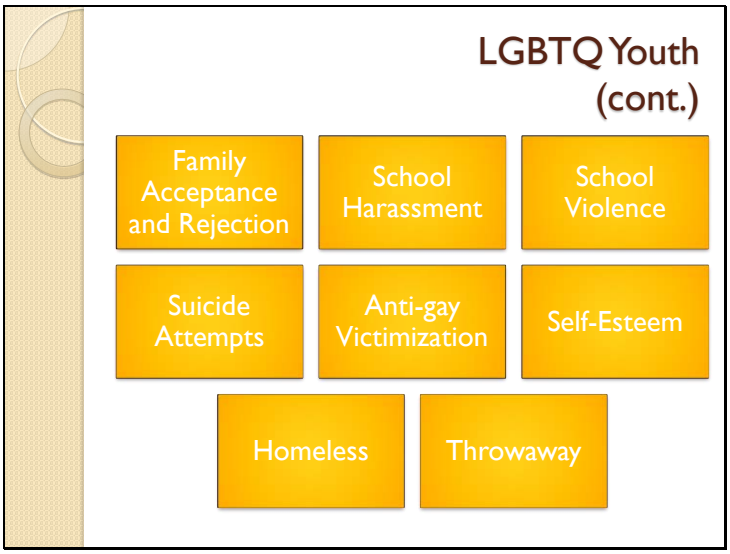


Click on the boxes to hear more statistics related to LGBTQ youth.

Family Acceptance and Rejection: Nearly half (42%) of LGBTQ youth in out-of-home settings who participated in a study on family acceptance and rejection of LGBTQ adolescents were either removed or ejected from their homes because of conflict related to their LGBTQ identity.

School Harassment: A national survey of LGBTQ youth in high schools and middle schools in 48 states found that one in three reported being harassed as a result of his or her sexual orientation, and an equal proportion said they had been harassed because of their gender expression. Most youth (85%) reported hearing homophobic remarks from other students, whereas nearly one-fourth (24%) heard such remarks from faculty or school staff, and few faculty intervened to help.

School Violence: Lesbian, gay, and bisexual students are more likely to be in a physical fight, to be threatened or injured with a weapon at school, and to skip school because they felt unsafe, compared with their heterosexual peers.

Suicide Attempts: Compared with their heterosexual peers, lesbian, gay, and bisexual youth were more than three times as likely to have attempted suicide during the past twelve months.

Anti-gay Victimization: LGBTQ young adults who had experienced high levels of anti-gay victimization in middle or high school were more than twice as likely to report symptoms of

depression and substance abuse problems, three times as likely to report suicide attempts, and more than twice as likely to have put themselves at risk for HIV infection during the past six months, compared with their LGBTQ peers who reported low levels of anti-gay victimization during adolescence.

Self-Esteem: Young adults who reported high levels of anti-gay victimization in school had significantly lower levels of self-esteem, social support, and life satisfaction than their LGBTQ peers who reported low levels of victimization.

Homeless: A study of lesbian and gay youth in New York city's child welfare system found that more than half (56%) of the youth interviewed said they stayed on the streets at times because they felt safer there than living in group or foster homes (Mallon, 1998 as cited in CWLA, 2006).

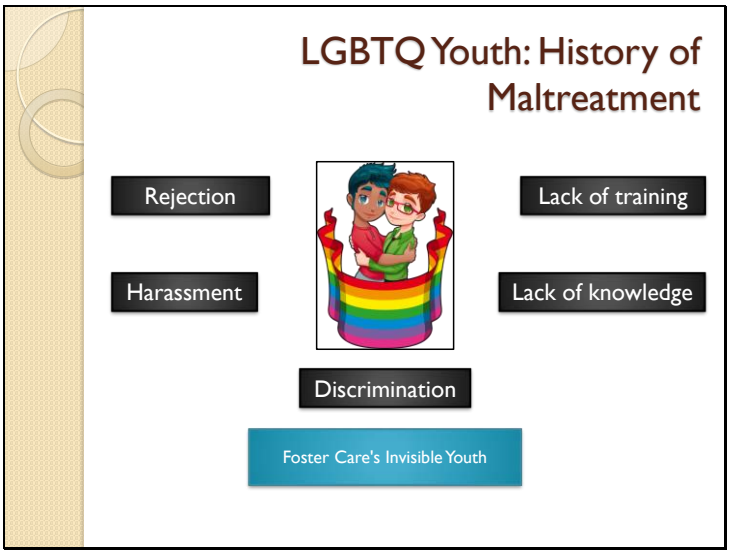
Throwaway: Among LGBTQ homeless youth in San Diego, 39% said they were ejected from their home or placements because of their sexual orientation.

Slide 15

Click on the link to see a short video about homeless LGBT youth.

A Day in Our Shoes – Homeless Youth: Video:
http://www.youtube.com/watch?v=PRGXERBKVt8

Slide 16



LGBTQ Youth: History of Maltreatment

As you can see, LGBTQ youth face a number of significant challenges. Unfortunately, those challenges do not end when they enter out-of-home care. LGBTQ youth commonly experience rejection, harassment, and discrimination from peers and staff - some of it intentional, and some unintentional. Even when staff members are well-meaning, they often lack the knowledge or training to provide appropriate services to LGBTQ youth. For example, staff members frequently respond to the harassment or assault of an LGBTQ youth by isolating or moving the youth – often to a more restrictive facility - rather than addressing the underlying prejudice. Although this response may make it easier to protect the young person, it punishes the victim and often results in drastically reduced services and psychological distress for LGBT youth.

Click on the link at the bottom of the slide to watch a short video about some of the challenges facing LGBTQ youth in the system.
Video: LGBT youth in foster care http://www.youtube.com/watch?v=nuSikwpqazA

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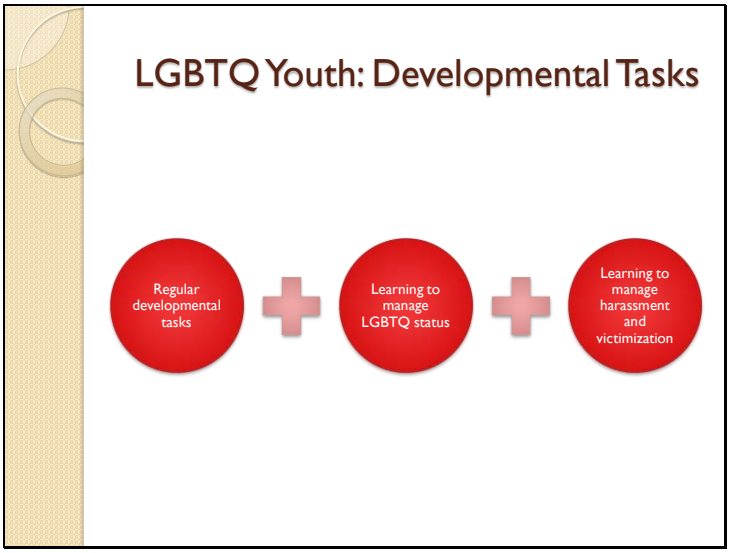

LGBTQ Youth: Developmental Tasks

LGBTQ youth have the same developmental tasks as their heterosexual and non-transgender peers, but they also face additional challenges in learning to manage a stigmatized (that is to say a shamed) identity and to cope with social, educational, and community environments in which victimization and harassment are the norm. Just like their heterosexual peers, they need to be able to explore, express, and develop an identity.

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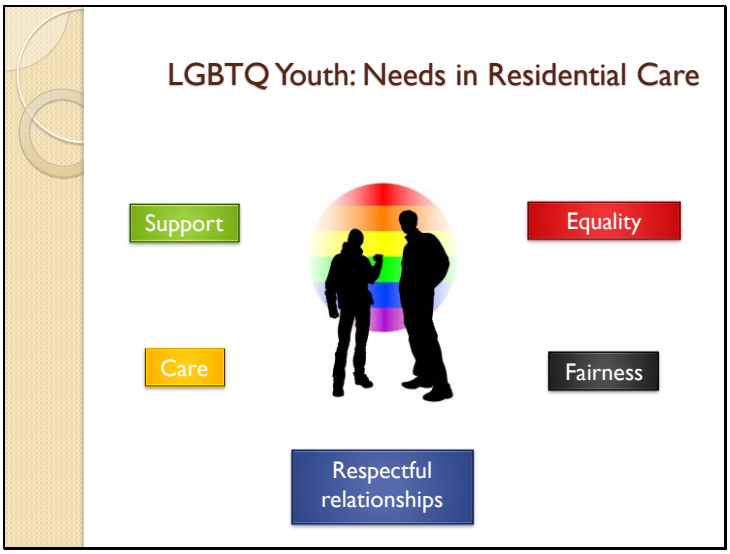

LGBTQ Youth: Needs in Residential Care

So what do they need most in residential care? They need supportive, caring, and respectful relationships. They also need to be in an environment in which every person is respected and every person is treated fairly and equally. This type of environment makes it safe for young people to explore their own emerging identities and to accept and value differences in others.

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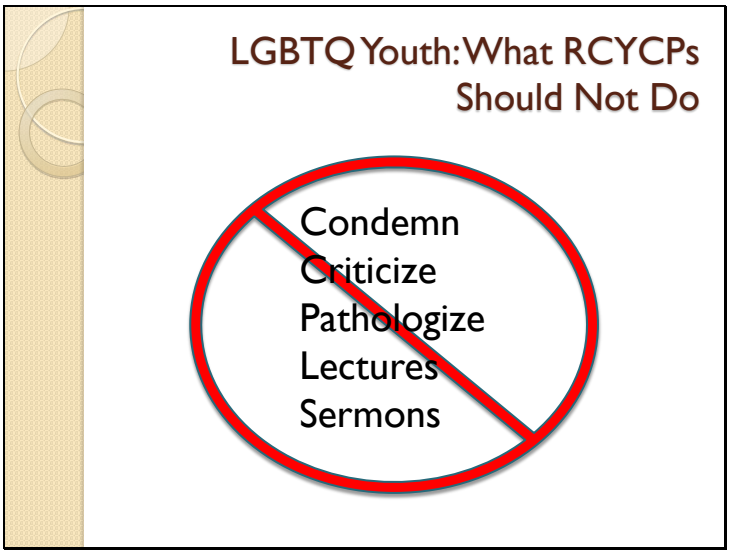

LGBTQ Youth: What RCYCPs Should Not Do

Once again, you should realize that your job as an RCYCP is critical to the success of the youth with whom you work. Regardless of how a youth self-identifies or how others perceive him or her, RCYCPs should treat all youth equally, respectfully, and with sensitivity to the developmental issues faced by all adolescents. RCYCPs should affirm all young people's intrinsic worth, regardless of their sexual orientation or gender identity.

- So in the interest of providing a safe and nurturing atmosphere for the youth in care, RCYCPS
- Should not condemn, criticize, or pathologize youth who explore their attractions for same-sex youth in an age-appropriate, consensual manner.
- By pathologize we mean treating someone like they are psychologically abnormal or unhealthy.
- RCYCPs should not subject LGBTQ youth to lectures, sermons, or other materials that condemn or pathologize homosexuality or gender nonconformity. For example, an RCYCP should absolutely not be telling LGBTQ youth that they are "sinful" or "going to hell."
- Permitting or condoning any of these practices sends a message to LGBTQ youth that they are deviant, immoral, or mentally ill.

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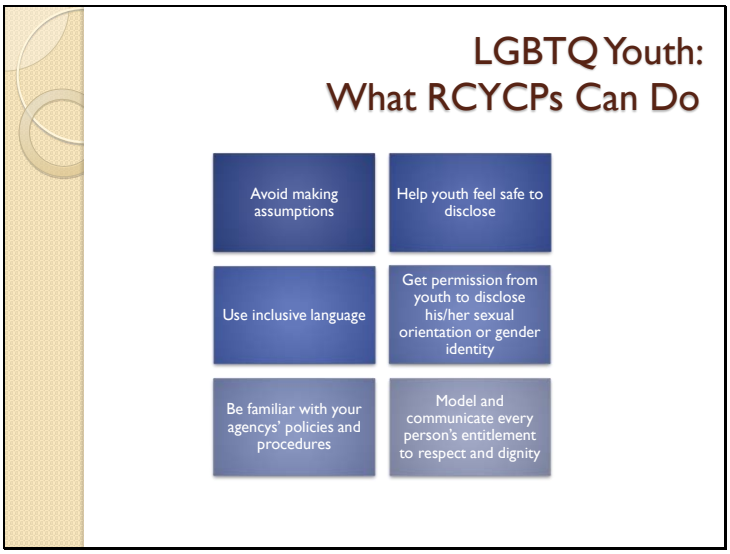

LGBTQ Youth: What RCYCPs Can Do

Also, RCYCPs:

- Should avoid making assumptions about a young person based on his or her physical appearance or behavior. Instead professionals working with youth should adopt an approach that helps youth feel safe to disclose information about themselves – at their own pace and on their own terms.
- Should take care to use inclusive language that avoids implicit assumptions about a young person's sexual orientation (for example, using neutral language such as "do you have a boyfriend or girlfriend?")
- Should not disclose a youth's sexual orientation or gender identity without the youth's permission. It could subject the youth to rejection, ridicule, and even violence. It can also derail an LGBTQ youth's development and adjustment, resulting in negative health effects and loss of trust. In certain circumstances, limited disclosure may be legally required to protect a young person's safety (for example, within the context of abuse/neglect). When disclosure is legally required, you should consult with a supervisor for guidance.
- As an RCYCP you should be familiar with your agency's policies and procedures, as well as the applicable confidentiality laws.

Finally, all RCYCPs should model and communicate the message that every person is entitled to respect and dignity and that disrespect or intolerance of any kind is not permitted. Staff should

promptly intervene whenever a young person uses homophobic or transphobic language or engages in behavior that is discriminatory or demeaning toward LGBTQ individuals or groups. This situation can be an opportunity for staff to discuss the issue of homophobia or transphobia or in general the facility's policy on treating everyone with respect.

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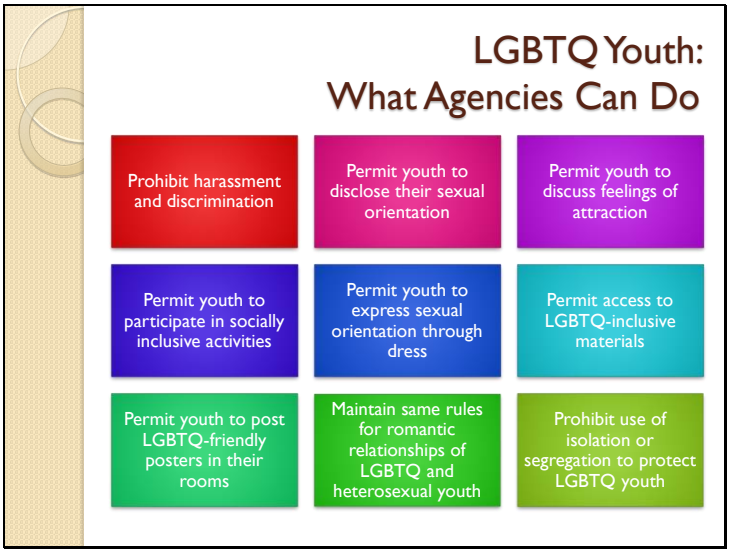

All agencies are different, and have different policies and procedures. While you should be familiar with your agencies policies and procedures, it is good to have general knowledge about some of the ways that organizations can promote positive adolescent development for LGBTQ youth. In particular, agencies benefit from policies and practices that:

1. Prohibit all forms of harassment and discrimination, including jokes, slurs, and name calling.
2. Permit youth to disclose their sexual orientation to other youth, caregivers, and agency personnel.
3. Permit youth to discuss their feelings of attraction to youth of the same sex, consistent with discussion of romantic attachments among heterosexual youth, without being penalized or shamed.
4. Permit youth to participate in social activities that are geared toward or inclusive of lesbian, gay, and bisexual youth.
5. Permit youth to express their sexual orientation through their choice of clothing, jewelry, or hairstyle.
6. Permit youth to have access to LGBTQ-inclusive, supportive books and materials, and . . .
7. Permit youth to post LGBTQ-friendly posters or stickers in their rooms.
8. Do not penalize youth who become romantically involved with a youth of the same sex when the same involvement with a person of a different sex would not result in punishment.
9. Prohibit the use of isolation or segregation as a means to protect LGBTQ youth when others subject them to discrimination, harassment, or violence.

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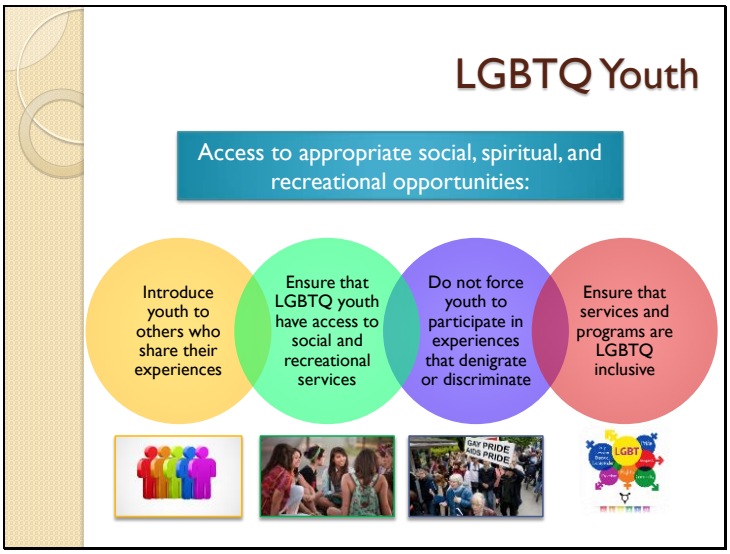

LGBTQ Youth

In addition to having policies and procedures in place to protect LGBTQ youth, agencies and RCYCPs can help by ensuring that LGBTQ youth in their care have access to appropriate social, spiritual, and recreational opportunities that encourage and support these youth in developing into self-assured, healthy adults. Some of the ways that this can be accomplished include:

- Introducing youth to others who share their experiences (this can be positive because these settings embrace LGBTQ youth for who they are – these activities and social relationships are also important in fostering the development of necessary life skills, such as forming and maintaining friendships, increasing communication skills, and handling interpersonal relationships and dating).
- Ensuring that LGBTQ youth are aware of, and have access to, social and recreational services and events consistent with their interests and geared toward the community with which they identify.
- Agencies and RCYCPs should not force youth to participate in activities or groups that denigrate or discriminate against LGBTQ youth or that simply decline to acknowledge their existence (e.g., religious services in which a youth is condemned because of his/her sexual orientation).

Agencies should also ensure that their own services and programs are LGBTQ inclusive. For examples, if facilities or programs provide books, magazines, and movies to youth, they should include materials with positive LGBTQ images and role models. When youth are given

information about sexuality and development, this information should be inclusive of LGBTQ individuals and should not present same-sex relationships or behavior, or gender-nonconforming behavior, as inappropriate or immoral. LGBTQ youth should be permitted to receive and possess LGBTQ-supportive books and magazines to the same extent that books and magazines are generally available to youth in the facility.

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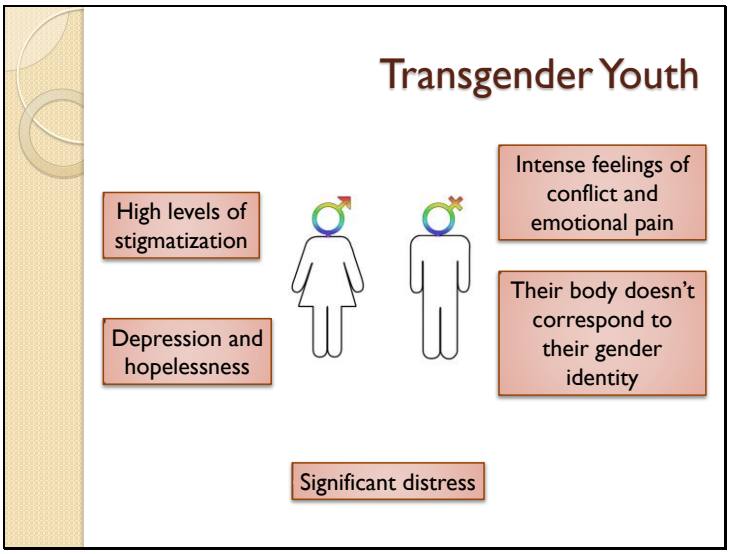

Transgender Youth

Let's talk now about transgender youth specifically. Transgender youth may present health concerns distinct from those common to lesbian, gay, or bisexual youth. Transgender youth experience very high levels of stigmatization, which may increase their feelings of depression and hopelessness. They may also experience significant distress because their body does not correspond to their gender identity.

The incongruity between a transgender youth's gender identity and anatomical sex can cause intense feelings of conflict and emotional pain.

Slide 24

Transgender Youth Videos

Click on the links to watch some videos about transgender youth.

Transgender Tween Enters Dating World, Faces New Host of Problems - Barbara Walters:
http://www.youtube.com/watch?v=QxhyFA8iV9o

Transgender at 11: Listening to Jazz:
http://www.youtube.com/watch?v=bJw3s85EcxM

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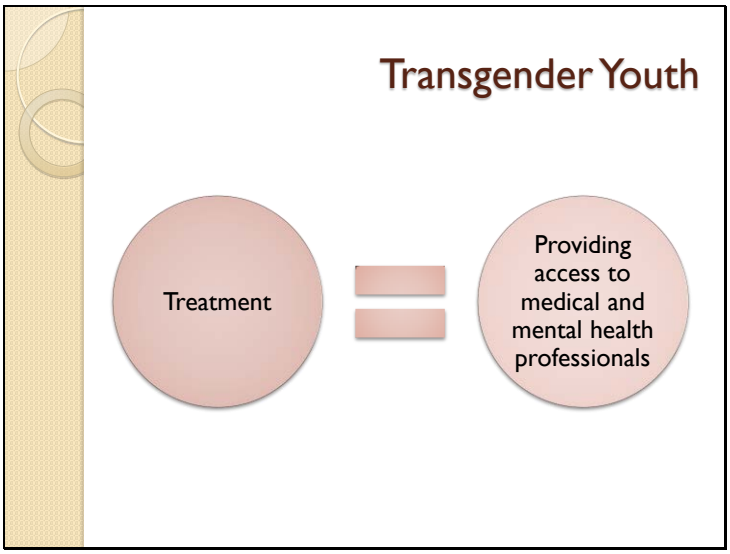
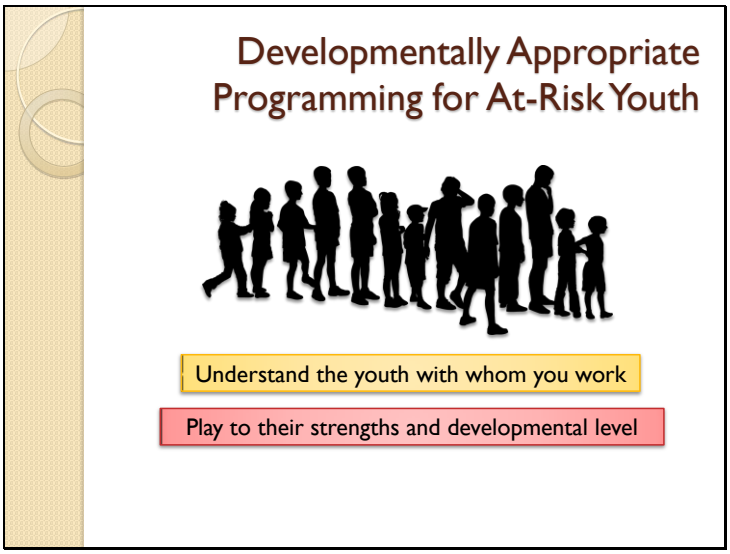


Transgender Youth

The most appropriate treatment for transgender youth involves providing access to medical and mental health professionals who can help assess whether hormone treatment is appropriate for care for these youth.

Slide 30



Developmentally Appropriate Programming for At-Risk Youth

As we finish up this module on development, let's briefly discuss the importance of developmentally appropriate programming for at-risk youth with whom you, as an RCYCP, will be working.

At-risk children and adolescents vary tremendously from one another based on their different family circumstances and histories. They are also different based on their developmental needs and abilities, which change as they age. In order to work effectively with youth in residential care, you will need to understand the individual youth as a whole with all of his/her unique needs, strengths, and challenges, as well as the family, and community in which s/he lives. You will need to bear this in mind in everything that you do as an RCYCP. That means, that whatever programming you do with kids needs to be appropriate to their individual developmental needs. For example, if you are working with a youth with ADHD you might not choose activities that require long periods of sitting quietly. That type of activity is not going to work with someone with ADHD.

Similarly, if you are taking the kids you work with to the movies, and they are 10 and 11 years old, taking them to a PG-13 movie would not be an appropriate choice. In fact, you might work with 16 year olds who are not socially and or emotionally mature enough for a PG-13 movie. Chronological age does not necessarily equate with social and emotional age or developmental level.

The underlying point is that you need to understand the youth with whom you work. Play to their strengths and developmental level and you will be most successful.

Slide 31

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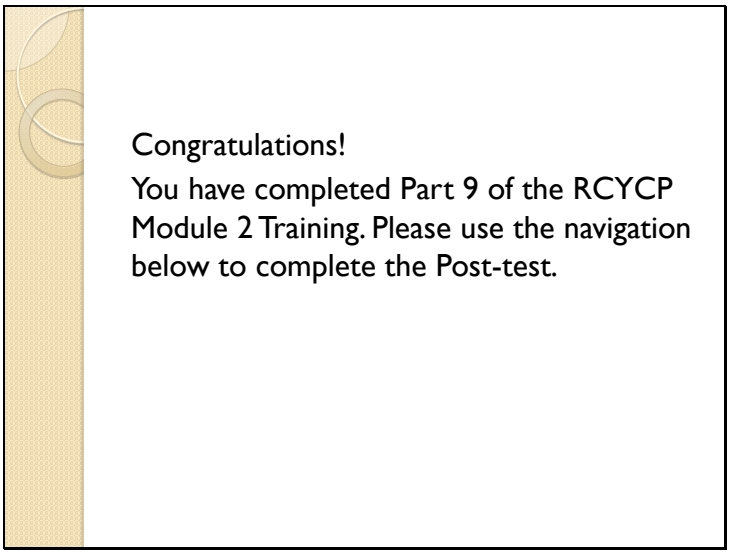

Congratulations! You have completed Part 9 of the RCYCP Module 2 Training. Please use the navigation below to complete the Post-test

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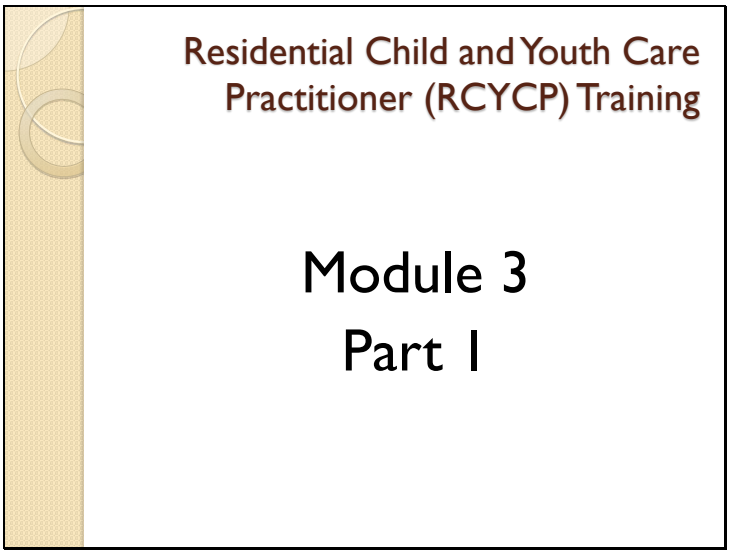

Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 3, Part 1 of the Residential Child and Youth Care Practitioner Training.

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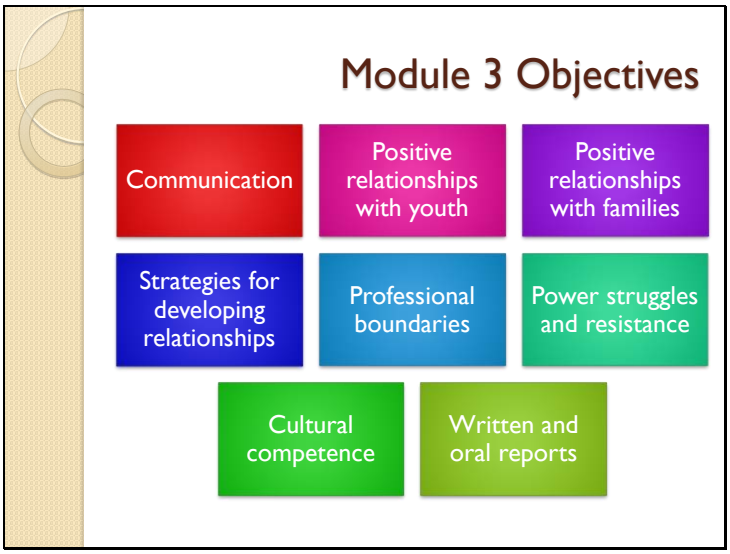

Module 3 Objectives

In this module you will learn about the following:

1. Communication, including what it is, why it is important, gender differences, family background influences, communication patterns in families, communication as it relates to the residential child and youth care populations, as well as communication skills.
2. The importance of building positive relationships with youth.
3. The importance of building positive relationships with families.
4. Strategies for developing relationships.
5. Professional Boundaries.
6. Power struggles and resistance.
7. Cultural competence, and
8. Written and oral reports.

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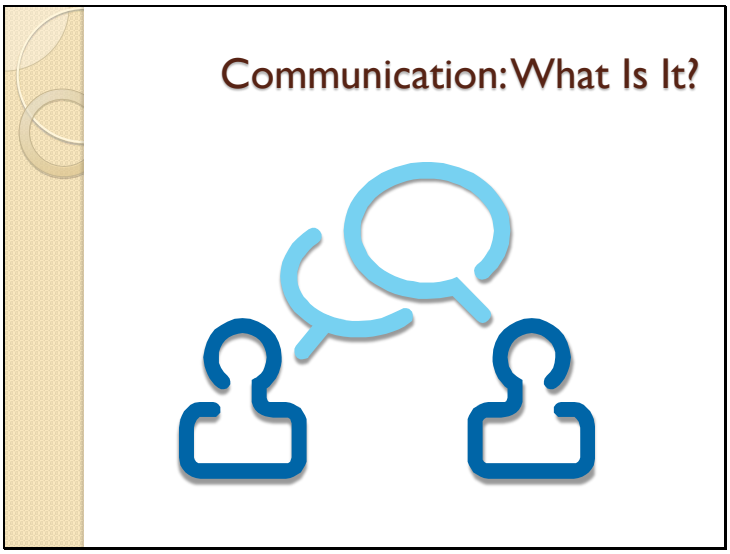

Communication: What Is It?

So what is communication? Communication is the sending and receiving of messages -- those that are intentional, unintentional, verbal, and nonverbal. It is at the heart of intimate human relationships and is the foundation on which all else is built. In order for intimate relationships to work, communication is essential.

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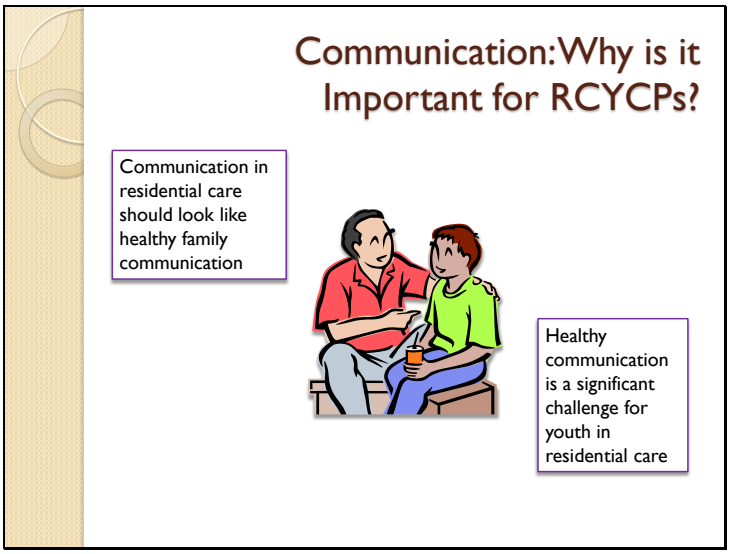

Communication: Why is it Important for RCYCPs?

Why is it important for Residential Child and Youth Care Practitioners to know communication? For two reasons: First, residential care is an extension of the child's family life and so communication in residential care should look like healthy family communication. Second, as we will discuss in more detail later, healthy communication is often a significant challenge for the youth in residential care, and so they need as much help and guidance as possible.

So let us discuss communication in general and then talk more specifically about youth in residential care.

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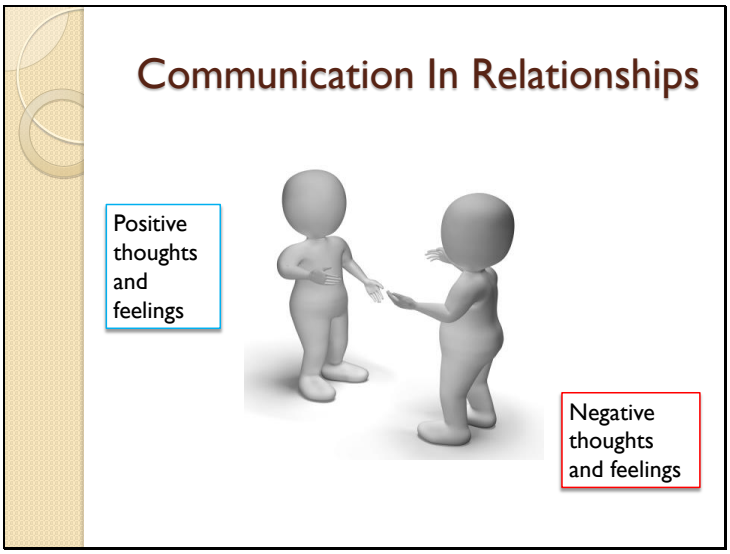

Communication In Relationships

Communication in relationships (that is to say, in any important type of relationship) is not just about trivial day-to-day aspects of lives, but deeper more important issues. In order for relationships to be successful, individuals need to be able to communicate both positive and negative thoughts and feelings.

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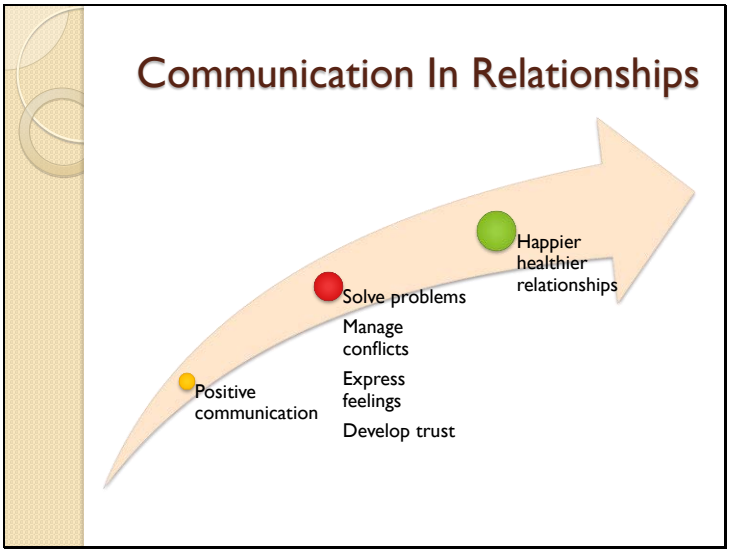

Communication is critical to the ability to solve problems, manage conflicts, express feelings, and develop trust.

Frequent positive communication leads to happier, healthier relationships – for example, more laughing and sharing.

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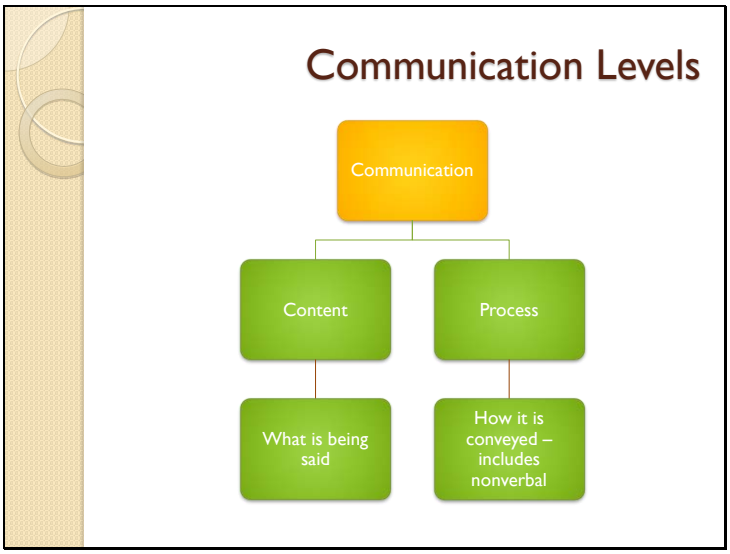

Communication Levels

There are two levels in any communication: content and process. Content relates to what is being said, and process refers to how it is being said and includes all nonverbal elements of the exchange.

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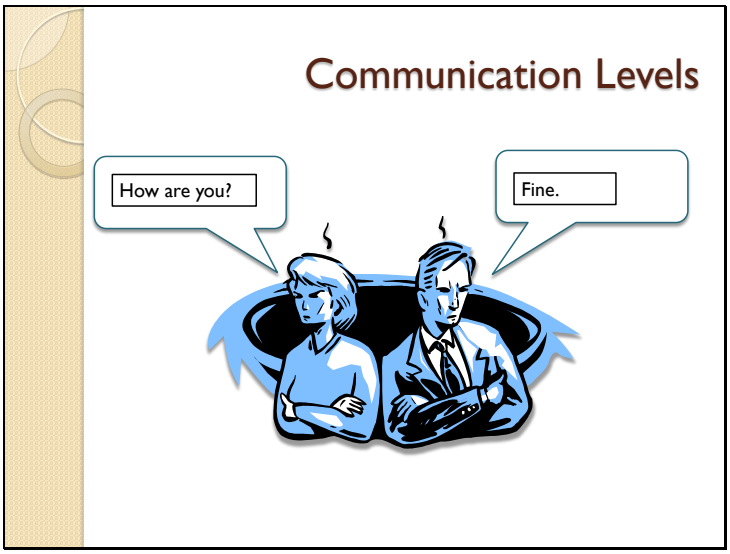

Sometimes there is a mismatch between what is being said and how it is being conveyed, so that we receive a “mixed message.” For example, you might ask someone how they are doing, and they might reply “fine,” but still convey that something is wrong.

You’ll see in the cartoon image that both people seem angry, based on their body language. The response to the question “how are you?” is “fine” – which contradicts the body language. This is a mixed message.

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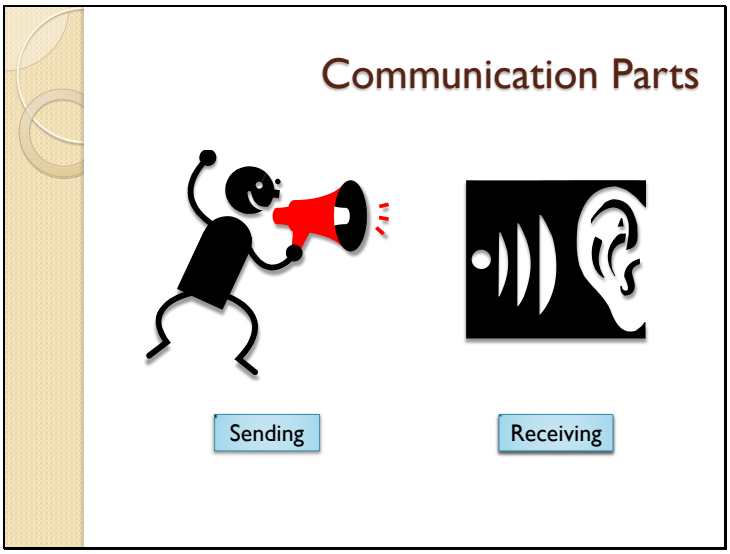

Communication Parts

In communication there are always two parts to every message: the sending and receiving of the information. Someone does the sending and someone does the receiving.

In order for communication to be straightforward, the sending of messages needs to be clear and done well, and the receiving of the information needs to be done well also.

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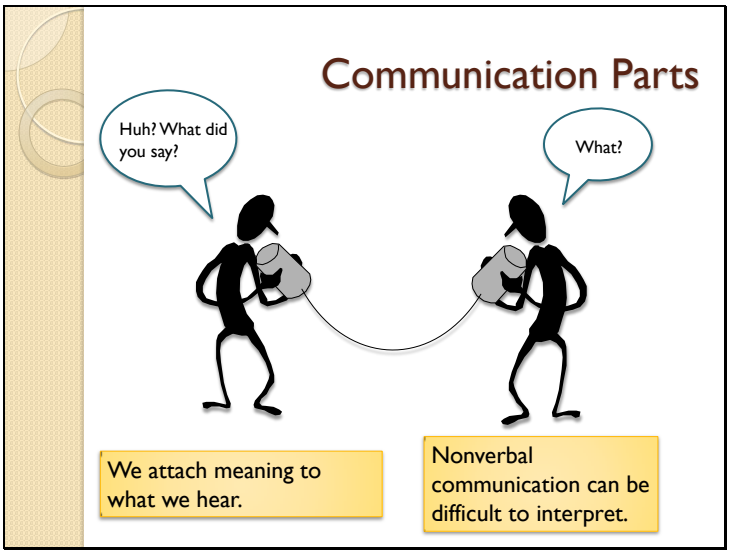

Communication can get very challenging for both parties. Verbal communication is not always clear. We attach meaning to what we hear – so saying "I love you," for example, can mean different things. Nonverbal communication can be difficult to interpret and has a significant influence on how accurately the message is given and interpreted.

Take, for example, mixed messages, which convey a mismatch between what someone is saying in terms of content, as well as what they are conveying through process. This is just one of many ways that communication can be challenging. There are many other factors and patterns that make communication challenging. Let's look at them now.

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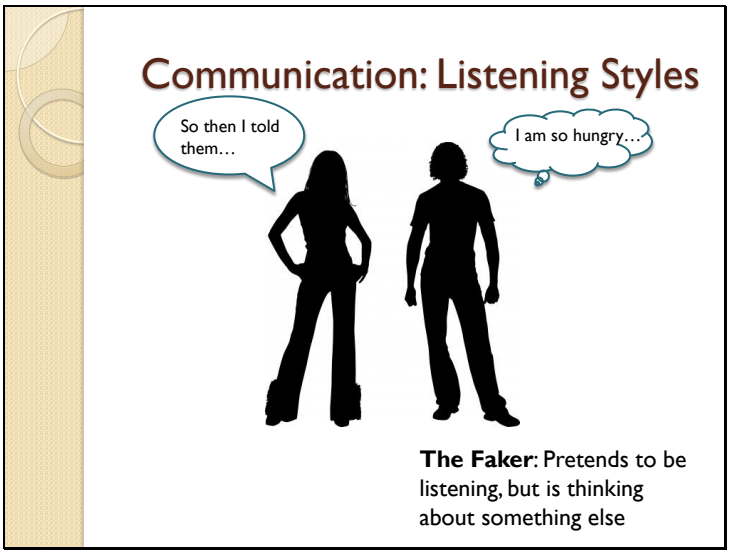

Communication: Listening Styles

How well we listen plays a significant role in our success as communicators.

Let's take a look at some different listening styles. Try to figure out your own style or styles as we go through each one.

There are many different listening styles: the faker, the dependent listener, the interrupter, the self-conscious listener, the intellectual listener, and the attentive listener.

The faker pretends to be listening. They smile, nod their head, and may appear to be intent, but in fact they are thinking about something else or are so intent on appearing to be listening that they are not hearing.

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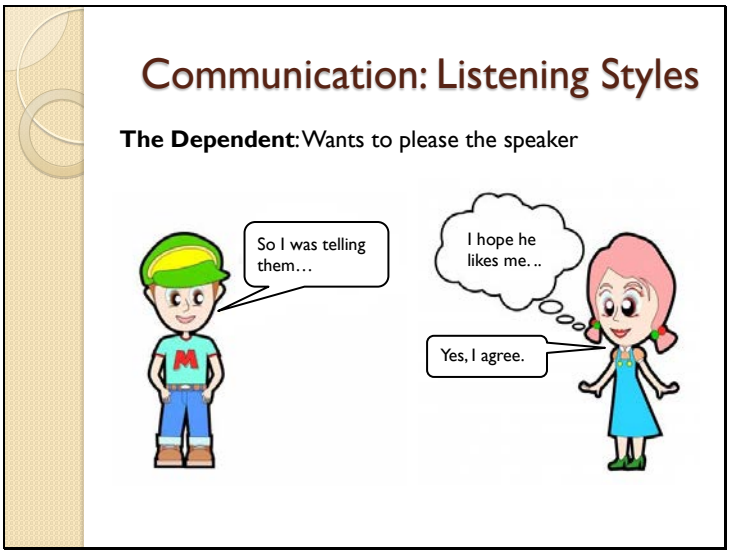

The dependent primarily wants to please the speaker. They are so concerned about whether the speaker has a good impression of them that they are unable to listen and respond appropriately. They may agree excessively with what the speaker says, not necessarily because they agree, but because they want to maintain the goodwill of the speaker.

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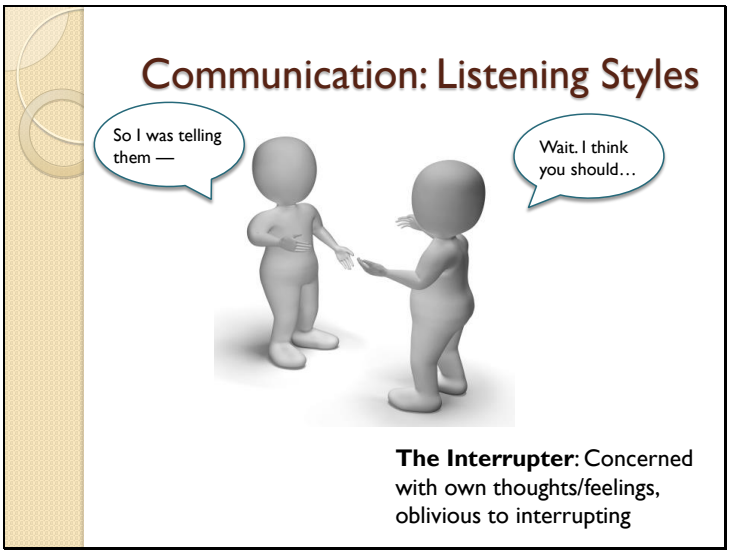

The interrupter may be concerned with his or her own thoughts or feelings, may not want to forget what he or she has to say, and may be oblivious to interrupting.

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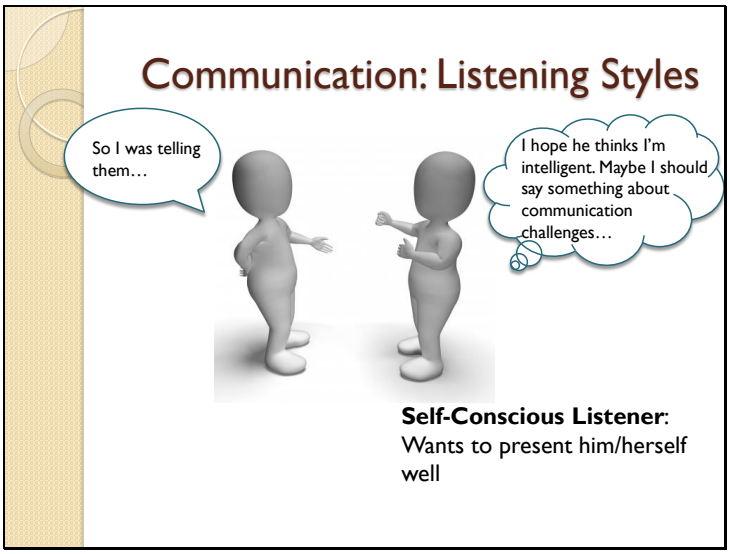

The self-conscious listener wants to present themselves well -- for example, as intelligent -- and so rather than listening, he or she is thinking about ways to respond that sound intelligent or impressive.

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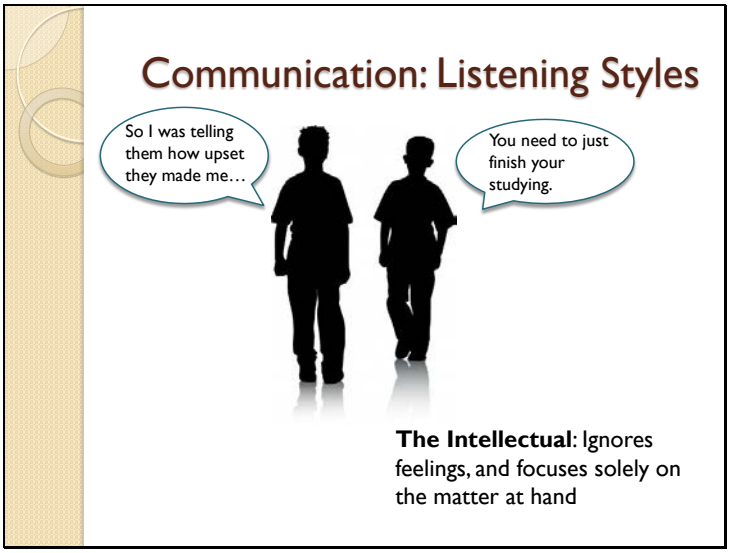

The intellectual ignores feelings, and focuses solely on the matter at hand.

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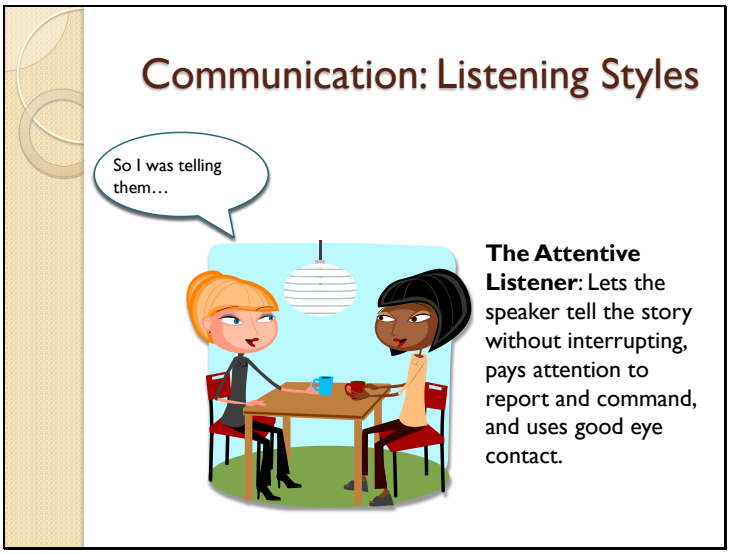

Finally, there is the attentive listener, whose style is associated with best communication outcomes: The attentive listener lets the speaker tell the story without interrupting. They pay attention to report and command and use good eye contact. This is the desirable type of listener, the type RCYCPs should strive to be.

Slide 20

Barriers To Communication

There are many barriers to communication that can make good/healthy communication difficult or challenging:

Physical/environmental barriers : for example, a long-distance relationship or living space that is not conducive to talking

Situational: for example, when there is no time to communicate, or not enough 1-on-1 time

Psychological: for example, fear of rejection, anxiety about talking, anger, or refusal to open up

And finally, gender and cultural differences: language barriers, or a closed culture that does not value openness and sharing

Let's take a look at some gender differences.

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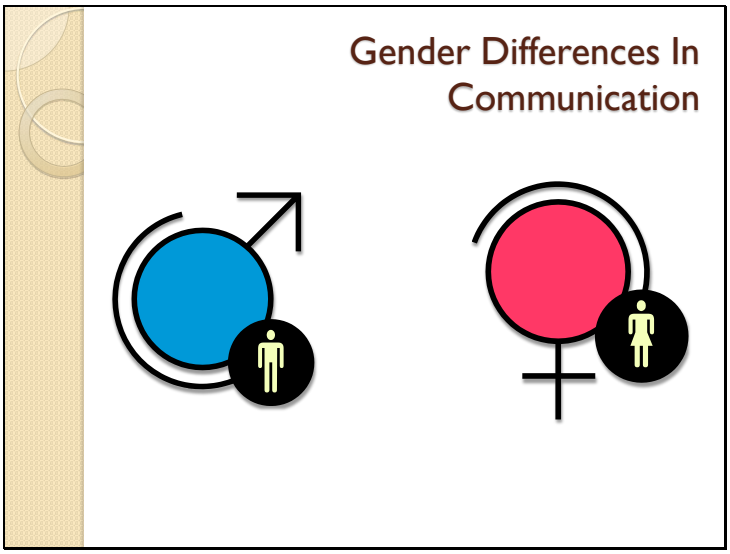

Gender Differences In Communication

Research on gender and communication has provided a great amount of insight into the ways in which gender has influenced communication for males and females. Specifically, males and females learn different styles of interacting that are practiced and reinforced as they grow up.

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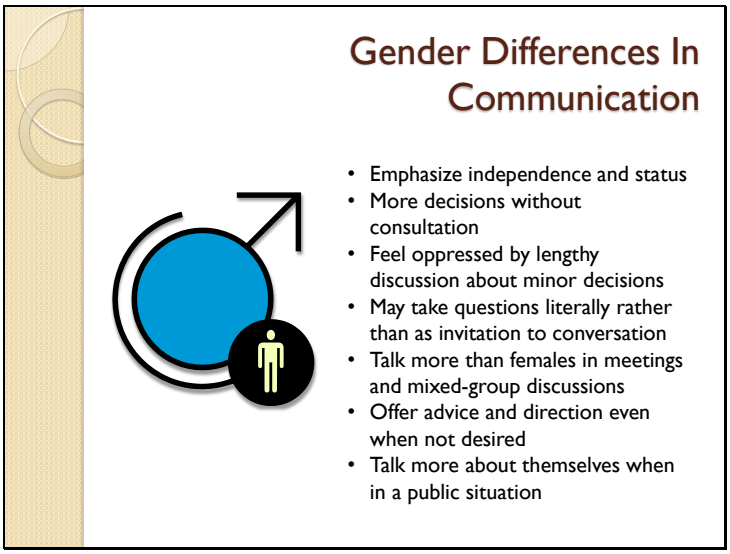

Males tend to emphasize independence and status. They tend to automatically make more decisions without consultation. They tend to feel oppressed by lengthy discussion about what they see as minor decisions. They may take questions literally rather than as an invitation to have a conversation for the sake of building a relationship. Males tend to talk more than females in meetings and mixed-group discussions. Males tend to be quicker to offer advice and direction, even when it is not desired by the other person. Males talk more about themselves than females do when in a public situation.

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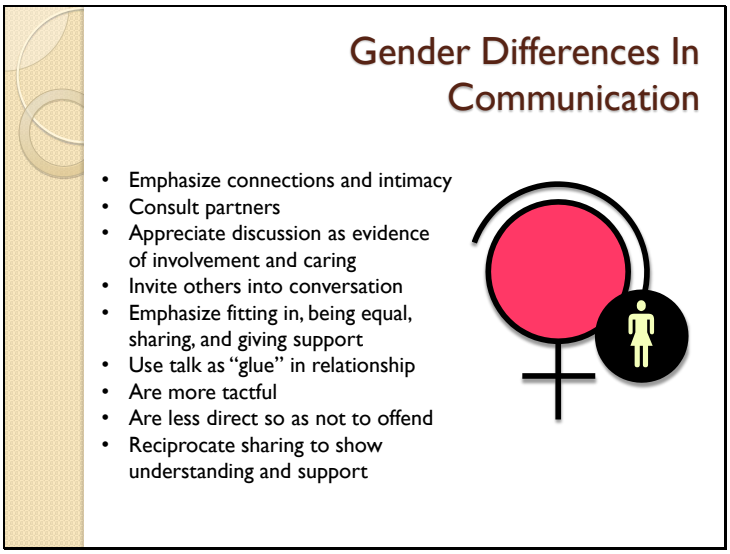

On the other hand, females tend to emphasize connections and intimacy. They feel it is natural to consult their partners at every turn, including good friends, significant others, or family members. Females tend to appreciate discussion itself as evidence of involvement and caring. Females tend to invite others into conversation by asking "what do you think?" Females tend to emphasize fitting in, being equal with others, sharing and giving support to those with whom they are talking. For females, talk is the glue that holds the relationship together. Females tend to be more tactful than males and are less direct in their conversations so as not to offend. When females share negative things in their lives, their female friends tend to reciprocate with the sharing of something negative as a way to show understanding and support.

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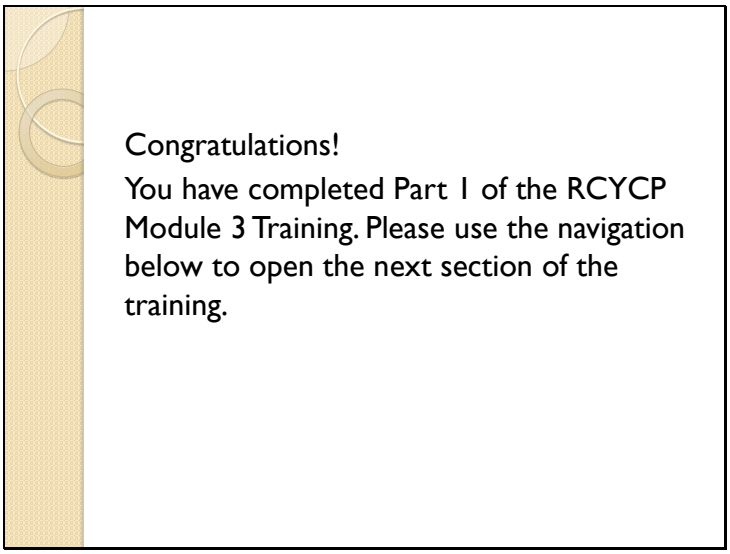

Congratulations! You have completed Part 1 of the RCYCP Module 3 Training. Please use the navigation below to open the next section of the training.

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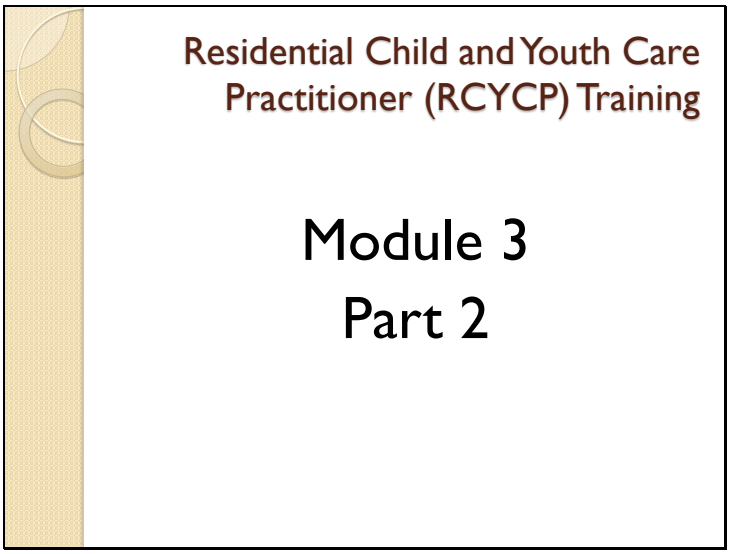

Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 3, Part 2 of the Residential Child and Youth Care Practitioner Training.

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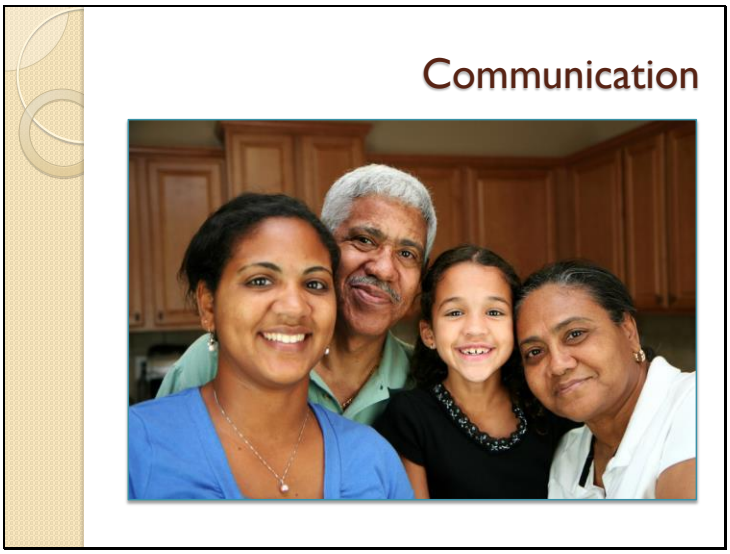

Communication

Gender obviously plays a role in communication, but did you know that our family background also influences how we learn to communicate? Let's talk about that now.

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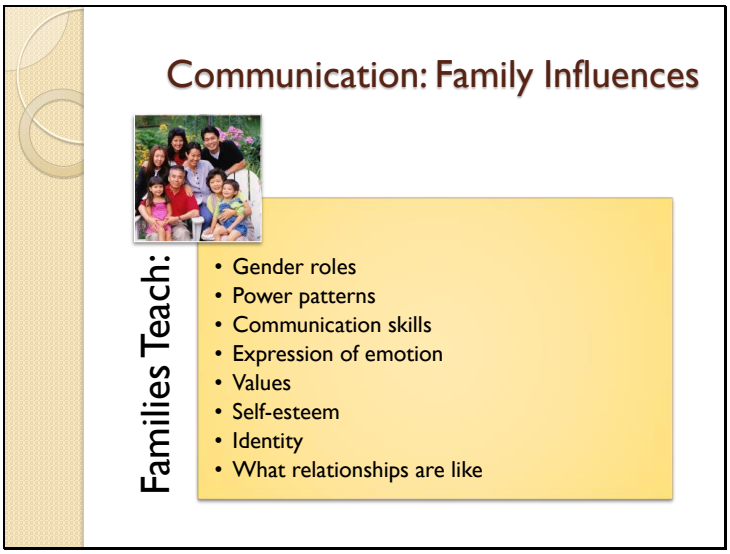

Communication: Family Influences

Families teach gender roles; power patterns; communication skills; expression of emotions like love, affection, anger, and sadness; values such as school, work, and sexuality; self-esteem; identity; and what relationships are like.

When we grow up, we take our knowledge about all of these things and bring them into our friendships and intimate relationships.

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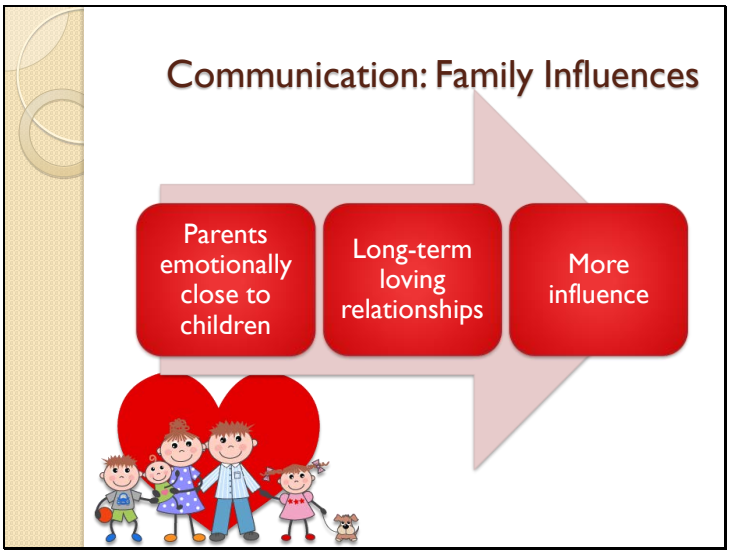

Not all children are influenced to the same degree by their families – parents who are emotionally close to their children and who have long-term loving relationships with them exert more influence than those who are not so close, and who relate to their children less frequently.

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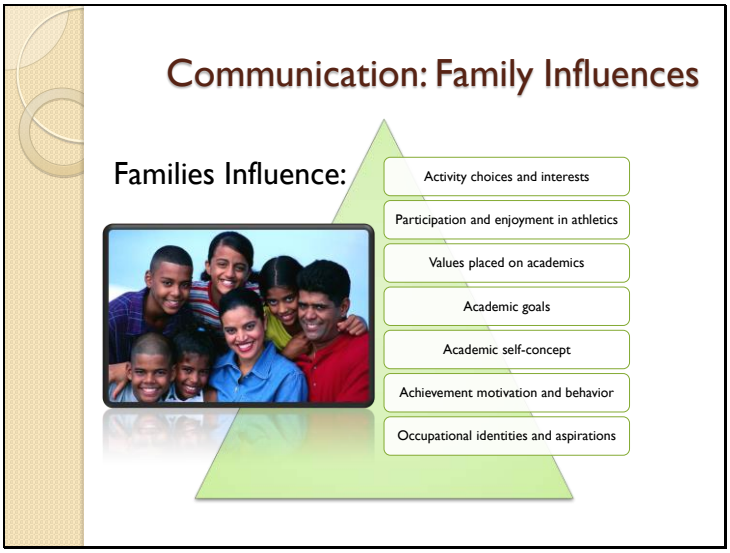

Parents have a significant influence over a number of different variables, including activity choices and interests, participation and enjoyment in athletics, academic values and goals like how important an education is, academic self-concept, for example thoughts such as “I believe I am smart,” achievement motivation and behavior, and occupational identities and aspirations.

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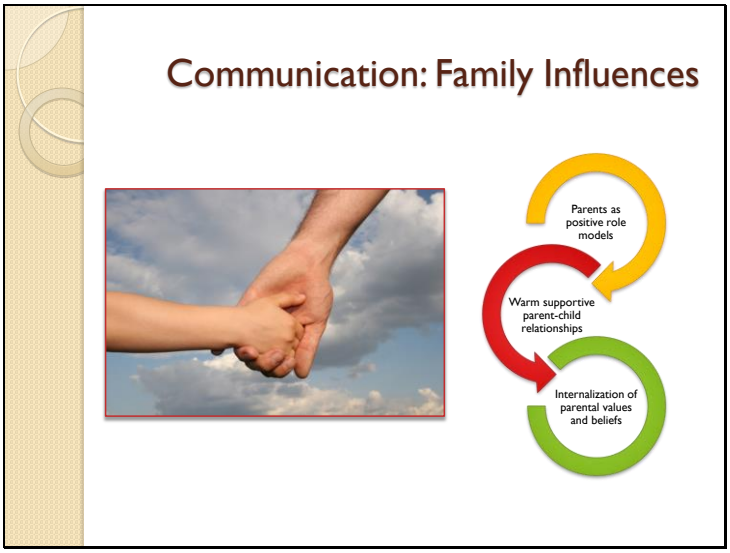

Adolescents are more likely to internalize parental values and beliefs if they experience warm, supportive parent-child relationships and view their parents as positive role models.

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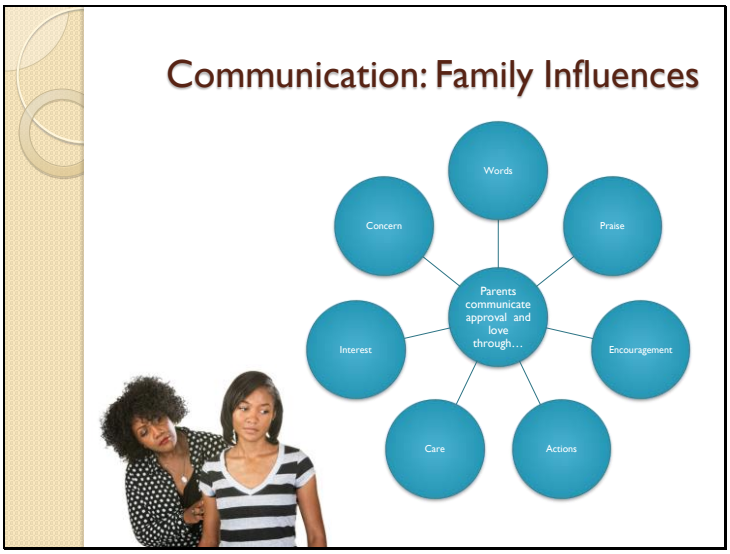

Parents communicate approval and love through words, praise, and encouragement, as well as through actions that demonstrate positive feelings and trust, and by demonstrating their care, interest, and concern.

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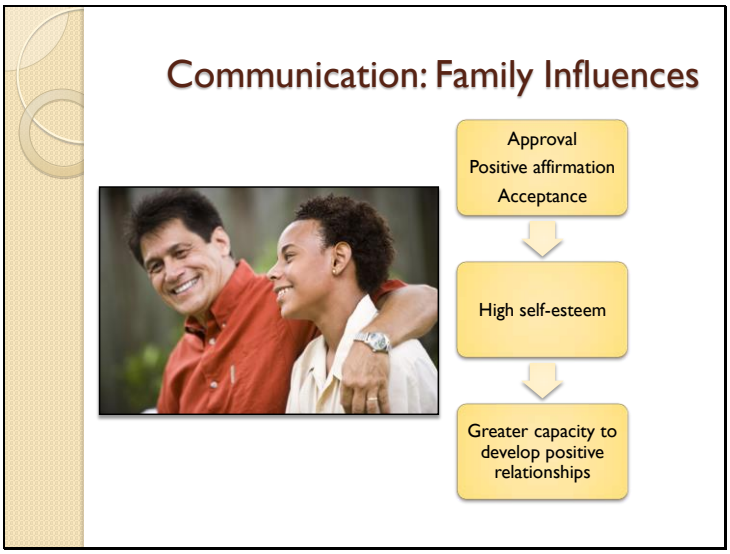

Children who grow up with approval and positive affirmation and acceptance develop good feelings about themselves, adequate self-concepts, and confidence in their own worth and abilities. High self-esteem then gives them greater capacity to develop positive relationships because they feel that they are lovable and expect to be loved.

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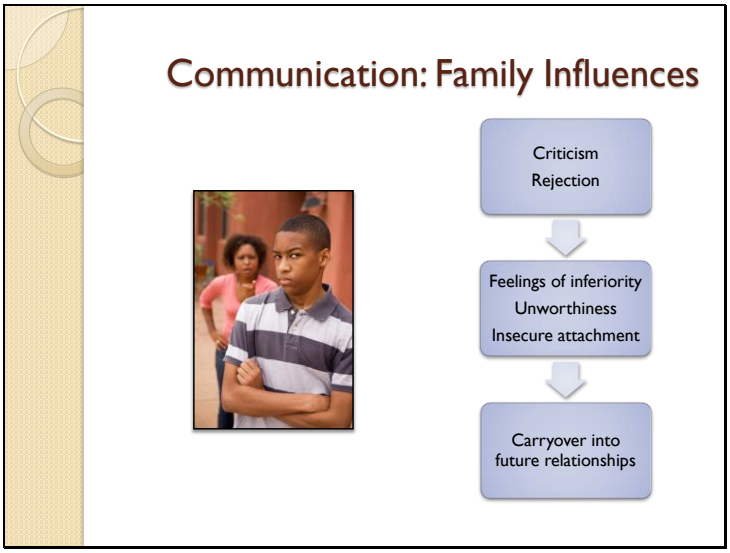

Parents also communicate criticism and rejection – overt criticism, disapproval, finding faults, ignoring, etc. This kind of communication, not surprisingly, results in feelings of inferiority, unworthiness, and insecure attachment that then gets carried over into all other areas of life – including future relationships (intimate and otherwise).

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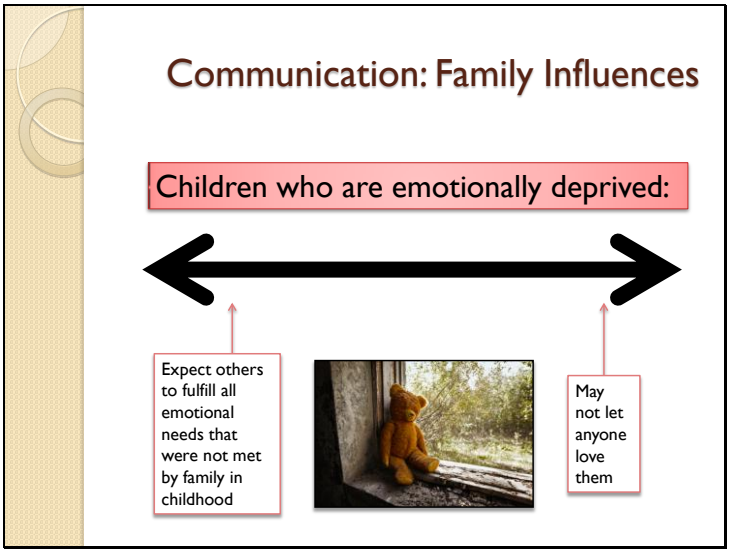
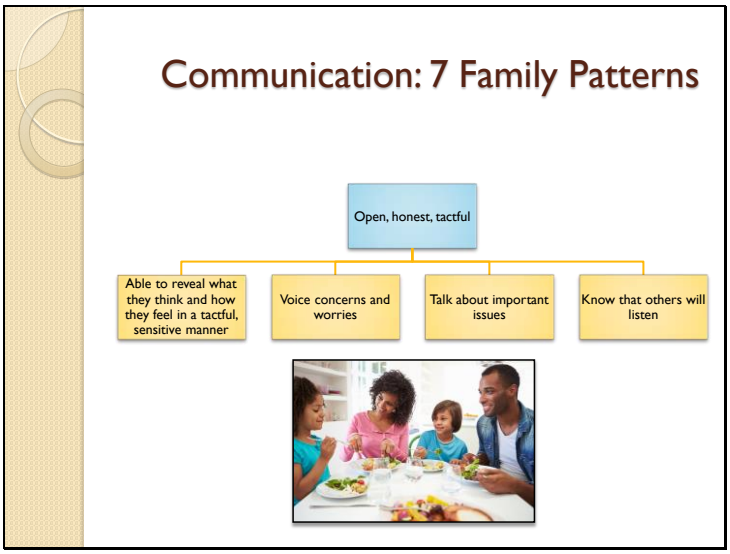


When children grow up emotionally deprived, they may transfer their needs for attention, love, recognition, and approval to their intimate relationships (or friendships) and expect others to fulfill all emotional needs that were not met by their family during childhood. At the other end of the spectrum, they may not let anyone love them.

Residential care populations tend to have a disproportionate amount of children with these extreme characteristics, which we will discuss later.

Slide 13



Let's talk now about 7 different types of family communication patterns.

In the first type, there is
1. Open, honest, tactful communication

In this type of household, family members are able to reveal what they think and how they really feel in a tactful, sensitive manner. They voice their concerns and worries and talk about important issues. They can talk about themselves and their lives and know that others will listen and understand.

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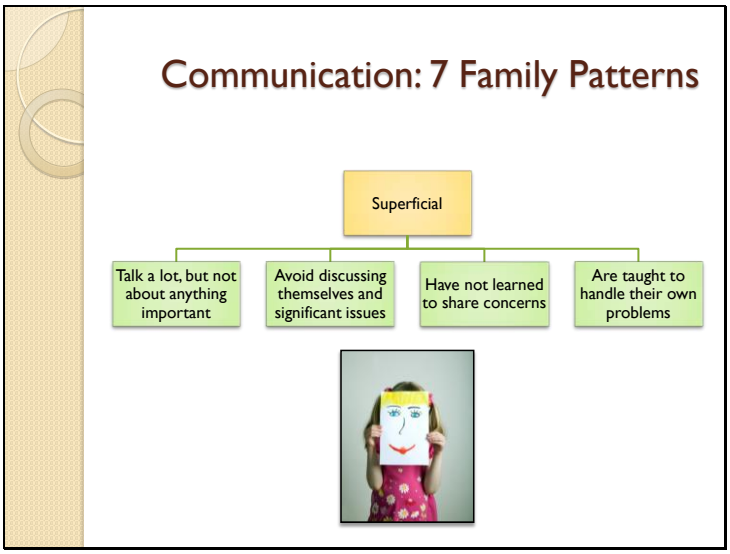

The second type is
2. Superficial communication

In this pattern, family members talk a lot, but never about anything important. They avoid discussing themselves and discussing significant issues. Because of denial, fear, or distrust, they haven't learned to share their concerns. They are taught to be independent and strong and to handle their own problems. As a result, they avoid discussing feelings and problems.

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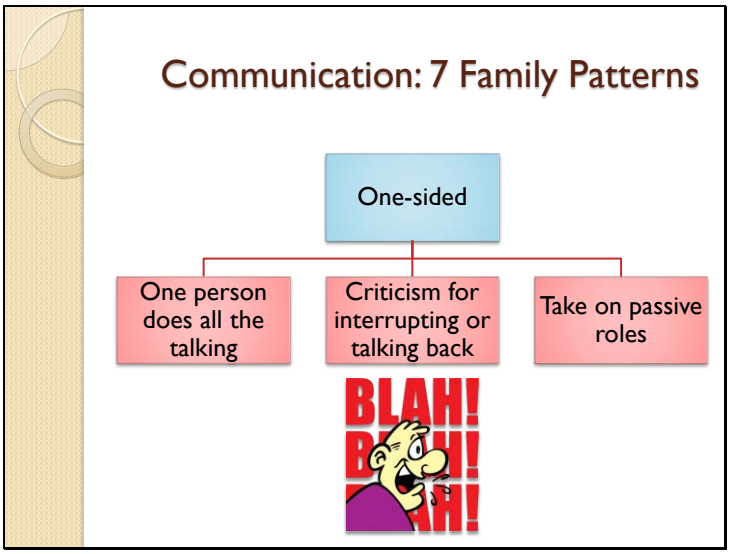
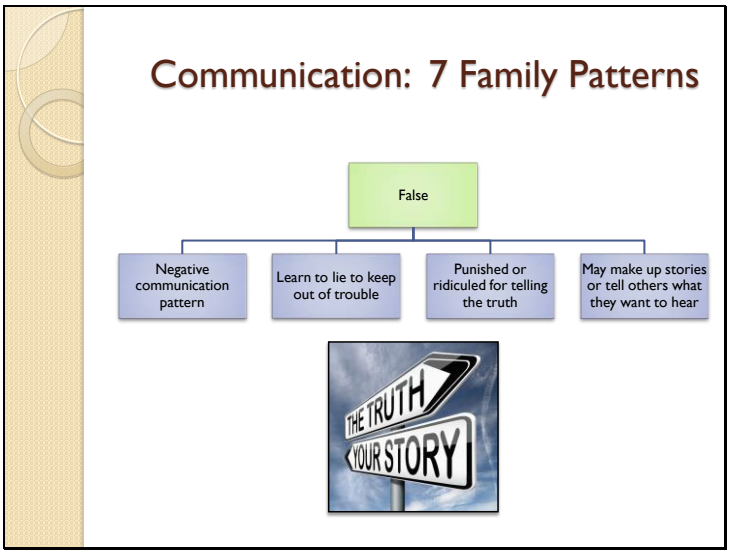


The third type is
3. One-sided communication

In some families, one person does all the talking while the others listen. If others try to talk, they are criticized for interrupting or talking back and so they learn to be quiet. They take on very passive roles (these people either go on to be passive communicators or to dominate the discussion).

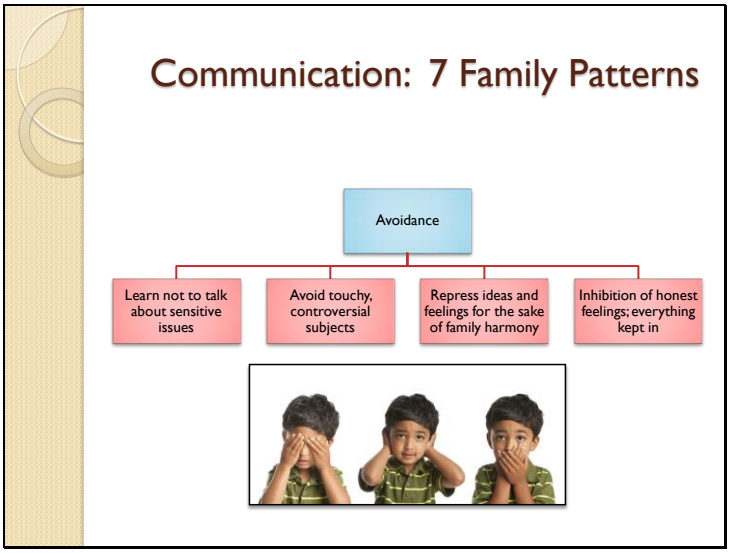
Slide 16



The fourth type is
4. False communication

This is a negative communication pattern. Family members may learn to lie to keep out of trouble. If they are punished or ridiculed when they tell the truth, they learn to make up stories or tell others what they think they want to hear. Sometimes they say just the opposite of what they really feel to give false impressions.

Slide 17



In the fifth type, there is
5. Avoidance of communication

In some cases, family members learn not to talk about sensitive issues because such discussion leads to fights. They hate arguments and so avoid touchy, controversial subjects. They repress their own ideas and feelings for the sake of family harmony, and they try to deny problems and hope they will go away. They are taught to inhibit honest feelings and to keep everything in. It becomes very difficult to resolve problems, because they are never discussed.

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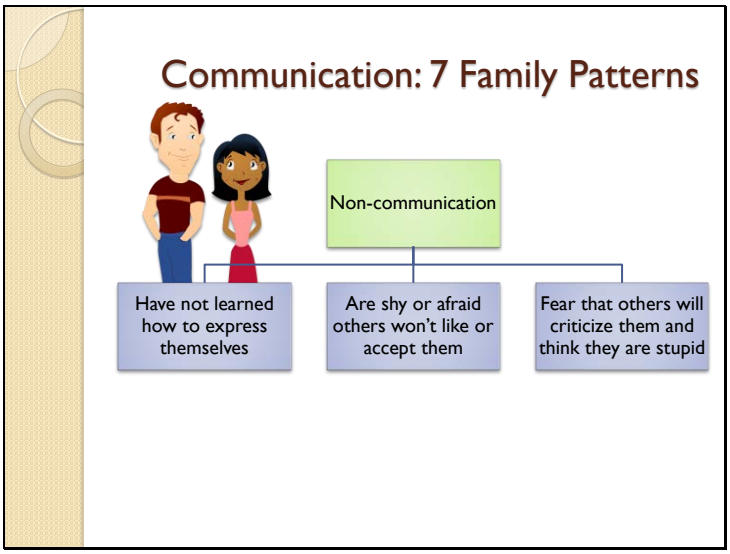

The sixth type is
6. Non-communication

Some people are nonverbal in the sense that they may not have learned how to express themselves, so they seldom discuss anything. They may simply be shy or afraid that others won't like them or accept them, or they fear others will criticize them and think they are stupid. As a result they keep quiet.

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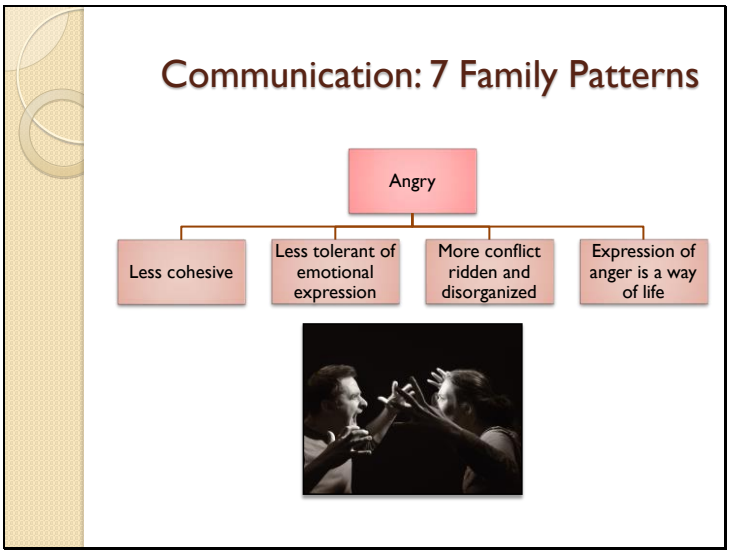

Finally, the 7th type is

7. Angry communication

Some people are not able to talk about anything without becoming angry. They have a very low tolerance for frustration and experience more emotional arousal than most people when they are frustrated. They perceive more life situations as annoying, and they get angry more often, are more likely to express verbal and physical aggression when provoked, have higher general anxiety, and make less effort at coping in a positive way. Angry people describe their family environments while they were growing up as significantly less cohesive, less tolerant of emotional expression, and more conflict-ridden and disorganized than those of less angry people. In patterns where the expression of anger is a way of life, the children may carry that pattern into their own intimate relationships.

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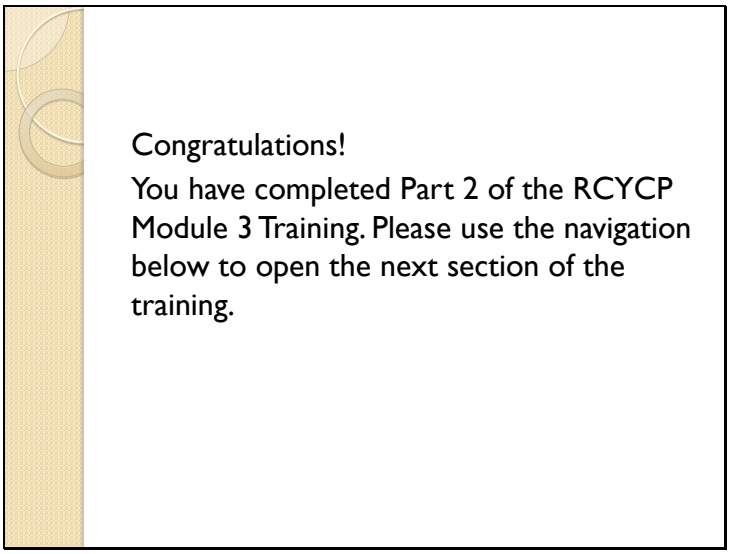

Congratulations! You have completed Part 2 of the RCYCP Module 3 Training. Please use the navigation below to open the next section of the training.

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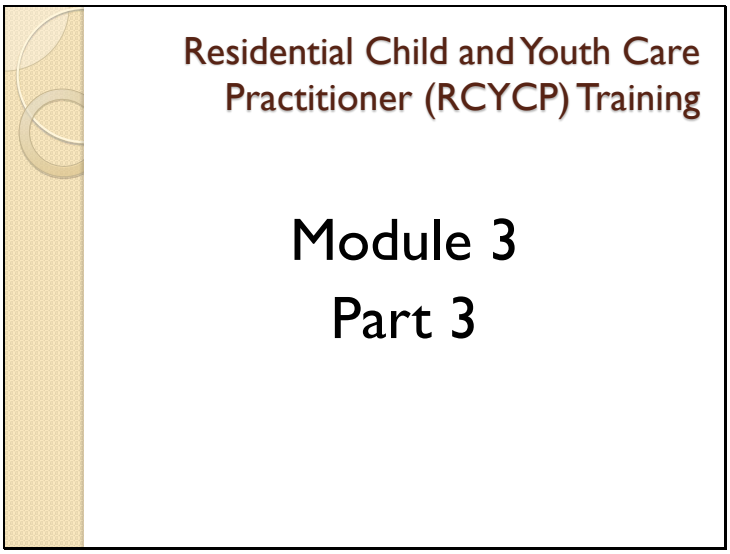
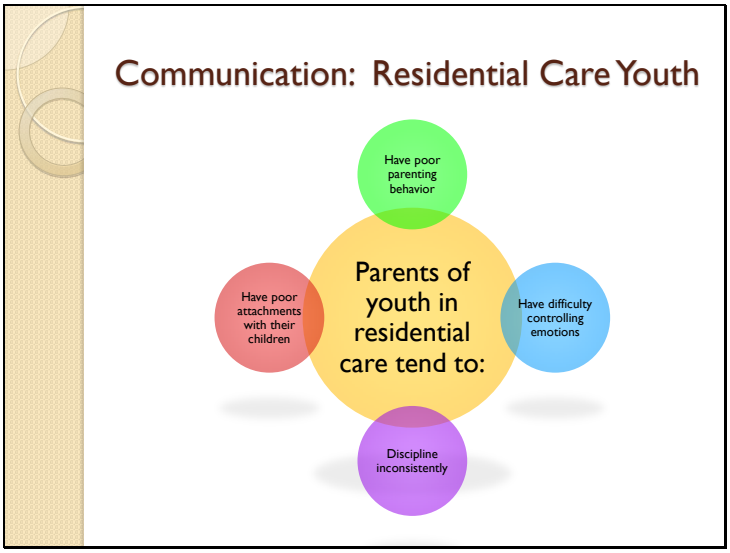


Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 3, Part 3 of the Residential Child and Youth Care Practitioner Training.

Slide 3



Communication: Residential Care Youth

So what do we know about communication and kids in residential care? We know parents of youth in residential care tend to have poor parenting behavior, including difficulty controlling emotions and disciplining inconsistently, and poor attachments with their children. This does not mean all parents of all youth in residential care tend to parent this way, but many do.

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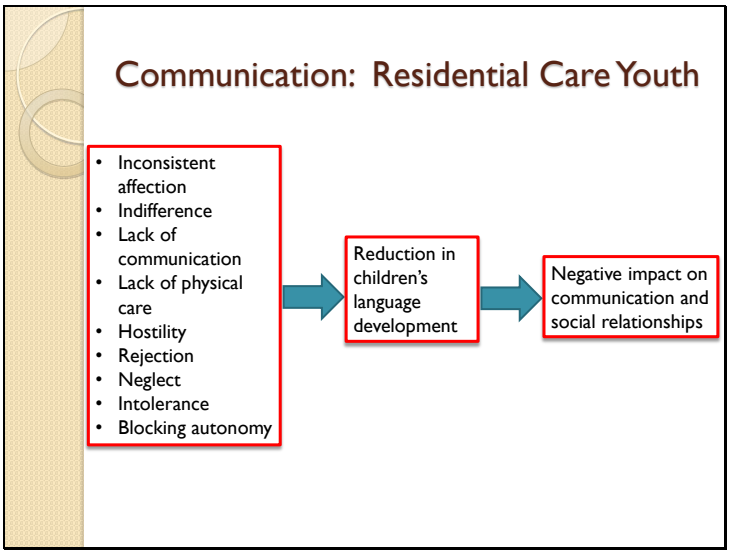

We also know that parenting practices have a significant impact on the development of language and communication abilities in kids.

Family attitudes such as inconsistent affection or a lack of affection, indifference toward children's demands for interaction, a lack of communication, a lack of physical care, hostility or rejection, neglect, intolerance, and blocking the development of the child's autonomy can all significantly reduce children's language development, thereby having a strong negative impact on children's ability to communicate and to have successful social relationships.

Slide 6

It is typical, therefore, that the population of youth seen in residential care tends to have communication and language skills well below their chronological age, as well as challenges that can take many forms.

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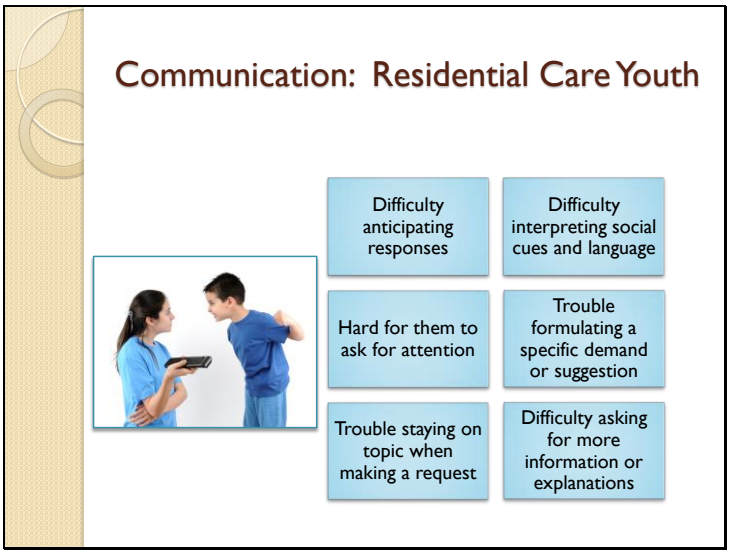

The following are the communication challenges that are most often seen in the residential care population of youth:

- Difficulty in knowing how people they are speaking to will react. Essentially they have difficulty being able to anticipate how someone will respond to them– especially adults
- Difficulty accurately interpreting social cues and language
- Clear limitations when using language as a resource to adequately demand attention. Essentially it is hard for them to ask for attention or use language rather than behavior to get attention.
- They are also limited when directly or indirectly demanding action. Essentially they have trouble adequately formulating a specific demand or suggestion.
- When making a request, especially in those situations in which a request has to be made to an important adult or figure of affection, they often have trouble staying on topic, instead jumping from one subject to another
- They also have difficulties when asking for more information or explanations about some particular event

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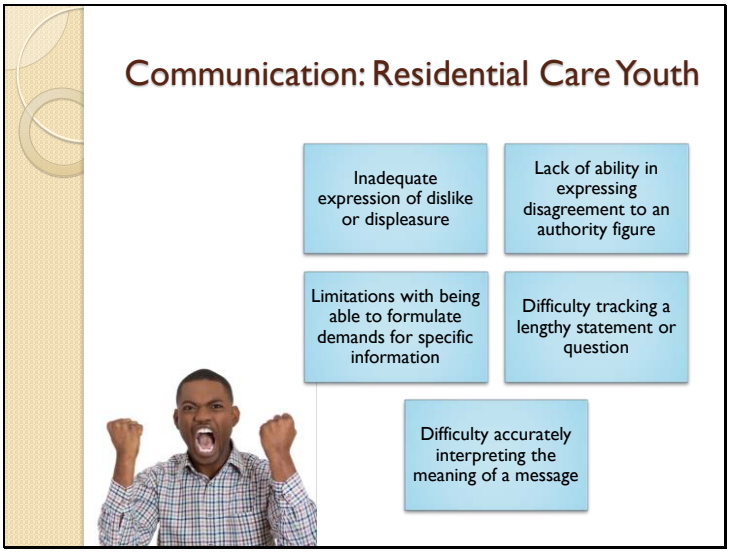

- They express dislike or displeasure inadequately; for example, they show anger or aggression, or turn inward.
- They show a pointed lack of ability in expressing disagreement before an authority figure like parents and teachers.
- They show limitations with being able to formulate demands for specific information
- They have difficulty answering when the question or affirmation is too long.
- They have difficulty making an accurate interpretation of the meaning of a message

Slide 10

So what do they need? They need to learn to communicate in a healthy, socially competent manner. As a piece of that, they need to feel unconditional warmth and caring in communication, known as unconditional positive regard.

So let us discuss the skills that will help us communicate and model communication in a healthy, caring, and successful way.

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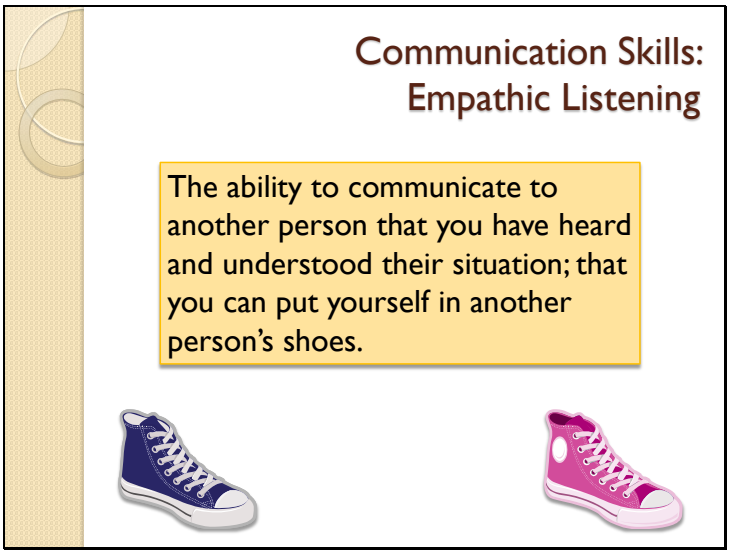

Communication Skills: Empathic Listening

Let's begin with empathic listening, one of the most basic and foundational skills, and without a doubt the most important and useful communication skill to have. Empathy is the ability to put yourself in another person's shoes – to understand their feelings and emotions. So Empathic Listening, also called active listening and reflective listening, is the ability to communicate to another person that you have heard and understood their situation.

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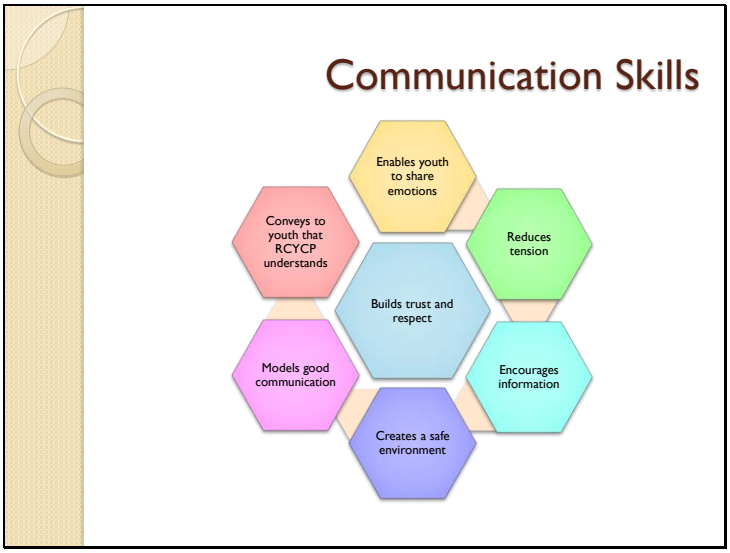

Communication

Why is empathic communication important?

- It builds trust and respect
- It enables youth to share their emotions
- It reduces tension
- It encourages the surfacing of information
- It creates a safe environment that is conducive to collaborative problem solving
- It models good communication skills
- It conveys to the youth that the RCYCP understands the essence of the problem

So what is it? Well it has many components:

Slide 14

So what does empathic communication look like? Well, it has many components:

- Reflecting feelings
- Consensual validation
- Paraphrasing
- Clarifying
- Non-verbal behavior
- Asking questions
- De-escalation
- I-messages

Let's look at each of them.

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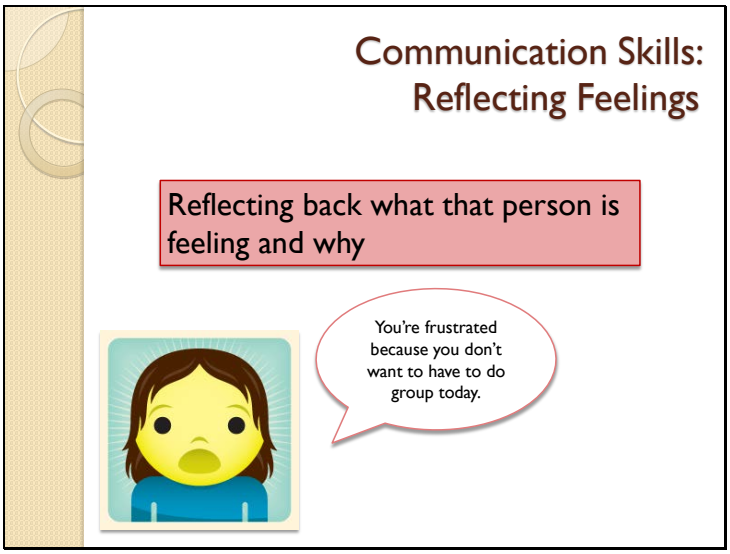

Communication Skills: Reflecting Feelings

Reflecting back feelings is helping someone understand what that person is feeling and why – so, for example, it might sound like this: "You're frustrated because you don't want to have to do group today."

"You're worried that your parents are going to be happier living without you and not want you back."

Imagine a youth says: "I'm sick and tired of having so much homework." You might reply: "You're angry because you feel like all of your free time is taken up with homework."

This skill lets the speaker know you are listening and empathizing with how they are feeling.

Slide 16

Communication Skills: Consensual Validation

Consensual validation is similar in that it also uses empathy, but instead of reflecting back, the listener offers a statement that both acknowledges and validates feelings. So, for example, in the same earlier scenario, a youth says to you: “I’m sick and tired of having so much homework.” If you reply with consensual validation, you might say: “That must be very frustrating for you,” or “That must be very annoying to you.”

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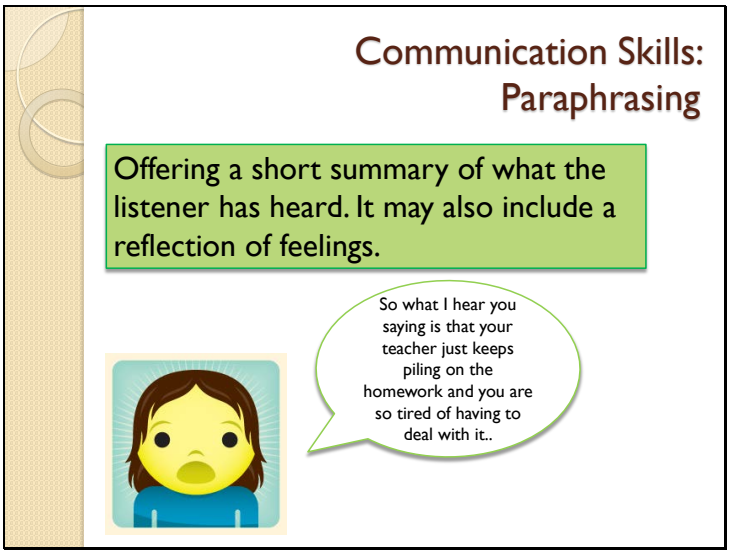

Communication Skills: Paraphrasing

Paraphrasing: This is another technique that is empathic in that it lets the listener know that you are paying attention and are interested in what they have to say. It is a short summary of what the listener has heard. It may also include a reflection of feelings. It sounds like this: “So, what I hear you saying is…”

So, for example, you might say: “So, what I hear you saying is that your teacher just keeps piling on the homework and you are so tired of having to deal with it.”

This type of statement is then likely to keep the youth engaged and interested in talking more about what is going on with him or her.

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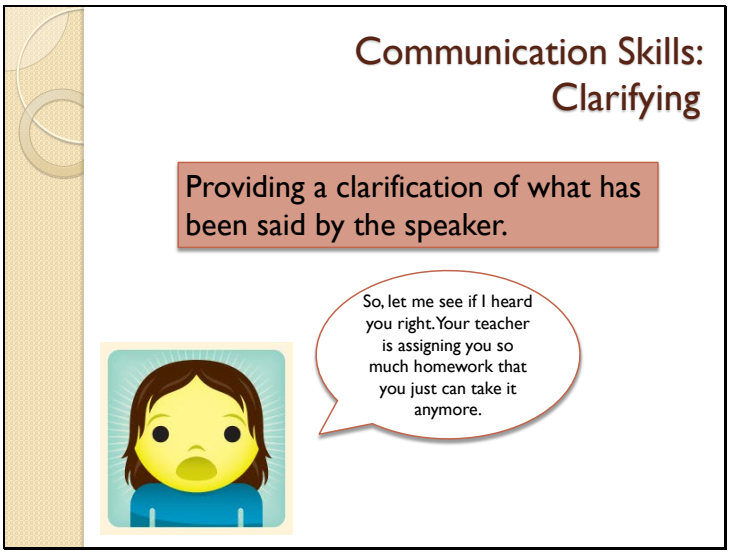

Communication Skills: Clarifying

Clarifying is another active listening skill that lets the speaker (or youth in this case) know that someone is listening and cares. The skill is just what it seems – a clarification of what has been said by the speaker. An example might be saying:

“So, let me see if I heard you right -- your teacher is assigning you so much homework that you just can’t take it anymore.”

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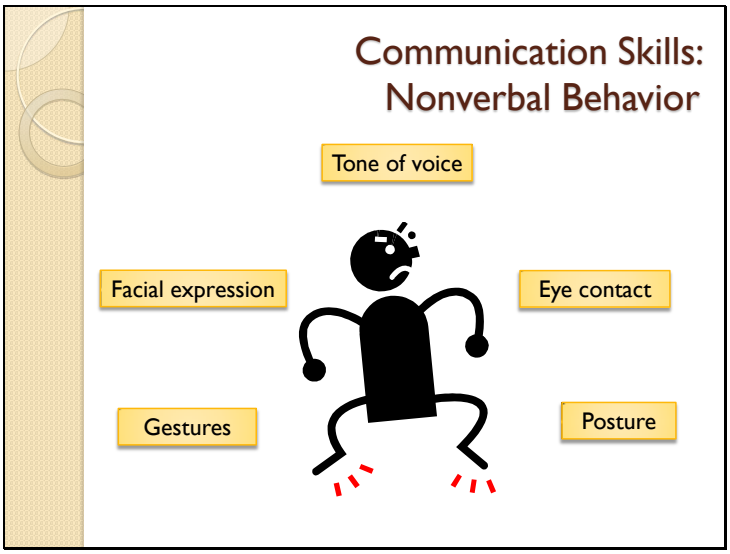

Communication Skills: Nonverbal Behavior

Another skill is making sure your nonverbal behavior conveys genuineness, warmth, caring, and interest.

By nonverbal behavior, we mean: tone of voice, facial expression, gestures, eye contact, and posture. So, for example, if you're multitasking while someone is talking, what does that convey? What about avoiding eye contact?

Make sure you are making good eye contact, using a soft tone of voice, and using body language that is neutral or benign.

Slide 20

Communication Skills: What Not To Do

Active listening IS NOT:

- Interrogating or asking a lot of questions, although one may need to get some information.
- Discounting the speaker's feelings, by saying things like "it's not that bad"
- Reassuring, by telling the child, "things will get better"
- Praising/agreeing
- Mocking/ridiculing
- Interpreting/analyzing/diagnosing
- Judging
- Preaching/moralizing
- Offering your own opinions, or advising
- Sharing your own experiences
- Teaching
- Changing the subject or moving in a new direction before the youth is ready

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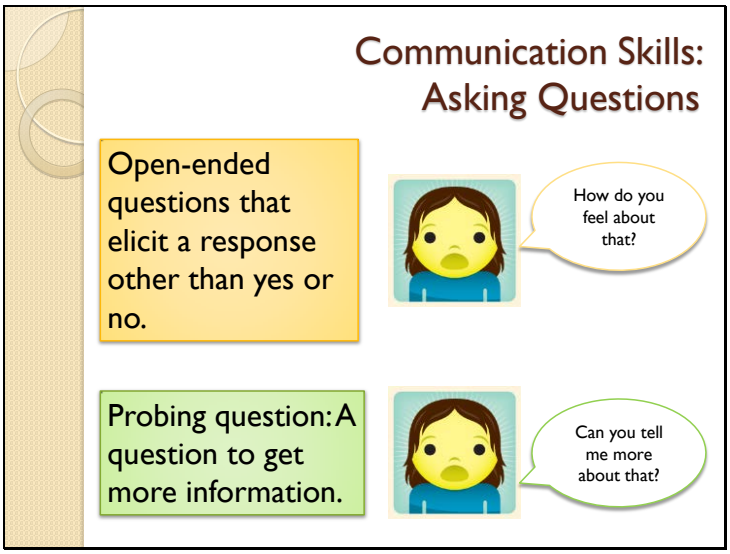

Communication Skills: Asking Questions

Asking questions is another important tool. In general, open-ended questions (that is, questions that elicit a response other than yes or no) are more effective. For example, you might ask, “So what was that like for you?” “How do you feel about it?” “What are your possibilities?” “If you could do anything you wanted, what would it be?” This is better than close-ended questions like “Are you happy with that…?” because you will likely get a one-word response like “yes” or “no.”

A useful type of question is a probing question, where you try to get more information. In Probing questions you might say: “Can you tell me more about that?”

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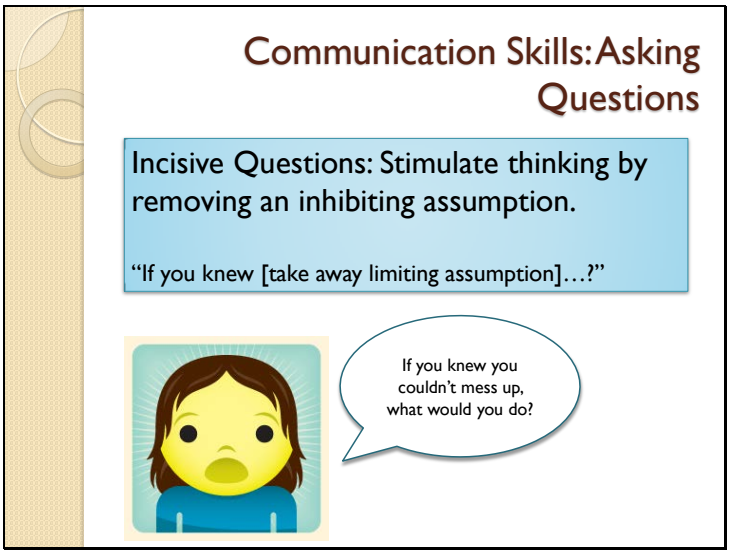

Incisive questions are another useful type of question. They are helpful in situations where it is obvious that a speaker is feeling constrained by something and can't broaden their thinking because of that constraint.

Incisive questions stimulate thinking by removing an inhibiting assumption. For example, if a person carried around a chronic sense that she was stupid, an incisive question might be: "If you knew your thinking were brilliant, how would you handle this problem?" This type of question can be powerful and liberating: "If you knew you couldn't mess up, what would you do?"

So it works by "If you knew {take away limiting assumption}…"

Here are some other examples:
"If you knew that you always had a choice, how would you feel about your situation?"
"If things could be exactly right for you in this situation, how would they be?"
"If you were not holding back in your life, what would you be doing?"
"What do you really want?"
"What do you really think?"
"If you knew that you had all of the courage you needed in this situation, what actions would you initiate?"

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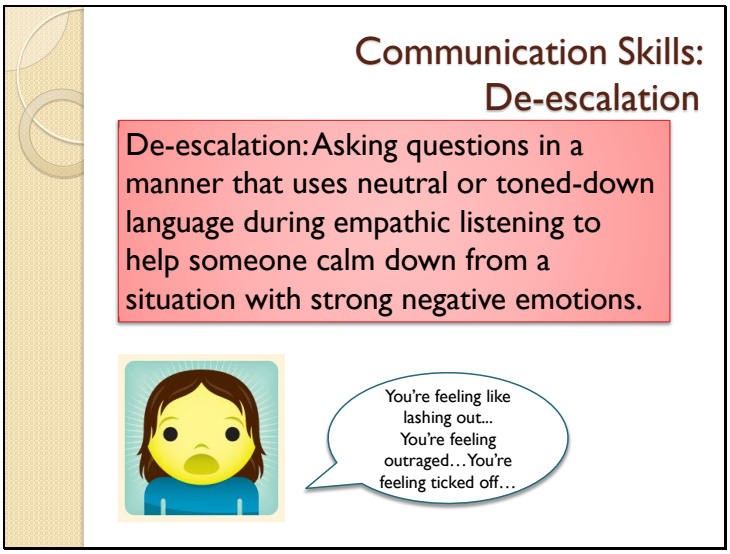

Communication Skills: De-escalation

De-escalation is another important communication skill to have, especially when working with residential youth.

De-escalation involves asking questions, but in a manner that uses neutral language or toned-down language during empathic listening to help someone calm down from a situation where she or he has strong negative emotions.

The way it works is that the RCYCP starts by using the same language as the person who is upset, and then, by degrees, chooses other words or phrases with less emotional content. For example, "You're feeling… like hurting someone" becomes "You're feeling like you want to lash out", which then might become "You're feeling outraged" to "You're furious" and so on and so forth, using the following adjectives in a de-escalating order: livid, ticked off, angry, agitated/irritated, annoyed, bothered, concerned, uncomfortable.

When using de-escalation, it is also important to focus on the future instead of the past

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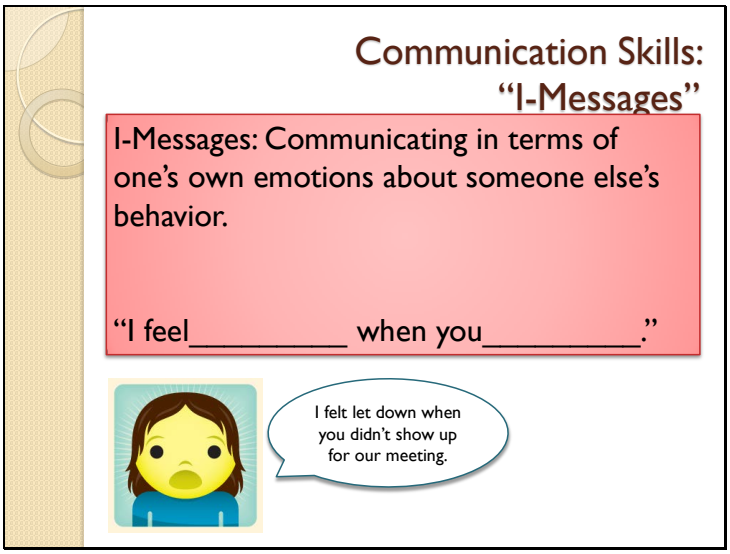

Communication Skills: "I-Messages"

Finally, let's discuss "I-messages." "I-Messages" are conceptually easy, but tricky to implement because most people are in the bad habit of using "you-messages" instead. For example, when we are angry at someone for breaking a promise, we are likely to say, "You broke your promise" in an accusatory manner, to which it is likely that the person will respond in a negative and defensive manner. One of the easiest ways to defuse an interpersonal conflict is to avoid accusatory language --- "you did…" "you are…" -- by instead using first-person statements. So instead of "You broke your promise," use "I felt let down when you didn't show up for our..." This use of I-statements decreases the likelihood of a defensive or hostile reaction.

So "I-messages" are about communicating in terms of one's own emotions about someone else's behavior: "I feel resentful when you don't do your chores, because it means more work for everyone else" vs. "You never do your chores. That is so awful."

Slide 25

Communication Skills: Video Examples

Click on the links to see some communication skills video examples.

Everybody Loves Raymond : Ray learning active listening
http://www.youtube.com/watch?v=aP55nA8fQ9I

Everybody Loves Raymond : Ray and Debra using Active Listening
http://www.youtube.com/watch?v=4VOubVB4CTU

Two students doing example of active listening
http://www.youtube.com/watch?v=lbVO1LAsM3g&list=PLKfOTZrseBqEynd3hi8b4bPktdZR2FIyq

Active listening example
http://www.youtube.com/watch?v=j40WT4XY00E&list=PLKfOTZrseBqEynd3hi8b4bPktdZR2FIyq

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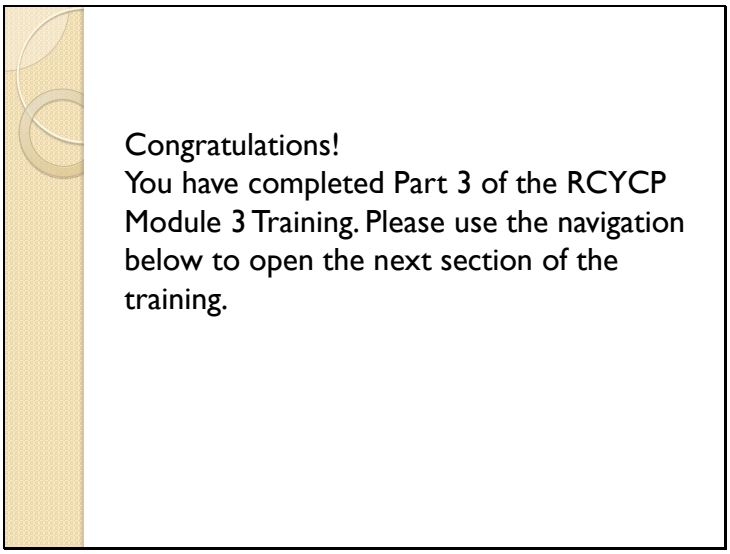

Congratulations! You have completed Part 3 of the RCYCP Module 3 Training. Please use the navigation below to open the next section of the training.

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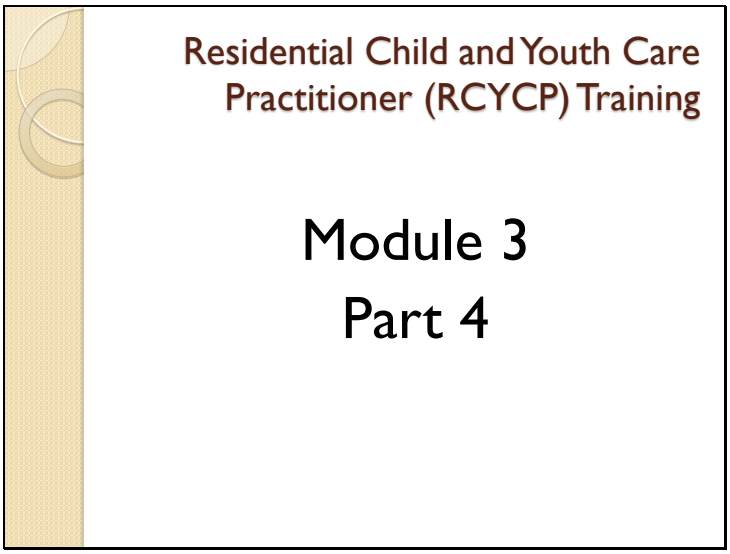
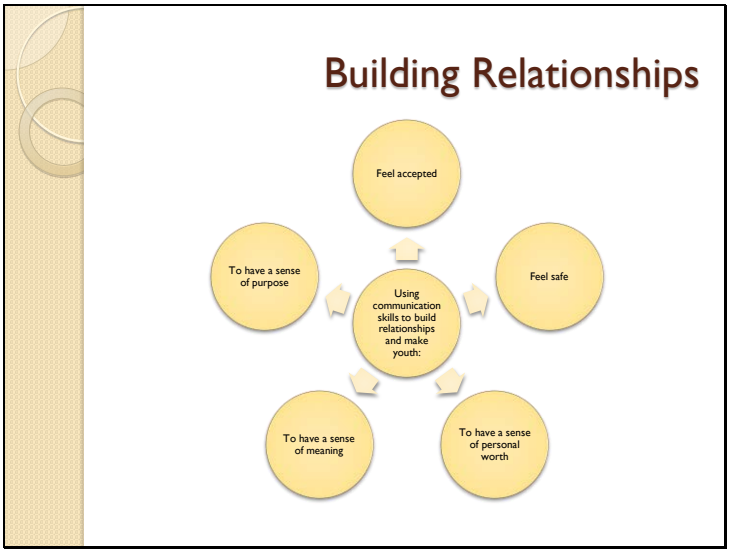


Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 3 Part 4 of the Residential Child and Youth Care Practitioner Training.

Slide 3



Building Relationships

Now that you have some important communication skills under your belt, let's talk about how you can use those skills to build relationships with youth and their families, and why building those relationships is so important.

By now, you should be able to speak to the importance of your role as an RCYCP in the lives of the youth with whom you will work. As previously discussed, residential youth need to feel accepted, to feel safe, and to have a sense of personal worth, meaning, and purpose in life. These needs are met within the context of the staff-youth relationships. Without this foundational relationship, there will be resistance to change.

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While the youth is often the primary focus of intervention, it should be clear that each individual youth should be understood in the context of his/her family in order for treatment to succeed. For example, you can deal with a youth's anger issues in treatment, but if the youth is sent home to a family life that is chaotic or challenging, the youth will likely continue to struggle.

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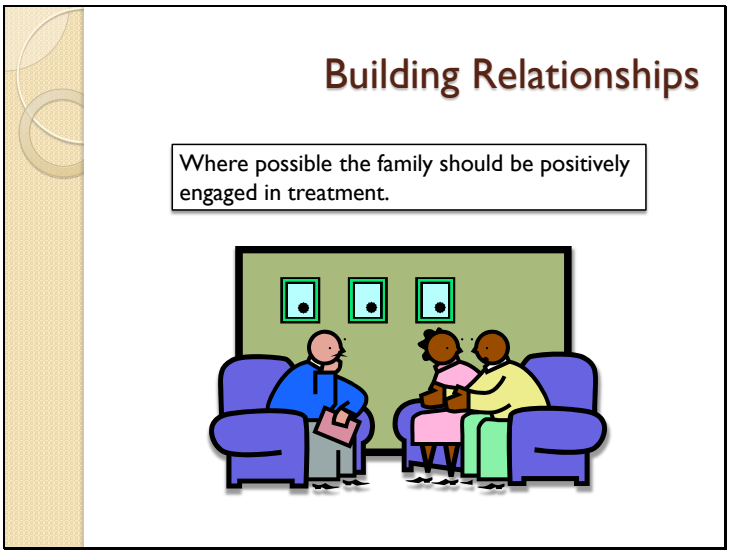

In circumstances where the youth's family is rejecting, or unable to be involved in the process, it is unrealistic to require that involvement.

Where possible, however, the family should be positively engaged in treatment. Discharge goals are more likely to be realized if parents are invested in the process, and support and assist the child.

So let's talk about ways to engage families.

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Building Relationships: Family Engagement

Family engagement can be tricky. Some parents have had stressful experiences with social service agencies and are likely to have developed trust issues or are fearful of revealing too much and being judged. Some parents are resentful or distressed at the placement of a child and can be resistant to working with workers. These types of trust issues can make your job harder.

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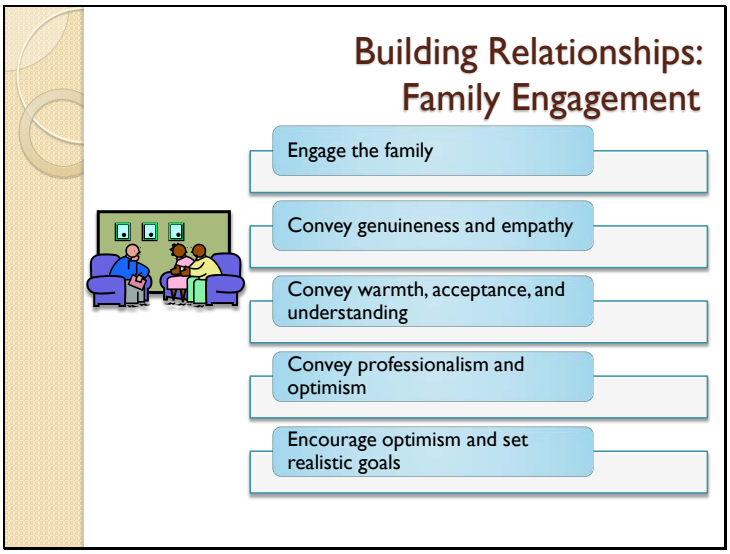

So what kinds of things can you do to engage families? First and foremost, use the communication skills in this module to:

Engage the family and child as full partners in care planning, decision making, and practice. Make it clear to them that they are valuable partners in the work.

- Convey genuineness and empathy for the family.
- Convey warmth, acceptance, and understanding.
- Convey professionalism and optimism for positive change.
- Encourage optimism and jointly set realistic goals for the child and family.

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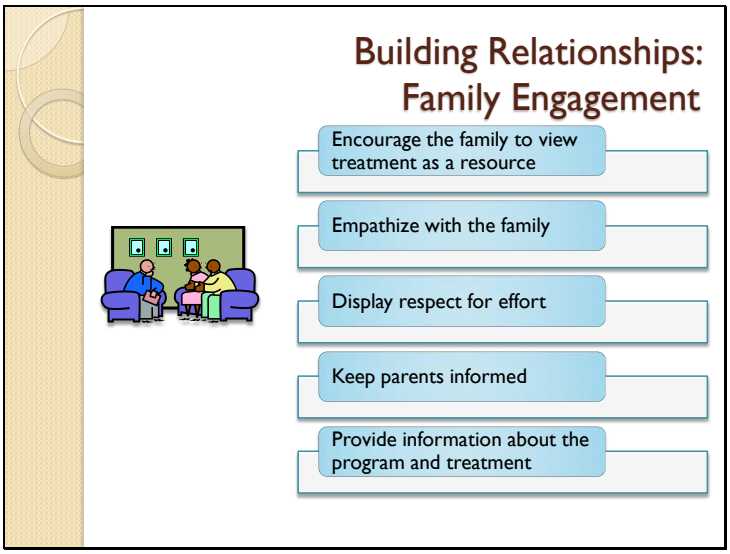

Encourage the family members to view treatment as a supportive resource for them – workers should be able to present themselves as having parenting expertise to help the family. Empathize with the family over the challenges they have experienced, and display respect for their efforts and continued commitment.

Keep parents informed of the child's progress, any difficulties encountered, and how those were dealt with.

And finally, provide them with information about the program, treatment, methodology, process, etc.

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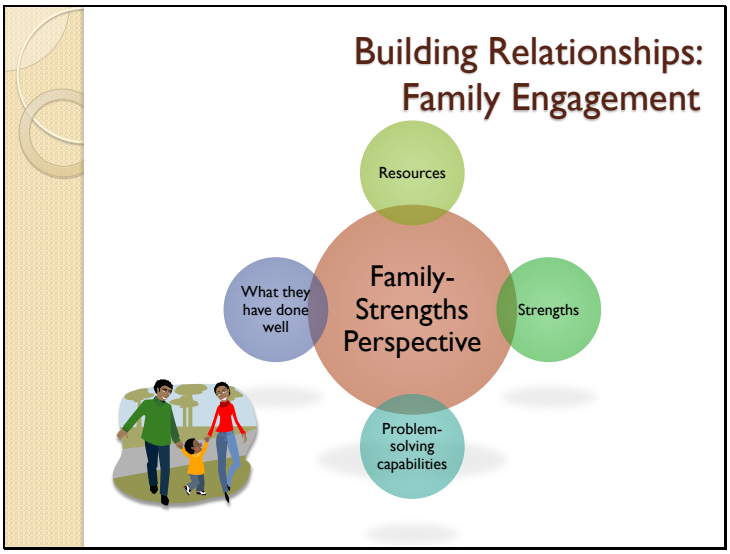

Second, you must work from a family-strengths perspective: that means that you look at the family's resources, strengths, and problem-solving capabilities, and not just at their deficits and weaknesses. The emphasis is on what a family has in terms of resources and what they have done well, as well as how those resources and strengths can be used in treatment.

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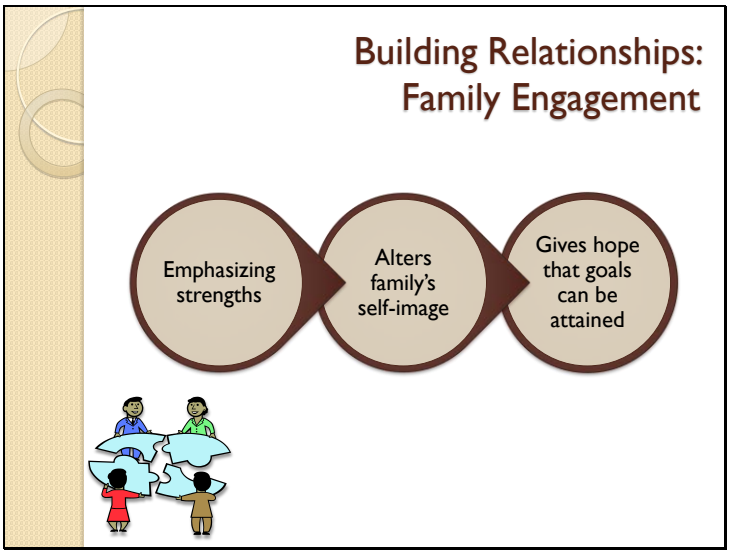

Emphasizing strengths helps alter the family's self-image and gives family members hope that their goals can be attained.

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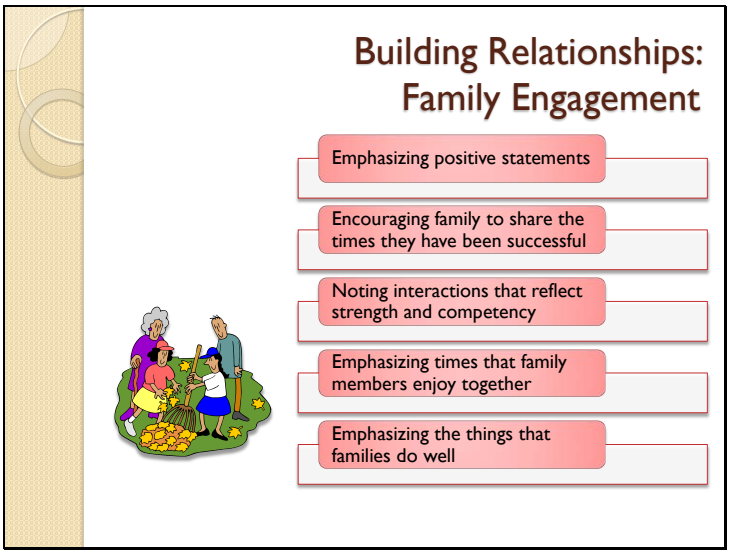


Engaging families can be done by:

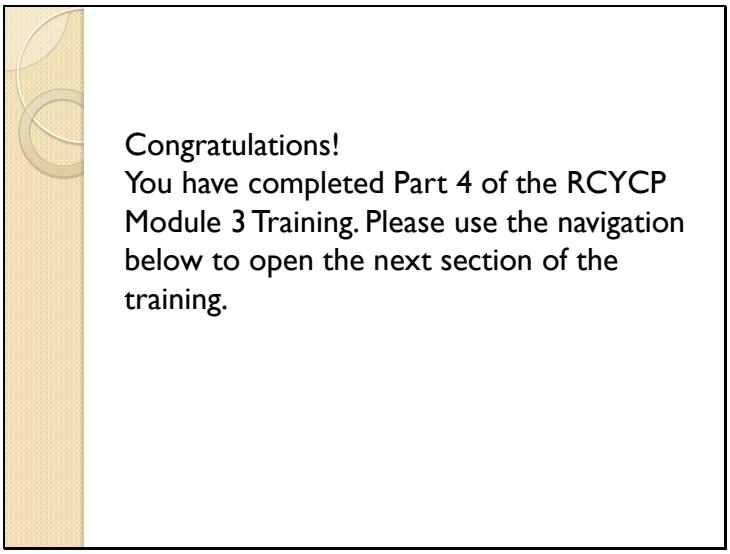
- Emphasizing positive statements reported by family members.
- Encouraging family members to share their story about themselves. You might pay attention to times that the family has coped with or managed problems successfully.
- Noting family interactions that reflect strengths and competency.
- Emphasizing those times that family members enjoy together.
- And finally, emphasizing the things that families do well.

Slide 12

Video: Family Partnerships

Video on partnerships (family to family) --- Annie E. Casey

Slide 15



Congratulations! You have completed Part 4 of the RCYCP Module 3 Training. Please use the navigation below to open the next section of the training.

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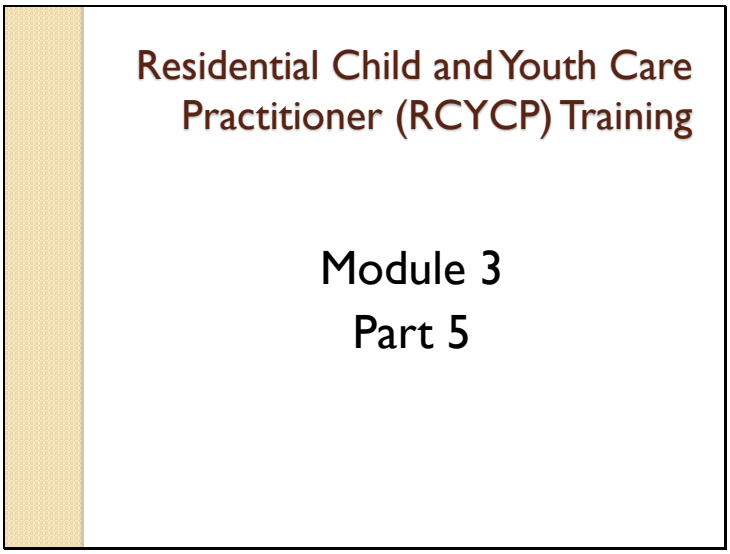

Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 3 Part 5 of the Residential Child and Youth Care Practitioner Training.

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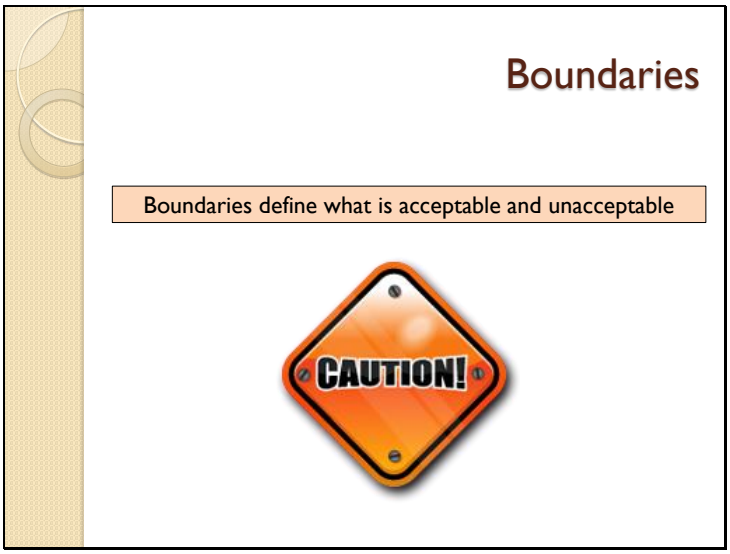

Now that you know more about building relationships with the youth and their families, we are going to turn to a very important component of relationships: boundaries.

So what are boundaries? Boundaries define what is acceptable and unacceptable for a professional, both at work and outside of work.

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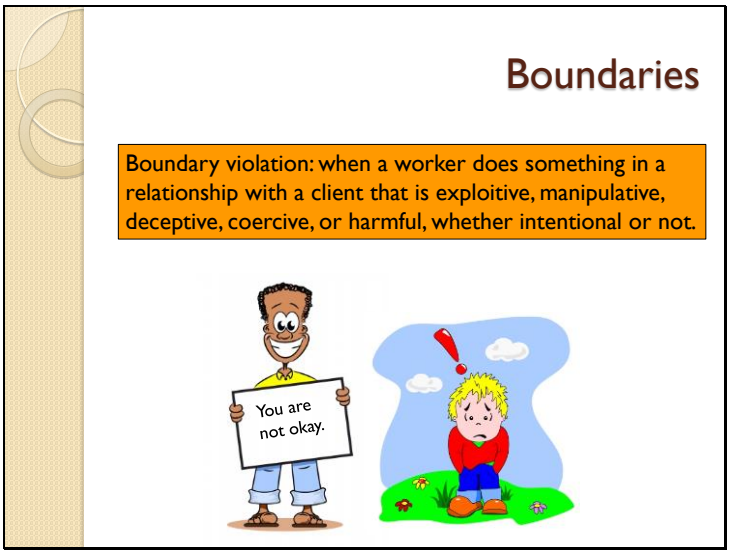

A boundary violation occurs when a worker does something in a relationship with a client that is exploitive, manipulative, deceptive, coercive, or harmful in some way (whether intentional or not). While some violations are intentional, or cross the line in an obvious way (e.g., sex with a client), others are not intentional and not as obvious, but still do damage.

For example, a worker who discloses personal or intimate details about his or her own life, ostensibly to be helpful to the client, ultimately may confuse the client and compromise the treatment. Imagine, for example, that a worker discloses to a youth that she was bullied as a child, too, but didn't let it bother her and she turned out okay. That may send a message that the youth is not strong or capable because bullying *is* bothering him or her.

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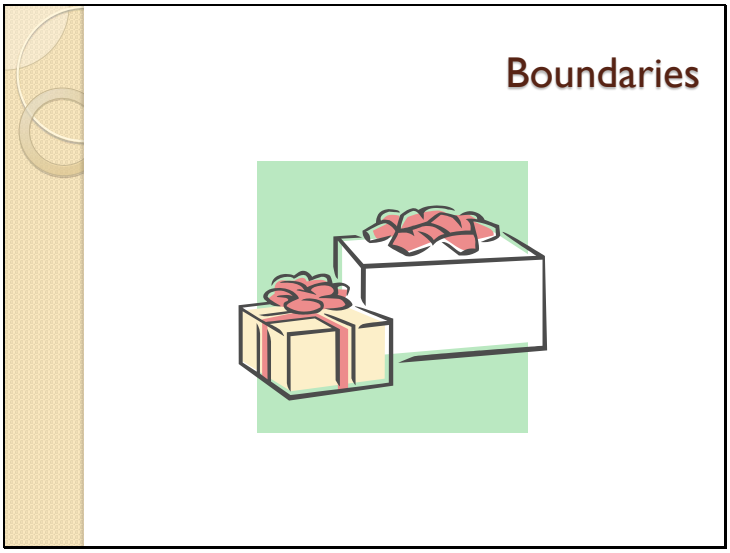

Here is another example: A residential worker accepts a small personal gift from a youth, thinking it's not that big a deal to accept the gift, but the gift from the youth may reflect fantasies about a friendship or more intimate relationship with the worker. Or possibly, the youth wants something later in return. An RCYCP once wrote of a case in which a youth gave a small gift to the RCYCP, then later asked for the RCYCP to buy/give him cigarettes as if they had a quid pro quo arrangement. What starts out innocently can become complicated and troublesome very quickly.

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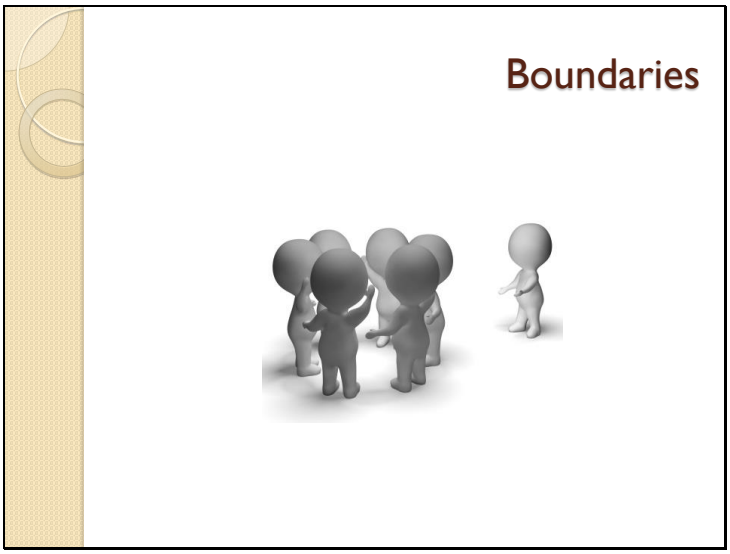

Even the most innocent and indirect relaxation of boundaries can lead to serious consequences. Take the following example:
Staff working in a children's home were excitedly discussing a colleague's 50th birthday party and were overheard by a resident teenager they worked with closely. Staff wanted to include "Amy" (the resident) but senior management had to intervene because alcohol would be served and colleagues and their families would be socializing together outside of work. Amy was deeply hurt to learn that she could not attend, which in turn had an effect on her subsequent behavior in the home (Pemberton, 2009).

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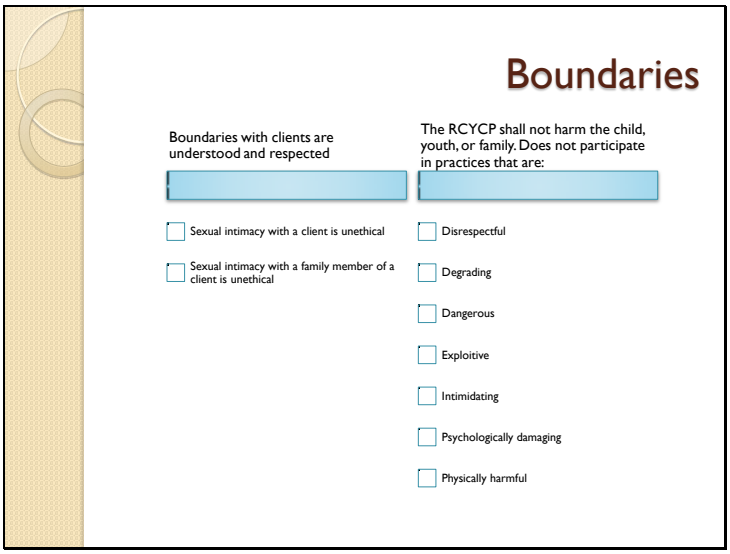

So the issue of boundaries is a tricky one. Let's begin with the ethical guidelines related to boundaries and go from there.

As an RCYCP, you are guided by the COMAR regulations as well as the Standards for Practice of North American Child and Youth Care Professionals. Specifically, the standard

- Ensures that the boundaries between professional and personal relationships with clients is explicitly understood and respected, and that the practitioner's behavior is appropriate to this difference.
- Sexual intimacy with a client, or the family member of a client, is unethical.

With regard to Responsibility to the Client (client is defined as the child, family and former clients):

- Above all, [the RCYCP] shall not harm the child, youth, or family.
- [and] Does not participate in practices that are disrespectful, degrading, dangerous, exploitive, intimidating, psychologically damaging, or physically harmful to clients.

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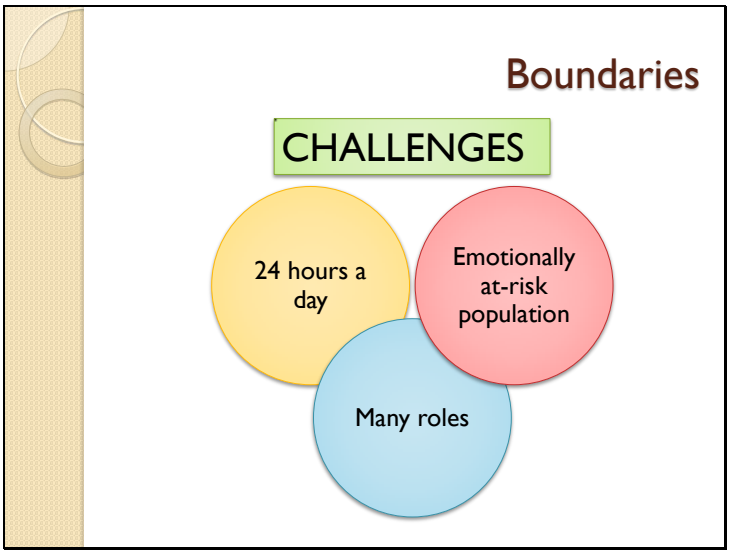

While the ethical guidelines seem straightforward, when it comes to residential care, the issue of boundaries can get quite complex.

A major challenge to maintaining boundaries is that residential care is a 24-hour-a day job, so RCYCPs have many roles. Also, the population is emotionally at-risk.

Group homes are not as structured as other types of facilities, and so boundaries between teens and staff are not as limited. This presents many challenges. Also, there are significant variations across sites. For example, one group home may say that RCYCPs may never bring a teen home with them, whereas there are others that encourage this same action.

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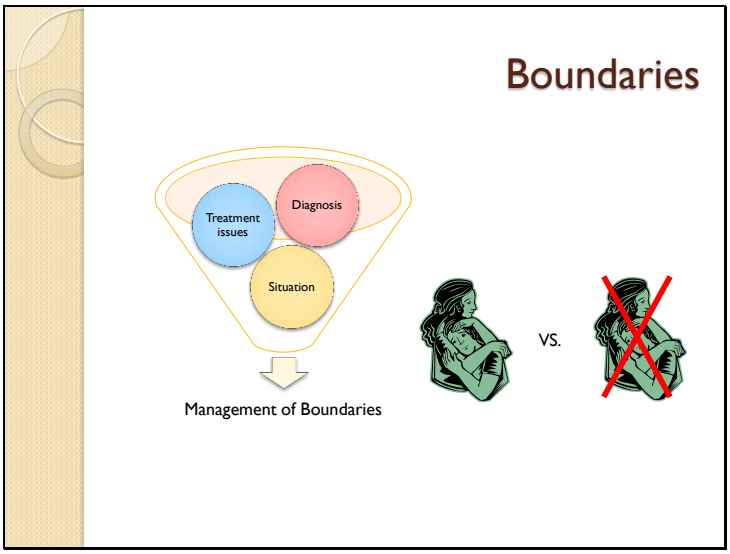

Additionally, youth can be admitted to residential care with a number of different diagnoses – for example, attachment issues, substance abuse problems, aggression, mental health difficulties, sexualized challenges, challenges with authority, criminal behavior, etc. Depending on the youth's treatment issue, as well as situation, boundaries will be managed in different ways. For example, placing one's arm around a distraught youth who just received bad news about a family member might be appropriate for one individual, but not for another, depending on the youth's family history, and mental and emotional diagnoses.

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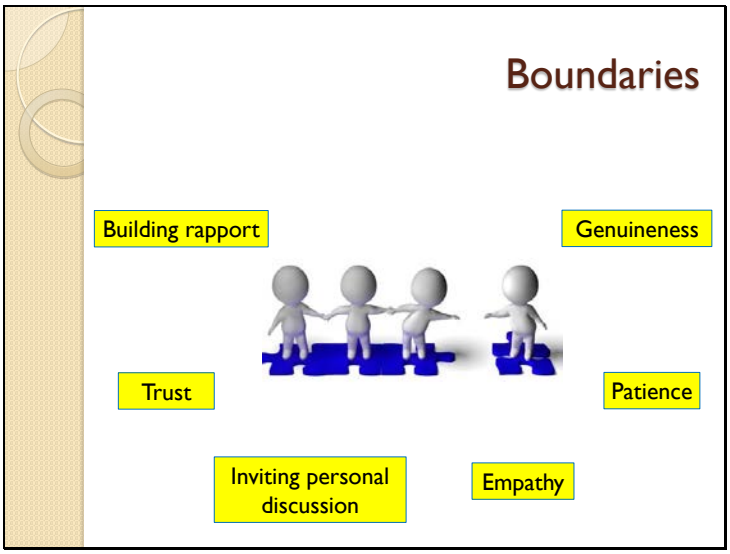

Furthermore, a significant component of the work revolves around the relationship between worker and youth – building rapport, trust, inviting personal discussion, empathy, patience, and genuineness.

Children and adolescents entering residential care typically have attachment challenges – that is, difficulty establishing and maintaining healthy relationships -- and require a setting and people who will help to establish a secure base.

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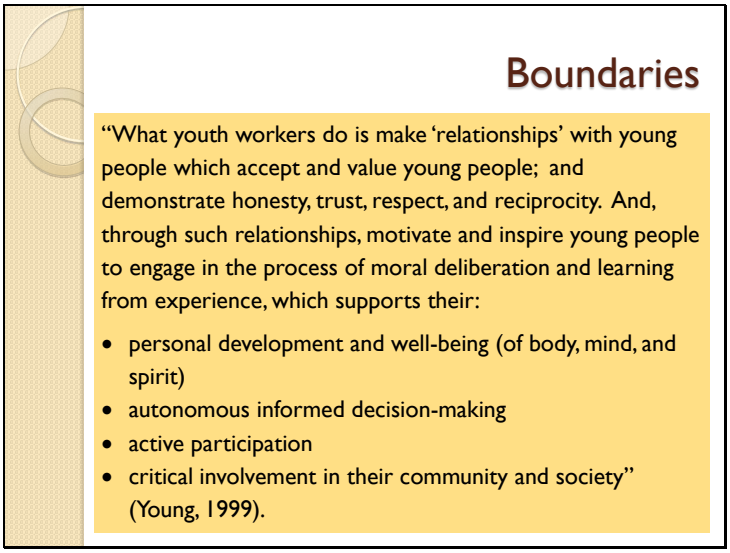

Take this quote about the relationship between RCYCP and youth that illustrates how vastly important the relationship is, and by its very nature, how personal it can get:

What youth workers do is make 'relationships' with young people which accept and value young people; and demonstrate honesty, trust, respect, and reciprocity. And, through such relationships, motivate and inspire young people to engage in the process of moral deliberation and learning from experience which supports their:

- personal development and well-being (of body, mind, and spirit)
- autonomous informed decision making
- active participation
- critical involvement in their community and society" (Young, 1999).

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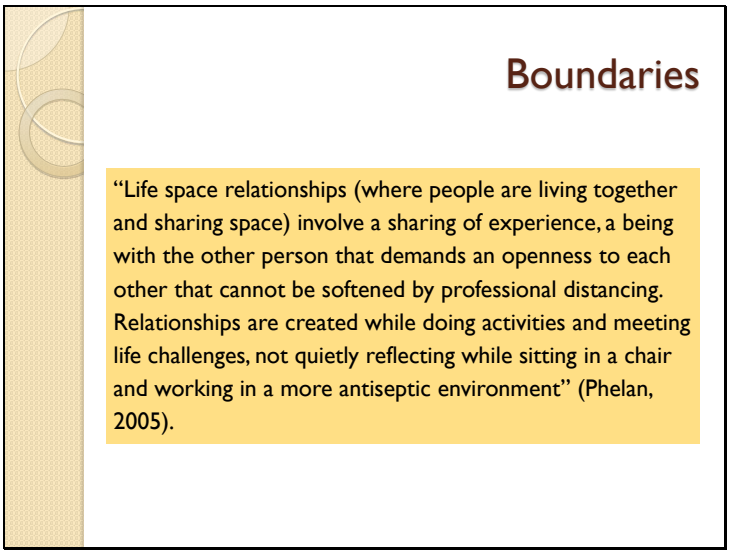

The boundaries in child and youth care work are much more intimate than in other professions and, because of this, require a rigorous attention to clear and reflective establishing of safe, respectful personal space. Once again, take this quote that illustrates the very personal nature of residential care relationships:

Lifespace relationships (where people are living together and sharing space) involve a sharing of experience, a being with the other person that demands an openness to each other that cannot be softened by professional distancing. Relationships are created while doing activities and meeting life challenges, not quietly reflecting while sitting in a chair and working in a more antiseptic environment" (Phelan, 2005, p.352).

That is to say the work we do as RCYCPs is by its very nature complex and personal.

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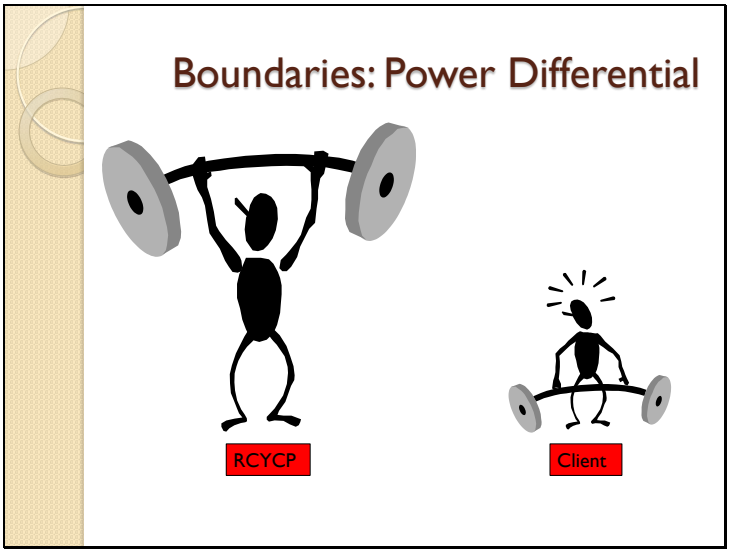

In addition to the complexities of the life space issue, some concern about boundaries is, in part, based on the fact that there is a power differential between RCYCP and clients.
The job of RCYCPs is to move clients forward – earn their trust, confidence, and respect.

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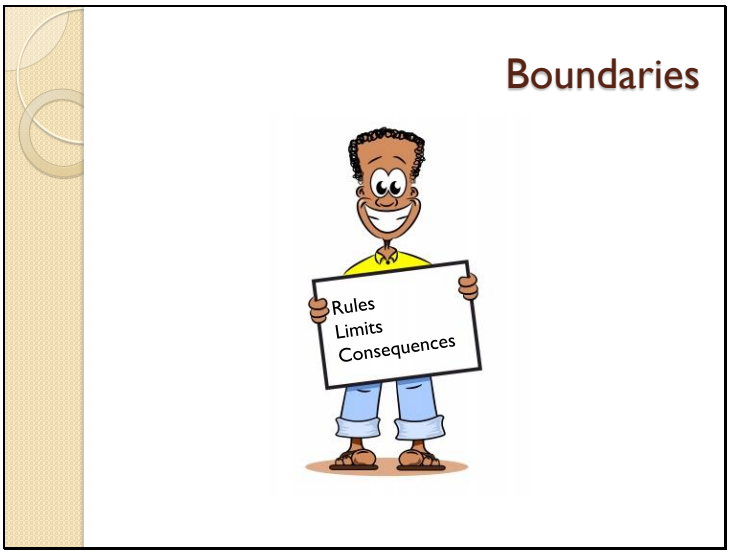

Many professionals struggle with the development of the relationship. They want to build rapport, earn trust, etc., and in doing so, “befriend” clients. But RCYCPs are not friends, per se. In addition to building rapport and a trusting relationship with youth, they are also rule enforcers, limit setters, and tasked with doling out consequences.

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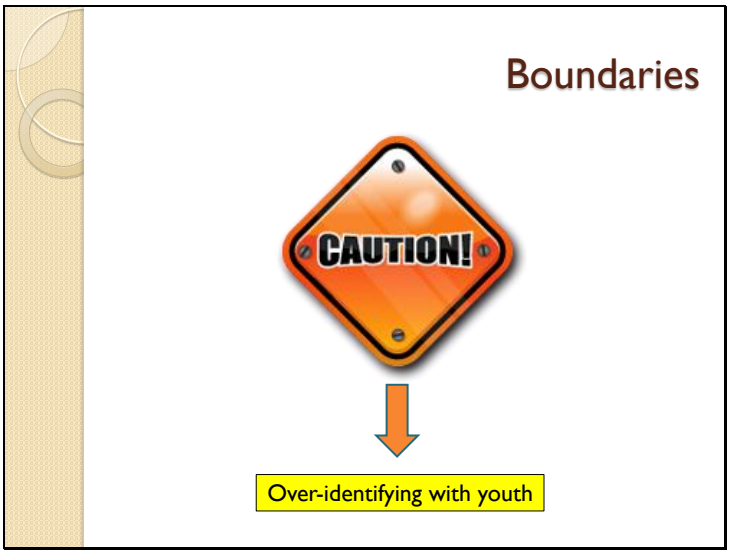

One particular challenge, especially for younger RCYCPs, is not over-identifying with youth.

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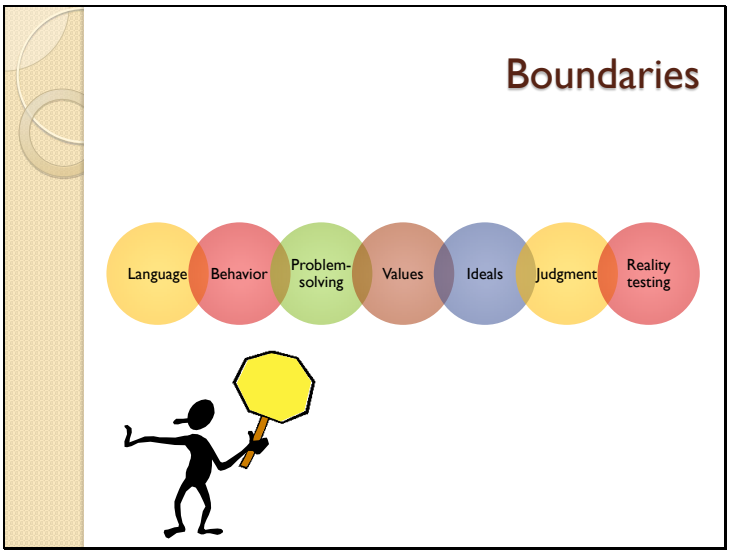

As an RCYCP, you must realize that you are a model of mature conduct, and therefore employ appropriate language, behavior, problem-solving approaches, values and ideals, judgment of right from wrong, and reality testing.

Young workers – who are closer in age to residents – are more vulnerable to boundary violations than older workers.

Let's look at some more boundary violation examples and boundary tips.

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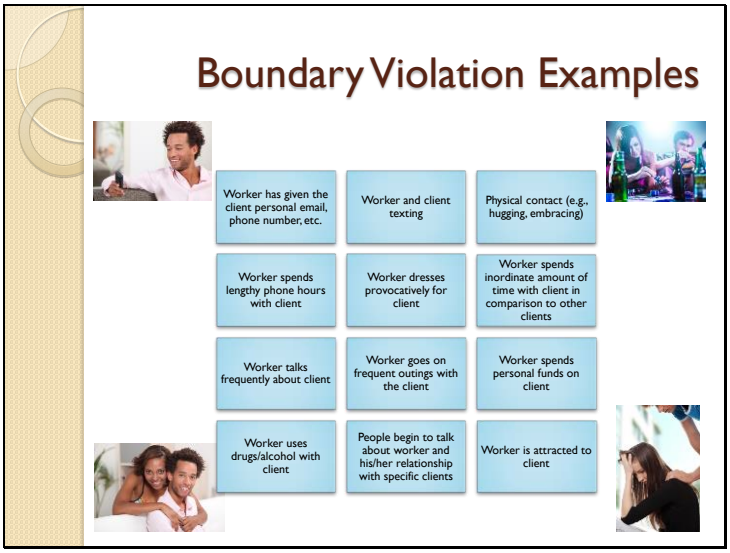

Here are some boundary violations: This is not an exhaustive list, but signals some boundary issues. Some are more blatant than others.

- Worker has given the client his/her personal e-mail address, cell phone number, home address or phone number, or may disclose his/her Facebook account information
- Worker and client communicate with each other via cell texting on the worker's work or personal phone
- Worker is warm-natured and enjoys physical connectedness with clients, such as hugging or embracing upon contact, kissing, or rubbing the shoulder, hands, or face to provide comfort and support to the client
- Worker spends lengthy phone hours with the client during the work day or even on personal time
- Worker may tend to dress provocatively on days when scheduled to meet/see the client
- Worker spends an inordinate amount of time with the client, scheduled or unscheduled, in comparison to other clients
- Worker talks frequently about the client, and may even openly share how much he or she likes, fantasizes about, or can relate to the client
- Worker may begin to spend frequent time with client on various outings (e.g., movies, restaurants, etc.)
- Worker freely shares and discusses his/her own personal experiences with the client
- Worker spends his/her own personal funds to support client's needs
- Worker engages in the use of drugs and/or alcohol with the client

- Co-workers begin to talk about the worker and his/her relationship with specific clients
- Clients own family and/or personal friends begin to talk about the amount of time the worker spends with the clients
- Worker finds him/herself attracted to a particular client, going out of the way to extend time spent around client, treating client as someone special, disclosing confidential information about other clients, acting impulsively in relation to the client, disclosing personal details to the client

If you find yourself or another worker in any of these types of situations, you must talk to a supervisor immediately.

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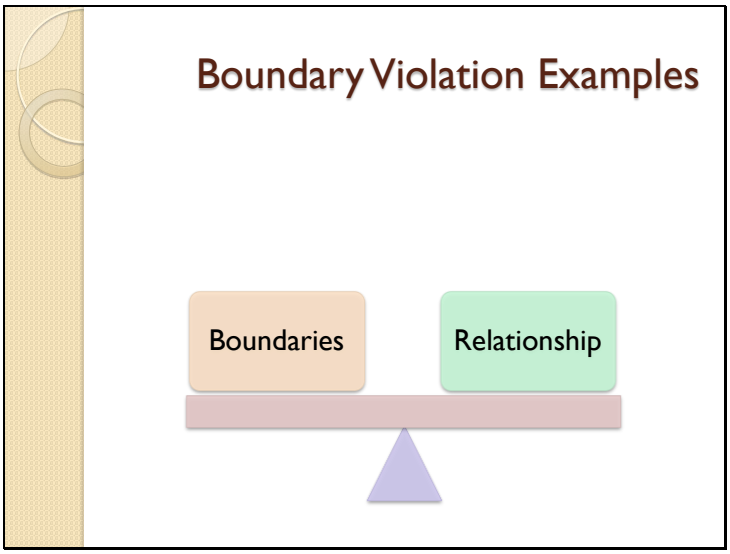

RCYCPs have to strike the right balance. Boundaries are essential to help young people and workers stay safe, but should never prevent the building of positive, meaningful helping relationships.

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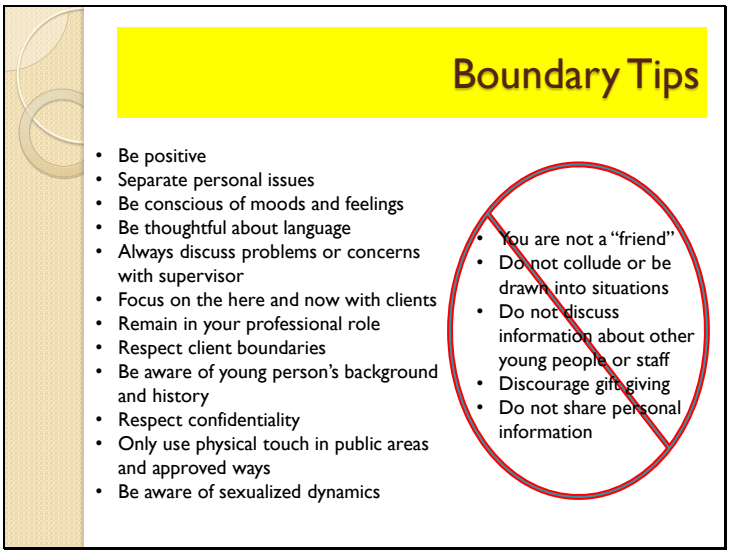

Here are some tips that might be helpful to you as an RCYCP:

- Be positive. Learn to separate personal issues that affect your mood when working directly with a young person. Use supervision, team meetings, and other support mechanisms to help with this.
- Be conscious that your moods and feelings affect communication – particularly body language and eye contact, which can affect interactions with young people.
- Be thoughtful about the language you use. Remember, you are not a young person's "friend" in the way they understand it, so sensitively challenge inappropriate terms such as "buddy," "pal," and "friend."
- Always discuss problems and concerns with team or supervisor.
- If a young person asks a question you are uncomfortable answering, ask yourself why and if they need to know. Use this to divert the focus back to the here and now – that is, the relationship with the young person and you as their counselor.
- Be careful not to collude with young people or be drawn into situations. Remain in your professional role as this ultimately offers safety to the young person.
- Respect the personal space and privacy of the young person at all times. Do not encroach on their personal boundaries, either in fun or to gain compliance.
- Make sure you are aware of the young person's background and history. This will help you to understand where their own boundaries lie and how they will respond to yours.
- Respect confidentiality. Do not discuss information about other young people or staff. Be aware of being overheard while on the phone or in other rooms.

- Young people should be discouraged from offering gifts to staff. They should know they already have the professionals' positive regard and don't need to "buy" favor.
- Sharing and explaining to a young person the thinking behind what you say builds mutual trust and respect and offers young people a new way to look at the world and their place in it.
- Do not share personal information
- Only use physical touch in public areas and in ways that are approved by your employer
- And finally, be aware of sexualized dynamics at all times.

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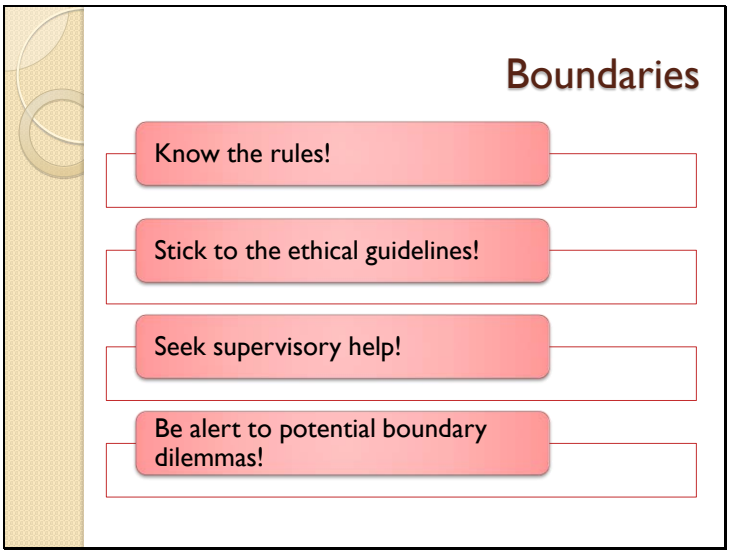

Unfortunately, there is no easy solution to the boundary dilemma. It is all very challenging. First and foremost, you need to know your facility's rules regarding boundaries – what is okay and not okay.

Beyond that, when in doubt stick to the ethical guidelines and seek supervisory help. Be alert to potential situations that might create boundary dilemmas.

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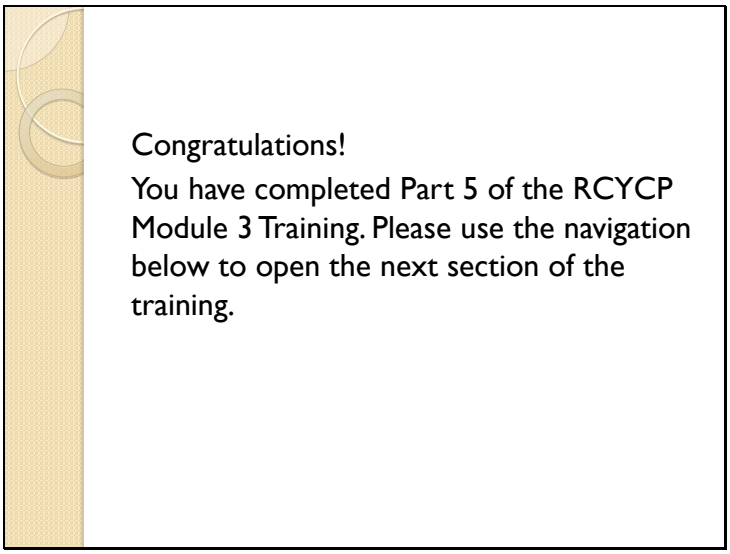

Congratulations! You have completed Part 5 of the RCYCP Module 3 Training. Please use the navigation below to open the next section of the training.

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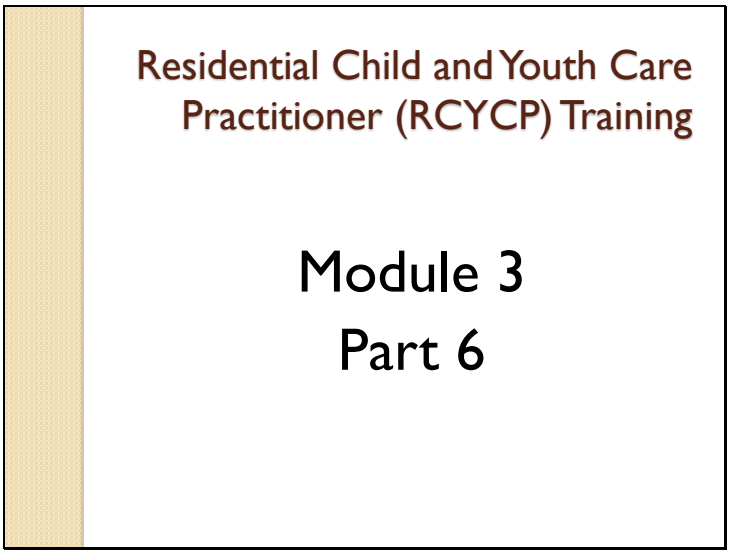

Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 3 Part, 6 of the Residential Child and Youth Care Practitioner Training.

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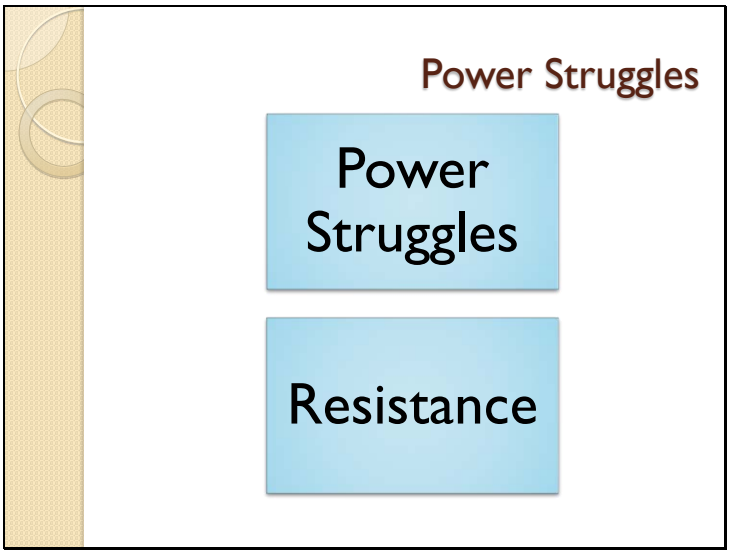

Power Struggles

Another challenge for you as an RCYCP working with youth is power struggles and resistance.

Undoubtedly, you as a residential counselor will encounter power struggles and resistance by youth with whom you are working. Let's talk about it now.

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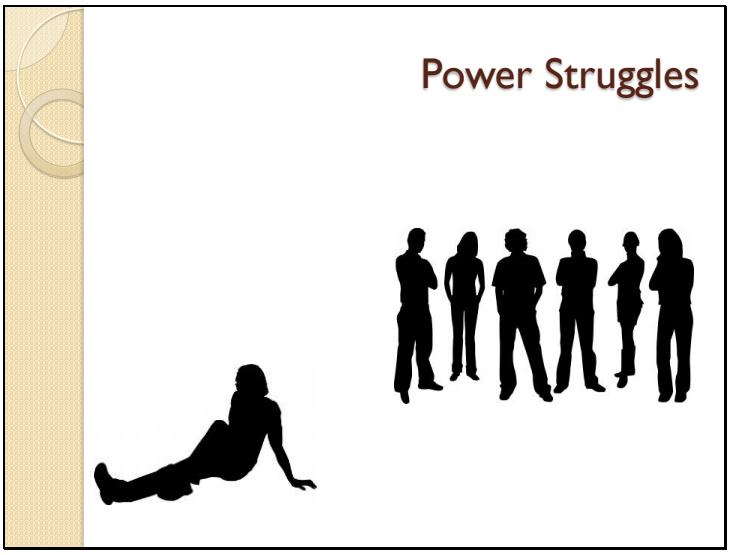

Power Struggles

When residents engage in negative behavior such as aggression, defiance, and provocation, the group is negatively impacted. Some negative behaviors are intentional and designed to cause disruption, or gain favor with other group members. Some negative behavior is the result of anxiety, shame, anger, or due to a diagnosed disorder specifically -- for example, conduct disorder.

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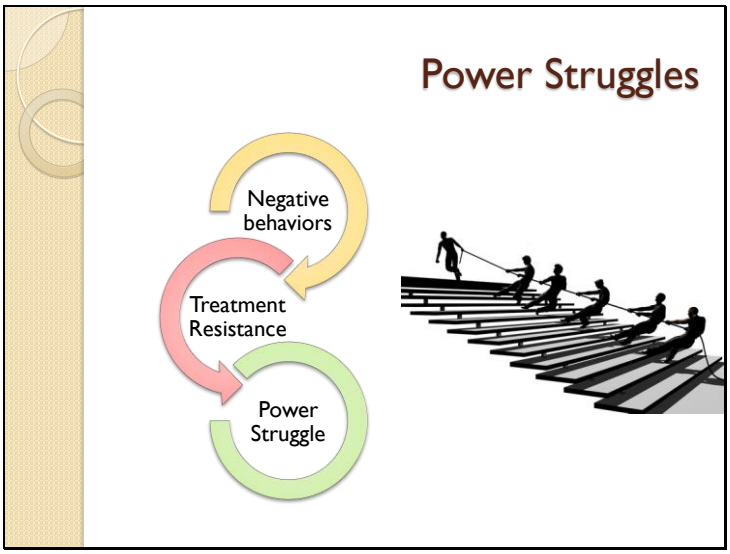

These types of behaviors are considered “treatment resistance” and become the basis of the power struggle.

So what should you do and not do as an RCYCP when you encounter treatment resistance and power struggles? Let’s talk about some different strategies.

Slide 6

Negative reactions by staff members -- for example, shunning, avoidance, yelling, denying, or denigrating -- can damage the alliance, bond or attachment created between staff and youth. Youth need to feel connected to staff so that individual expression of differences can occur productively rather than in anger.

Do not engage in a power struggle.

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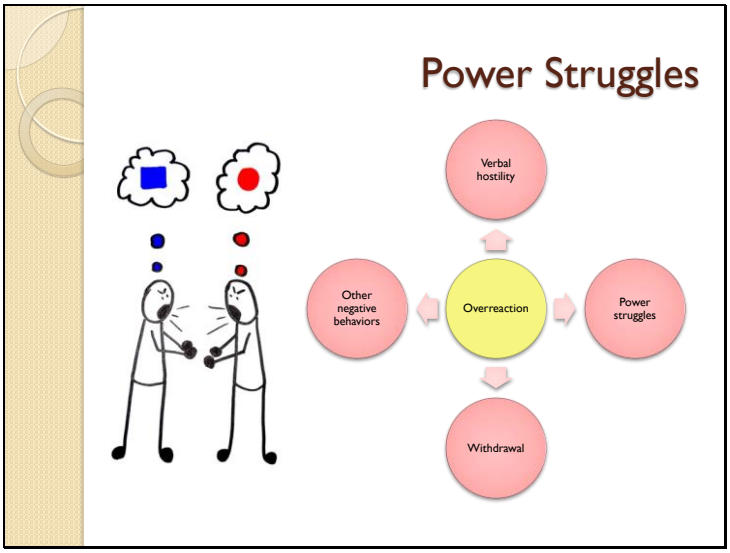

Overreaction can make things worse and lead to more verbal hostility, power struggles, withdrawal, and other negative behaviors.

Taking a superior attitude or tone will likely antagonize youth and is not recommended.

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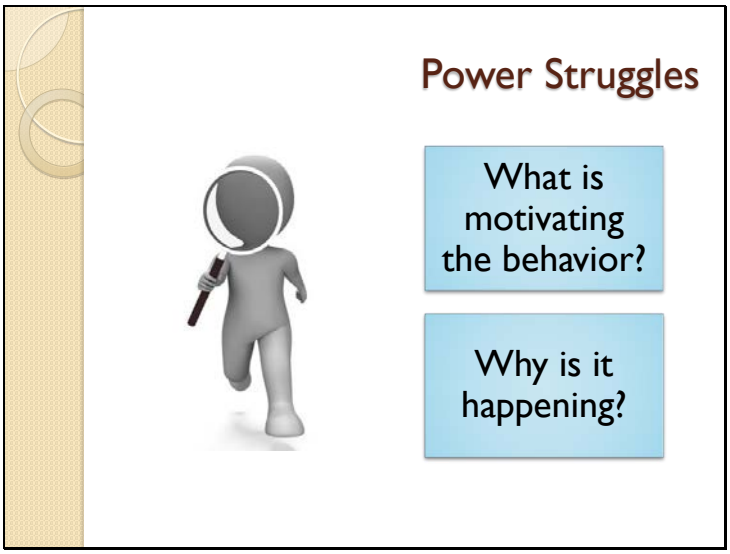

RCYCPs need to know what is motivating the behavior to figure out how/why it is happening and how to address it. For example, is the behavior the result of shame? Will the staff reaction be seen by the youth as something to fear, an attempt at humiliation, or as a challenge?

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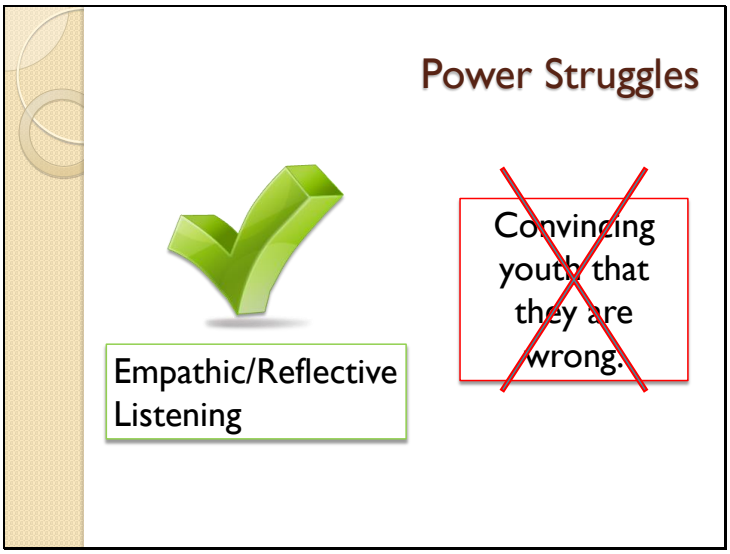

Power struggles can be minimized with empathic/reflective listening rather than attempting to convince youth that they are wrong or not seeing things correctly.

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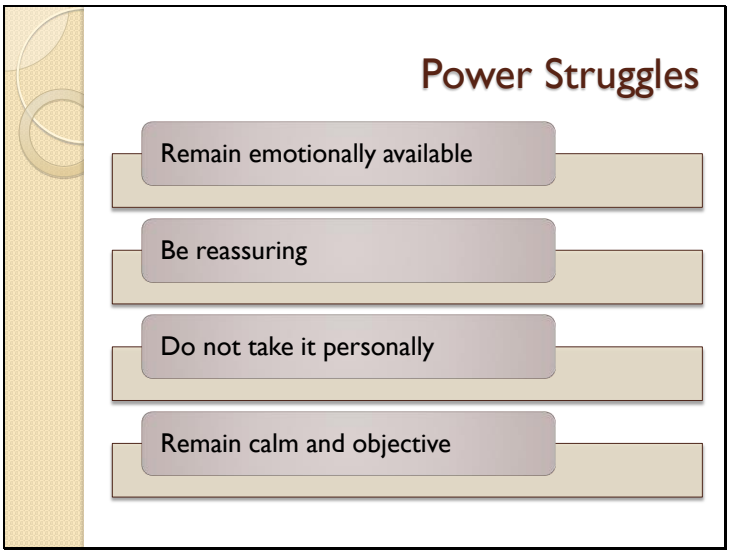

Some other ways to head off power struggles are to:

- Remain emotionally available, not angry or distant.
- Be reassuring, as opposed to being punitive, holding a grudge, or acting offended.
- Do not take it personally – it helps to remember the struggles the youths have encountered in their lives.
- Remain calm and objective, as difficult as that can be. Remember, once objectivity is lost, the relationship will suffer and can lead to more power struggles.

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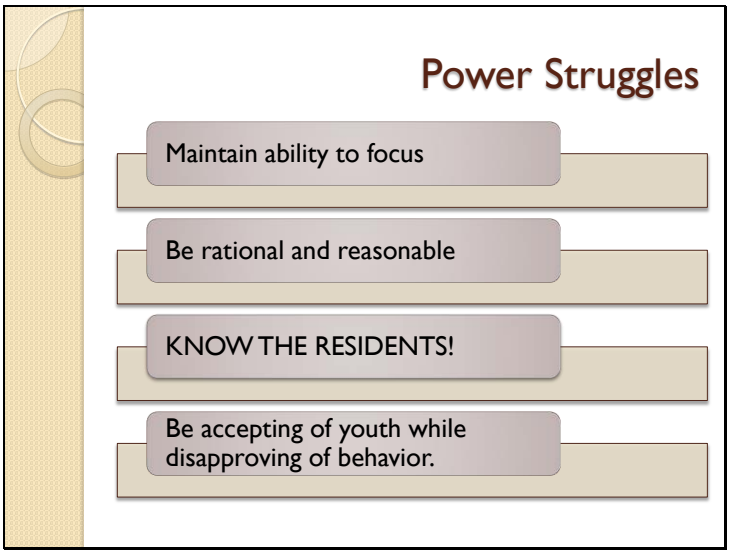

- Maintain ability to focus.
- Be rational, and reasonable.
- Act preemptively -- that is to say, before getting into a situation where there is a power struggle. Know the residents. Be aware of their moods, rules, boundaries, stress tolerance, fantasies, desires, values, goals (or lack thereof), as well as what sets them off.
- Be accepting of the youth as a person, and focus disapproval on his or her behavior.

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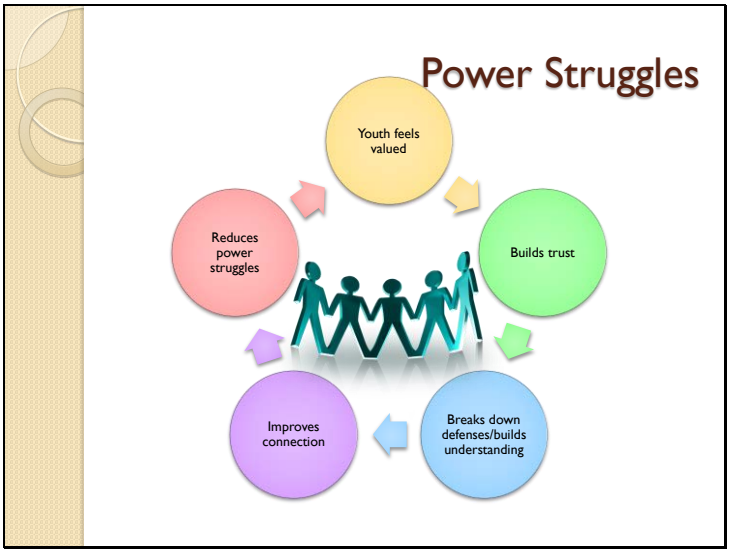
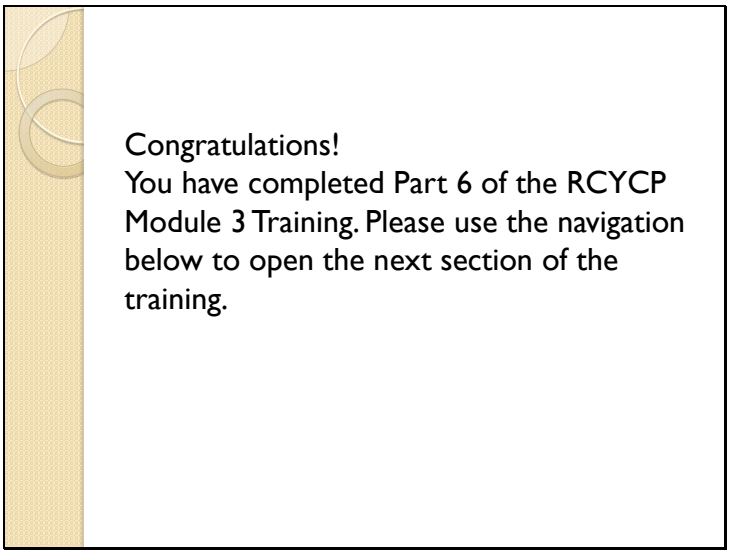


Finally, remember that when youth feel that they are valued and understood, they trust workers and learn to see them as genuine, caring, and reasonable. Using an empathic approach allows you as an RCYCP to figure out what is going on for that youth – what is the root problem and how to address it. This process helps to break down the youth's defenses, build understanding, improve connection and reduce the likelihood of future power struggles. This applies to younger children as well. Helping children learn these skills early is crucial to their later success.

Slide 14



Congratulations! You have completed Part 6 of the RCYCP Module 3 Training. Please use the navigation below to open the next section of the training.

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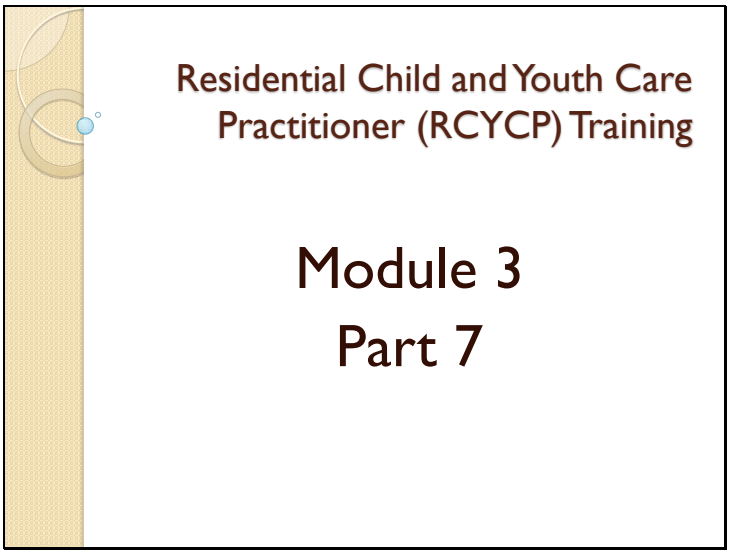

Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 3, Part 7 of the Residential Child and Youth Care Practitioner Training.

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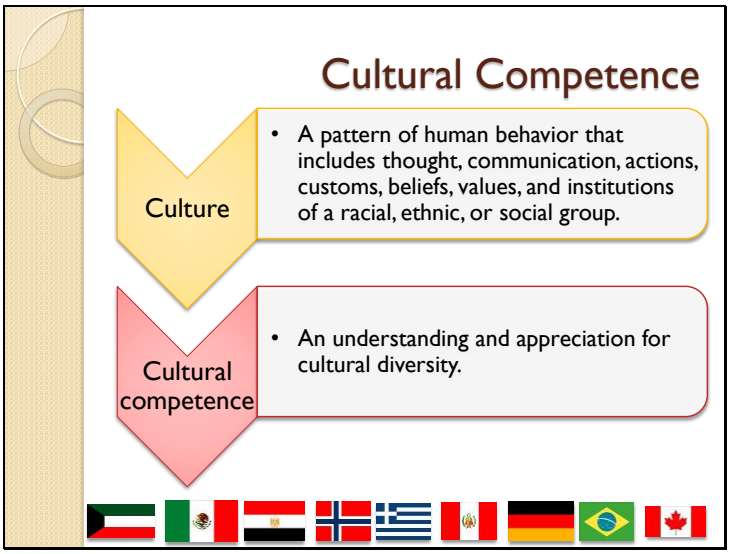

Cultural Competence

Let's talk about cultural competence now – what it is and why it is important.

The term "culture" can be thought of as a pattern of human behavior that includes thought, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, or social group.

Cultural competence at its most basic definition can be thought of as an understanding and appreciation for cultural diversity. The idea behind culturally competent practice is that people are served best when there is an understanding and appreciation of the impact of a person's culture and cultural status on their life, and that by ignoring these elements, we, as providers of service, will not only be ineffective, but potentially destructive as well.

Let's take a look at the different levels of cultural competence that people and provider organizations can achieve.

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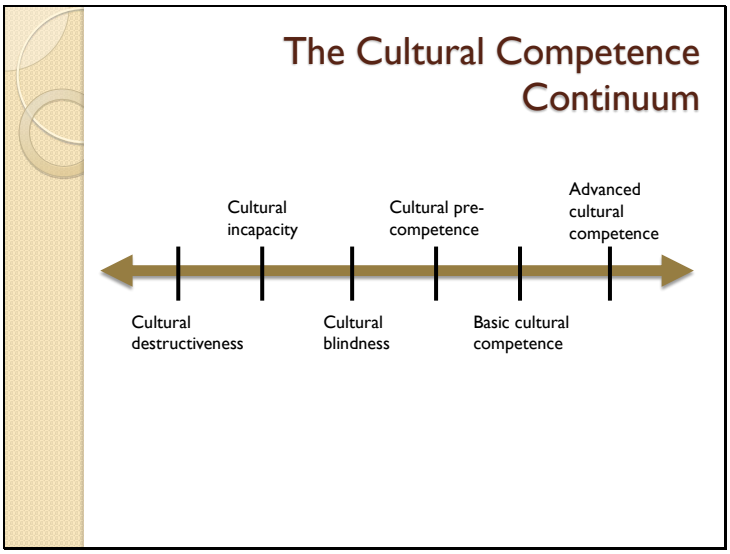

The Cultural Competence Continuum

This is what is known as The Cultural Competence Continuum: It is a tool used to identify and/or evaluate how culturally competent an individual or organization is. The idea is that cultural competence exists within a continuum from low to high in the achievement of competence.

There are 6 points along the continuum moving from cultural destructiveness to advanced cultural competence.

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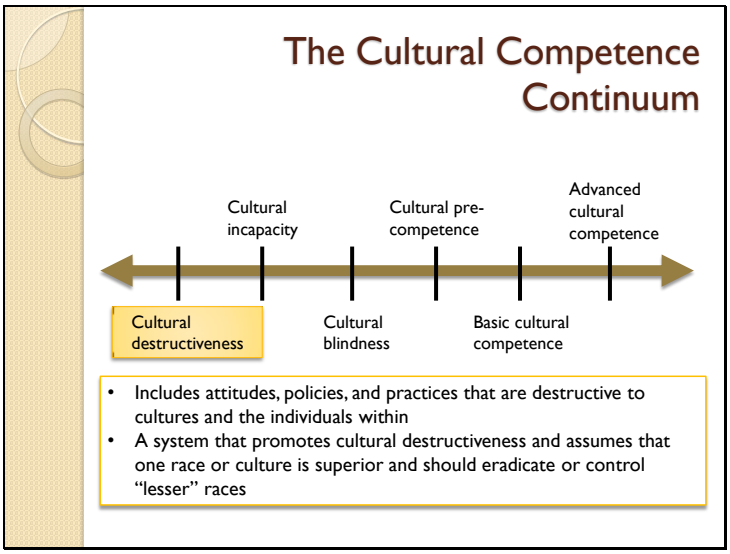

1. Cultural destructiveness lies at one end of the continuum.
- It is the most negative end of the continuum
- It includes attitudes, policies, and practices that are destructive to cultures and the individuals within those cultures
- It is a system that promotes cultural destructiveness and assumes that one race or culture is superior and should eradicate or control "lesser" races because of their perceived inferior position

Examples of cultural destructiveness include programs or policies that promote cultural genocide, or the purposeful destruction of a culture

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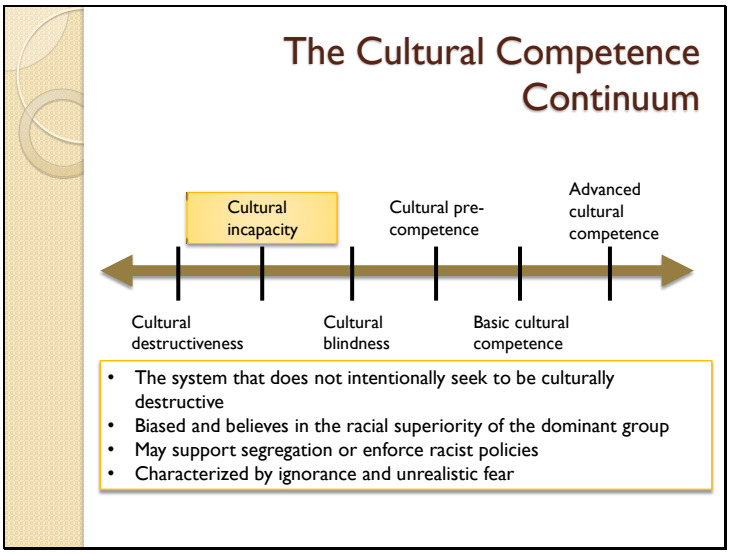

2. Cultural incapacity is next on the continuum. Within this level:

- The system, agency, or individual does not intentionally or consciously seek to be culturally destructive
- Instead, the capacity to help people and communities of color is missing
- The agency or individual remains extremely biased, believes in the racial superiority of the dominant group, and assumes a condescending attitude toward the perceived lesser races and cultures
- Agencies and individuals may disproportionately apply resources and discriminate against people of color
- They may support segregation as a desirable policy or may act as agents of oppression by enforcing racist policies that reflect racial stereotypes
- Agencies at this point on the continuum are characterized by ignorance and an unrealistic fear of people of color
- There may be discriminatory hiring practices, as well as subtle messages to people of color that they are not valued or welcome
- There are generally lower expectations for clients from minority groups

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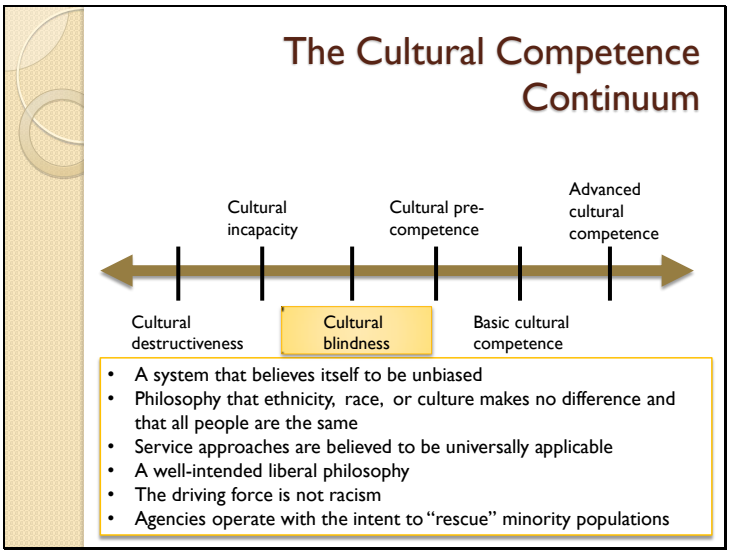

3. At the cultural blindness level of the continuum

- The system and its agencies, or an individual, has expressed the belief of being unbiased
- The philosophy at this level is that ethnicity, race, or culture makes no difference and that all people are the same
- Service approaches at this level are those that are traditionally used by the dominant culture because they are believed to be universally applicable
- It is a well-intended liberal philosophy
- The driving force is not racism
- The consequences of this belief are services that are potentially useless to all but the most assimilated people of color
- Agencies or people at this level may participate in special projects for minority populations when grant money is available, but operate with the intent to "rescue"
- Agencies at this level suffer from a lack of information and are unaware of the avenues to obtain more information

Finally, attitudes, policies, and practices reflect ethnocentrism, which is evaluating other peoples and cultures according to the standards of one's own (typically dominant) culture.

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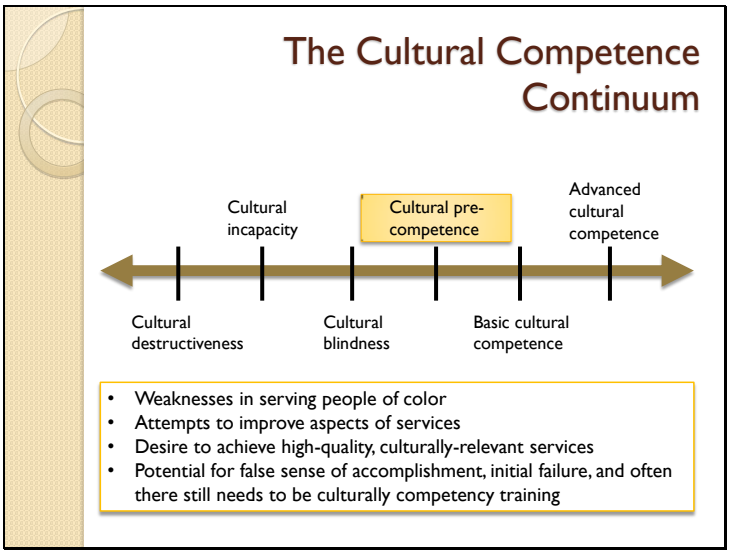

4. At the cultural precompetence level:

- Agencies or individuals realize that they have weaknesses in serving people of color.
- There are attempts to improve some aspects of their services to specific populations.
- Agencies may try innovations in service approaches, hire diverse staff, explore how to reach out to people and communities of color, initiate culturally relevant trainings for their workers, recruit minority individuals for boards or advisory committees.
- There is a desire to achieve high-quality, culturally relevant services.
- The danger at this point along the continuum is that:
    - There is a false sense of accomplishment, or
    - The initial failure causes the belief that the approach is not practical, and
    - The hiring of staff of color is no guarantee that services will be improved; often professionals of color are trained in the dominant culture's frame of reference and may also need cultural competency training.

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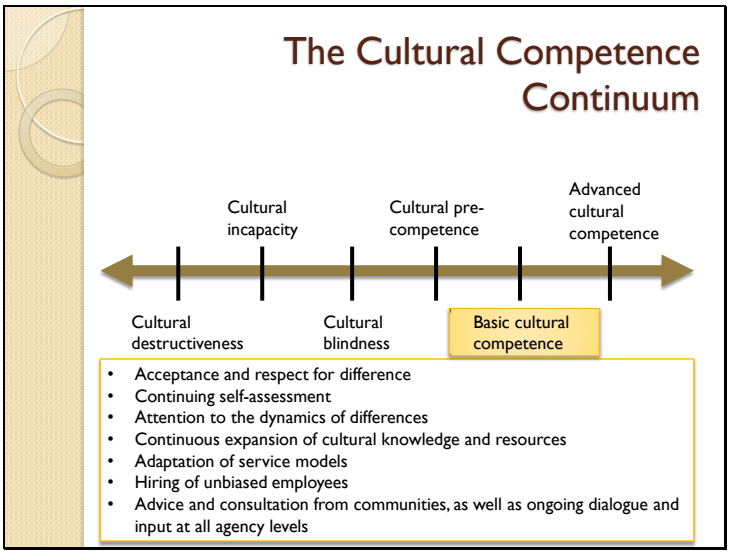

5. At the basic cultural competence level there is:

- Acceptance of and respect for differences
- Continuing self-assessment regarding culture
- Careful attention to the dynamics of difference
- Continuous expansion of cultural knowledge and resources
- Adaptation of service models in order to better meet the needs of communities of color
- An effort to hire unbiased employees
- An effort to seek advice and consultation from communities
- Active decisions about what the agency is capable of providing to clients of color
- And finally, there is ongoing dialogue and input from communities of color with the culturally competent agency at ALL levels of the organization

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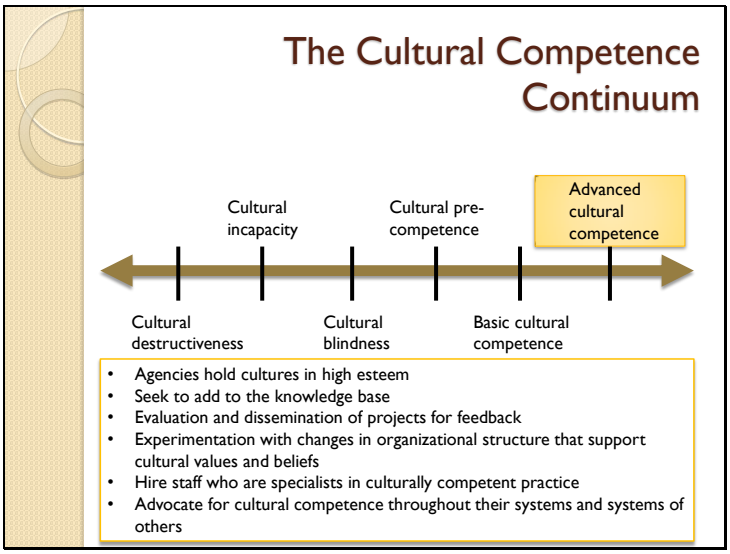

6. At the most advanced level of cultural competence:

- Agencies or individuals hold cultures in high esteem
- They seek to add to the knowledge base of culturally competent practices by developing new therapeutic approaches that adapt to cultural differences
- They evaluate and disseminate the results of demonstration projects for examination and feedback from stakeholders
- They experiment with changes in its organizational structures that support the cultural values and beliefs of the people whom they serve
- They hire staff who are specialists in culturally competent practice
- They advocate for cultural competence throughout their systems and the systems of others
- This is considered the most positive end of the continuum

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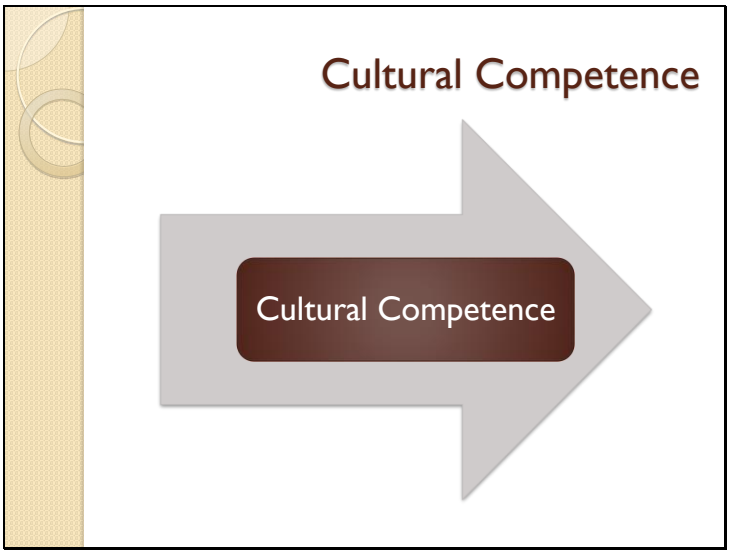

Cultural Competence

Cultural competence is a goal toward which individuals and agencies can strive. It is a developmental process that does not happen overnight. So what does cultural competence mean for you as an RCYCP working in residential care?

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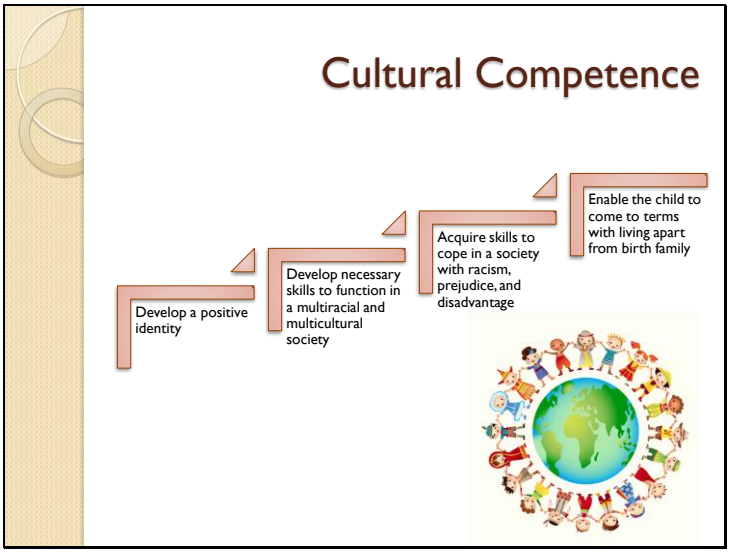

To begin with, ethnic minority youth are overrepresented in residential care. So, within residential care, the idea of cultural competence is to meet a child's emotional, psychological, religious, physical, and social needs in a way that enables the child:

1. To develop a positive identity for him/herself as an ethnic minority child.
2. To develop the necessary linguistic, cultural, religious, and social skills to function effectively as an adult in a multiracial, multicultural society.
3. To acquire skills to cope as both child and adult in a society in which the child is likely to encounter racism, prejudice, and disadvantage.
4. And to enable the child to come to terms with living apart from the birth family.

Slide 13

Example of Cultural Competence in Residential Care

To illustrate this concept of cultural competence and what it looks like in practice, let's look at an example of cultural competence in action at a residential youth center.

Residential counselors at Warren Youth Services in Calgary, Alberta in Canada took a culturally competent approach to working with Inuit adolescents from Nunavut (an aboriginal tribe) who are placed there.

There were a number of complex challenges faced by the Nunavut youth when they were placed in a residential facility in Calgary. They were from very small, rural communities that were culturally homogenous (similar). The largest Nunavut community had a population of approximately 6,000, however, most were less than 600, whereas Calgary is a metropolis with a population of over one million. Additionally, Calgary is culturally and socioeconomically diverse. The worldview of the Nunavut youngster is shaped by the rural living and their culture which has a specific language, customs, food, dress, family patterns, symbols, art, music, habits, traditions, spirituality, communication style, and social dynamics such as gender relations, as well as their understanding of their existence, as a people, and a culture that predates the larger Canadian society.

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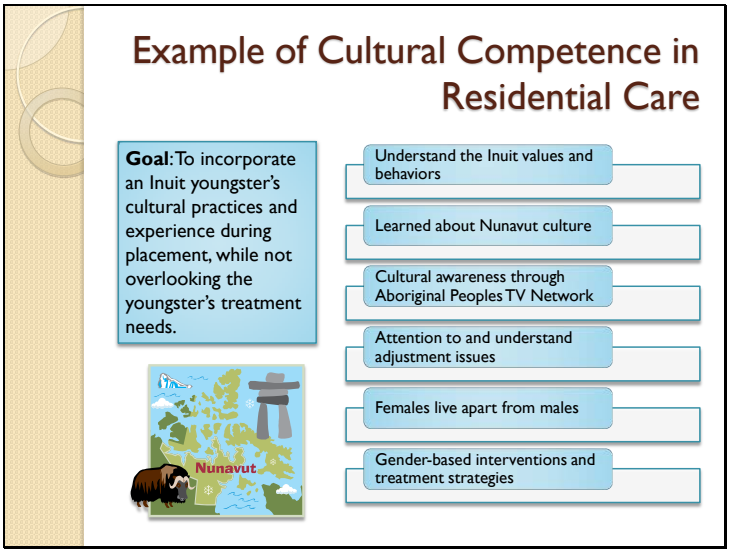

The goal for the Warren Youth Services staff was "to incorporate an Inuit youngster's cultural practices and experience during placement while not overlooking the youngster's treatment needs. This includes staff recognizing and maintaining the identity and characteristics of the Inuit culture while assisting the youth to fit into the host community so that he or she participates in the larger society" .
Additionally, staff worked to understand how the cultural considerations would have an impact on the issues that brought the child/youth to residential care.

Some of the ways they incorporated culture into treatment were the following:

- Staff were encouraged to understand the Inuit values and behaviors and how these differed significantly from those of the dominant Canadian culture, including the rural – urban differences.
- Staff learned firsthand about the Nunavut culture by accompanying youngsters on trips to their homes in Nunavut to reconnect with their heritage.
- Cultural awareness was instilled in staff and residents by watching Aboriginal Peoples Television Network (APTN).
- Staff paid attention to, and understood, adjustment issues having to do with cultural diversity, acculturation issues, English as a second language, and the potential to face discrimination that have been historically endured by Aboriginal people.
- Staff followed requests by the females that they live separate and apart from the males as is done in their culture – therefore a space was rented to accommodate that living situation request.

- Staff were made aware of gender differences that required different intervention and treatment strategies – for example, girls' aggression is experienced differently than males – it is more covert and it involves behaviors such as manipulation, excluding other girls, and name calling) and is more likely to be self-harming than boys.

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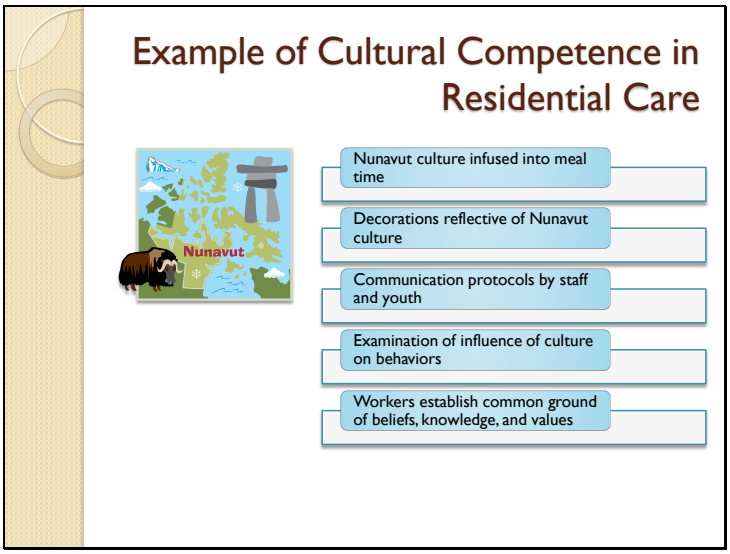

- Staff were made aware of how important it was for these youth to not lose their sense of meaning, or their own values, that are linked to their customs, traditions and heritage.
- Direct care staff understood that in Nunavut culture meal time is not just about the consumption of food, but an opportunity for sharing and bonding as well and make allowances for that in the home; additionally, both native food and food common to Calgary were served.
- Young people were encouraged to decorate the house and their rooms with pictures, posters, art objects, and other materials reflective of their ethnology such as the Nunavut flag.
- Different protocols of communication required staff to be able to follow and to understand the nuances in meaning, by listening, observing, and processing the exchange of dialogue.
- Staff were cautioned not to make false interpretations of behavior and to examine how cultural upbringing has influenced psychological characteristics of the youth.
- Workers established common ground or grounding of their shared beliefs, knowledge, and values so that there was a common base to work from. This finding of common ground helps youth to trust staff as well as think positively about themselves and their own capabilities.

Using these techniques, Warren County Youth Services worked hard to integrate cultural competence into treatment practices.

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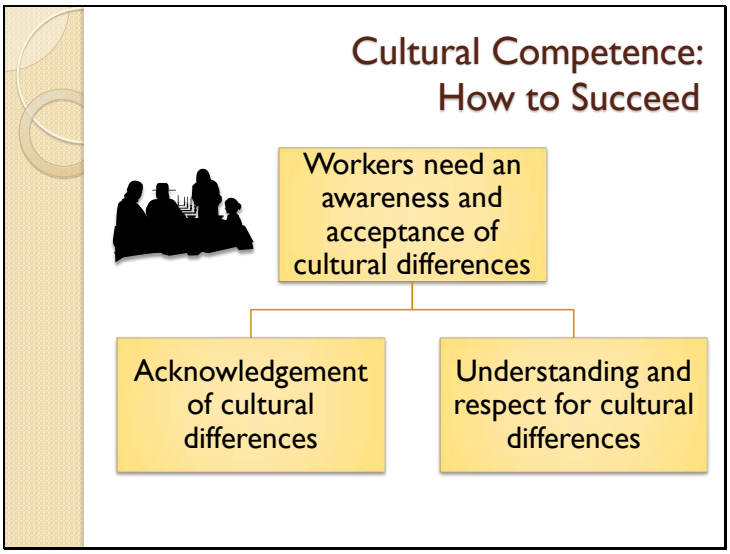

Cultural Competence: How to Succeed

According to research in this field, in order to succeed at cultural competent practice:

1. Workers need an awareness and acceptance of cultural differences

This can happen in a number of different ways:

First, practitioners need to acknowledge cultural differences and to become aware of how they affect the helping process

Secondly, an understanding and respect for cultural differences between the worker and youth or youth's family will help the worker gain credibility, as well as allow the worker to use youth and family's strengths that are tied to that culture

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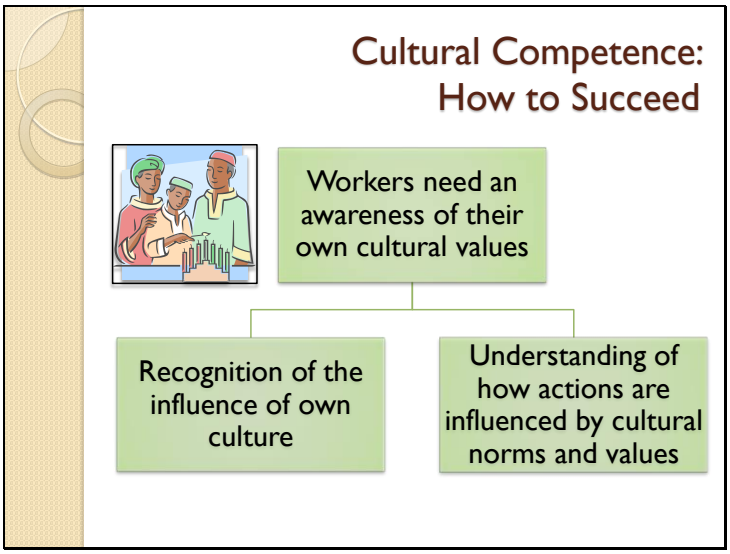

Also, workers need an awareness of their own cultural values.

In order to fully appreciate cultural differences, workers need to recognize the influence of their own culture on how they think and act.

Workers should also understand how their day to day actions are influenced/shaped by cultural norms and values and then reinforced by friends, family, social institutions.

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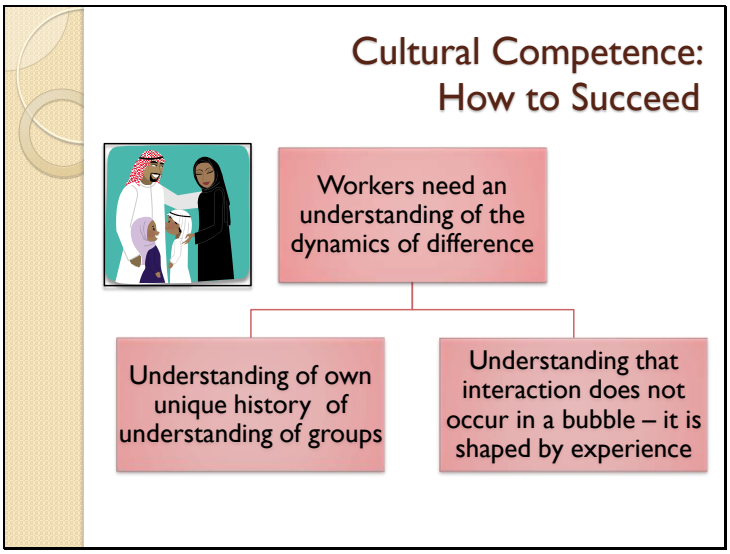

Workers need an understanding of the "dynamics of difference" in the helping process.

When people interact they are bringing to the interaction their own unique history with the other group, as well as culturally prescribed patterns of communication, etiquette, and problem solving – people may also bring stereotypes or positive/negative feelings about the other culture. It is important to understand that all of these factors influence interactions – interaction does not occur in a bubble. An example: in some cultures a weak handshake is preferable to a strong handshake which is considered rude. In other cultures the opposite is true. People who are not aware of these cultural differences and shake hands differently might interpret the interaction negatively when it is simply a miscommunication.

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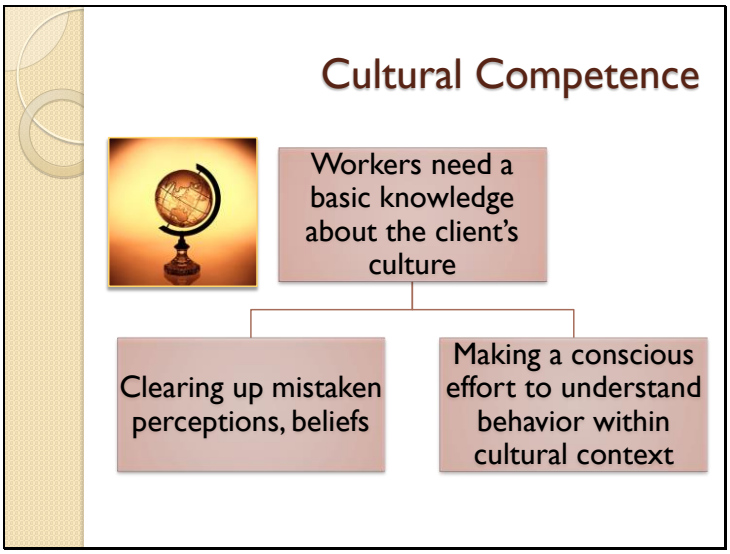
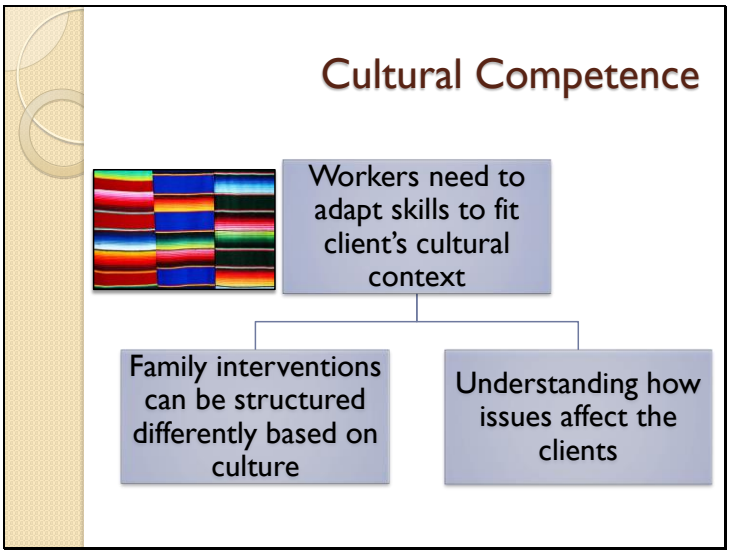


Cultural Competence

Workers need a basic knowledge about the client's culture

Having a basic knowledge of culture can clear up mistaken perceptions, beliefs about another's behavior. Additionally, making a conscious effort to understand behavior within the context of culture is important, for example asking the question "What does the client's behavior signify in his/her group?" This allows workers to assess individuals based on their own cultural norms, rather than the dominant society or those of the worker's. The worker must be able to take the knowledge gained and use it to adapt the way in which services are delivered.

Slide 20

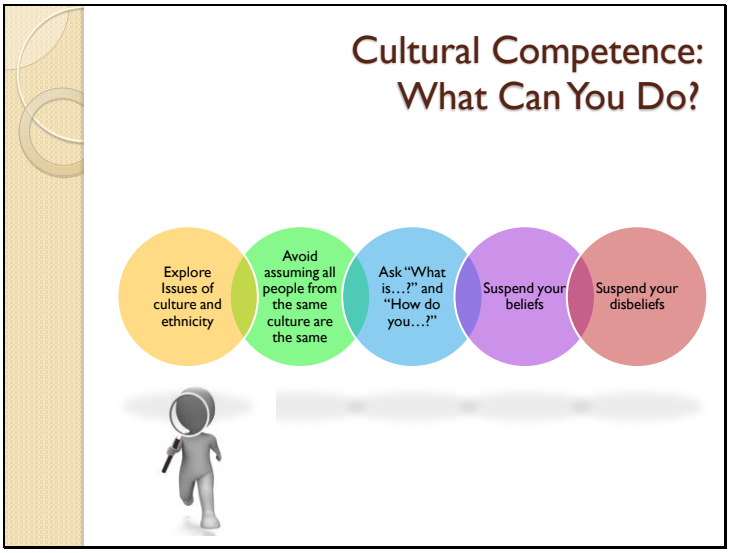


Workers need the ability to adapt practice skills to fit the client's cultural context

A worker can adapt different skills to meet clients' cultural needs, for example, family interventions might be structured differently based on culture.

Understanding how issues affect your clients is important- otherwise you will be shortchanging your clients

Slide 21



Cultural Competence: What Can You Do?

So how can you as an RCYCP become more culturally competent in your work with residential youth? Here are some things to do:

Culture and ethnicity are always important, but not always obvious: explore issues such as culture and ethnicity even when worker and client "look" the same.

People who are different from you are not necessarily the same as each other: avoid assuming that all people from the "same" country, family, or local culture follow the same rules of behavior, preferences, and so on.

Ethnicity and culture are socially constructed: as well as asking "What is?" ask, "How do you…{experience} sadness, joy, saying hello, saying goodbye, leaving home?"

Suspend your belief: step outside your own cultural rules that are often 'taken for granted.'

Suspend your disbelief: step into other people's ideas, customs, and patterns.

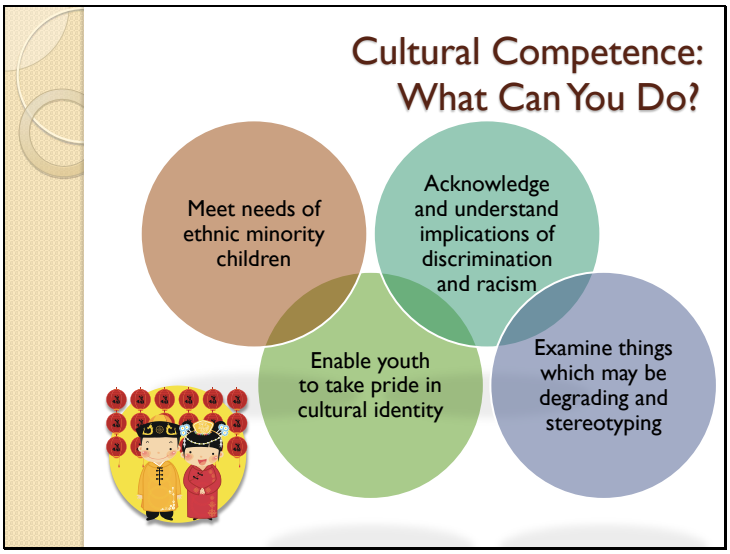
Slide 22

Be 'clumsy' rather than 'clever': the value of 'not knowing' can be a useful tool for gaining information and the potential of curiosity. That is to say, offer up your not knowing how culture affects a youth with regard to something specific, for example how it impacts what they eat, or in a general way – how culture affects them at all.

Be sensitive not superficial.

Talk through emotional and cultural issues, value and acknowledge cultural identities, heritage and histories of ethnic minority people

Slide 23



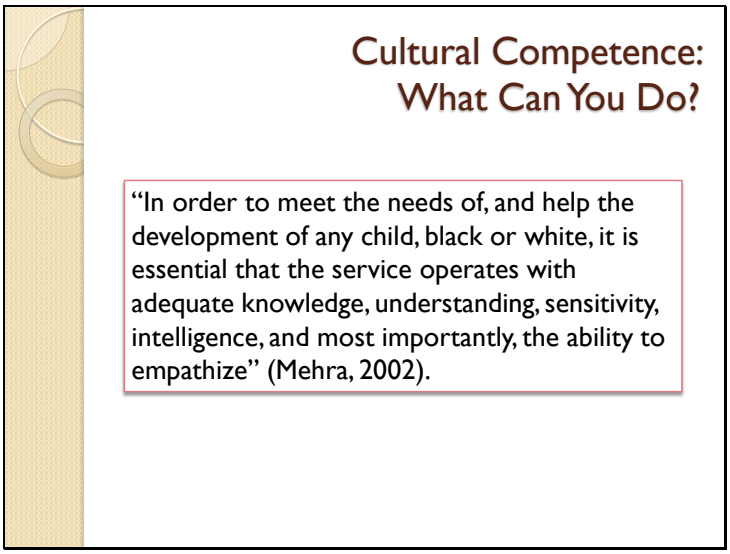
Meet the cultural, religious, linguistic, skin care, hair care, and dietary needs of the ethnic minority children in care.

Enable ethnic minority youth in care to take pride in their race, skin color, physical features, religious, linguistic and cultural identity.

Acknowledge and understand the implications of discrimination and racism upon ethnic minority children in residential care, for example, lack of personal growth, dignity, worth, and power.

Examine the use of language, personal norms and values, which may be degrading and stereotyping to ethnic minority people and supporting those who take a stand against any kind of discrimination and racism

Slide 24



And finally, in the words of one cultural competence scholar:

Above all else, "In order to meet the needs of, and help the development of any child, black or white, it is essential that the service operates with adequate knowledge, understanding, sensitivity, intelligence and, most importantly, the ability to empathize" (Mehra, 2002, p.255).

Slide 25

Cultural Competence Videos

Click on the links to see some videos about cultural competence.

Overcoming Cultural Stereotypes: http://www.youtube.com/watch?v=MDw68BQxKEk

Understanding the Importance of Multicultural Counseling: http://www.youtube.com/watch?v=xZUgD-NbRvo

Slide 28

Cultural Competence Self-Test

Slide 29

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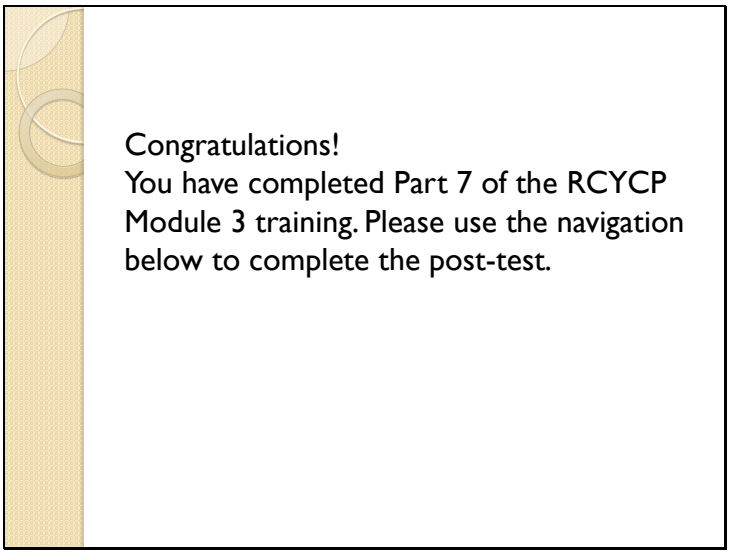

Congratulations! You have completed Part 7 of the RCYCP Module 3 training. Please use the navigation below to complete the post-test.

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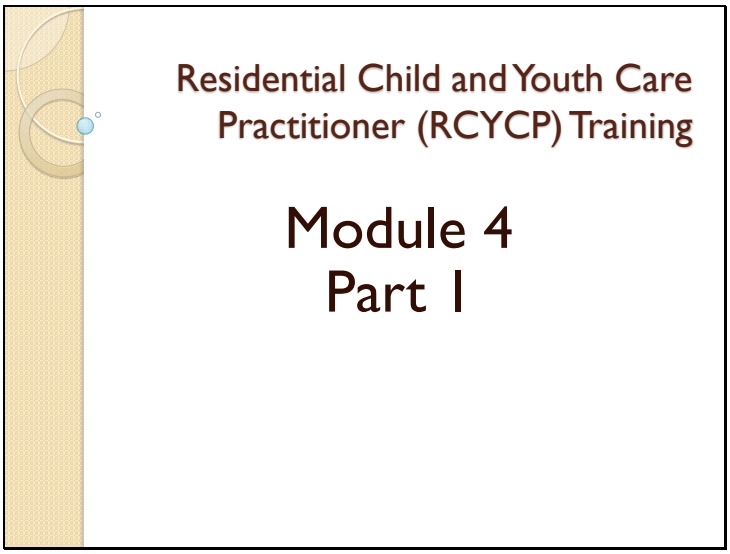
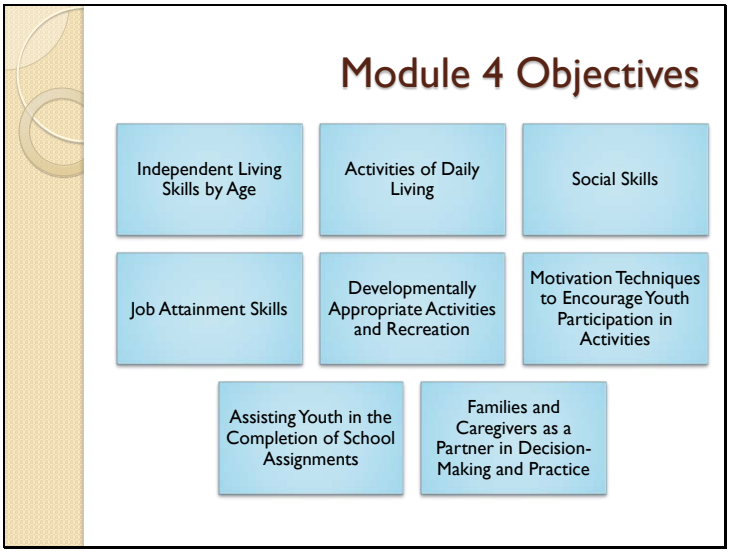


Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 4, Part 1 of the Residential Child and Youth Care Practitioner Training.

Slide 3

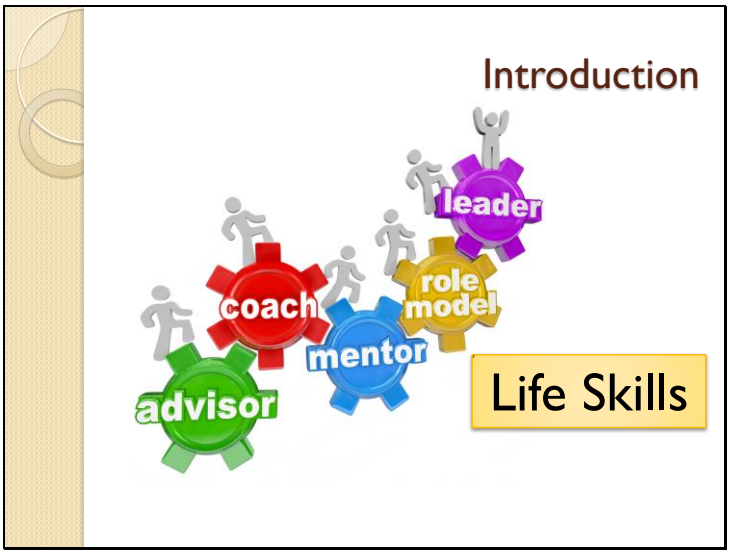


Module 4 Objectives

In this module you will learn about the following:

- Independent Living Skills By Age
- Activities of Daily Living
- Social skills
- Job Attainment Skills
- Developmentally Appropriate Activities and Recreation
- Motivation Techniques to Encourage Youth Participation in Activities
- Assisting Youth in the Completion of School Assignments
- Families as a Partner in Decision-Making and Practice

Slide 4



Introduction

Life skills – the things people learn outside the classroom – are so important for success in life. Many of the kids that you work with will need assistance in learning these skills. While you, as the RCYCP, will not be the primary teacher of life skills, you will have the opportunity to support that learning in various ways.

In this section you will learn about these life skills, as well as different activities and resources that will be helpful to you in working with youth. You might not currently be working with older youth who are getting ready to transition to independent living, and so the information in this module can also be considered as a preview of things to come for a younger age group. For example, a topic such as check-writing can be used to introduce younger youth to the concept of a checking account and how checks are used, rather than teaching them the specifics of checkbook balancing. The information contained in this module will also be helpful for you if you plan on working with older youth at some point in your career.

Let's begin now and talk about some general developmental guidelines, and then we will get more specific.

Slide 5

Daily Living Skills: Toddlers

What are the appropriate daily living skills based on age?

Let's Begin with Toddler Skills:
By age 18 months to 2 years, children can start to help around the house with simple chores such as putting away toys, dusting, helping with laundry sorting, placing items in the washer and dryer, setting the table, or using the dustpan. By age 2, children can begin to assist adults in other ways. For example, they can pick out their clothes, clear non-breakable items from the table, or help bathe themselves. Children take great pride in being able to help. Modeling these tasks and helping children learn them sets them up for future independent skills. It is important for adults to reinforce these skills with praise such as, "I love the way you are helping to clean up your toys."

Slide 6

Daily Living Skills: Early Childhood

Early Childhood Skills:
In the early years, children continue to be eager and willing to help out, assisting with chores and tasks. It is important to note, however, that they are still developing cognitively and physically, and have age-specific motor skills, so that your expectations should be in line with their abilities. You can think of this process as laying the groundwork for future accomplishments and skills. As children get older and more developmentally skilled, they are better able to accomplish tasks independently.

Adults should continue to model skills and behaviors, as well as monitor children as they perform tasks. In terms of hygiene, for example, young children can wash their hands, brush their teeth, comb their hair, pick out their clothes, and get dressed. They can also continue to help around the house, making beds, helping with laundry, putting away groceries, helping with cooking (for example, stirring and adding ingredients), and cleaning the house (for example, sweeping, dusting, clearing the table, putting away utensils, and setting the table). Because children at this age are in school, they have developed skills that begin to prepare them for more independence. For example, learning to tell time is helpful so that children can set a wake-up alarm and get ready for school. Math skills allows them to pay more attention to money. They can count coins and figure out change when shopping -- once again, building the foundation for future independent living skills.

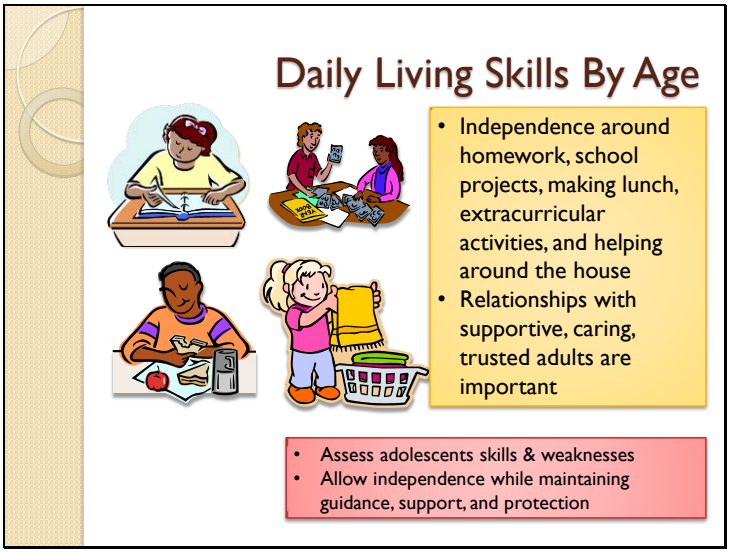
Slide 7

Daily Living Skills By Age

Skills in Middle Childhood:
Children in this age group are now used to being in a classroom and a more formal learning style. There are many opportunities for learning to occur at this stage, both formally and informally. In addition to more independence with hygiene and household tasks, children at this stage will develop abilities like time management and money management through their school skills.

Life skills in the social realm also become important at this age. Children can use guidance on conflict resolution and decision making. Participating in extracurricular activities, groups, and teams can help kids learn these skills.

Slide 8



Adolescent Skills:
An important goal for adolescents is to obtain the skills that will successfully transition them to adulthood. The learning of these skills ideally has been going on both formally and informally since childhood. It can be incredibly useful at this stage to assess adolescents for their skill sets and weaknesses. A balance that needs to be achieved at this stage is allowing independence around activities, while offering some guidance, support, and protection before they are out on their own.

At this stage, adolescents can independently complete homework, school projects, get to school on time, make and pack their own lunch, do extra-curricular activities, and continue to help out around the house. Their skills sets are such that they can do more in terms of laundry, yard work, meal preparation, and other chores around the house. They are learning skills and responsibility as well. They might begin a job and save money during this time period. Relationships with supportive, caring, trusted adults are important in building success with these skills.

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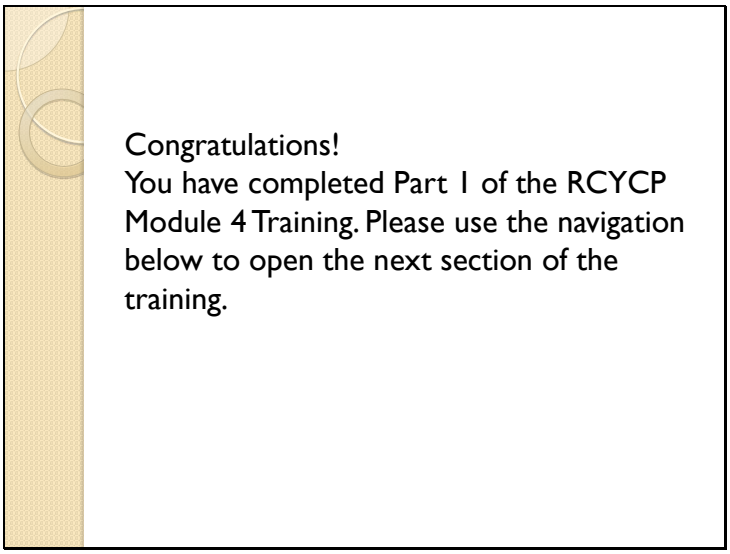

Congratulations! You have completed Part 1 of the RCYCP Module 4 Training. Please use the navigation below to open the next section of the training.

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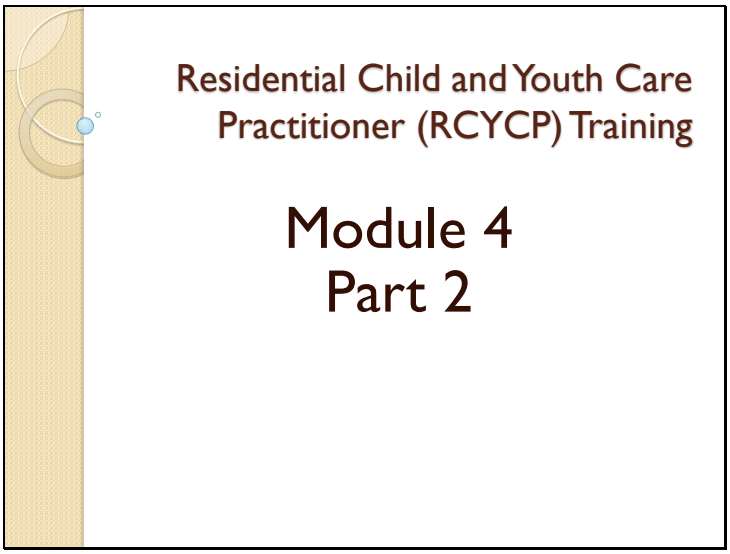

Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 4, Part 2 of the Residential Child and Youth Care Practitioner Training.

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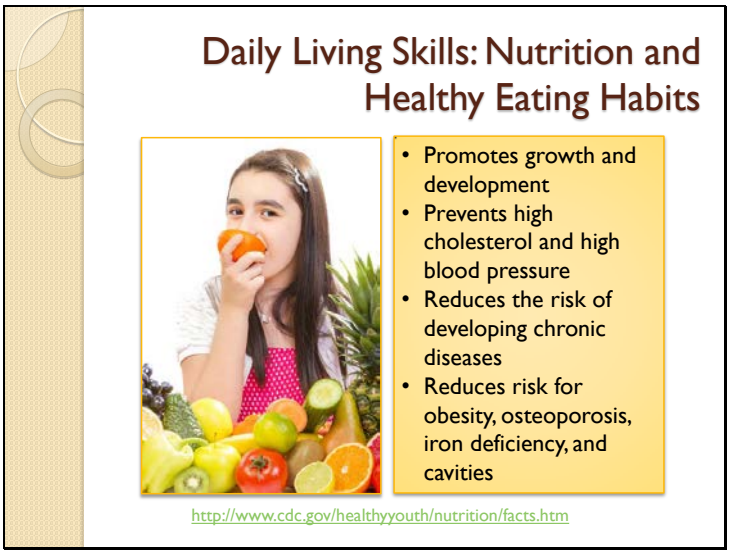


Daily Living Skills: Nutrition and Healthy Eating Habits

Now that you have a general sense of developmental abilities, let's talk about life skills more specifically. We will begin with the life skills of daily living.

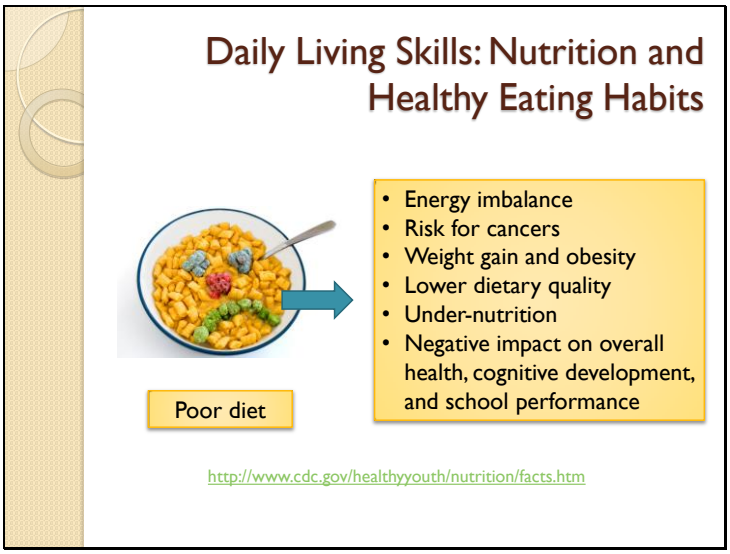
- Let's discuss nutrition and healthy eating habits. Why is it important to eat healthy?

According to the Centers for Disease Control (CDC):

- Proper nutrition promotes the optimal growth and development of children;
- Healthy eating helps prevent high cholesterol and high blood pressure, and helps reduce the risk of developing chronic diseases such as cardiovascular disease, cancer, and diabetes;
- Healthy eating helps reduce one's risk for developing obesity, osteoporosis, iron deficiency, and dental cavities.

(From http://www.cdc.gov/healthyyouth/nutrition/facts.htm)

Slide 4



So what happens when people eat poorly? According to the CDC:

- A poor diet can lead to energy imbalance (e.g., eating more calories than one expends through physical activity) and can increase one's risk of being overweight and obesity;
- A poor diet can increase the risk for lung, esophageal, stomach, colorectal, and prostate cancers.
- Individuals who eat fast food one or more times per week are at increased risk for weight gain and obesity.
- Drinking sugar-sweetened beverages can result in weight gain, being overweight, and obesity.
- Hunger and food insecurity (i.e., reduced food intake and disrupted eating patterns because a household lacks money and other resources for food) might increase the risk for lower dietary quality and under-nutrition. In turn, under-nutrition can negatively affect overall health, cognitive development, and school performance.

(Consequences of a Poor Diet (from http://www.cdc.gov/healthyyouth/nutrition/facts.htm))

Pic from www.freedigitalphotos.net
Junk Food Stock Image
By digitalart, published on 02 May 2011
Stock Image - image ID: 10039971

Slide 5

So what are the recommendations for healthy and nutritious eating?
The Dietary Guidelines for Americans recommend a diet rich in fruits and vegetables, whole grains, and fat-free and low-fat dairy products for persons aged 2 years and older. The guidelines also recommend that children, adolescents, and adults limit intake of solid fats – major sources of saturated and trans fatty acids – as well as cholesterol, sodium, added sugars, and refined grains.

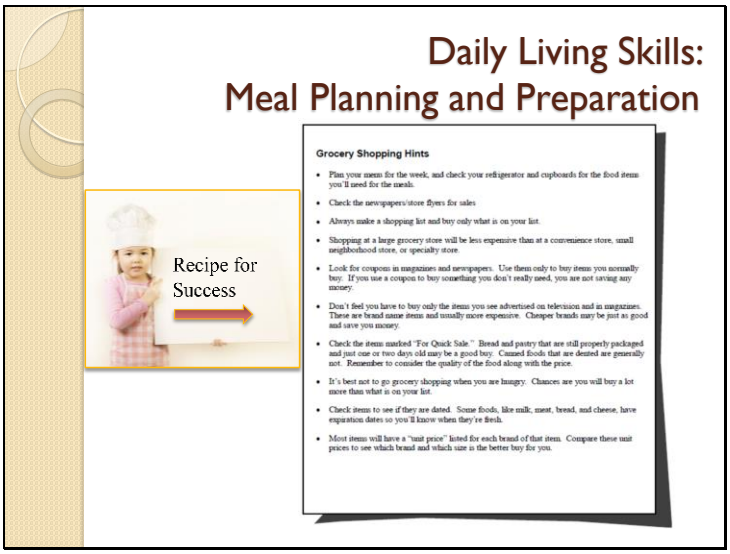
Slide 6

So what can you do to help residents with nutrition and healthy eating? First, find out how much they know. What foods do they think are healthy? What do they consider unhealthy? There are a number of valuable internet resources that can be used by teens to familiarize themselves with healthy habits, as well as help them with meal planning.

The following is a brochure from the CDC on nutrition:
http://www.choosemyplate.gov/food-groups/downloads/MyPlate/DG2010Brochure.pdf

Additionally, the "Choose My Plate" website is an incredibly useful and valuable tool that provides tips for healthy eating on a budget, sample menus and recipes, daily food plans, and many other resources.
http://www.choosemyplate.gov/

Slide 7



Daily Living Skills: Meal Planning and Preparation

To get a sense of a youth's meal planning and food preparation skills, have them plan a menu by first thinking through what their meals will be for the day or week. Some meals can probably be prepared without following a recipe. For others, especially those that are new to them, they might need to follow written directions. In order to follow recipes, they will need to be familiar with weights and measurements. You might guide them in developing a grocery list according to their planned menu.

Here are some grocery shopping hints:
You might also help them by assisting them in the kitchen while they prepare the meal.

Slide 8

Daily Living Skills: Food Storage

Proper food storage helps to preserve the quality and nutritional value of the foods people purchase, and also helps make the most of food dollars by preventing spoilage. Additionally, proper food storage can help prevent foodborne illnesses caused by harmful bacteria.

Proper storage of food means knowing where to keep it -- for example, the pantry, refrigerator, or freezer -- as well as for how long. You can help youth understand proper food storage by making sure they have the resources to find out what to do when they are uncertain. There are a number of resources on the web that chart proper food storage guidelines. Having youth read through and familiarize themselves with the material will be helpful. They can even print out food storage charts to keep with them or hang in an appropriate place, such as the kitchen. Here are two extremely helpful websites that detail food storage information:
http://nchfp.uga.edu/how/store/texas_storage.pdf
http://www.ext.colostate.edu/pubs/foodnut/09310.html

Slide 9

Daily Living Skills: Food Safety

You probably have some knowledge about food safety already. There are four major rules of food safety: Number 1 (and probably the most obvious) is to always wash your hands before cooking and eating. Most viruses that cause foodborne illness are spread through poor hand washing or poor hygiene practices. Viruses can be spread through almost any ready-to-eat food, including ice. Washing hands well keeps both the cook and the person or people eating the food healthy.

(From SOS Program of the Minnesota Department of Health Food Safety Center retrieved from: http://www.health.state.mn.us/foodsafety/sos/sos.pdf)

Slide 10

The second rule for food safety is to keep cooking areas clean. Keeping cooking areas clean prevents the cross-contamination of food. This will be discussed in more detail in just a minute, but to give an example of this: Imagine that an individual takes out ground meat to make hamburgers and some of the raw meat juice drips on the counter. Imagine that the same individual then cuts up an apple on that same counter, but has not cleaned the counter first. When that individual eats the apple, he or she is likely ingesting bacteria from the raw meat juice that was not cleaned up and is now on the apple. That person will likely get sick. This would have been prevented had that individual kept the cooking areas clean by wiping down the counters with antibacterial kitchen spray and paper towels.

Slide 11

The third rule for food safety is to keep food at safe temperatures. The temperature range in which bacteria grow best in perishable foods is between 40°F and 140°F. This is referred to as the temperature danger zone. People can control bacterial growth by keeping perishable foods out of this temperature danger zone. The food should be kept at temperatures below 40°F or above 140°F to prevent bacteria from growing.

Slide 12

Freezing or refrigerating foods will slow or stop the growth of bacteria in foods. It is important to remember, however, that neither refrigeration nor freezing kills bacteria. Some bacteria will continue to grow very slowly at refrigerated temperatures. Because of this, leftovers should not be kept any longer than three or four days.

Slide 13

In order to keep foods at safe temperatures, there are a number of other things to do:

- Always reheat foods as quickly as possible, so that foods do not remain in the temperature danger zone for longer than necessary.
- If foods have been left at room temperature for more than two hours, they should be considered unsafe and discarded.
- Thaw foods in the refrigerator or microwave oven. Gradual defrosting overnight is best because it helps maintain the quality of the food. Foods defrosted in the microwave should be used immediately.
- Food products that come from animal sources (for example, meat, poultry, fish, and eggs) should always be properly cooked.
- Hot foods should be put in the refrigerator or freezer immediately after use and not left to cool at room temperature before storing.
- Reheating should be done quickly (not in slow cookers or crock pots), and should only be done once.

Slide 14

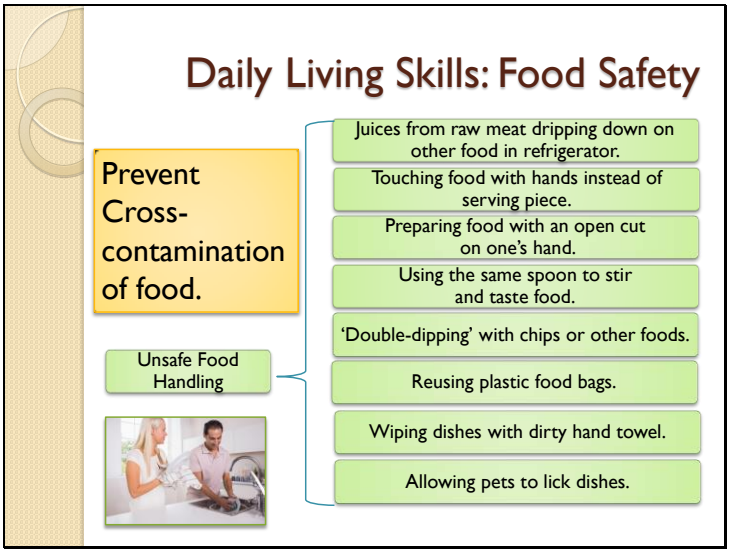
The fourth and last general rule for food safety is to prevent cross-contamination of food.

What is the “cross-contamination” of food?

The answer is this: Cross-contamination is the transfer of harmful organisms from a contaminated food to another food through unsafe handling. All food has the potential to be contaminated. Here are some examples of unsafe food handling practices that involve cross-contamination:

- Failure to wash hands before preparing food.
- Working with food when you are ill.
- Cutting raw meat on a cutting board and not washing the board before cutting something else.
- Touching raw meat and not washing your hands before touching other food.
- Using the same plate for cooked meat after using it for raw meat – for example, when grilling.
- Sharing water bottles or other drinks.
- Eating or drinking out of food containers, and then returning them to the refrigerator.
- Not washing your hands after sneezing or blowing your nose.

Slide 15



Here are some more examples:

- Improperly wrapping raw meat, allowing juices to drip down on other food in the refrigerator.
- Touching food with hands instead of using a serving piece.
- Preparing food with an open cut on one's hand.
- Using the same spoon to stir and taste food.
- "Double-dipping" with chips or other foods.
- Reusing plastic food bags.
- Wiping dishes with a dirty hand towel.
- Allowing pets to lick dishes.

Slide 16

To prevent cross-contamination, wash cutting boards, knives, utensils, and counter tops in hot soapy water after preparing each food item and before going on to the next food item or preparation step. This is especially important after using the cutting board for meat or poultry. Be sure that everyone working with food washes their hands, too.

Slide 17

While the youth with whom you work may know some of the obvious food safety rules, they are not likely to know all of them. Get a feel for what they do know and help familiarize them with the ones that they don't. One of the best resources for food safety -- and the source for this information -- is the Minnesota Department of Health Food Safety Center. The following document about food safety includes lessons, activities, and quizzes that you can use with your youth if you are so inclined:
http://www.health.state.mn.us/foodsafety/sos/sos.pdf

Slide 19

Daily Living Skills: Setting The Table

In the event that you are working with youth who do not know how to set a table properly, this short video from etiquette expert Emily Post's great-great-granddaughter, Lizzie, goes over the rules:
http://www.youtube.com/watch?v=V52nGn-coKo

Slide 20

Daily Living Skills: Table Manners

Table manners are important for making a good impression on others. As an RCYCP, you can stress the importance of good table manners, as well as model them for the youth in your care. While the following list is by no means exhaustive, there are a number of basic manners that should be followed when dining with others.

1. Place your napkin in your lap once you are seated.
2. Use "please" and "thank you" when appropriate.
3. Wait until everyone is served before beginning to eat.
4. Chew with your mouth closed.
5. Don't talk with your mouth full.
6. Avoid making slurping and "smacking" noises.
7. Use your utensils to eat, unless you are eating finger food.
8. Don't use your utensils like a shovel, or as if you've just stabbed the food you're about to eat.

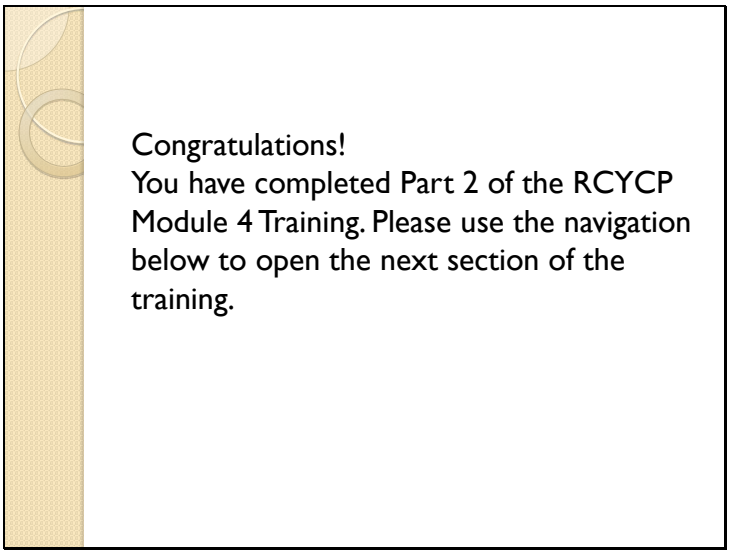
By stockimages, published on 13 October 2013
Stock Photo - image ID: 100209379
From: www.freedigitalphotos.net

Slide 21

9. Avoid behaviors such as burping, nose-blowing, teeth-picking, etc., at the table. Instead, ask to be excused and use the bathroom.
10. Remember to use your napkin at all times.
11. Wait until you're done chewing to sip or swallow a drink. (The exception is if you're choking.)
12. Cut only one bite of food at a time.
13. Avoid slouching and don't place your elbows on the table while eating (though it is okay to prop your elbows on the table while conversing between courses.)
14. Instead of reaching across the table or in front of another person for something, ask for it to be passed to you.
15. Always say "excuse me" whenever you leave the table.
16. Electronic devices should be turned off or silenced.

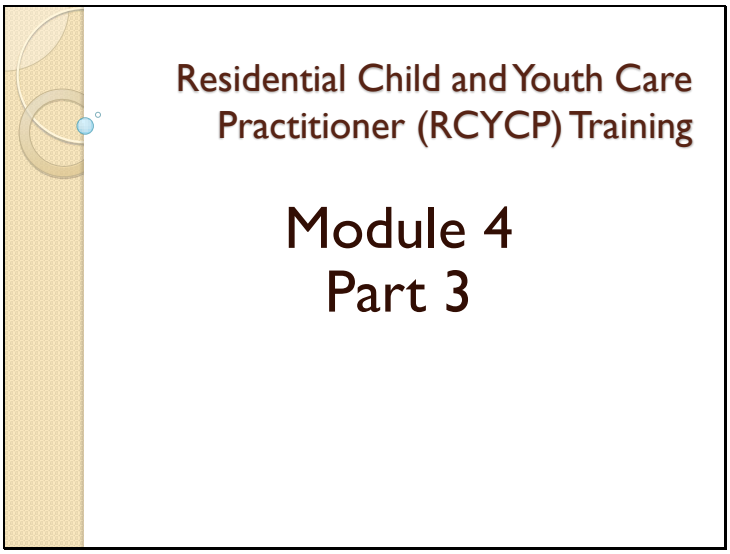
By stockimages, published on 13 October 2013
Stock Photo - image ID: 100209379
From: www.freedigitalphotos.net

Slide 22



Congratulations! You have completed Part 2 of the RCYCP Module 4 Training. Please use the navigation below to open the next section of the training.

Slide 2



Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 4, Part 3 of the Residential Child and Youth Care Practitioner Training.

Slide 3

Daily Living Skills: Household Cleanliness

It should come as no surprise that the kind of environment people live in can greatly influence their well-being. Having a clean place to live is important for several reasons. Keeping one's living space clean reduces the risks of germs, bacteria, pests, and rodents, which can have a harmful effect on people's health. A clean home will also make people feel better about themselves and help them to stay organized.

It is likely that many of the youth you work with will need assistance with learning to keep a household clean. One of the activities you can do with your youth to get a sense of what they know with regard to household cleanliness is to have them look at the following apartment floor plan and describe in the designed spaces how and with what kind of cleaning supplies they would clean each of the rooms. When they are finished, you can discuss it with them.

Slide 4

You will need to make sure the youth you work with know how to clean the house and do their laundry. You can work with them, perhaps guiding them in the use of appropriate disinfectants, cleaning supplies, and techniques, and then shadow them while they learn. Use the following information to help guide them:

Helpful Hints:

- The easiest way to clean a room or apartment is to first put everything where it belongs.
- Wash and dry the dishes and put them away. (Load the dishwasher if there is one.)
- Wipe off the table and countertops with a paper towel and cleaning solution.
- Put clothes in the closet or drawers, remembering to sort those items that need to be washed or dry-cleaned.
- Make the beds. If the sheets need to be changed, wash them.
- Dust wooden furniture using a cloth and furniture polish.
- Use a damp cloth in place of furniture polish for non-wood surfaces.
- Vacuum rugs and floors.
- Sweep the kitchen floor first, and then wash it.
- Using a sponge and soapy water, clean the top of the stove. Be certain that the burners are off while cleaning.
- Clean the mirrors using paper towels.
- Empty wastebaskets and take out the garbage.

Slide 5

Less Frequent Tasks:

- Using a sponge or damp cloth and soapy water, clean the inside of the refrigerator.
- Defrost the freezer every two or three months, or according to the appliance maintenance directions.
- Clean the oven when it is cold. Make sure the oven setting is on “off.” Use a damp sponge to wipe it out. Newer ovens may be self-cleaning; check for directions inside the door.

Have youth become familiar with some of the various cleaning products on the market. There are many!
One cleaning product may be more expensive than another, but it is not necessarily better. Teach youth to shop wisely.

Slide 6

Some tips for cleaning the bathroom:

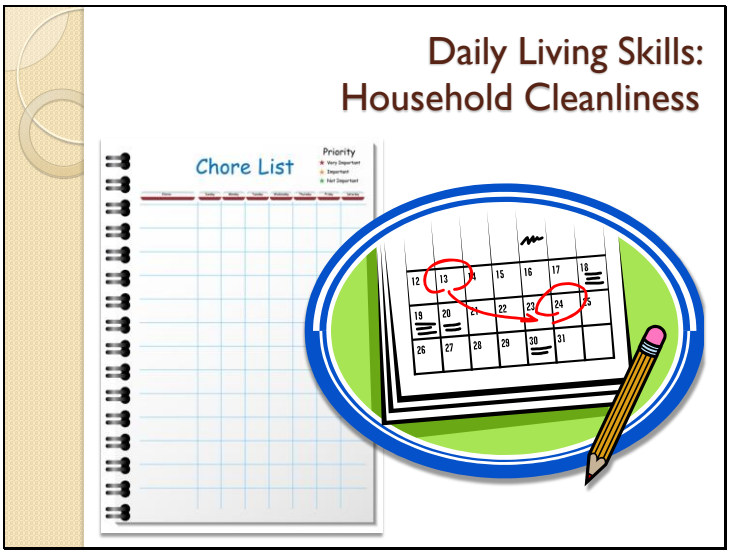
- Using a cleaning product and sponge, clean the sink, tub, and tiles.
- Always use a separate sponge or brush to clean the toilet bowl. Wash the floor. Wash any bathroom rugs.
- Put out fresh towels and washcloths.

Slide 7

Here are some hints for doing laundry:

- Wash light- and dark-colored clothing separately.
- Read clothing labels for washing instructions. Some clothes must be “hand washed” or washed in cold water.
- Do not wash clothing marked “dry clean only.”
- Follow the directions on the laundry detergent package, which will tell you how much detergent and what water temperature to use.
- If shrinkage is a possibility, remember to use cold water.
- Use bleach carefully. It can discolor and damage clothing if not used properly. Read the directions on the bottle or box.
- “Color-safe” bleach is available for use on colored clothing.

Slide 8



Once youth know how to keep a clean house, you can work with them on determining how often they will need to perform different chores. While some tasks, like vacuuming, emptying the garbage, or cleaning the dishes, have to be done fairly often, others, like washing the windows, and defrosting the freezer, don't need to be performed as frequently. A cleaning chart will be helpful in keeping track of which chores need to be done and arranging tasks around their schedule.

Slide 9

Daily Living: Home Safety

There are a number of different ways to stay safe at home. While not all of the youth that you work with will be moving toward independent living, it is still helpful to know and educate them in the things that they can do to stay safe at home. Let's review some safety tips now.

- Don't open the door to anyone who is unknown without first finding out who the person is and what he or she wants.
- Install a peephole or wide-angle viewer in the door so anyone who is outside can be seen without opening the door. A short chain between the door and its frame is not a good substitute, as it can be easily broken.
- Ask to see an identification badge or card for any repair worker, meter reader, police officer, etc., before allowing him or her inside.
- Put deadbolt locks on the doors; do not rely on spring-latch locks with the key hole in the knob.
- Be sure to keep the entry way, porch, and yard well-lit.
- Do not put personal identification on key rings or anything else that can be seen by strangers.
- Never give out personal information over the internet (for example, address, location, name, age, school, telephone number or information about family members).
- Don't give any information to "wrong number" callers. Ask what number the person was trying to reach.

- Hang up immediately on any threatening or harassing telephone calls. If the caller persists, call the police and the phone service provider.
- Check the references of any person calling about a survey or credit check before volunteering information. Offer to call the person back instead of responding immediately.

Slide 10

- Know which telephone numbers to call for medical emergencies, fire, and/or police assistance.
- Know whom to call for assistance if needed -- for example, parents, neighbors, friends, friends' parents, etc.
- Know what to do and whom to call if a child or adult has ingested a poisonous substance.
- Know and follow the basic rules for preventing fires at home: no smoking in bed, avoid using frayed electrical cords, do not use a gas stove as a source of heat, use extension cords properly.
- Have a smoke detector and carbon monoxide detector in the home. Be sure to check it and replace the battery when necessary.
- Use caution when throwing away matches, smoking materials, or any hot substance.
- Keep a fire extinguisher in the home.
- Have an escape plan ready if a fire breaks out in the home.

Slide 11

- Store hazardous materials properly and away from children and pets. Understand the importance of safely storing cleaning, painting, and other toxic materials away from children and pets.
- Keep a basic emergency supply kit for natural disasters that includes bottled water, battery-operated radio, flashlight, extra batteries and a first-aid kit. Other items can be added. The following website is extremely helpful for disaster planning: http://www.ready.gov/basic-disaster-supplies-kit
- Keep a first-aid kit with the following materials:
    - antiseptic cream or ointment
    - Band-Aids (different sizes)
    - Gauze pads
    - Rubbing alcohol
    - Roll of gauze bandages
    - Scissors
    - White tape
    - Cotton balls
    - Aspirin
    - Ipecac Syrup
    - Non-aspirin pain reliever
    - Tweezers
    - Oral thermometer

Slide 12

Everyone at one time or another will need to turn to a community agency or organization for information or assistance. It is extremely important that the youth you work with know how to access community resources in case of an emergency.

Slide 13

Additionally, many of the youth you work with will need to access non-emergency community resources from time to time, so having them become familiar with the resources that are available in their community is helpful. A good way to do this is to have them do some research. Ask them to find the information for the following resources. You will likely need to help them with this task.

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This website lists a number of different Maryland health hotlines and websites that might be useful for residential care youth:
http://msa.maryland.gov/msa/mdmanual/01glance/html/healthho.html

This website lists a number of 24-hour state and national hotlines, as well as county-specific numbers in Maryland:
http://marylandlearninglinks.org/3465

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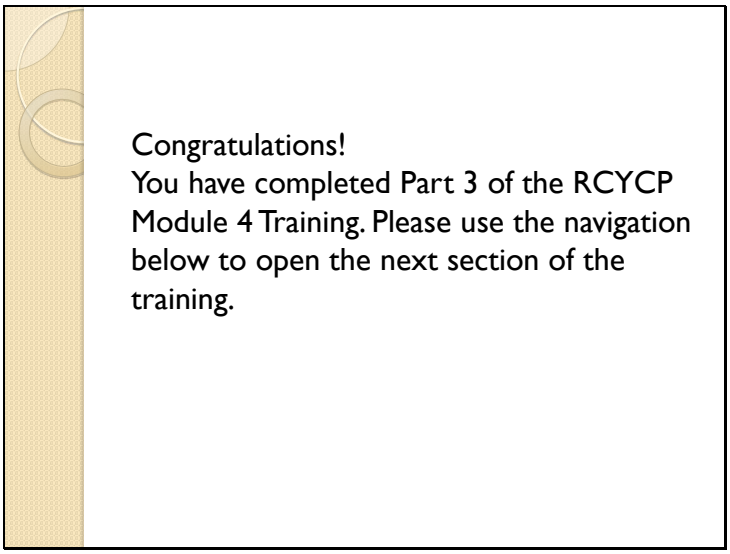

Congratulations! You have completed Part 3 of the RCYCP Module 4 Training. Please use the navigation below to open the next section of the training.

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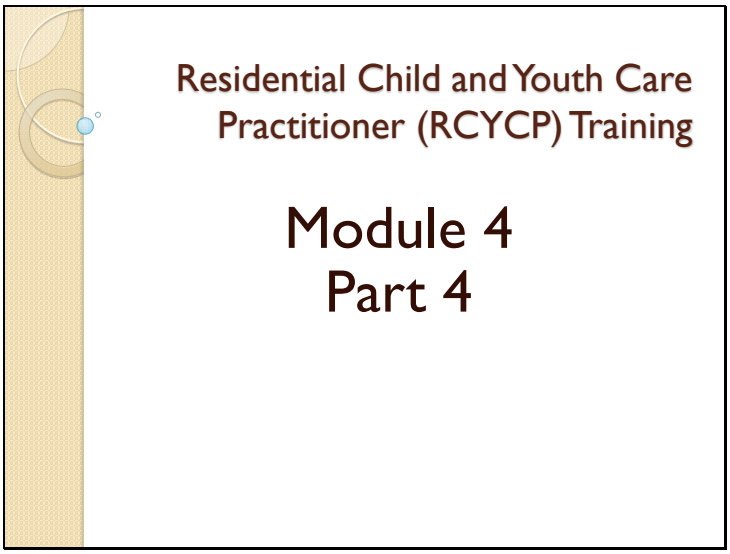


Residential Child and Youth Care Practitioner (RCYCP) Training

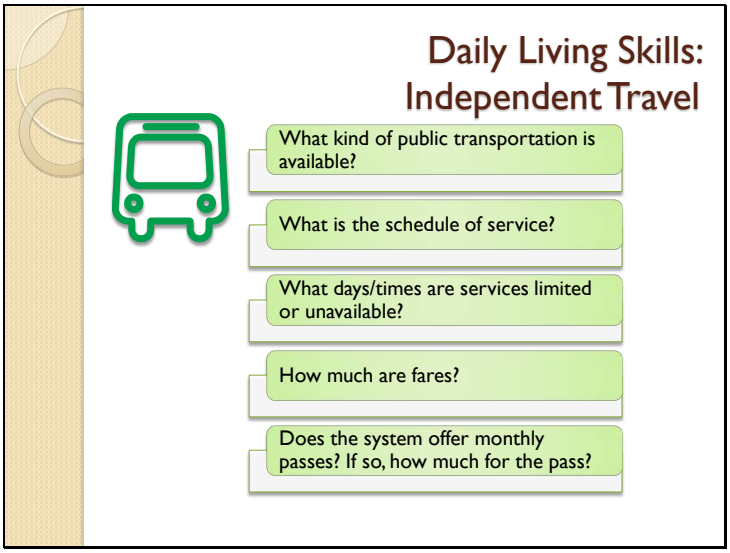
Welcome to Module 4, Part 4 of the Residential Child and Youth Care Practitioner Training.

Slide 3

Daily Living Skills: Independent Travel

Public transportation is generally a convenient and cost-effective way to get around, as well as a good alternative to using a car. Most cities and towns have some type of public transportation – including buses, trains, or a subway system. Larger cities often have more than one.

Slide 4



Just as it is important for the youth you work with to be familiar with community resources, it is also important for them to be familiar with transportation and how to get around independently. Once again, helping them research the public transportation system so they know what is available will be immensely helpful. You can have them find out the following:

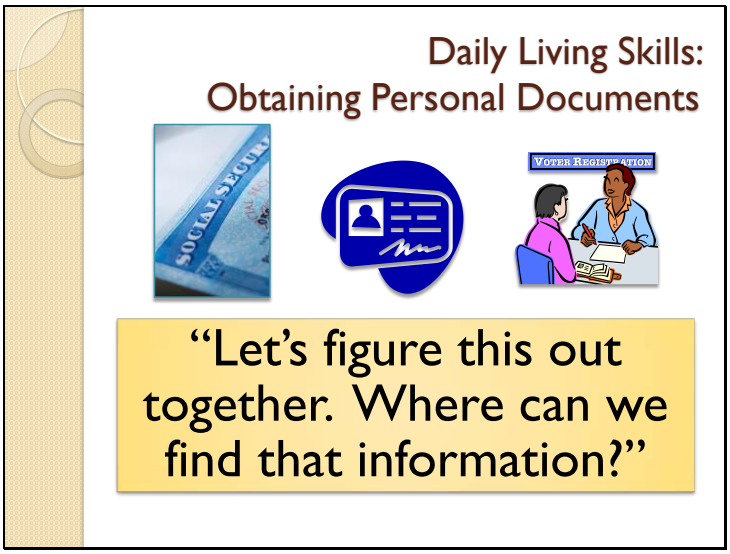
1) What kind of public transportation is available in the community?
2) Is public transportation available 24 hours per day every day or is there a schedule of service?
3) On what days and/or at what times are the services limited or not available?
5) How much are single fares? Are the fares different for people of different ages?
6) Does the transportation system in the community offer monthly passes for riders who use the system regularly? If so, at what price?

Slide 5

Depending on the rules of your organization that pertain to day trips with youth, a field trip that uses public transportation, such as the bus or subway, can be fun and useful.
Being able to give directions, follow directions, and read road maps are important skills that people need throughout adulthood. You can help youth learn these skills by having them find a route and give directions from point A to point B. The following activity is an example of something fun you can do to help youth learn to give directions.

ACTIVITY : Imagine that you're standing in front of the building/house where you are now and a person stops his car to ask you how to get to the post office. Can you give him directions? If so, write them down.

Slide 6



Daily Living Skills: Obtaining Personal Documents

Each of us at one time or another needs to obtain personal documents, like social security cards, driver's licenses, and voter registration cards, to name a few. Just as you do not need to memorize the list of documents that people might need, nor the requirements to obtain them, the youth you work with don't need to memorize those lists, either. They do, however, need to know how to access the information when they need it. For example, if they ask you what they need to do to get their driver's license, you can say, "Let's figure that out together. Where can we find that information?" Then you can show them how to search and read through information on the web that pertains to the documents they need.

Slide 7

The following websites are extremely useful for helping youth with these tasks:

- All things to do with Maryland Driver's License information: http://www.mva.maryland.gov/Driver-Services/Apply/md-drivers-license.htm
- Official Social Security website (obtaining cards, changing name, benefits information etc.) http://www.ssa.gov/

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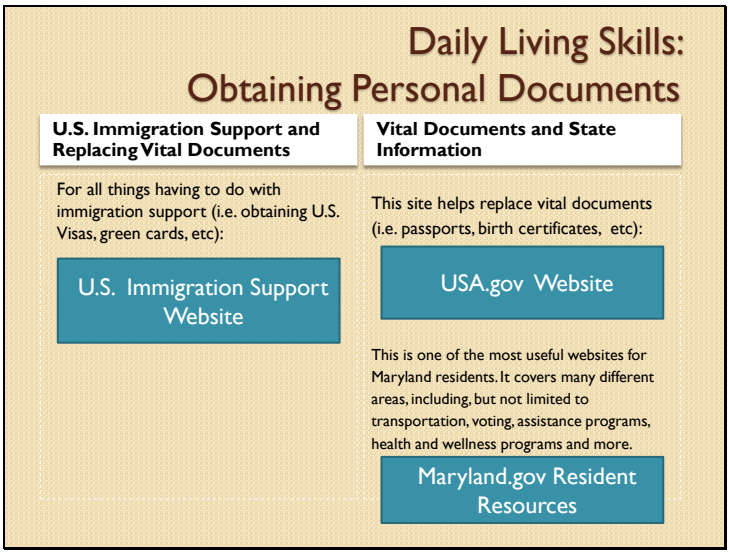
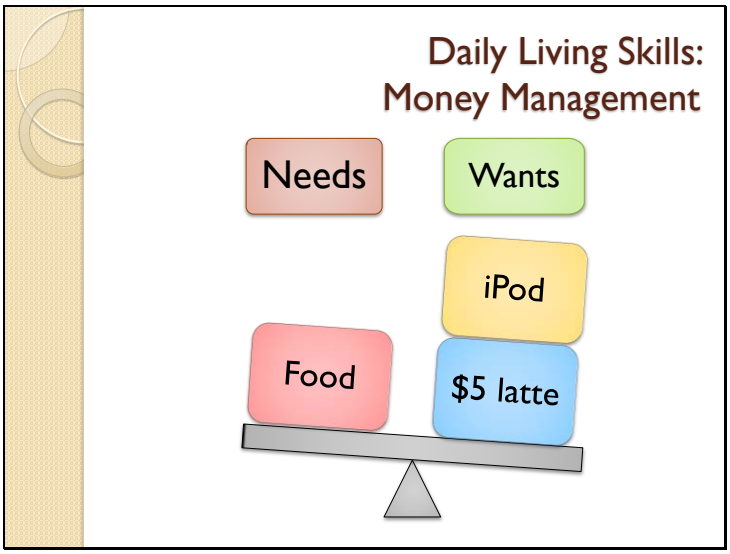


- U.S. Government website for immigration support (U.S. Visas, green cards etc.)
http://www.usimmigrationsupport.org/
- U.S. Government website to help people with replacing vital documents (for example, birth certificates, passports etc.)
http://www.usa.gov/Citizen/Topics/Family-Issues/Vital-Docs.shtml
- This is one of the most useful websites for Maryland residents. It covers many different areas, including, but not limited to transportation, voting, assistance programs, health and wellness programs and more.
http://www.maryland.gov/pages/residents.aspx

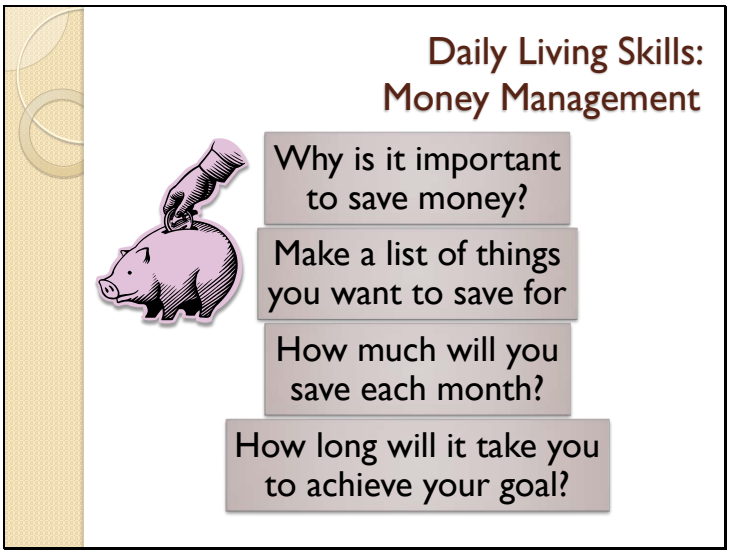
Slide 10



Daily Living Skills: Money Management

One of the best ways to get the youth you work with to start thinking about money management is to have them think about the differences between needs and wants. What do they need, and what do they want? For example, people need food to survive, but do people need a five-dollar coffee drink every day? Does this spending make sense when trying to keep a budget and save money? An iPod might generally be considered a want, but if people need to study and are distracted by noise at home and at the library, then perhaps an iPod might be closer to a need. An activity that you can do with your youth is to have them make a list of their needs vs. wants. Are their needs really needs? Can they move any of their needs to their wants category? By doing this activity, you are helping them begin to identify their values and goals for the future. This leads to our next discussion about saving money.

Slide 11



Saving Money:
Some people find it difficult to save money; they seem to spend all the money they have. Storing a little money away each month, if possible, is always important. Savings will help people get through the unexpected events that may occur in life, such as illnesses or accidents, and will help them prepare for things they may want, like a car, college or vocational program, vacation, new clothes, etc.

One of the ways to get youth thinking about why it is important to save money is to have them make a list of items or events that they want to save for. Have them figure out how much they will save each month. How long will it take them to achieve their goal? To assist them in figuring out if they will be able to save money, they will need to know about spending plans and budgets.

Slide 12

Developing a Budget:
A spending plan or budget is a strategy for saving and spending money. It is meant as a guide to help people track how much money they have coming in, and how it needs to be divided to meet expenses, reduce debt and reach their savings goals more easily. Using a spending plan or budget is a helpful way to take control of finances. By paying attention to what they are spending their money on, youth can make decisions about how to spend their money on things that matter to them and their long-term goals. For example, buying an expensive coffee daily can really add up. That becomes more evident when people are following a spending plan. So how is a spending plan or budget created?

Slide 13

A useful activity is to have the youth put together his or her own spending plan or budget. If they do not have a real income or expenses yet, you can help them come up with some realistic numbers to use. There are a number of internet resources that can help them with creating a budget. Here are a few:

http://njaes.rutgers.edu/money/pdfs/fs421worksheet.pdf

http://www.realsimple.com/static/pdfs/money_monthly.pdf

https://www.cpg.org/linkservid/3F745413-09C1-A487-CA9A0B9CCA7EFCB4/showMeta/0/?label=Monthly%2FAnnual%20Spending%20Plan

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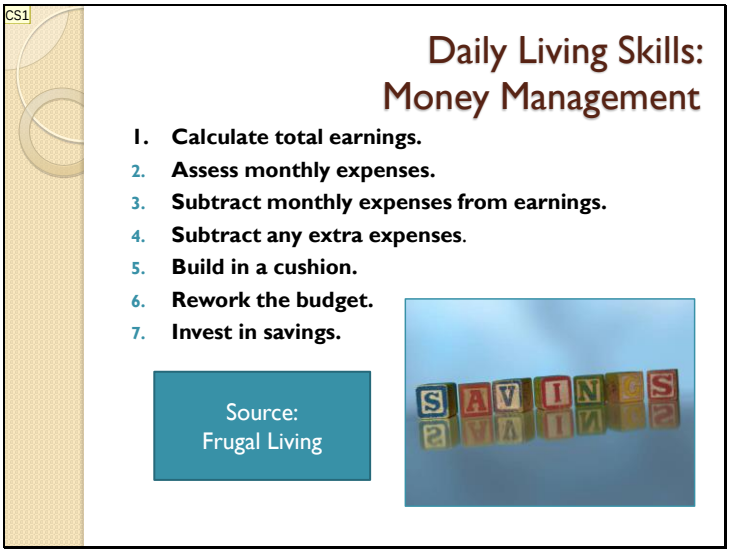

First,

1. Calculate total earnings.

Have them calculate how much money they expect to make this month after taxes, and only include income sources that they know they can depend on.

Earnings: _____

2. Assess monthly expenses.

Have them make a list of all of their regular monthly expenses, including any money that they spend on recreation and non-necessities like eating out, entertainment, or hobbies, as well as any minimum payments that they have to make towards their debts.

Monthly Expenses: _____

3. Subtract monthly expenses from earnings.

The resulting figure is how much they can expect to have left after covering all of their regular monthly expenses.

Remaining Money: _____

4. Subtract any extra expenses.

Have them review their plans for the upcoming month, and make a note of any extra expenses that they are likely to incur. This includes, but is not limited to: home or car repairs, medical or dental bills, gifts, trips, parties, extra meals out, subscription renewals and holiday-related purchases. Subtract the extra expenses from the figure that they arrived at in Step 3.

Remaining Money: _____

5. Build in a cushion.

Have them look at how much money they expect to have left after covering all of their anticipated expenses, and decide if what remains is enough cushion against unexpected expenses (car or home repairs, medical bills, missed work time, etc.) If they're not sure how much extra to build in, 10-percent is a good rule-of-thumb.
Cushion: _____

6. Rework the budget.

If your budget comes out on the negative side, go over your monthly expenses again, and look for places to make cuts. Keep at it until your budget works.

7. Invest in savings.

Use any remaining cash to pay down debts, or to build up their savings and investments.
Money to Invest: _____

Tips:

1. To allow for adequate planning time, have them make their spending plan before the start of the month.
2. If their circumstances change, have them adjust their spending plan accordingly.
3. No two months are exactly alike, so have them make a new spending plan each month.

(The following is from: http://frugalliving.about.com/od/frugalliving101/ht/Frugal_Budget.htm)

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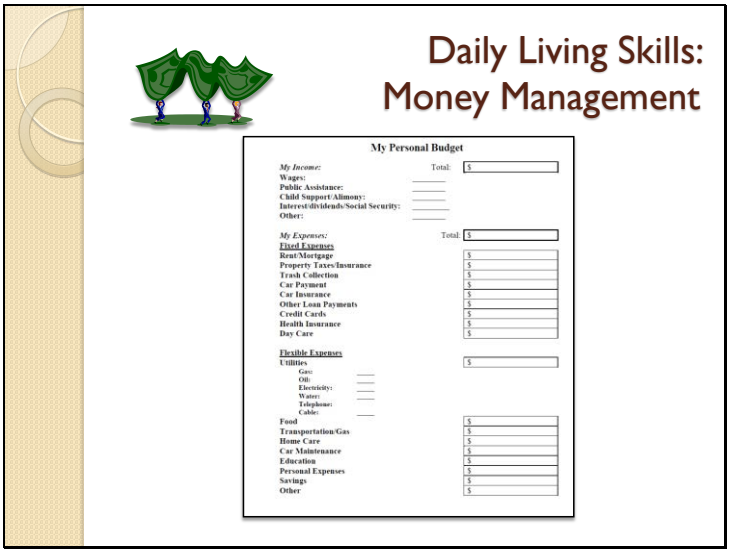
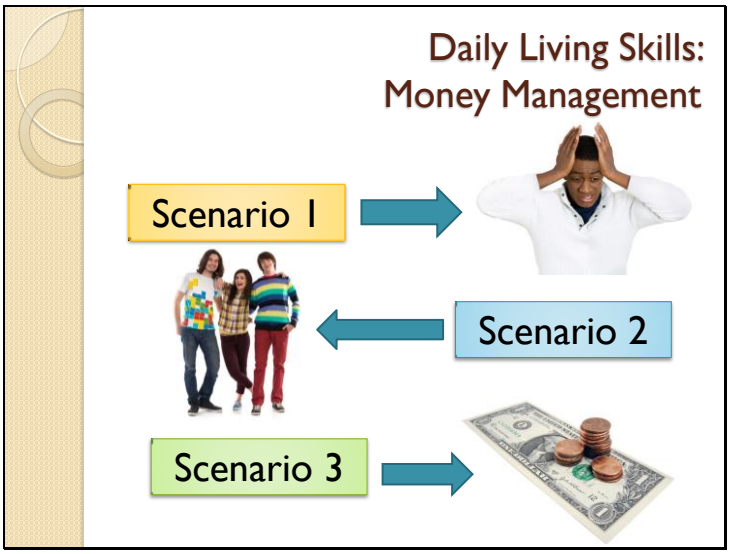


Keeping a budget:
In addition to helping the youth you work with learn how to create spending plans for themselves, you can help them by discussing the importance of keeping to their budgets. You might discuss how sticking to their budget might be difficult, but it is necessary for financial survival. Although there might be a little room to be flexible on some budgetary items, they will basically have to keep within their budget's limits in order to not end up with empty pockets before the end of the month.

Slide 16



Throughout their lives, the youth will have to be prepared to deal with many situations that might tempt them to ignore their spending plans. Giving in to these temptations will only lead to a financial crisis. Have them consider the following scenarios and discuss them.

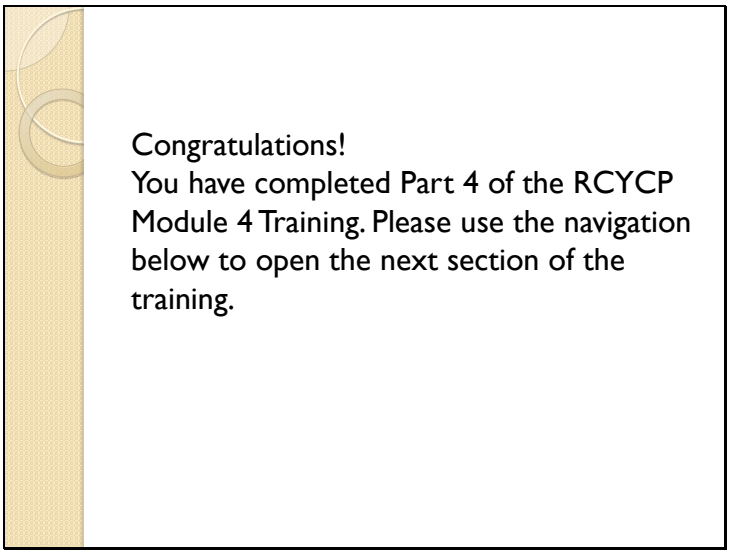
Consider the following:
[Scenario 1]
Your friend calls you in the middle of a crisis. He tells you that he needs to borrow $100 for an emergency. He promises that he will give the money back to you within a few days. However, this friend has not always been particularly reliable, and the only money you have has already been set aside for next month's rent, which is due in three days. You really want to help your friend, but are afraid you'll get evicted if you don't pay the rent in three days.
What would you do?

[Scenario 2]
It is Friday, and you have $20 left until your next paycheck. Your refrigerator is empty, and it will be another four days until you are paid again. Your friends stop by and ask you to go out to dinner and then a movie. You really don't feel like sitting around your apartment by yourself, but by the time you paid for dinner and the movie, there would be no money left for food.
What would you do?

[Scenario 3]

You have lost your monthly bus pass, and you are thinking about purchasing a new one. You have no money budgeted for this extra expense, although you may be able to use some of the money you set aside for recreation. You aren't sure that you want to use your recreation funds, but you don't want to walk 4 miles to and from work each day, either.
What would you do?

Slide 17



Congratulations! You have completed Part 4 of the RCYCP Module 4 Training. Please use the navigation below to open the next section of the training.

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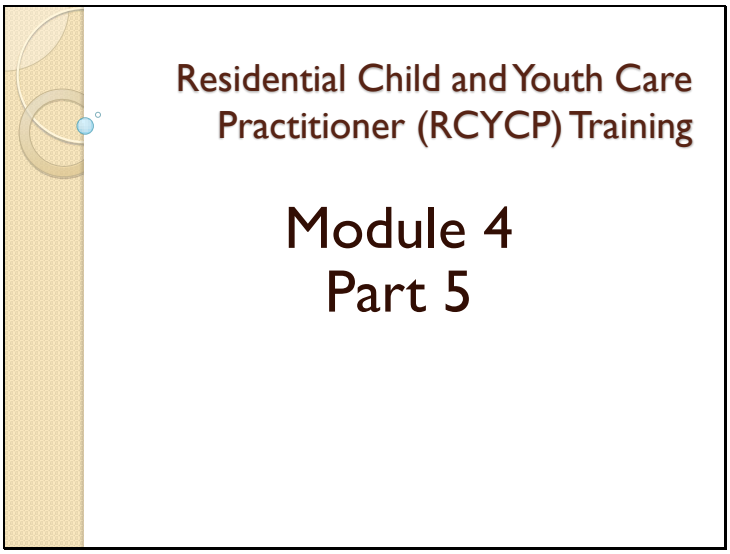


Residential Child and Youth Care Practitioner (RCYCP) Training

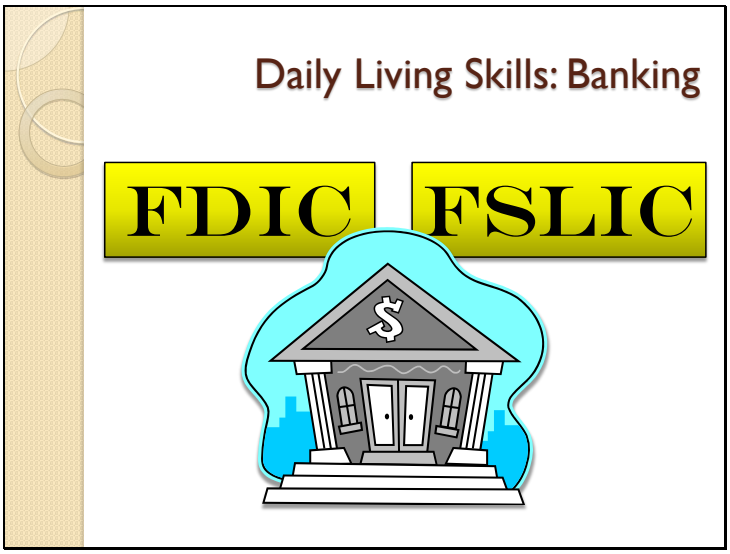
Welcome to Module 4, Part 5 of the Residential Child and Youth Care Practitioner Training.

Slide 3

Daily Living Skills: Banking

By working on budgeting with your residents, you have helped them figure out how they are going to spend their money. Now you can help them with banking. It is likely that they will have very little information and experience with personal banking. Things that are obvious to you may not be obvious to them. This section will provide a general overview of banking that you will then be able to pass along to the youth with whom you work.

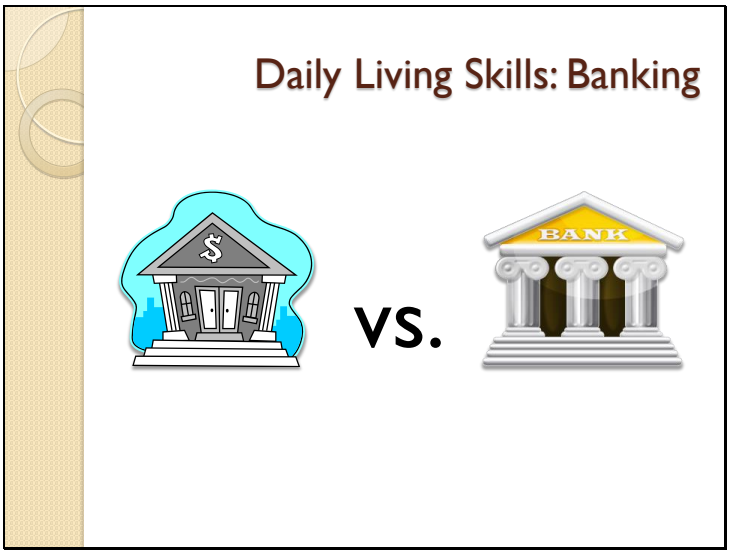
Slide 4



As you probably already know, it's not practical for people to carry all their cash on them or to leave large amounts of money in their home. It's also not a good idea to send cash through the mail, as it can be stolen. Savings and checking accounts are the most common methods of storing money. These are services offered by most banks, and savings and loan associations. However, not all places with names that sound like the names of banks are financial institutions that are regulated by the federal government.

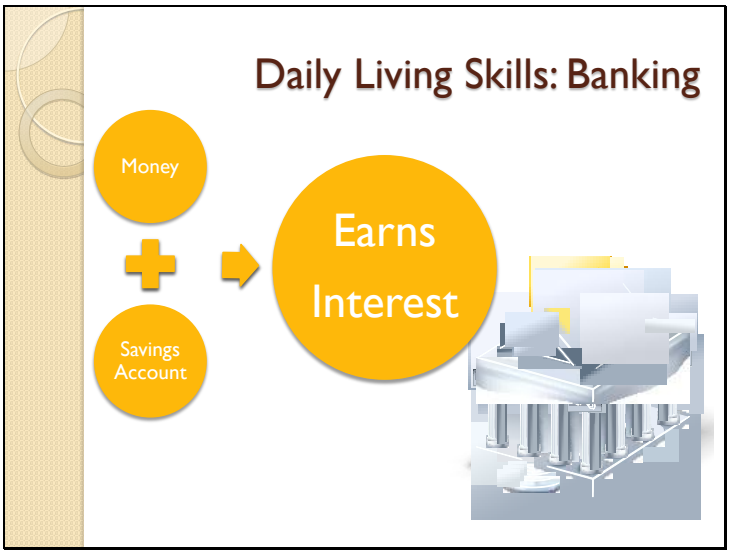
When depositing money in the bank, it is important to make certain that it is protected by the Federal Deposit Insurance Corporation (FDIC). When using a savings and loan, be sure that it is protected by the Federal Savings and Loan Insurance Corporation (FSLIC). The FDIC and the FSLIC guarantee that if a bank or savings and loan goes out of business, people's deposits are protected up to $100,000.

Slide 5



It is important to remember that all banks don't have the same interest rates, the same service charges, or the same minimum account balance amounts. A majority of larger banks offer online services to make banking easier -- for example, making bill payments and monitoring the account. You can explain to the youth you work with that they should find a bank that works for them and their financial goals. An activity you can do with them is to have them get information from a few different banks to compare options.

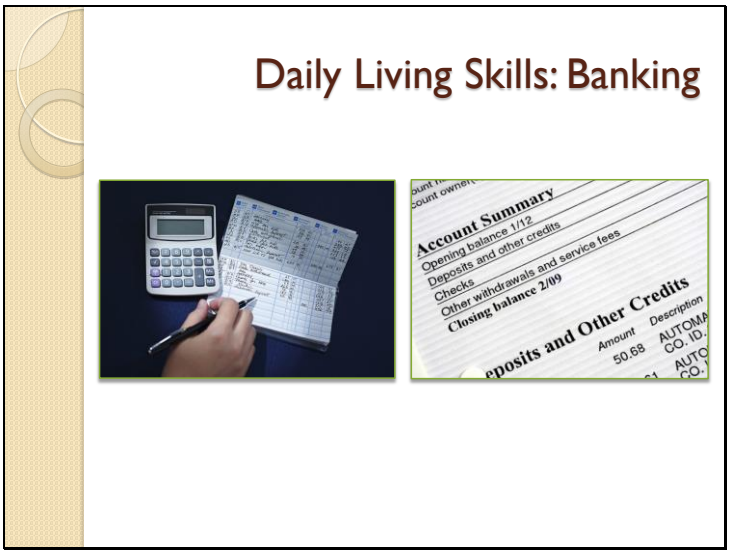
Slide 6



Savings Accounts:
As we saw in the budgeting section, it is important to build up some saved money, and even saving just a little money at a time can help people reach their financial goals.

Money in a savings account earns interest. The bank pays people interest for the privilege of holding their money. Savings accounts can also be used to temporarily store money. You can let the youth know that if they have difficulty with balancing a checkbook or they use checks irresponsibly, they can use saving accounts in combination with money orders to pay their bills.

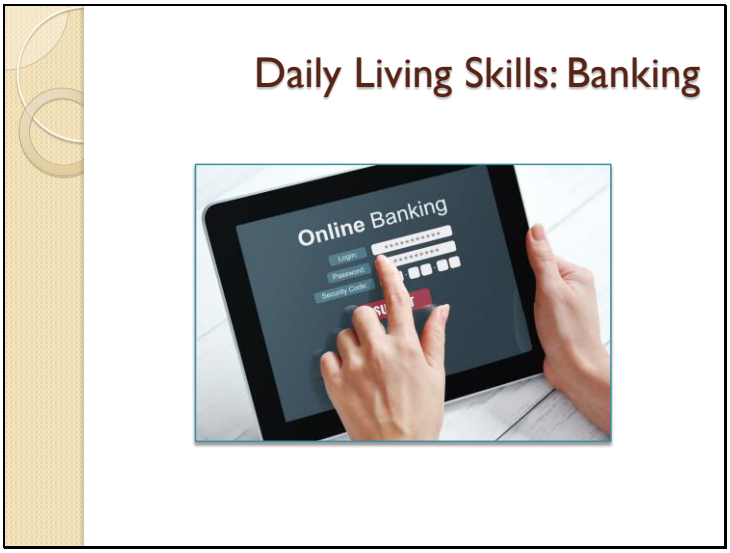
Slide 8



Checking Accounts:
Checking accounts are different from savings accounts. They provide people with an alternative to cash. Instead of paying bills or purchasing items with cash, people can usually write a check for the amount of the bill. The bank will then subtract the amount of the check from their account and give their money to the agency to which they made out the check.

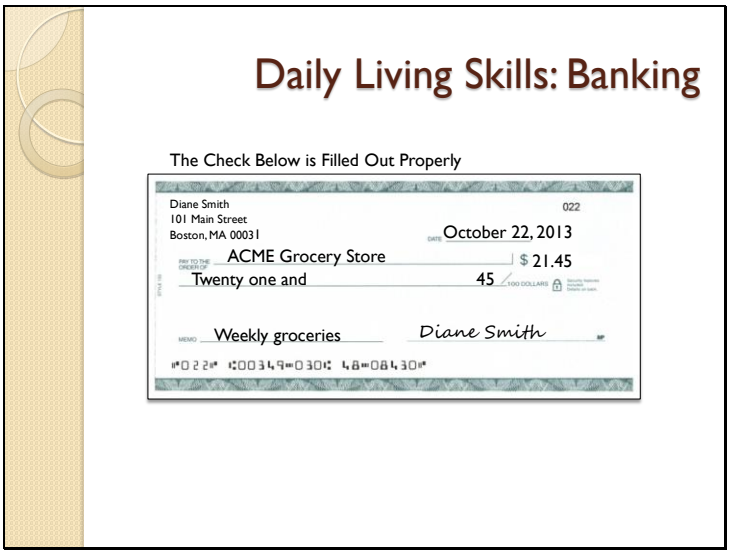
People are responsible for keeping a record in the back of their checkbook of the checks they have written and the deposits they have made into their account. At the end of the month, they will receive a monthly bank statement that summarizes their account activity and returns their canceled checks. (A canceled check is a check that has been cashed by the person or company to whom it was written.) The canceled checks can be used as receipts for their purchases.

Slide 9



Many banks offer a telephone service that enables people to call in at any time to inquire about their account balance, as well as online services. (Some banks will not offer checking accounts to people under age 18.)

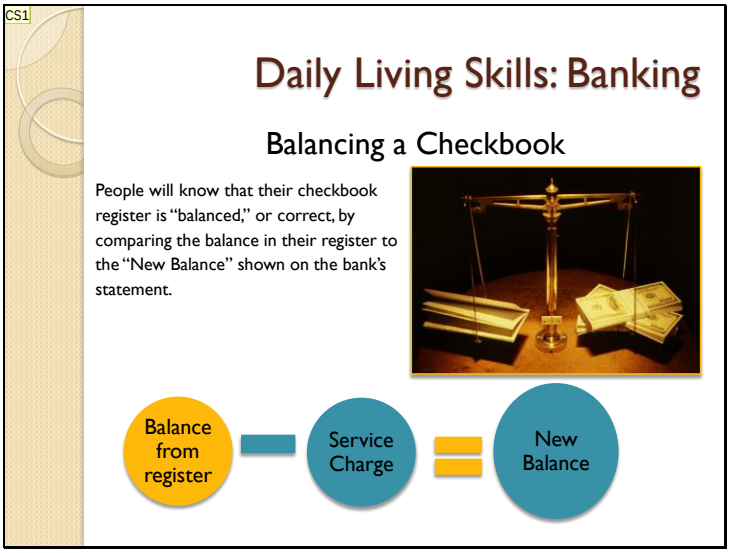
Slide 10



No matter what type of checking account someone opens, most have the same kinds of checks. It is important that people write checks properly so that the bank will do exactly what a person wants. The youth you work with should always follow these rules when writing a check:

1. Always write a check in ink.
2. Date the check the day it is written. Never pre- or postdate it. Write the amount of the check in numbers close to the dollar sign so that no one can insert a number before the amount that is written.
3. Write the amount of the check in words starting on the far left side. After the last word, draw a line to fill the unused space.
4. Always sign the check the same way, and make sure it matches the respective signature card at the bank.
5. Never sign a blank check.
6. Record each check in the check register immediately after it is written.

Slide 11



Balancing a Checkbook

People will know that their checkbook register is "balanced," or correct, by comparing the balance in their register to the "New Balance" shown on the bank's statement. To teach youth to balance a checkbook, have them complete the following steps.
First they must obtain their new checkbook balance:
1. Have them enter the balance from the register on Line A.
A. _____
2. Have them enter the amount of any service charge on Line B.
B. _____
3. Have them subtract Line B from Line A.
C. _____
This is the new checkbook balance.
Now they can obtain the current bank balance.
They should compare the check numbers and amounts on the statement with the checks listed on the register. Below, have them write down any checks written during the statement period and listed in the register but not in the bank's statement.
Check Number
_____
_____
_____
Amount

_____
_____
_____
Total: $ _____
2. Have them write down the new balance from the statement on Line D.
D. _____
3. Have them enter any deposits shown in the register but not in statement on Line E.
E. _____
4. Have them add Lines D and E; enter this subtotal on Line F.
F. _____
5. Have them enter total amount of checks not shown in statement on Line G. (Total from Step 1 above).
G. _____
6. Have them subtract Line G from Line F. Place result on line H.
H. _____

Slide 12

A useful activity is have to have youth practice writing checks and balancing a checkbook. The following website is informative and has practice activities that you can do with the kids in your care. Balancing a checkbook can be difficult in the beginning. Your experience can be helpful in mentoring your youth in this activity:
http://www.hotworkforce.com/Jobseeker/downloads/FIDC-Adult-English/FDIC_Module3Eng_PG.pdf

Slide 13

Automated Teller Machines, or ATMs:
Although ATMs are very popular, convenient, and easy-to-use, for both depositing and withdrawing funds in either checking or saving accounts, they also bear certain risks for people who might have difficulty managing money. Because ATM machines allow people access to their money at all times, there may be a greater temptation to spend money in a way they hadn't planned. This is an important point to get across to the youth with whom you work.

Slide 14

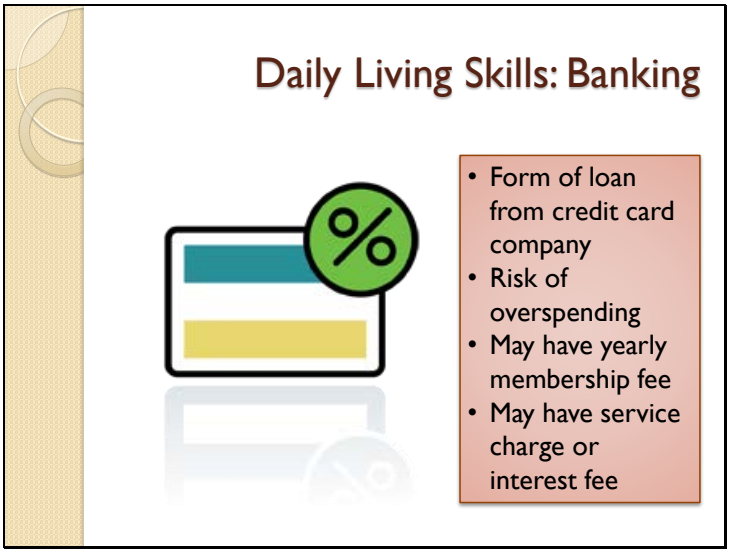
Some ATM machines, if they are not affiliated with their respective banks, will not provide users with their account balance. This makes it difficult to keep track of their money, especially if they forget to record the ATM transaction in their checkbook register. Similarly, many grocery stores now offer customers the opportunity to pay for purchases with their ATM cards, but without giving a balance.

Slide 15

The following tips are important for youth to know about ATM use:

- They should choose their secret password very carefully. They should not use their name, initials, phone number, or birth date.
- They should never write their password on their ATM card. If they lose the card, anyone who finds it would be able to withdraw their money.
- They should not announce their password to others. Once they tell a secret to someone, it's not a secret anymore.
- They should remember to take their receipt after each transaction, even when they're in a hurry. They'll need the receipt to help them balance their monthly statement, and, if they have any questions about their transaction, they'll need the receipt to speak to the bank personnel.
- They should be sure to enter all of their transactions (deposits or withdrawals) in their checkbook or savings register, so that they'll always know what their balance is.
- They should always remember to retrieve their ATM card from the machine after they've finished their transaction!

Slide 16



Understanding Credit And Charge Cards:
Credit and charge cards are different from checking accounts. Checking accounts use the money that is available in someone's account, while credit and charge cards are a form of loan from the credit company to that person. While this type of loan seems to make shopping more convenient, it also bears certain risks, like overspending. In addition, many credit institutions have a yearly membership fee. Some credit and charge card accounts also include an additional "service charge" or interest fee for certain kinds of transactions. It is important to understand how and when these additional fees are included.

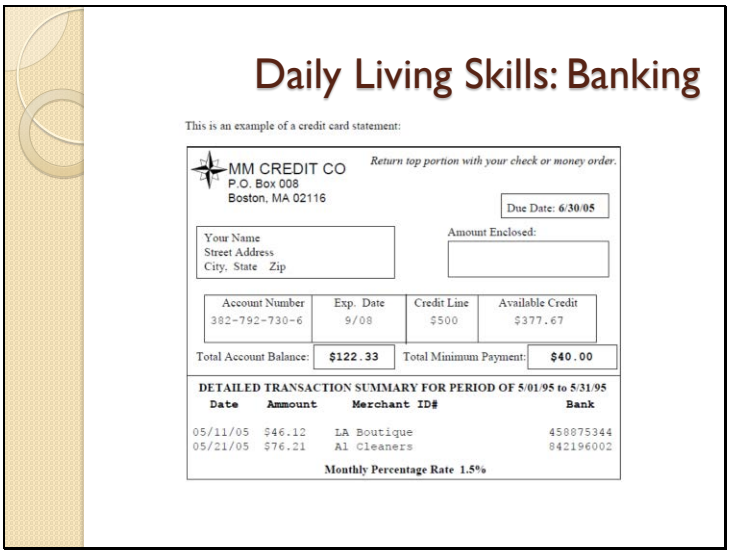
Slide 17

In order to get a credit or charge card from a bank, service, or store, people must fill out an application form. Approval will be based upon a number of considerations, including their present income, length of employment, the balance and activity in their checking or savings account, and their credit history. (For example: Have they ever had credit/charge cards before? Did they pay their bills on time? Have they bounced checks?) Approval is not automatic. If they have just begun full-time employment or do not have a credit history, their application might not be approved. However, they can always re-apply at a later date.

Slide 18

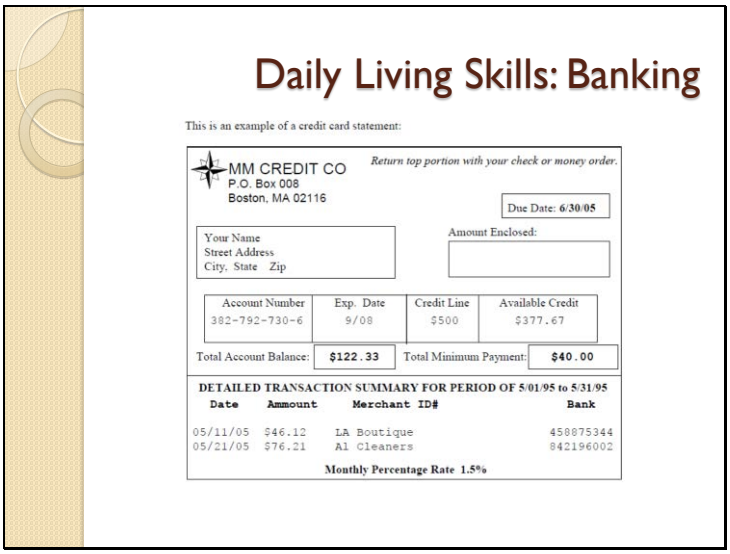
A credit card allows people to borrow up to a certain amount, called their “credit limit.” When they purchase something with a credit card, the credit card company is actually paying for them. At the end of the month, the credit card sends them a statement telling them how much money they owe the company. If they have a charge card from a particular store, similar loaning and billing procedures are followed.

Slide 19



Let's take a look at a credit card statement, which shows how much is owed and when to make payments. The total balance is the amount of money owed to the credit card company for charging things during a specific time period. The total minimum payment is the part of the total balance that must be paid by the payment date. The available credit lets the card holder know how much more they can borrow before reaching the limit on their credit line. "Credit line" means the same thing as "credit limit," and people can't charge more than their limit. Generally, the credit card company will decline the credit card's use after the credit limit has been reached. The transaction date, amount, and merchant ID number show when and where the card was used, and how much was charged.

Slide 20



The statement shows the two ways to pay off credit card charges:
1. The card holder can choose to pay the total balance (in this case, $122.33) all at once and be finished with it.
2. Or the card holder can pay an amount that is at least the total minimum payment (in this case, $40.00) and up to the total balance due, and then continue to make payments on the remaining balance at a later time.

Option 1 is good, but the youth might not have that much money available. If they are only able to pay a little at a time, they would use the second option. When they use Option 2, however, the credit card company charges interest for the privilege of putting off payment until later. In the end, they're paying for their loan -- that is, the things they charged -- and the interest on the loan, which means that their total payment will exceed the amount of purchases they made.

Slide 21

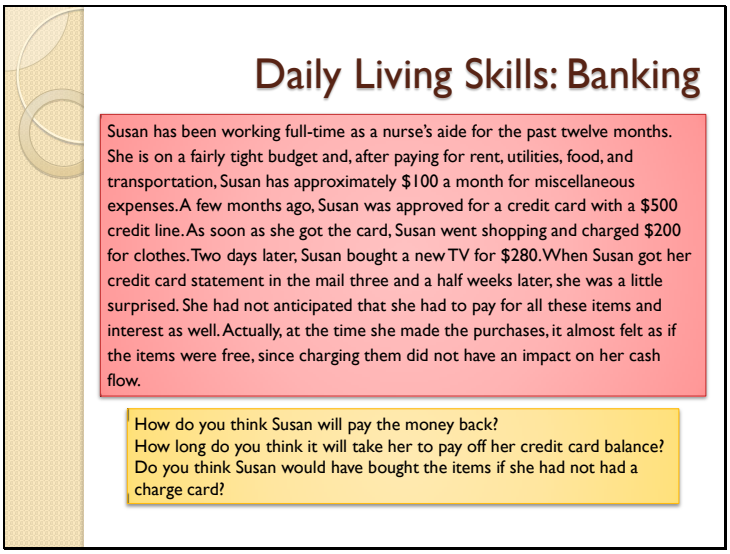
You can inform the youth you work with that paying off loans from the credit card company as soon as possible is beneficial. If they wait, they can end up paying a lot of money in interest fees – sometimes more than they spent on the items.

Once again, you can have the youth with whom you work do some research into different credit card options – either by calling the companies directly, or visiting a store and asking for information about their credit card.

Slide 22

As previously mentioned, although there are advantages to credit cards, they also bear risks. Many people get themselves into dangerous “credit holes,” meaning they buy much more than they can afford because it seems so simple to use the credit card now and pay later. Most of these people can never pay off the debt they owe, and the high interest rate on credit cards makes things worse. Some people spend years paying off debts that they have created through careless charging.

Slide 23



An activity to do with your residents is to have them consider the following scenario and answer the questions that follow:

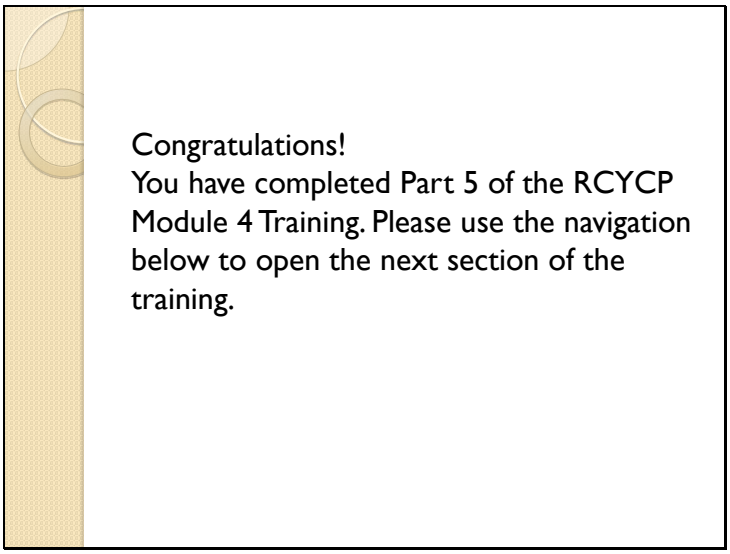
Susan has been working full-time as a nurse's aide for the past twelve months. She is on a fairly tight budget and, after paying for rent, utilities, food, and transportation, Susan has approximately $100 a month for miscellaneous expenses. A few months ago, Susan was approved for a credit card with a $500 credit line. As soon as she got the card, Susan went shopping and charged $200 for clothes. Two days later, Susan bought a new TV for $280. When Susan got her credit card statement in the mail three and a half weeks later, she was a little surprised. She had not anticipated that she had to pay for all these items and interest as well. Actually, at the time she made the purchases, it almost felt as if the items were free, since charging them did not have an impact on her cash flow.

- How do you think Susan will pay the money back?
- How long do you think it will take her to pay off her credit card balance?
- Do you think Susan would have bought the items if she had not had a charge card?

Slide 24

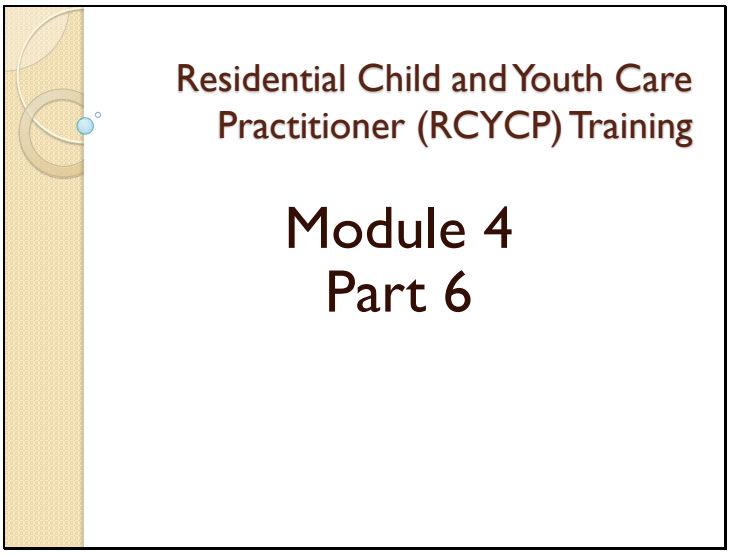
While credit cards can be helpful in establishing a good credit history -- necessary to apply for larger bank loans or to finance a car, for example -- they can negatively impact your ability to get additional credit if they are misused. You can help youth become aware of the long-range effects of bad credit.

Slide 25



Congratulations! You have completed Part 5 of the RCYCP Module 4 Training. Please use the navigation below to open the next section of the training.

Slide 2



Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 4, Part 6 of the Residential Child and Youth Care Practitioner Training.

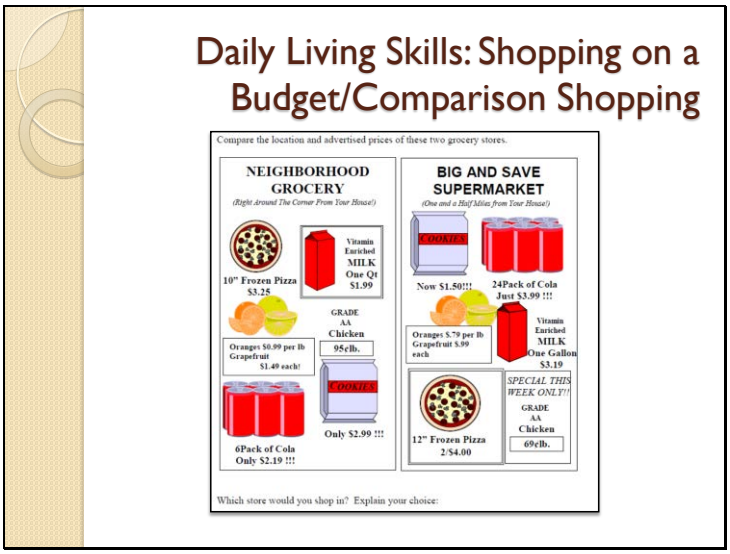
Slide 3

Daily Living Skills: Shopping on a Budget/Comparison Shopping

Now let's talk about spending money wisely through comparison shopping.
Eventually, the youth you work with will be living on their own and financially responsible for themselves. When on a limited budget, it is important for them to be educated consumers and to develop the ability to determine the best value for their money. Comparing prices might take a little extra time, but it often saves a great deal of money. One way for them to shop economically is to have them compare different brands of the same product. Often, store brand products are cheaper than name-brand products. Another way to help them determine the best buy is through unit pricing.

You might have to explain that at times, price-per-unit shopping isn't always the wisest method. In some cases, it depends on the amount of an item they need. The larger size of milk may be cheaper in relation to the smaller size, but that doesn't make it a better buy if the milk spoils before they can drink it all!

Slide 4



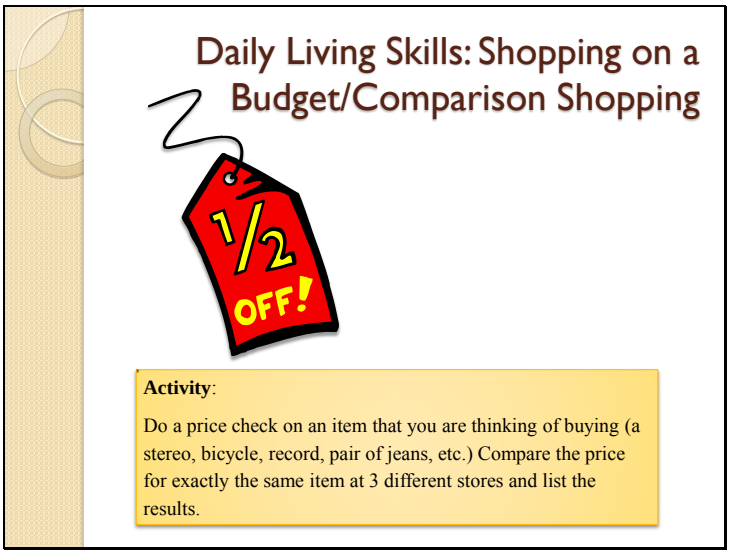
Here is an activity that you can do with your residents:

Have them look at the page and decide which store they would shop in.

Slide 5

As you probably know already, learning how to comparison shop can save money. This is something to discuss with the youth. When they've worked hard to earn their paycheck or allowance, they will want to get the most for their money. They will be frustrated if they find an item they have purchased selling for a lower price at another store. Checking the price of an item takes a little time, but often saves a great deal of money. If they know exactly what they want in advance (which brand, which size), they can do a price check by scanning newspaper advertisements or calling several stores.

Slide 6



You can guide your residents in the following activity:

Do a price check on an item that they are interested in (a stereo, bicycle, pair of jeans, etc.) Compare the price for exactly the same item at three different stores and list the results.

Have them keep in mind that there are additional factors to consider when you want to determine the best value, such as the quality of the product, warranty, and style.

Slide 7

Clipping coupons can save people a great deal of money. The amount to be saved on each coupon might not seem much, but it will add up! Have the youth you work with go through the advertising circulars and grocery flyers in the Sunday newspaper and clip the coupons they think they would use.

Explain that obtaining a supermarket card can allow shoppers to take advantage of that store's special discounts, on top of the savings from any coupons that they may have.

Slide 8

In addition to helping your kids with shopping, it will be useful for them to know how to return an item. The most important information to impart is to know the return policy of the store from which they have purchased something, and ask about it before they make a purchase. They should keep their receipts, and make sure to keep the merchandise tags on an item until they are certain they want to keep it.

Slide 9

Daily Living Skills: Housing

Housing is another important area that requires decision-making and planning.
Some of you will be working with youth who will be transitioning to independent living. This is a big step, and one that requires a lot of planning and preparation. They will need a lot of information and guidance, particularly with regard to housing. Before they can even begin to plan, however, they will need to make some decisions. You can help them think through the following issues:

1. What type of living arrangement do they want: for example, living with a roommate, with family, alone, etc.?
2. What are the housing options available to them: single rooms, apartments, duplexes, shared houses, etc.?
3. How much money can they afford to pay for housing while keeping within their budget?
4. Which community do they want to live in? In particular, you may need to guide them to think in terms of a community's available housing options, cost, distance from their job, training program or school, access to public transportation, safety issues, etc.
5. Do they know how to find different types of rental housing, furnished rooms, roommates wanted, etc., using the classified ad section of the newspaper?
6. Do they understand the abbreviations and terminology of a real estate listing – for example, terms like studio, lease, heat included, furnished, etc.?

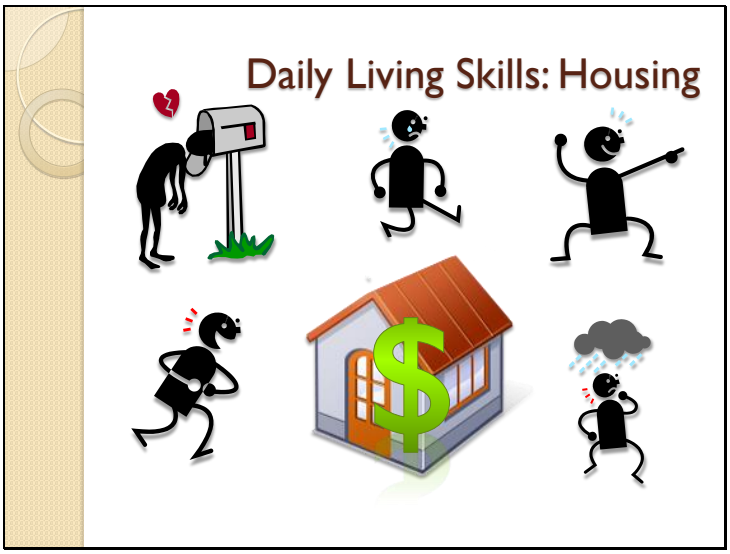
Slide 10

7. Do they know places other than the newspaper to look for help in finding a roommate, apartment, etc.?
8. Can they write and place an ad for a roommate?
9. Do they know how to fill out a rental application that includes referrals and references?
10. Do they know which questions to ask and what to look for when looking at an apartment -- for example, security deposit, terms of lease, condition of apartment, size of rooms, etc.?
11. Are they able to plan a budget to cover the up-front costs of moving? This might include a security deposit, first and last month's rent, needed furniture, additional household items, etc.
12. Do they know the importance of reading the lease or rental application carefully, and are they able to answer all the application's questions?

Slide 11

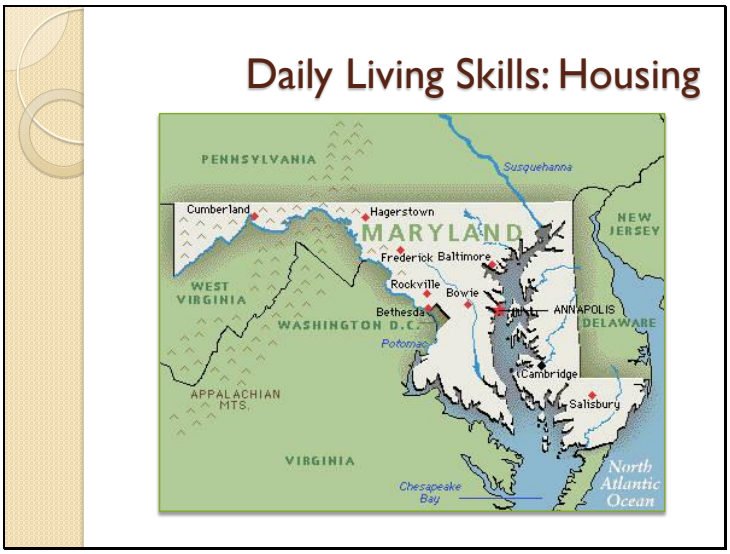
13. Do they plan on having a roommate, and if so, have they thought about which traits or characteristics they would or would not want in a roommate?
14. Are they aware of which of their own habits might bother a roommate?
15. Do they know how to arrange for utilities (telephone, gas, electricity) to be connected, and know the approximate costs for start-up?
16. Do they understand which utilities they will need to pay for, and will their budget allow for these monthly costs?
17. Do they know what to do to maintain an apartment or living situation?

Slide 12



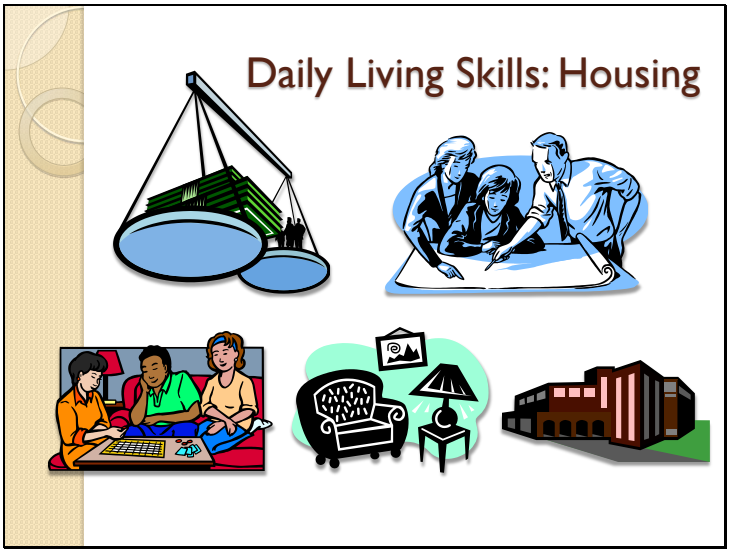
Moving out on one's own is a big step. They will have to plan for this event long before they will actually live independently. By the time they move out, they will need to have some money saved for the start-up costs. They will have to know where, and possibly with whom, they want to live. They will need a steady income, and a support system. They will have to be ready emotionally as well as financially. The anticipation of moving out to live on their own can also create many different feelings. Excitement, loneliness, insecurity, happiness, and homesickness are all common feelings during this stage of life.

Slide 13



The more they have planned and prepared for moving out, the more successful the youths' move will be. There are many things to be considered and many decisions to be made. Before deciding what kind of living arrangement would best fit their needs, they have to think about the geographical area they would like to live in. They will need to consider such factors as availability of support systems, transportation, and location of work or school while making their choice.

Slide 14



Another important part of preparation for independent living is the financial aspect. The youth will need to have enough money saved to make the transition. The amount saved greatly depends on their future plans, anticipated living situation, and preferences. If they are considering living with a roommate, renting a furnished room, or living on a college campus, their start-up costs (as well as their ongoing expenses) will probably be lower than if they want to move into an apartment by themselves. Have them consider the advantages and disadvantages of living with a roommate.

Slide 15

Furnished rooms are often advertised in the newspaper and usually consist of a bedroom with a shared kitchen and bathroom. This type of arrangement can be offered through private homes or rooming houses. Although this arrangement is inexpensive, requires very little start-up money, and is often used as transitional housing, it can have some disadvantages. Lack of privacy, visitor restrictions, house rules, and other tenants are some of the drawbacks of living in a furnished room.

Slide 16

For those who plan to attend college, campus housing might be an option. Many four-year and selected two-year schools offer dormitory housing and optional meal plans. Dormitory rooms are usually furnished and shared with a roommate. Costs for this type of living arrangement vary greatly, depending on each individual school.

Slide 17

Finding an apartment can be difficult for young people starting out. Some landlords prefer not to rent to young tenants due to their lack of references, and potential income restrictions, as well as general concerns about reliability and responsibility. It might take some time, therefore, to find an apartment. Presenting themselves as responsible tenants and having proof of a steady income will help transitioning youth find an apartment that best suits their needs.

Slide 18

Prior to looking for an apartment, the youth will also have to decide whether or not they are willing to sign a detailed rental agreement, called a lease. Most landlords require tenants to sign a lease, which defines responsibilities and expectations for both parties. Leases offer protection to the tenant and the landlord. They are legal documents and, therefore, binding. By signing a lease, tenants usually commit to keeping the apartment for 12 months and are held financially responsible for the rent during this period. Leases also specify rules and restrictions for tenants, i.e., pets, use of apartment facilities like a laundry room, noise levels, and parking. Most leases also require that tenants do not sublease, or rent the apartment to someone else, without permission.

Slide 19

Newspaper want ads are probably the most common way to find an apartment. The weekend editions, in particular, carry large advertisement sections for apartments. In order to read and understand the ads as well as talk to landlords and building managers, they will have to be familiar with certain terms.

- Efficiency apartment: A small apartment, usually furnished, with a private bathroom and kitchenette or small kitchen.
- Lease: A contract or legal agreement that allows a tenant to rent an apartment or house for a certain amount of money for a specific time period.
- Security deposit: A specific amount of money that the landlord requires prior to a tenant moving in to cover any damage to the apartment while the tenant is living there. The landlord keeps the money until the tenant moves out. He or she will then inspect the apartment and return the deposit if there is no damage. If there is some damage, the landlord may use all or part of the deposit to repair the damage.
- Studio apartment: A small apartment consisting of one main living space, a small kitchen, and a bathroom.
- Sublet: To rent an apartment from another person who rents the space.
- Utilities: Public services, such as gas and electricity.

Slide 20

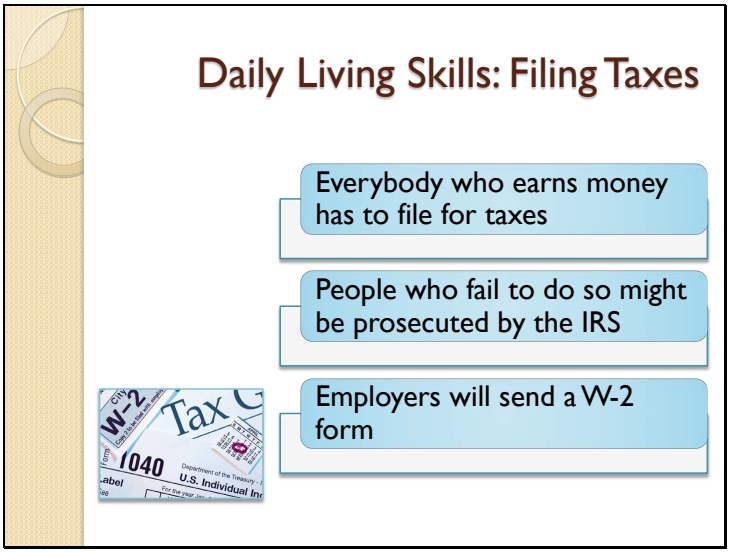
Subsidized Housing:
Most cities and towns in Maryland have Housing Authorities that own and manage apartments for low-income families, the disabled, and the elderly. To be considered for this type of subsidy, applicants have to fit into one of the above categories as well as meet income guidelines, and possibly other criteria. If a transitioning youth is eligible, the Housing Authority might pay a percentage of their rental costs for public housing.

Slide 21

Daily Living Skills: Filing Taxes

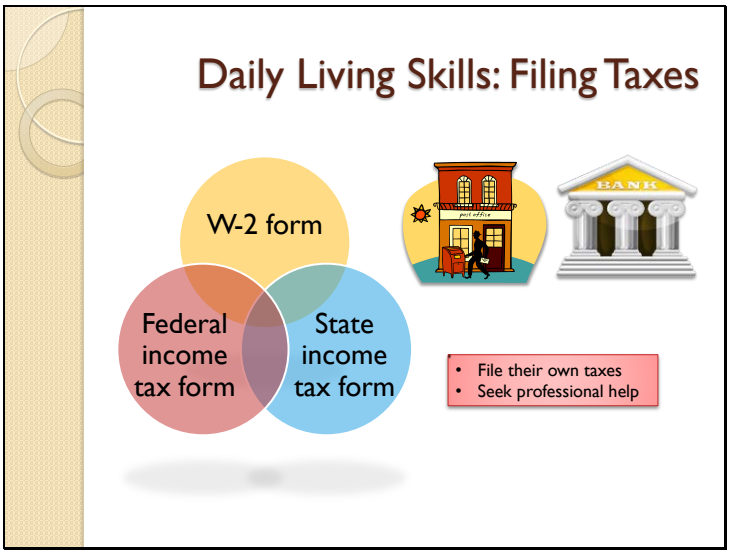
The youth you work with may, or may not, be familiar with paying taxes, especially if they have not been employed before. You can provide them with some basic information and resources that will help them when the time comes. The following information will be helpful to them:

Slide 22



Everybody who earns money, unless it is tax-free, has to file for taxes. People who fail to do so might be prosecuted by the Internal Revenue Service, or IRS, the federal agency responsible for tax collection. At the end of each year, their employer will send them a W-2 form, which lists the amount of money they have earned and the deductions taken out of their paycheck during that year.

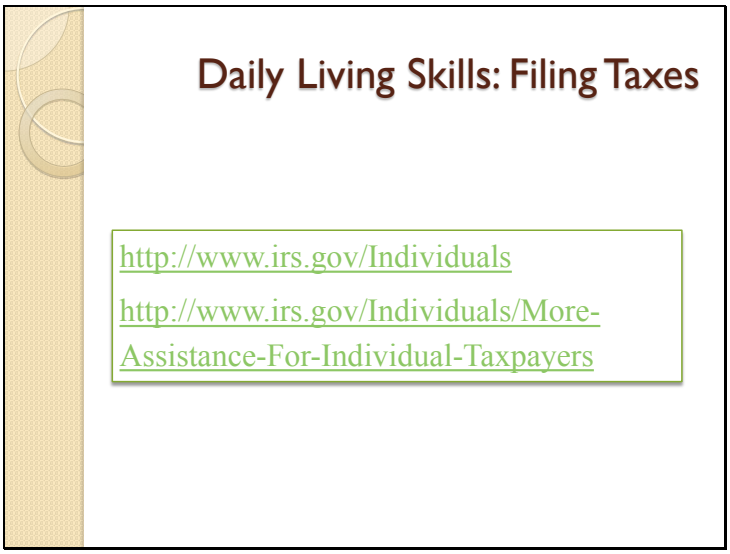
Slide 23



To file their taxes, the youth will need to obtain the W-2 form and both a federal and a state income tax form. These are usually available, along with an instructional brochure, at a post office or bank and often mailed directly to their residence. They can either file their own taxes, utilizing the information on their W-2 and by following the instructions provided in the instructional brochure, or seek out professional help. The IRS offers free tax preparation assistance to low-income taxpayers and others who qualify.

Transitioning youth who are paying taxes need to be aware of the deadlines associated with filing them. Depending on their status, they will either get a refund by mail or they may have to pay out additional taxes that were not collected through their paychecks.

Slide 24



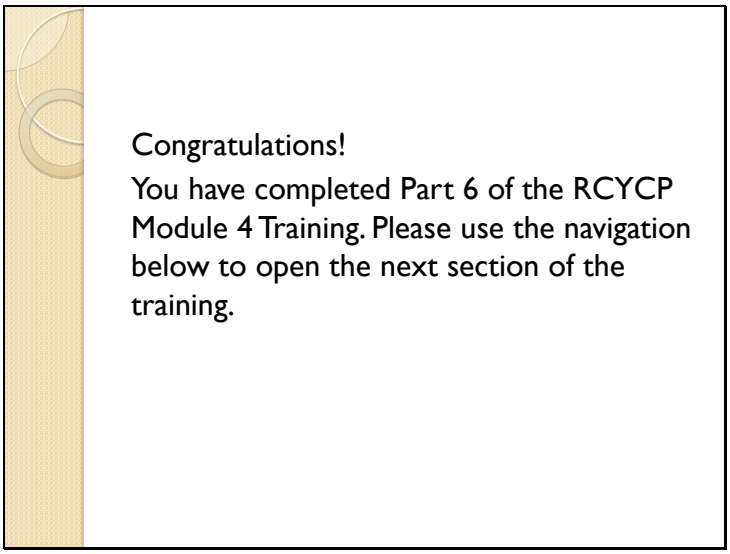
The IRS website has a number of helpful resources for individuals. Follow the links to access the information.

http://www.irs.gov/Individuals
http://www.irs.gov/Individuals/More-Assistance-For-Individual-Taxpayers

Slide 25

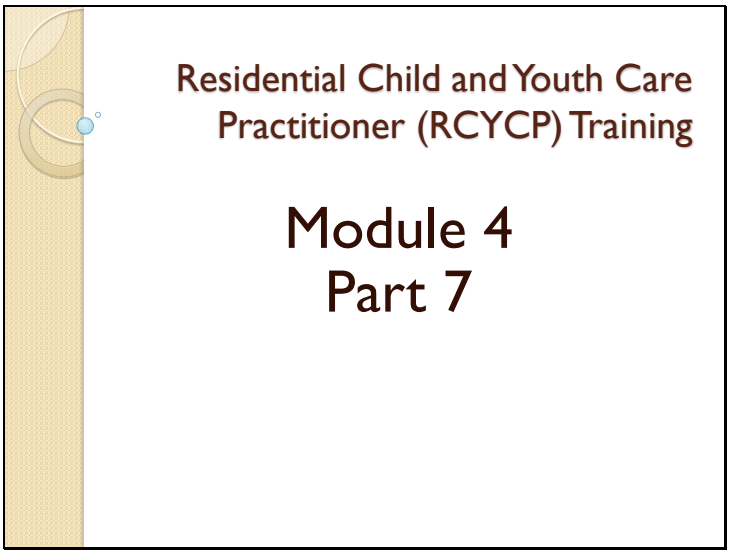
Part of becoming more independent is learning how to take care of oneself. As we've mentioned previously, you, as a residential counselor, will guide and mentor youth through this process. While you may not always have all of the answers, helping youth know how to access information to get answers can be helpful. In this section we will discuss many of the things that youth need to know to adequately care for themselves.

Slide 26



Congratulations! You have completed Part 6 of the RCYCP Module 4 Training. Please use the navigation below to open the next section of the training.

Slide 2



Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 4, Part 7 of the Residential Child and Youth Care Practitioner Training.

Slide 3

Daily Living Skills: Self-Care

Let's begin with knowing and understanding the legal consequences of unlawful behaviors. Youth, for example, should know that there are legal consequences for illegal behavior. If they shoplift something from a store, they will be arrested and face charges. If they speed while driving they will likely get a ticket. They should also:

- Know what to do and whom to call if they are a victim of a crime.
- Know what the term "underage" means.
- Know which behaviors are criminal and can be punished under the law.
- Know which traffic violations can result in a traffic ticket or arrest for a minor.
- Know how to get a lawyer if they should ever need one, whether they have money for legal services or not.
- Understand what their legal rights are and what to do if they are ever questioned by the police or arrested.
- Know at what age it is legal to get married and what tests and forms have to be completed first.
- Know that shoplifting or stealing is considered larceny, regardless of how small the theft.
- Understand how the court system works.

Slide 4

One of the best resources for learning about laws in the State of Maryland that affect youth is:
http://www.peoples-law.org/categories/4486/2

Another helpful website is hosted by Maryland Legal Aid, an organization that provides free civil legal services in Maryland to qualified people:
http://www.mdlab.org/

Here are two more websites that provide information and resources to Marylanders who need legal assistance:
http://mlsc.org/legal-help/

http://www.anasys-apr.com/probono/MLSCProviders.pdf

Slide 5

Let's move on to personal hygiene.

Discussing hygiene with kids in a way that is helpful can be tricky, but is important. Kids with poor hygiene face consequences. Some are medical: they may be more prone to developing rashes and infections. But equally important, they may quickly become known at school for being dirty. A reputation for poor hygiene can be hard to shake and damaging to self-esteem (Griffin, 2013).

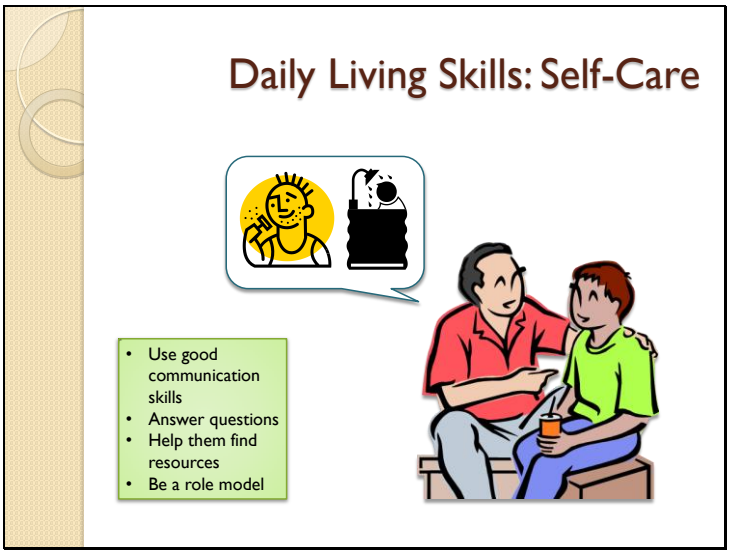
[From Griffin, M. R. Teen hygiene tips. WebMD Feature. Retrieved 9 September 2013 from: http://www.webmd.com/parenting/features/teen-hygiene]

Slide 6

So what constitutes good hygiene?

- Showering. Once puberty hits, showering every day becomes essential to prevent odor. Washing hair. Some might choose to wash their hair on a daily basis. Others might prefer to skip days.
- Using deodorant or antiperspirant. Even before a child hits puberty, the sweat glands become more active and body odor becomes stronger. Using deodorant or an antiperspirant should become part of their daily hygiene.
- Changing clothes. With the onset of puberty, it becomes necessary to wear clean clothes daily so as to prevent odor issues. That includes underwear, socks, shirt etc.
- Preventing acne. As kids approach puberty, they can help to minimize acne by washing their face twice a day. They might also choose to use over-the-counter soaps, lotions, or topical medications geared to prevent or treat acne.
- Shaving and hair removal. Once again, as kids approach puberty they are likely to notice increasing amounts of hair that they are interested in removing – for males it is facial hair, for females it may be leg hair and underarm hair. Girls may also be interested in tweezing facial hair (such as eyebrows). Both genders may need lessons in proper shaving techniques.
- Maintaining good oral health. Twice-daily brushing and daily flossing are crucial for maintaining good hygiene. Brushing and flossing are important to prevent tooth decay, tooth discoloration, as well as to prevent bad breath.

Slide 7



So how can you help them? Most kids are receptive to advice about good hygiene because they have a vested interest in succeeding socially. Others, however, might pay less attention to hygiene issues and may need more guidance from you.

Remember to use good communication skills and empathy when discussing such issues with youth. Answer questions they might have, or help them find resources, such as pediatricians, to answer their questions. It can be helpful to have females talk to females about hygiene, and males talk to males. Be a strong role model and practice good hygiene yourself. Hygiene discussions can involve larger groups of youth in a manner that indicates that good hygiene practices are an important responsibility for everyone. Be sure to avoid singling anyone out for poor hygiene. That can be both embarrassing and hurtful.

Slide 8

Part of Self-Care is learning how to stay healthy.

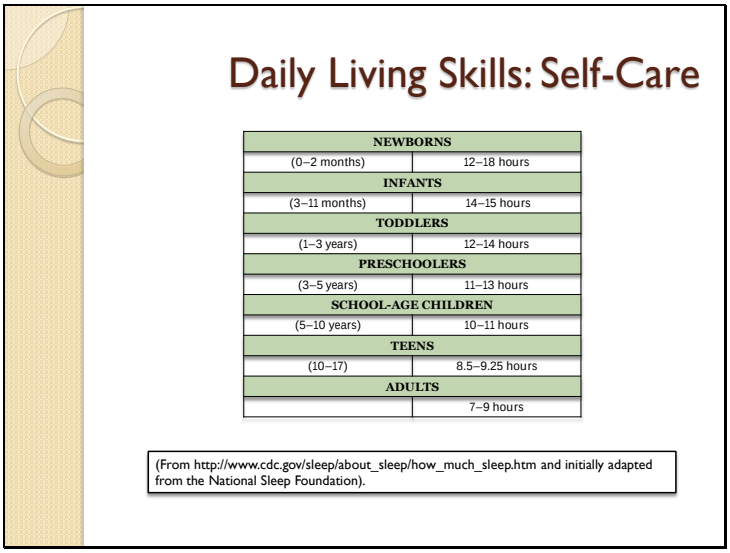
Staying healthy is best accomplished through:

Exercise: According to the Centers for Disease Control and Prevention, children and adolescents should have 60 minutes or more of physical activity each day, with the majority of that time being aerobic activity, such as brisk walking or running. They should also do muscle strengthening exercises (such as push-ups and sit-ups), as well as bone-strengthening activities (such as running or jumping rope).

Nutrition: Eating healthy is the key to maintaining good physical and emotional health. For a review of healthy eating, please refer back to the nutrition section in life skills.

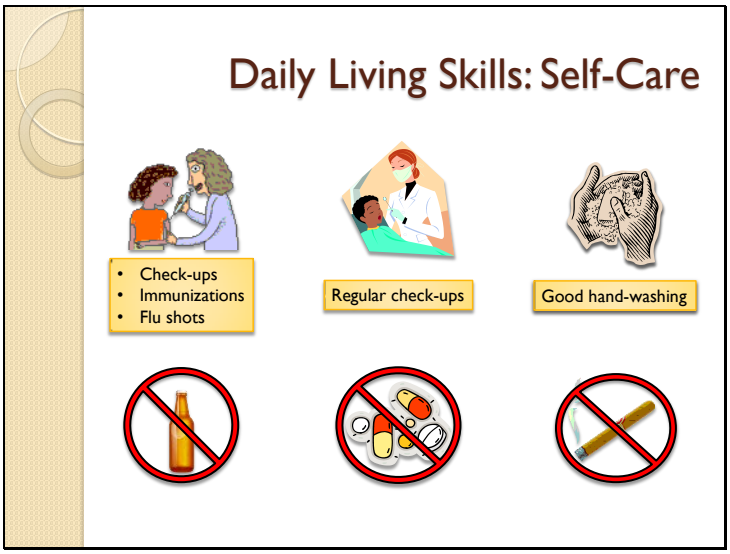
Sleep: According to the National Sleep Foundation, although individual sleep needs vary, each age group has a target range for how much sleep they need. Click on the next slide to see what is considered a “good night’s sleep” for your residents.

Slide 9



According to the National Sleep Foundation, this chart is a good guide for how many hours of sleep different age groups need per night.

Slide 11



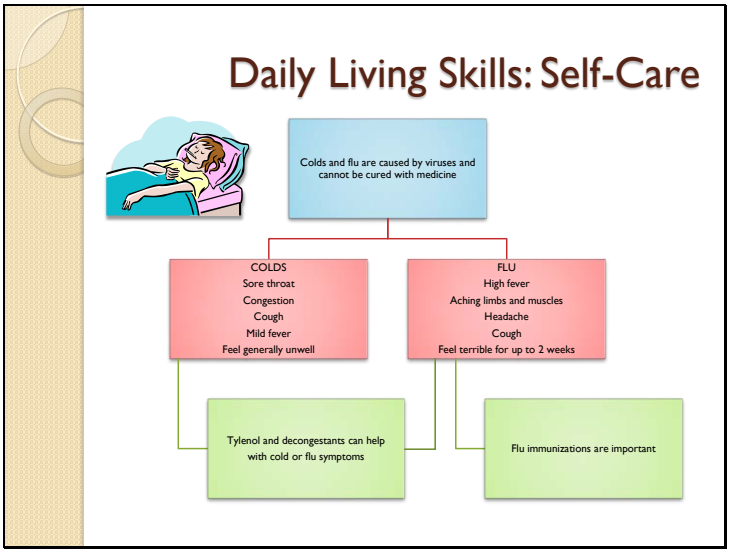
Staying healthy is also accomplished by:

- Going to the doctor for regular check-ups: Annual well visits to the doctor are important to maintain health, as well as stay up to date on immunizations, flu shots and the like. Doctors now do cholesterol screenings as well.
- Going to the dentist for regular check-ups: Youth should be going to the dentist every six months for cleanings and well-checks to maintain good oral health.
- Refraining from substance use (drinking, drugs)
- Refraining from smoking
- Practicing good hand-washing and doing it when appropriate

Slide 12

We know the ways to stay healthy; inevitably, however, we get sick. One important life skill for older youth is the ability to care for themselves when they have a minor illness. Are they aware of common health problems like colds, flu, and stomach viruses, and how to care for themselves when they have a minor illness? What are situations or circumstances that would lead them to contact a doctor or go to the hospital?

Slide 13

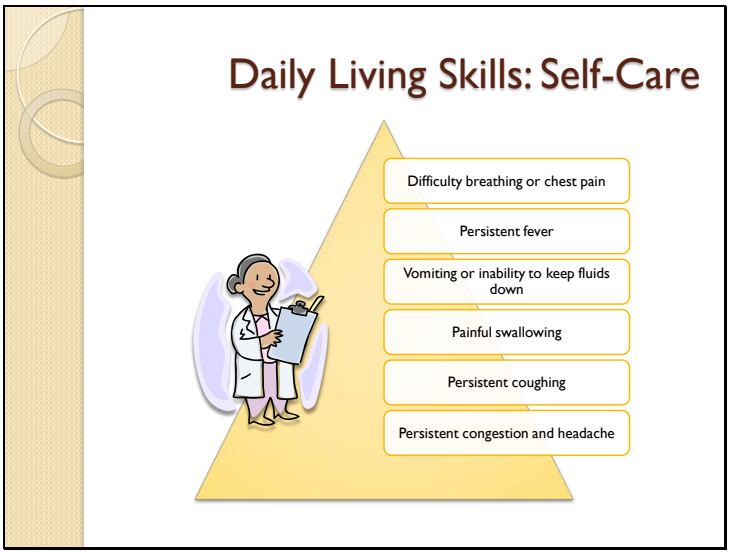


Here is what you can help them learn:
It is inevitable that people will get colds or the flu during the year. They are caused by viruses and cannot be cured with medicine. With colds, people will have a sore throat, congestion, cough, mild fever, and feel generally unwell. The flu is a seasonal viral infection that generally makes people feel terrible for up to two weeks. People will have a high fever, aching limbs and muscles, headache, and cough. Flu immunizations are important to help people avoid the flu. Over the counter medicines such as Tylenol and decongestants can help with cold or flu symptoms.

Slide 15

- Additionally, youth can take care of themselves when they are sick by:
- Getting rest to help their body fight the illness.
- Drinking fluids to stay hydrated, like water, chicken broth, and tea with honey and lemon. Hot liquids especially can help relieve nasal congestion, help prevent dehydration, and soothe the nose and throat.
- Using humidifiers – either warm or cool moist mist -- in their rooms at night.
- Gargling with warm salt water, which can soothe sore throats.

Slide 16



There are times when people will need to see a doctor for the cold or flu. Once again, you as a counselor can help educate the youth in your care about when to see a doctor for the cold or flu. They should contact a doctor if they have:

1. Difficultly Breathing or Chest Pain:
Aside from a stuffy nose and some general muscle aches, a cold or the flu should not make people short of breath or cause pain in the chest. These could be symptoms of a more serious problem. People who have these symptoms should contact a doctor or go to the emergency room.

2. Persistent Fever:
A fever that won't go away can be a sign of a secondary infection that should be treated.

3. Vomiting or Inability to Keep Fluids Down:
People's bodies need to stay hydrated. If people are unable to keep fluids down due to illness, they will need to see a doctor or go to the hospital to receive fluids intravenously.

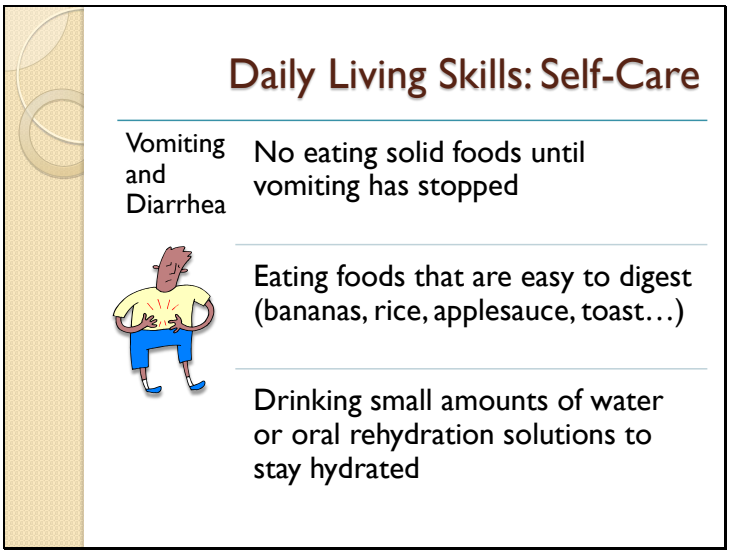
4. Painful Swallowing:
Although minor discomfort when you swallow can come from a sore throat, severe pain is not normal and can be a sign of an infection or injury that needs to be treated by a doctor.

5. Persistent Coughing:

When a cough won't go away for two to three weeks, a call or visit to the doctor is warranted. It is possible there is another cause for the cough, or the doctor may want to try to treat it with medication.

6. Persistent Congestion and Headache:
Colds and allergies that cause congestion and blockage of the sinus passages can lead to a sinus infection. If these symptoms are present, people should contact their doctor for a visit.
(From: http://www.webmd.com/cold-and-flu/when-see-doctor)

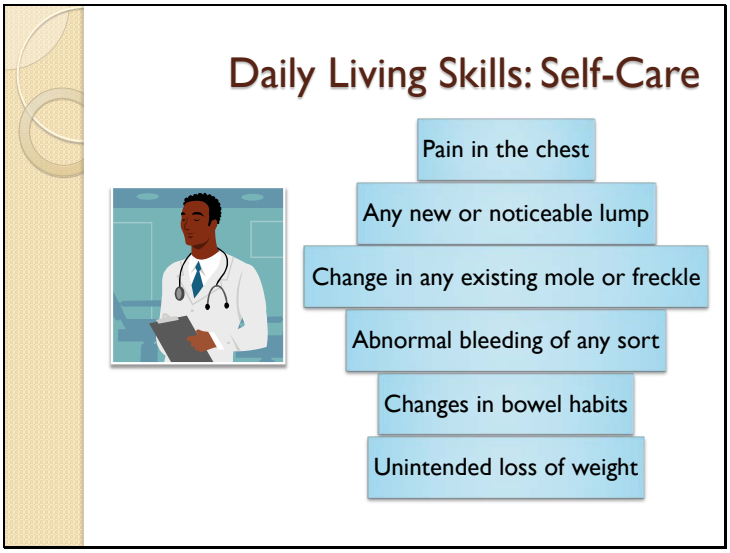
Slide 17



Vomiting and diarrhea are typically the result of a viral infection, and occasionally a food-borne illness. Typically, people can treat vomiting and diarrhea themselves by:

- No eating solid foods until vomiting has stopped, and then eating foods that are easy to digest, such as bananas, rice, applesauce, and toast.
- Drinking small amounts of water or oral rehydration solutions to stay hydrated.
- People should contact a doctor if they are unable to stay hydrated, or if vomiting persists for several days.

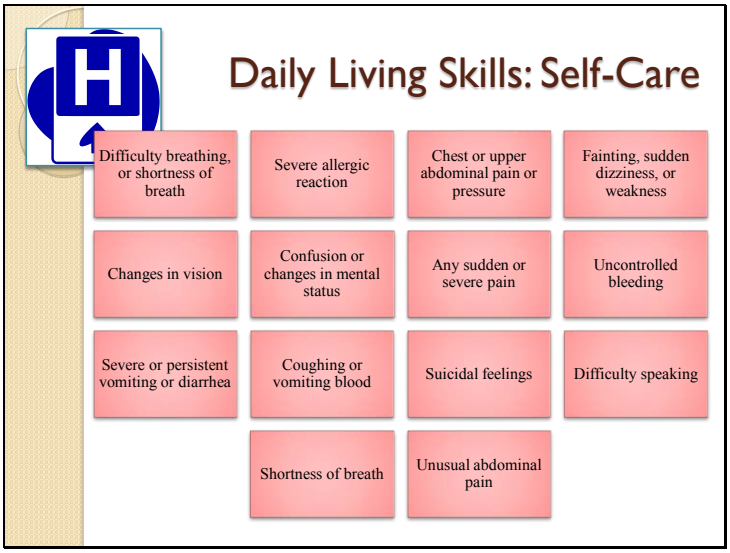
Slide 18



Other symptoms that warrant a call to the doctor include:

- Pain in the chest, especially if associated with exercise.
- Any new or noticeable lump, anywhere on the body.
- Change in any existing mole or freckle.
- Abnormal bleeding of any sort.
- Changes in bowel habits.
- Unintended loss of weight.

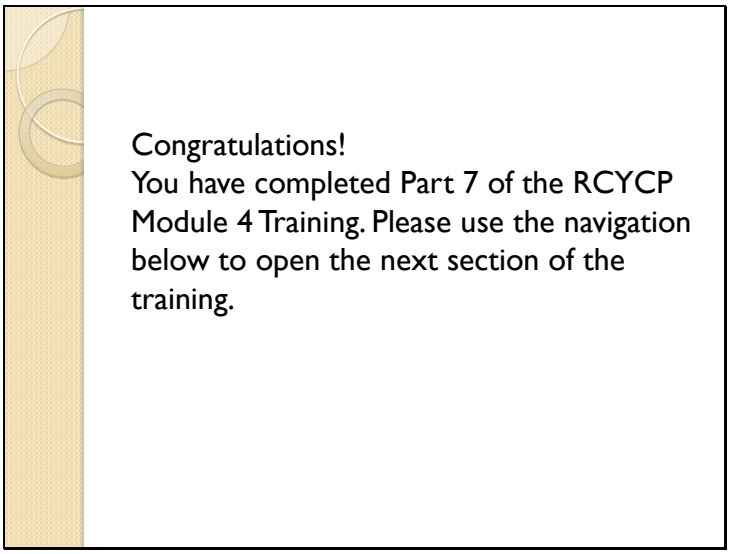
Slide 19



What happens if an illness or injury is not minor? How can someone tell that this is the case, and what should he or she do? The following are some of the conditions that require a trip to the emergency room, according to the American College of Emergency Physicians:

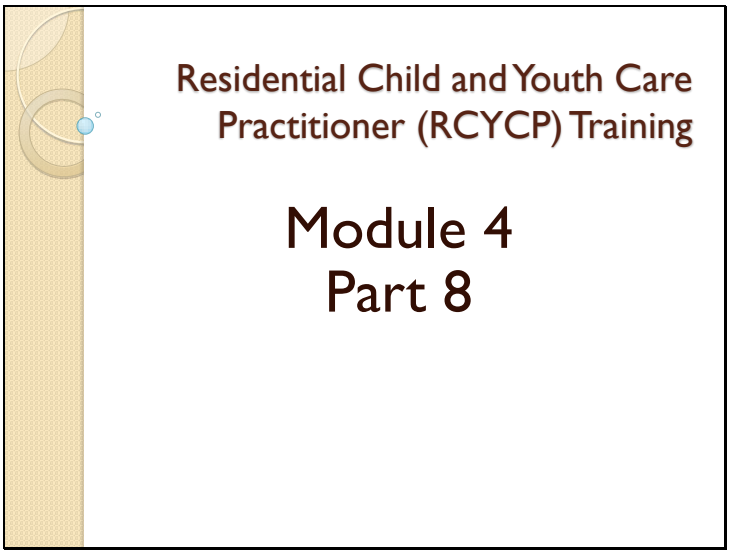
- Difficulty breathing, or shortness of breath
- Severe allergic reaction
- Chest or upper abdominal pain or pressure
- Fainting, sudden dizziness, or weakness
- Changes in vision
- Confusion or changes in mental status
- Any sudden or severe pain
- Uncontrolled bleeding
- Severe or persistent vomiting or diarrhea
- Coughing or vomiting blood
- Suicidal feelings
- Difficulty speaking
- Shortness of breath
- Unusual abdominal pain

Slide 21



Congratulations! You have completed Part 7 of the RCYCP Module 4 Training. Please use the navigation below to open the next section of the training.

Slide 2



Residential Child and Youth Care Practitioner (RCYCP) Training

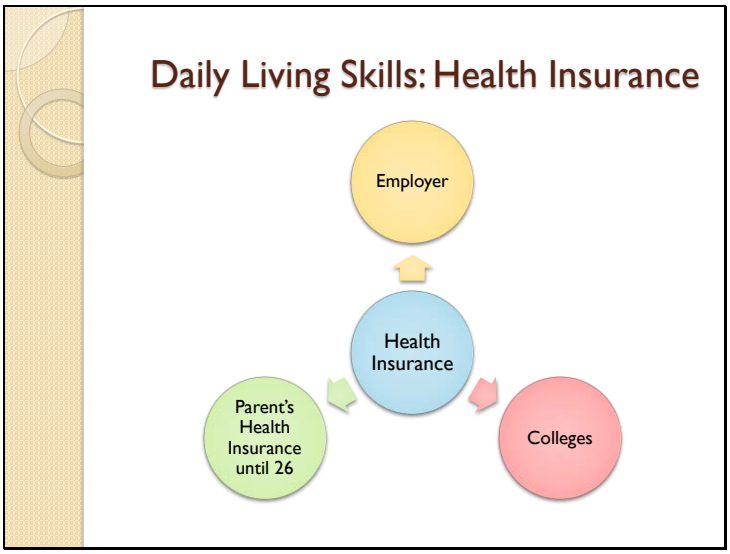
Welcome to Module 4, Part 8 of the Residential Child and Youth Care Practitioner Training.

Slide 3

Daily Living Skills: Health Insurance

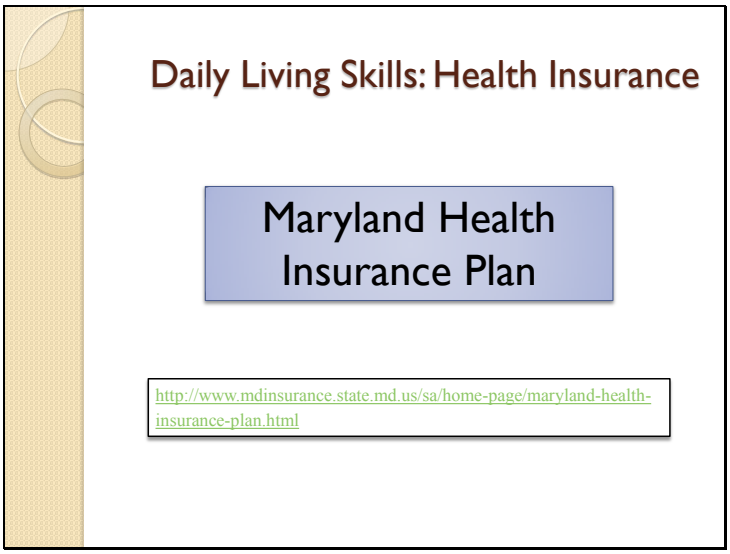
Now that you have helped your residents learn how to care for themselves when they are sick, we can talk about paying for medical care. So how do people pay for their medical care? Taking good care of one's health is very important. However, health care costs are rising steadily, and the cost of medical care for a serious injury or illness can be extremely high if people are not covered by health insurance.

Slide 4



Most people obtain health insurance – that is, financial coverage for ongoing and unexpected medical expenses -- through their employers. Most often, people are eligible for employee health insurance if they work full time. Certain students can get insurance, too. Colleges will often offer basic health insurance to students, sometimes included in their tuition. Some individuals may be covered on a parent's health insurance up to the age of 26.

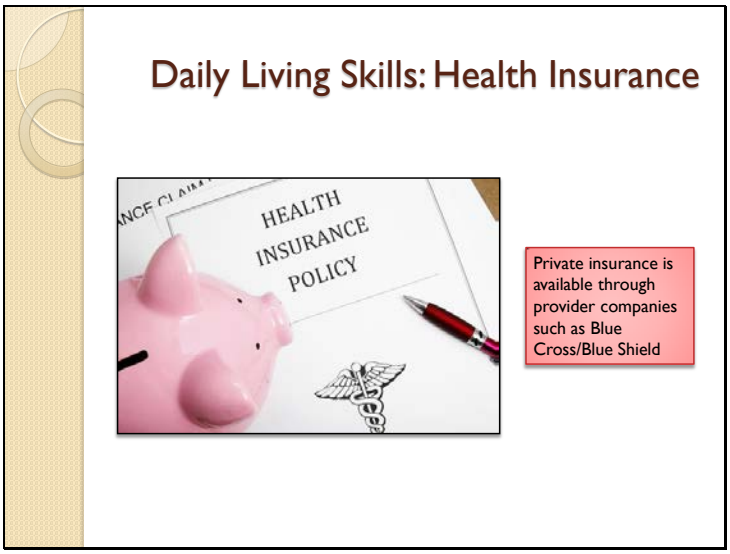
Slide 5



For those people who are not on their parent's health insurance, employed full-time, or receiving student health insurance, states often have health insurance programs. For example, The Maryland Health Insurance Plan is a state-administered health insurance program for Maryland residents who do not have access to health insurance.

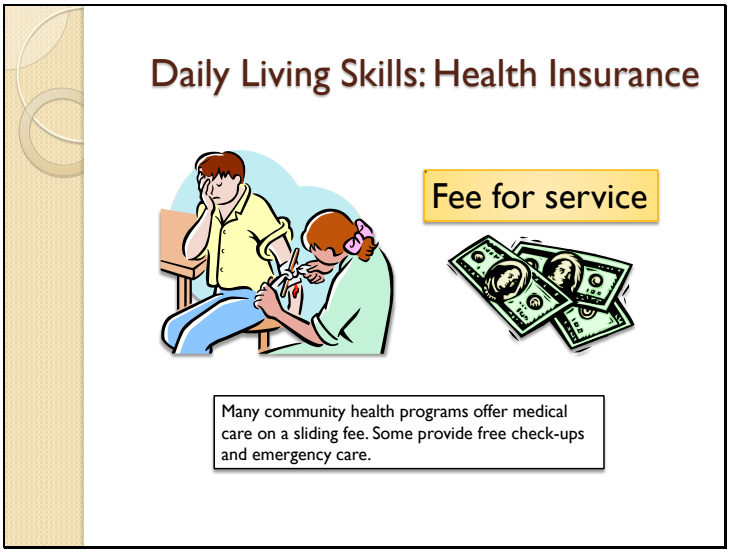
More information about the Maryland Health Insurance Plan is available at this website: http://www.mdinsurance.state.md.us/sa/home-page/maryland-health-insurance-plan.html

Slide 6



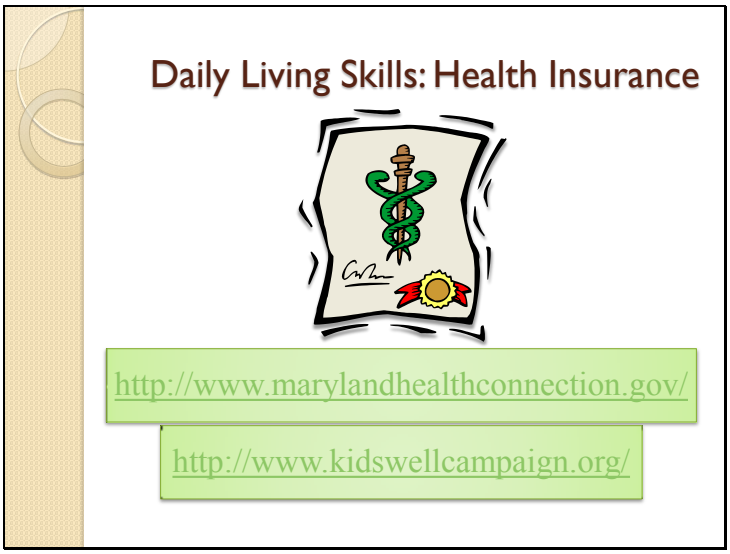
For people who are not eligible for state insurance, who don't go to college, who don't work full-time for one employer, or who are not covered on parent insurance, private insurance is available through provider companies such as Blue Cross/Blue Shield, although coverage can be expensive.

Slide 7



If none of the options listed above are viable possibilities for individuals, then they will have to pay for doctor's visits and health care facilities themselves. Thankfully, many community health programs offer medical care on a sliding-fee basis. This means that the fee for services is based on income. Some even provide free check-ups and emergency care in certain locations.

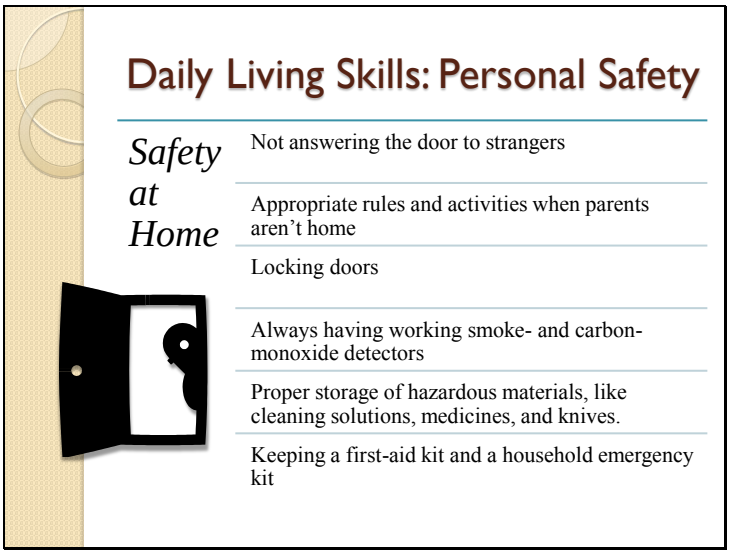
Slide 8



Obtaining and using health insurance can be confusing and overwhelming. You can help the youth you work with most by helping them to understand the process of obtaining health insurance and how it works generally, as well as guide them to resources that can provide additional information and assistance. Another couple of great resources for Marylanders are:

- http://www.marylandhealthconnection.gov/
- http://www.kidswellcampaign.org/

Slide 9



Daily Living Skills: Personal Safety

While obvious and fairly universal personal safety guidelines exist -- like, "don't take rides from strangers" -- there is no complete list of every safety rule young people need to know, and what may be considered safe for one person can vary for others, depending on circumstances and situations. In general, you will want to get youth thinking about the following:

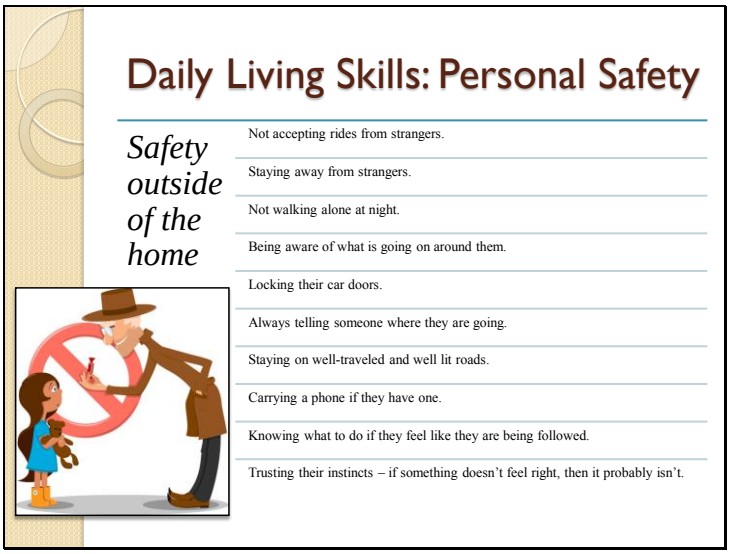
- Safety at home
- Not answering the door to strangers
- Appropriate rules and activities when parents aren't home
- Locking doors
- Always having working smoke- and carbon-monoxide detectors
- Proper storage of hazardous materials, like cleaning solutions, medicines, and knives.
- Keeping a first-aid kit and a household emergency kit

Slide 10

Let's talk about another way youth will need to take care of themselves: personal safety.

Personal safety ranges from simply feeling safe in one's environment to the steps an individual takes to ensure that he or she feels protected from, or not exposed to, danger or risk. Learning how to keep oneself safe is a learning process that begins when children are young (for example, learning not to put their fingers in an electrical outlet), and continues throughout young adulthood (for example, learning to keep themselves safe at social gatherings where alcohol is involved). As an RCYCP, you are, once again, in a position to help guide them to think about, and make choices, that keep them safe.

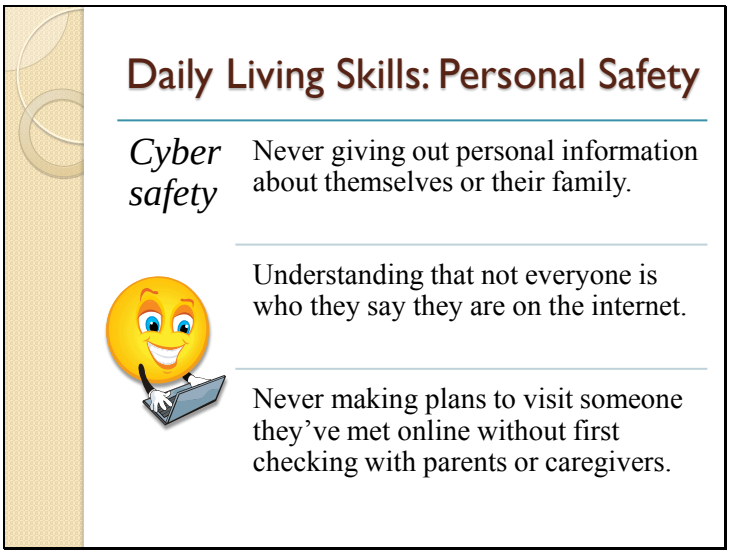
Slide 11



Safety outside of the home:

- Not accepting rides from strangers.
- Staying away from strangers.
- Not walking alone at night.
- Being aware of what is going on around them.
- Locking their car doors.
- Always telling someone where they are going.
- Staying on well-traveled and well lit roads.
- Carrying a phone if they have one.
- Knowing what to do if they feel like they are being followed. For example, they might cross the street, go to a more populated area, enter a store or other public place, or go to the home of someone they know to make themselves less vulnerable.
- Trusting their instincts – if something doesn't feel right, then it probably isn't.

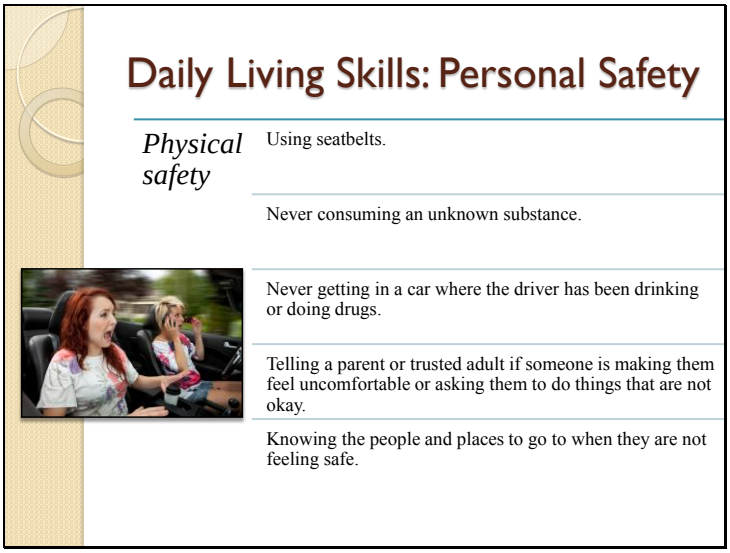
Slide 12



Cyber safety:

- Never giving out personal information about themselves or their family.
- Understanding that not everyone is who they say they are on the internet – predators often pretend to be someone they are not.
- Never making plans to visit someone they've met online without first checking with parents or caregivers.

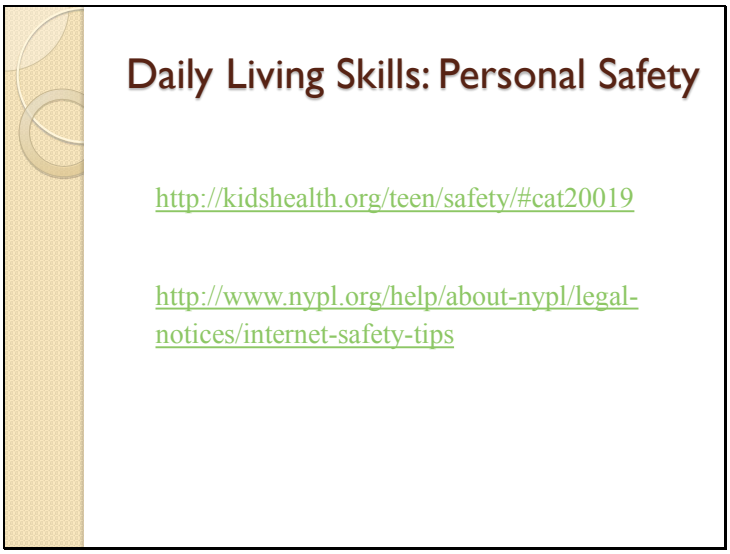
Slide 13



Physical safety:

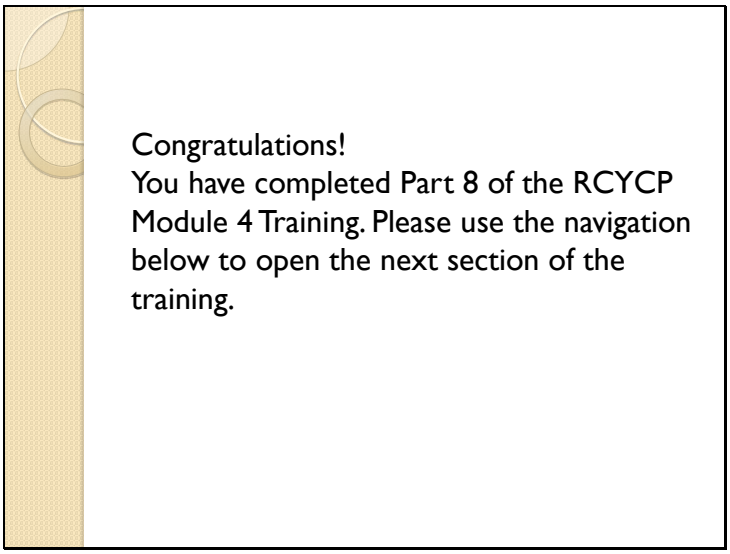
- Using seatbelts.
- Never consuming an unknown substance.
- Never getting in a car where the driver has been drinking or doing drugs.
- Telling a parent or trusted adult if someone is making them feel uncomfortable or asking them to do things that are not okay.
- Knowing the people and places to go to when they are not feeling safe.

Slide 14



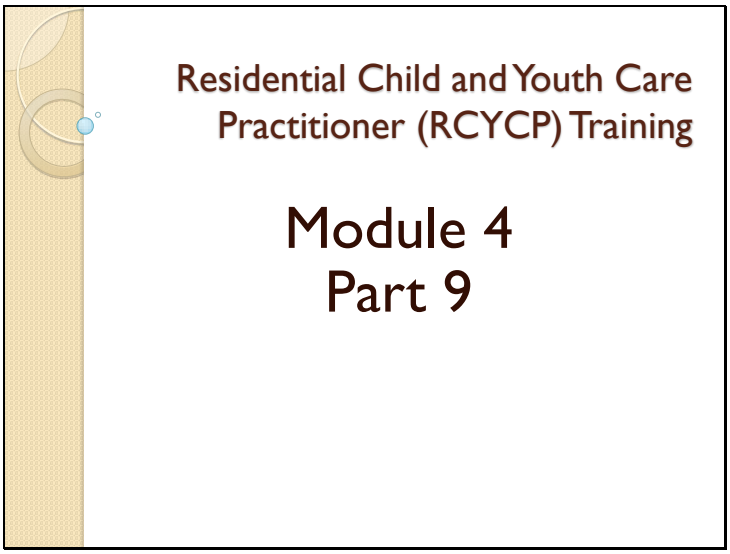
Some great resources are:
http://kidshealth.org/teen/safety/#cat20019
Internet Safety Tips for Children and Teens:
http://www.nypl.org/help/about-nypl/legal-notices/internet-safety-tips

Slide 16



Congratulations! You have completed Part 8 of the RCYCP Module 4 Training. Please use the navigation below to open the next section of the training.

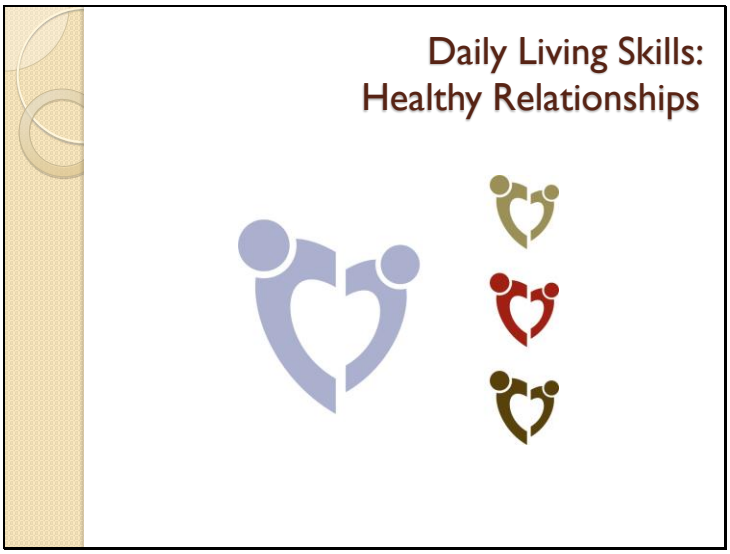
Slide 2



Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 4, Part 9 of the Residential Child and Youth Care Practitioner Training.

Slide 3

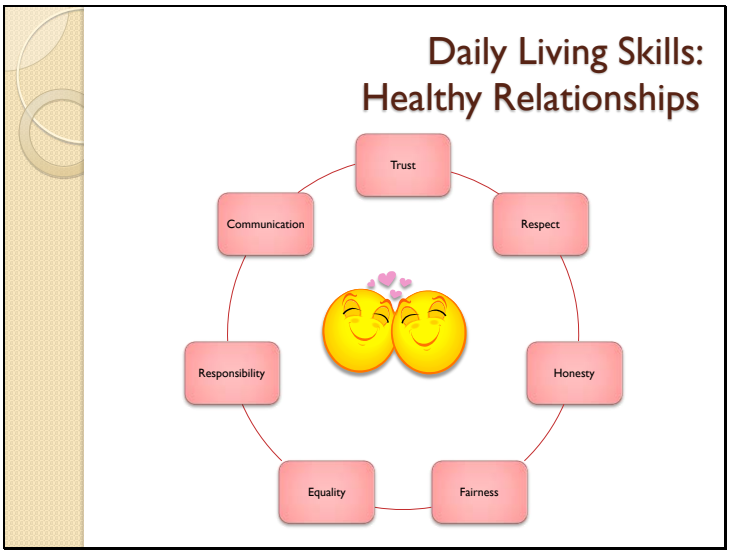


Daily Living Skills: Healthy Relationships

Let's talk about healthy relationships now.

Many of the youth you work with have had turbulent family lives. Many have witnessed violence and unhealthy relationships. Because of this, helping youth learn what healthy relationships look like will be important for their future success in the world.

Slide 4



So what is a healthy relationship? Healthy relationships are based on trust, respect, honesty, fairness, equality, responsibility, and open communication. People in a healthy relationship are kind, trusting, respectful, and caring. The relationship makes the people involved feel safe and good about themselves.

People in a healthy relationship are able to work through disagreements without worrying about their safety. Each feels that their own needs are being taken into account, just as they take their partners' needs into account.

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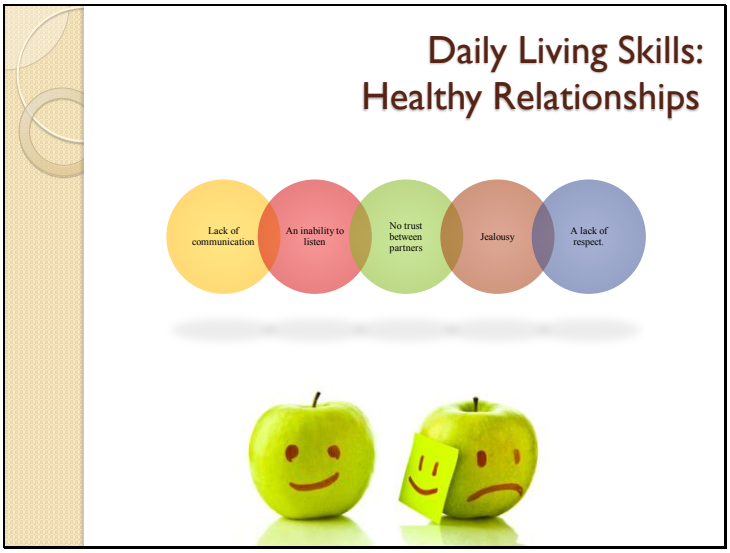

People involved in an unhealthy relationship are jealous, deceitful, and hurtful. Unhealthy relationships make people feel bad – in general and about themselves.

Sometimes relationships don't work out. The danger signs of an unhealthy relationship should be easily recognizable: lack of communication, an inability to listen, no trust between partners, jealousy, and a lack of respect.

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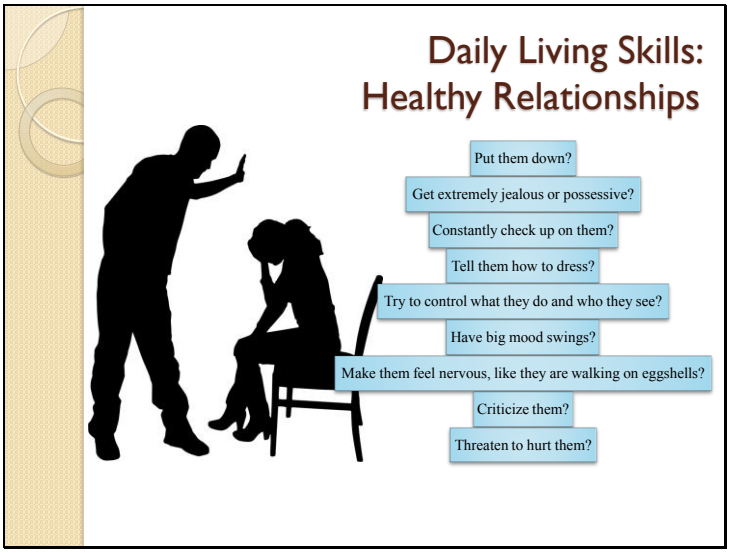


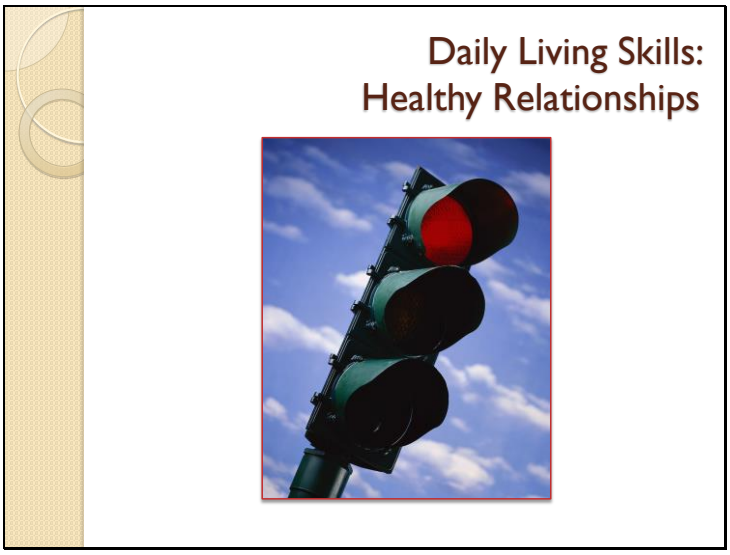
Here are some other danger signs to pay attention to:

Does the other person:

- Put them down?
- Get extremely jealous or possessive?
- Constantly check up on them?
- Tell them how to dress?
- Try to control what they do and who they see?
- Have big mood swings?
- Make them feel nervous, like they are walking on eggshells?
- Criticize them?
- Threaten to hurt them?

(From: http://www.pamf.org/teen/abc/unhealthy/dangersigns.html)

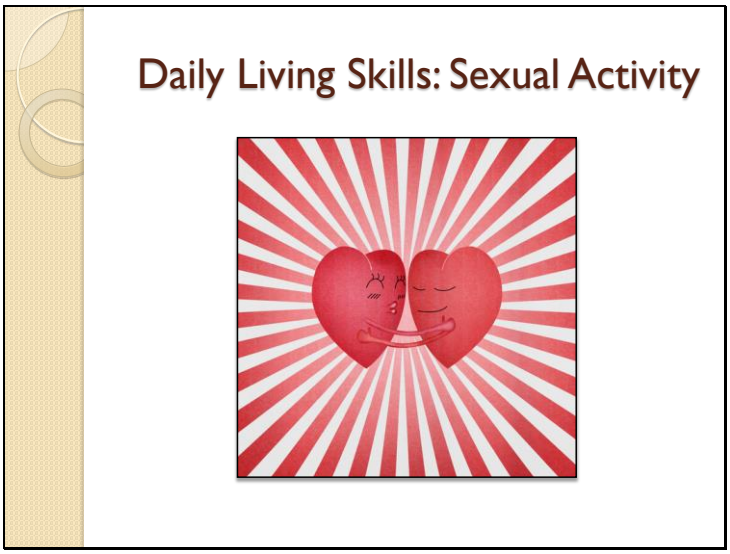
Slide 7



Abuse always escalates, and it rarely gets better. Knowing these warning signs can help act as red lights in a relationship.

Not all of these signs will be in every abusive relationship. If one or more of these warning signs exist in a relationship, it doesn't necessarily mean that the relationship is abusive, but it may not be as healthy as it could be.

Slide 8



Daily Living Skills: Sexual Activity

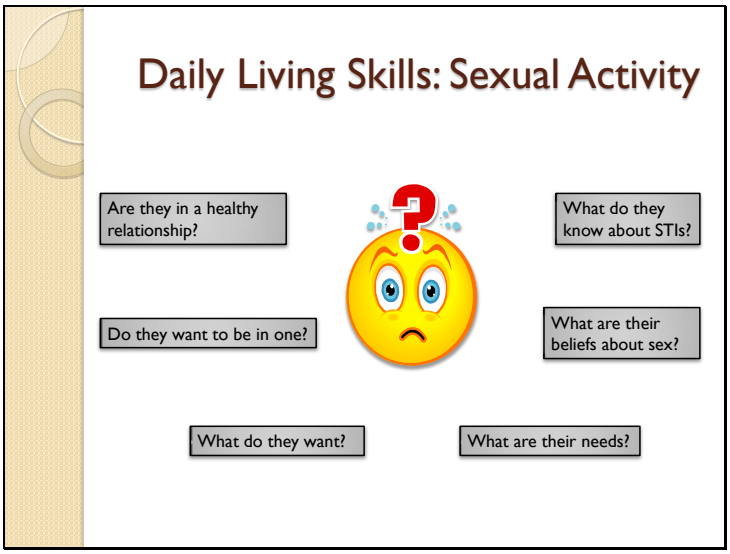
For many, even a healthy, stable relationship can be tested when important decisions come into play. Youth who are entering romantic relationships will have to make decisions about sexual activity.

Adolescence is a time of sexual awakening. As young people reach their teen years, they will discover a whole new range of sexual interests, feelings, and urges due to the maturation of the sexual and reproductive systems in their bodies. They will become aware of their own sexual orientation, which most psychologists agree has been set since the age of five or six, and they will experience sexual attraction based on that orientation. The issues of relationships and sexuality are very complex. Teenagers will face important decisions about relationships and intimacy that will have a great impact on the rest of their lives. They have to be prepared to for these decisions, and you have to be prepared to help them think through the process completely so that they can make decisions that are healthy and right for them.

Slide 9

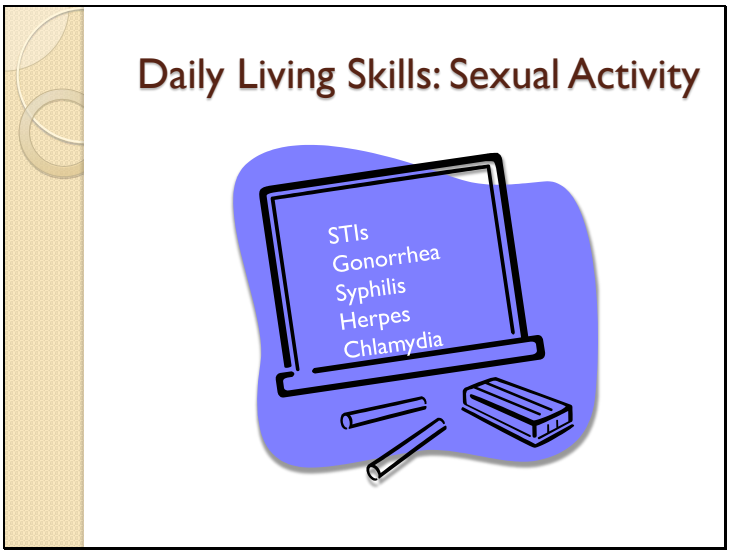
There might be a point during your work with residential youth that you are asked for advice about sexual activity. Your job is not to tell an individual whether or not to have sex, but rather to offer guidance in relating the important issues that should factor into their decision making, such as healthy relationships, sexually transmitted infections, and birth control. It will also be important to provide resources to youth who are making decisions about sexual activity.

Slide 10



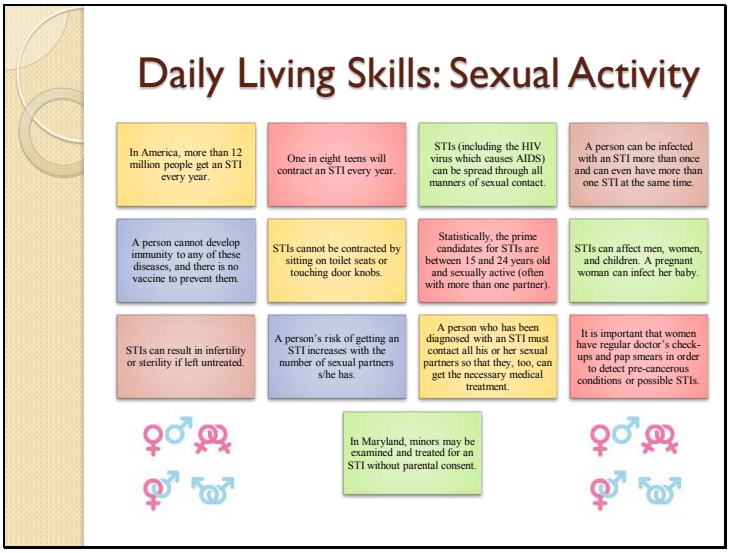
So assuming you have youth wanting to discuss this with you, are they in a healthy relationship? Do they want to be in one? What do they want? What are their needs? What are their beliefs about sex? Would they agree that “positive sexual experiences are those that are consensual, respectful, and protected” (Palo Alto Medical Foundation Sutter Health)? What do they know about sexually transmitted infections (STIs), birth control, and staying healthy? Here is some information that can help you in talking to them:

Slide 11



Sexually Transmitted Infections (STIs) are one of the risks people run when they have sex without the proper protection. There are a number of serious diseases that are spread by sexual contact -gonorrhea, syphilis, herpes, chlamydia, etc. Many of them can be quickly and efficiently cured by a doctor or clinician, but become quite dangerous if they are not treated.

Slide 12



Here are some facts people should know about STIs:

- In America, more than 12 million people get an STI every year.
- One in eight teens will contract an STI every year.
- STIs (including the HIV virus which causes AIDS) can be spread through all manners of sexual contact. In terms of sexually transmitted infections, sexual contact is described as any kind of intimate contact involving these four areas of the body: penis, vagina, mouth, or anus.
- A person can be infected with an STI more than once and can even have more than one STI at the same time. Treatment for an STI does not make someone immune from getting it again.
- A person cannot develop immunity to any of these diseases, and there is no vaccine to prevent them. In the case of herpes, the disease is permanent and there is no cure.
- STIs cannot be contracted by sitting on toilet seats or touching door knobs. Most STIs need to occupy warm, moist places to survive, which is why they affect the areas they do and will not last long outside of/away from the human body.
- Statistically, the prime candidates for STIs are between 15 and 24 years old and sexually active (often with more than one partner).
- STIs can affect men, women, and children. A pregnant woman can infect her baby.
- STIs can result in infertility or sterility if left untreated. It is important to get treatment even if the symptoms of the STI go away. The STI will remain transmissible and may continue to affect the body until it has been treated. No STI will go away by itself.
- A person's risk of getting an STI increases with the number of sexual partners s/he has.
- A person who has been diagnosed with an STI must contact all his or her sexual partners so that they, too, can get the necessary medical treatment.

- Symptoms of STIs may not always be noticed.
- It is important that women have regular doctor's check-ups and pap smears in order to detect pre-cancerous conditions or possible STIs.
- In Maryland, minors may be examined and treated for an STI without parental consent.

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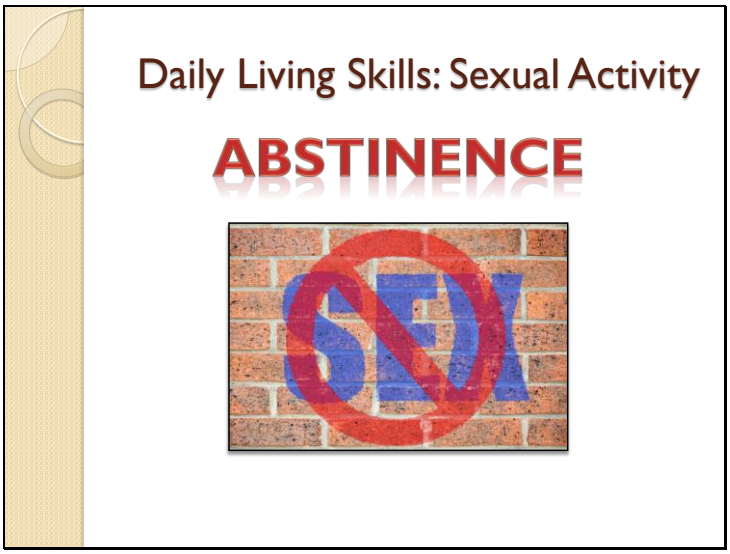
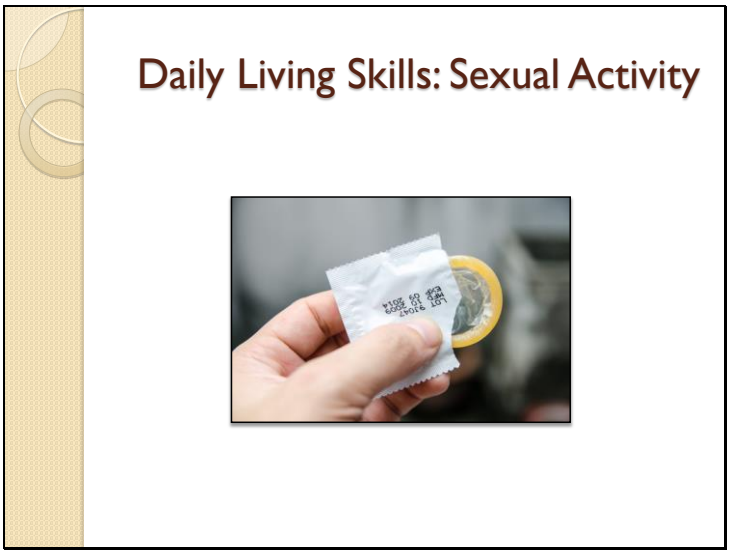


There is only one sure way to protect oneself against the risk of infection, and that is to have no sexual contact. Abstinence is the surest, safest, and most effective method of prevention. However, if people are going to have sex, they must protect themselves. While there is no guaranteed method of preventing STIs, there are some recommendations to lower risk of infection, especially if used in combination.

Slide 14



- A male should use a latex condom (a “rubber” or “skin”) during sexual intercourse, oral sex, and other forms of foreplay. People who are allergic to latex can use a polyurethane (a type of plastic) condom.
- A female can use the vaginally-inserted female condom OR insist that her male partner use a latex condom. The male and female condoms should not be used at the same time – they pull each other off.
- A dental dam (a square piece of latex used by dentists), or plastic food wrap should be used when performing oral sex on a female. Do not reuse these items.
- A male should urinate and wash his genitals with hot, soapy water immediately before and following sex.

Slide 15

This is not the time to be shy. Young adults (under age 25) are quickly becoming the fastest growing at-risk age group, currently accounting for up to 50% of all new cases of HIV infection in the U.S. It is a good idea for people to talk beforehand with their partners about the type(s) of protection they will both use. If someone refuses to use protection, then their partners can refuse to have sex.
For additional information, the Planned Parenthood website offers information and birth control resources:
http://www.plannedparenthood.org/health-topics/birth-control-4211.htm

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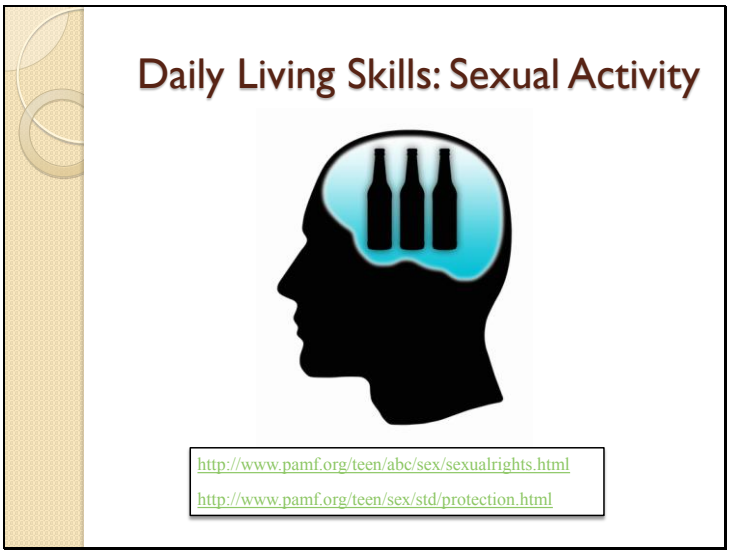

Finally, it is important for youth to know that a major obstruction to good decision making is the use of alcohol or drugs. Under the influence of any substance, individuals cannot think clearly and are much more likely to engage in dangerous behaviors or make unwise decisions which they will regret later.

Some other resources about sex for youth are:
http://www.pamf.org/teen/abc/sex/sexualrights.html
http://www.pamf.org/teen/sex/std/protection.html

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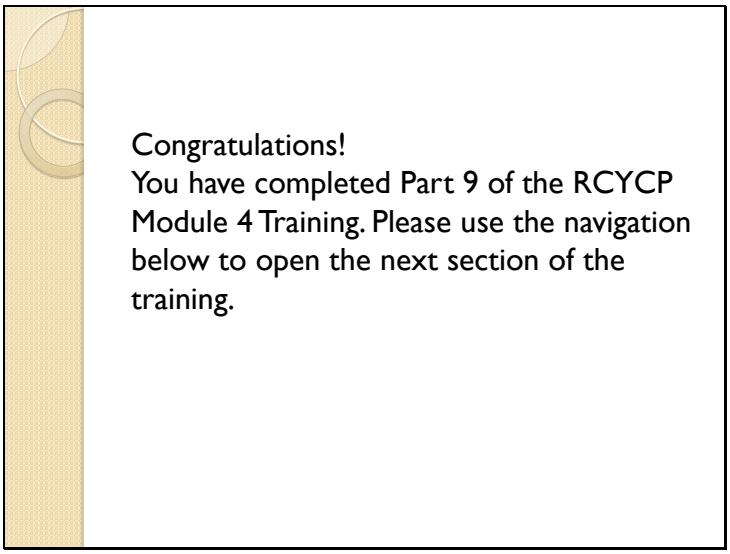

Congratulations! You have completed Part 9 of the RCYCP Module 4 Training. Please use the navigation below to open the next section of the training.

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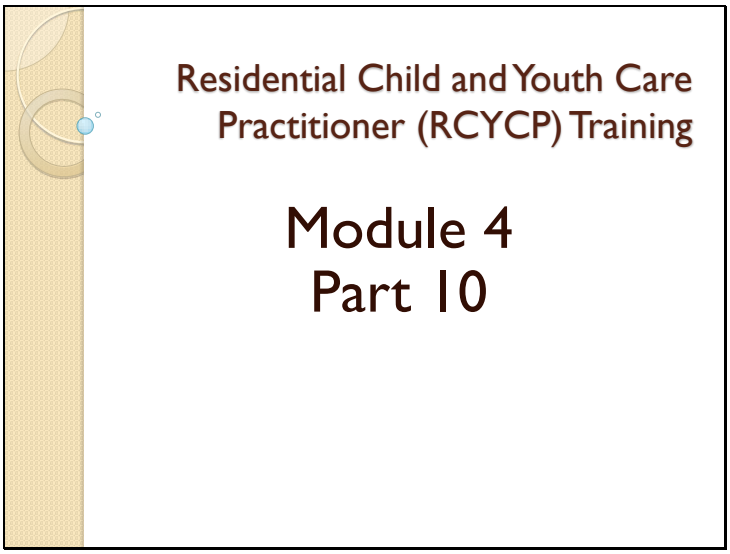
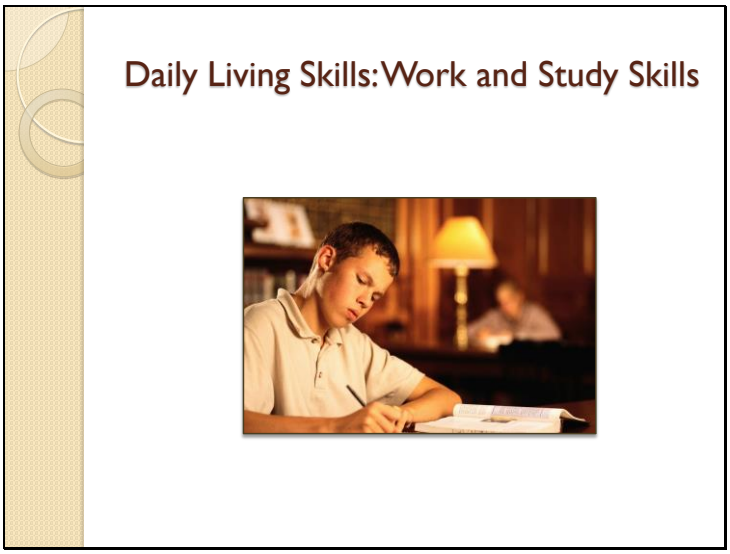


Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 4, Part 10 of the Residential Child and Youth Care Practitioner Training.

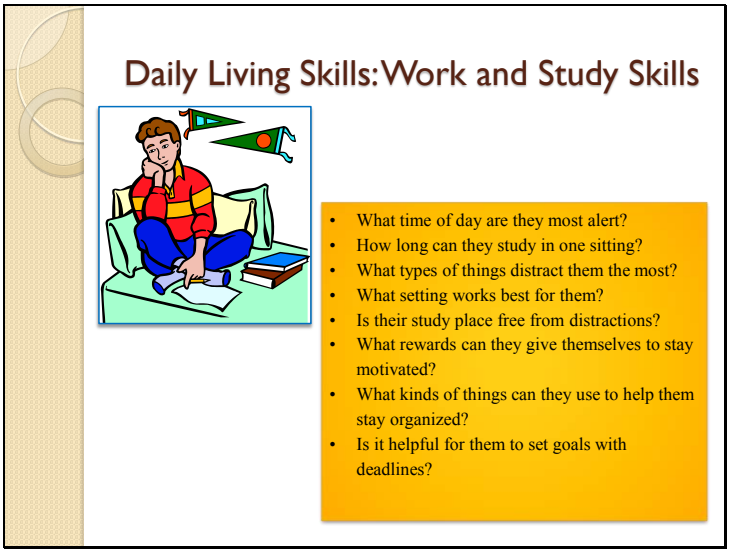
Slide 3



Daily Living Skills: Work and Study Skills

In order to achieve success in work and school, youth need to have good skills. They need to be able to manage their time effectively, as well as develop good study habits. You can support them in these endeavors by helping them figure out what works best for them.

Slide 4



- What time of day are they most alert?
- How long can they study in one sitting?
- What types of things distract them the most?
- What setting works best for them (a library, a bedroom, etc.)?
- Is their study place free from distractions?
- What rewards can they give themselves to stay motivated (a quick walk, a snack, etc.)?
- What kinds of things can they use to help them stay organized (binders, notebooks, index cards, calendars, etc.)?
- Is it helpful for them to set goals with deadlines?

Once they have found out what works best for them, developing a study or work routine can be helpful. Once again, you can help them formulate their plan and stick to it.

Slide 6

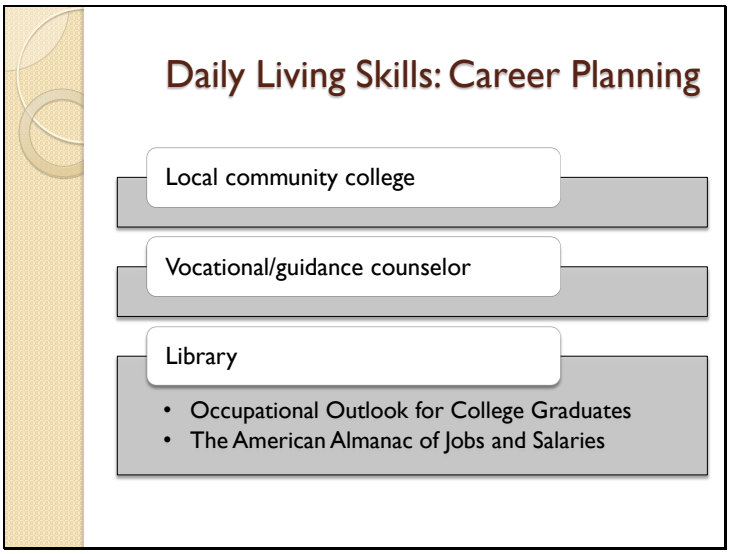
Daily Living Skills: Career Planning

As an RCYCP, you are a mentor of sorts. With older adolescents/teenagers you might be tasked with helping them on an educational or career path. Some ways to engage youth around these sorts of conversations is to find out what kinds of careers they know about and are interested in. What are their skills? What do they enjoy doing or studying? You might help them locate web resources to help identify what types of careers exist. There are also career assessments online that can be helpful.

The Casey Family Programs website has a number of helpful resources for youth: http://www.casey.org/?s=youth

Where do they see themselves in 5 years? In 10 years? What do they want for themselves? These questions might help youth begin to think about careers, if they haven't already.

Slide 7



If there is a local community college nearby, it can be a valuable resource for information on types of vocational and certificate programs they offer. The college catalog contains this information. Also, if you are helping youth who are in high school, you may direct them to their vocational counselor, or guidance counselor for additional resources.

To find about different careers, they can go to the library and use such resources as: Occupational Outlook Handbook: Published by the U.S. Department of Labor, this book describes more than 250 occupations.

The American Almanac of Jobs and Salaries: This publication by Avon Books lists job descriptions and salaries of many jobs.

Occupational Outlook for College Graduates: Also published by the U.S. Department of Labor, this book describes 120 occupations, especially those most suited to college students and graduates.

Slide 8

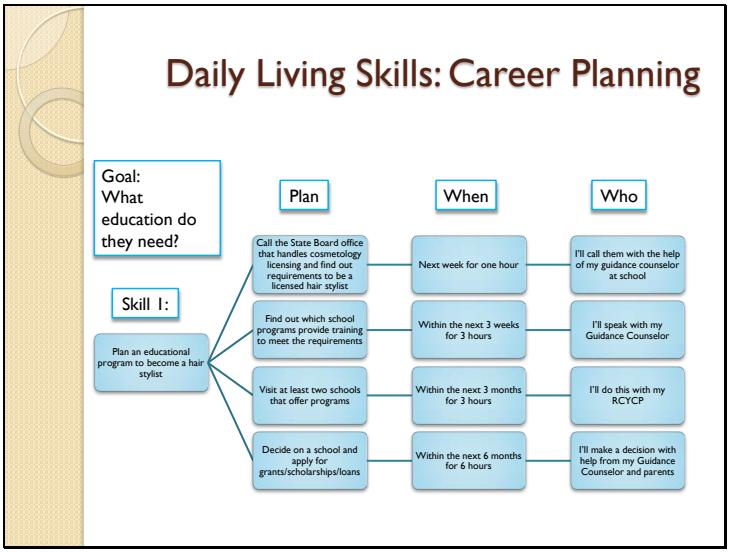
You probably know this already, but education matters! On average, people with more education make more than those with less education. Over a lifetime, individuals with a Bachelor's degree make 84% more money than those with only a high school diploma (Carnevale, Rose, & Cheah, 2011). Even within the same occupation, more education gets workers more money. For example, truck drivers with less than high school earn significantly less than truck drivers with a high school diploma (Carnevale, Rose, & Cheah). Education translates to earning potential and unemployment as well. More education means higher earnings and less chance of being without a job.

Slide 9

As an RCYCP, you can help provide this information to youth so that they understand just how important education is to their later success and can factor it into their decisions about career plans. There are a number of charts/graphs that depict the relation between education and earnings that may be helpful to show youth. You can access some at the website indicated in the slide.

https://cew.georgetown.edu/collegepayoff

Slide 10



Once the teens you work with have identified a career of interest they will need guidance creating a plan of action.

What are their goals in the short-term, mid-term, and long-term? What are the things that need to happen to accomplish their goals? For example, what education do they need? Do they need other things to accomplish their goals (skills, experience, licensure, etc.)? Helping residents think through their goals and come up with a plan to accomplish them will be important.

You can use the example here to help them think through the planning.

Slide 11

Once an individual has developed a career plan he or she might have a better idea about what kind of educational plan he or she needs to be successful in that career. Even if a youth is undecided about a specific career, getting an education is crucial for later opportunities and success. You might help youth by encouraging them to talk to school guidance counselors or vocational counselors. You might help youth in gathering information about different educational opportunities, for example vocational training/certification programs, 2-year colleges, 4-year colleges, or online colleges.

Slide 12

You might also be able to support youth in accessing information about financial aid through scholarships, grants, or loans. Maryland's Department of Higher Education lists out a number of different types of financial aid for students and can be a valuable resource to share with youth. The website address is noted in the slide.

http://www.mhec.state.md.us/financialaid/descriptions.asp

Slide 13

Searching for Employment

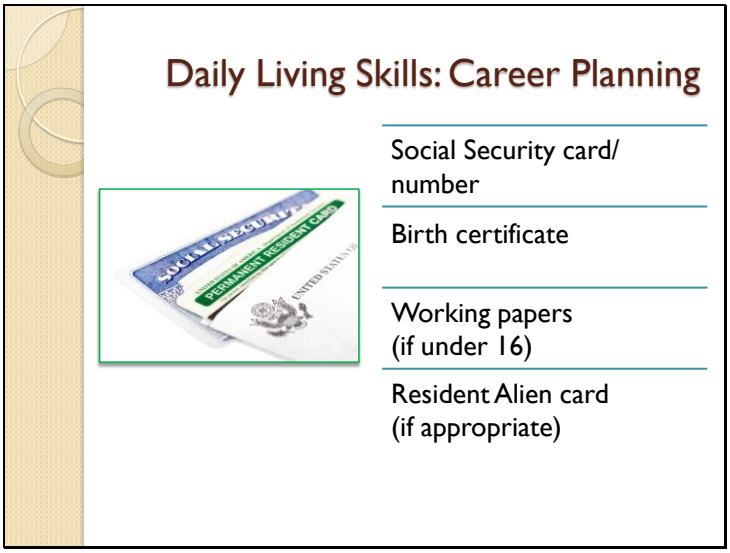
Finding one's very first job can be very exciting and rewarding. However, it might not always be easy. Once again, you, as an RCYCP, are going to be a mentor and sounding board to youth while they work through the challenges of finding employment. Most people have to apply for a job numerous times before becoming employed. That sometimes can be discouraging. Preparing youth for this process, as well as encouraging them along the way, will be helpful.

Slide 14

Job hunting means filling out applications, making telephone calls, going to interviews, etc. It can be a lot of work, but knowing what to expect and having practice answering the questions can make a big difference. If youth are prepared, they will have more self-confidence to do a great job.

What will they do to find a job? Newspapers, telephone calls to various job sites to see if employment is available, community listings, and help-wanted signs are all places to look for jobs. Many businesses, especially stores and restaurants, put help wanted signs in their windows. Guide the youth in keeping a lookout for them, and have them ask friends and relatives to look, too.

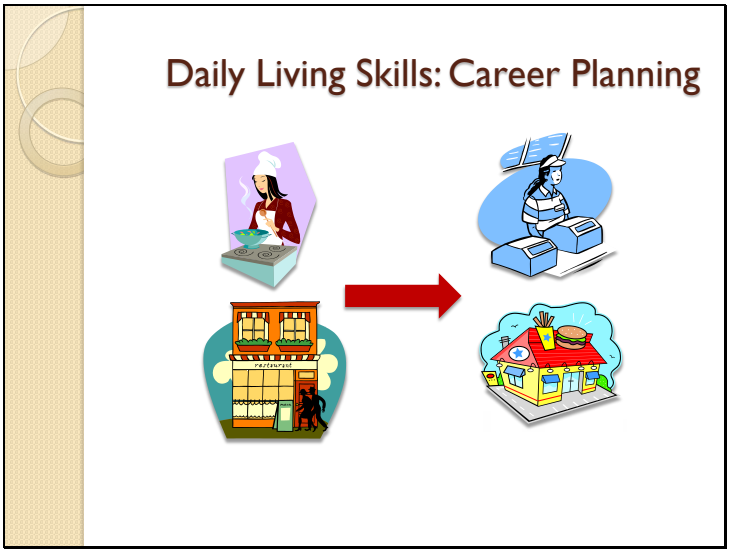
Slide 15



Before they begin to look for a job, they will need to make sure that they have all the necessary documents and working papers:

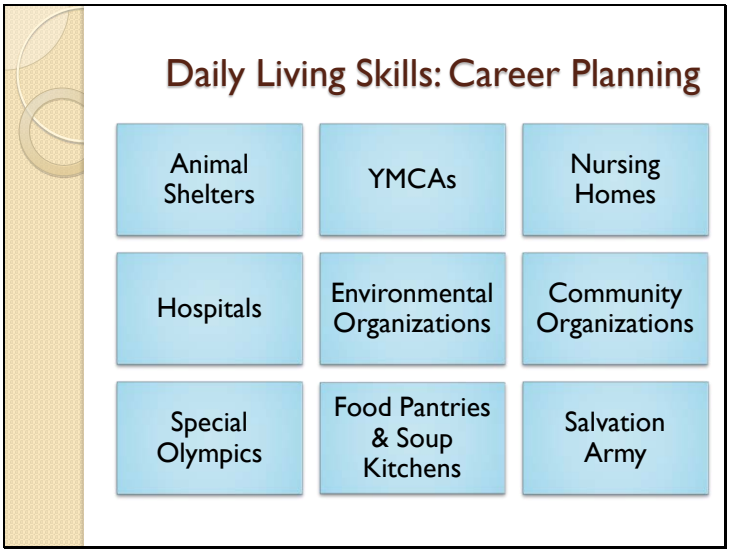
- Social Security card/ number
- Birth certificate
- Working papers (if under 16)
- Resident Alien card (if appropriate)

Slide 16



It is important for youth to know that first jobs might not always reflect their career interests. However, many entry-level jobs provide youth with general work experience and references that are important in finding next jobs, and can also help them gain knowledge in their choice of careers. For example, if they are interested in culinary arts, working in a fast food restaurant might be helpful. If they want to pursue a career in business, working in a retail store might be valuable to them. Sometimes, finding an entry-level job which reflects their interests can be difficult, but they should know that, despite some disappointment, every job provides important experiences.

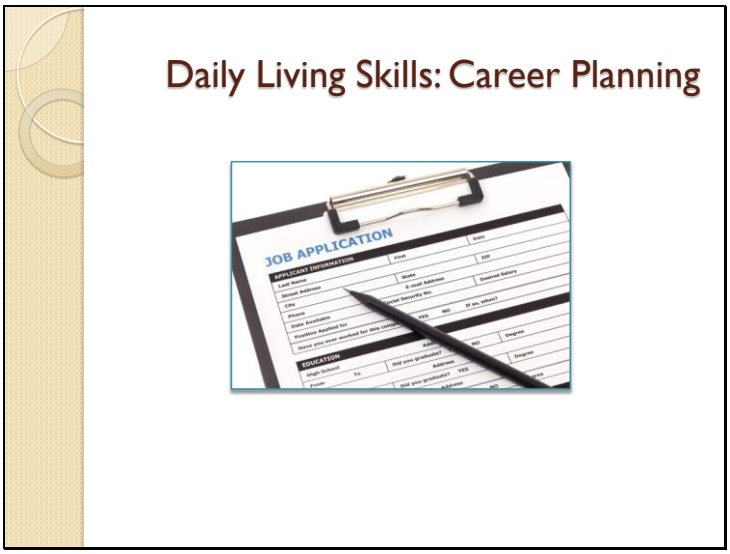
Slide 17



In addition to, or instead of, paid employment, the youth might want to evaluate whether or not volunteer work might be a good option for them.
Here are some types of organizations which usually look for volunteers:

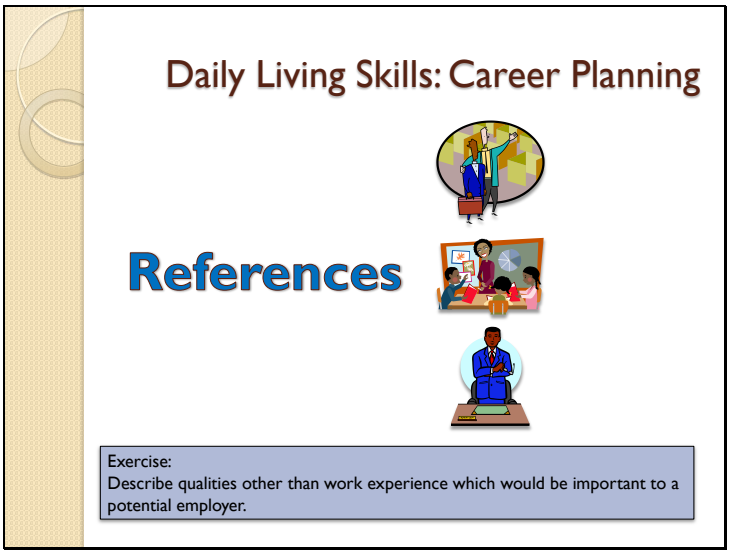
- Animal Shelters
- YMCAs
- Nursing homes
- Hospitals
- Environmental Organizations
- Community Organizations
- Special Olympics
- Food Pantries & Soup Kitchens
- Salvation Army

Slide 18



In guiding youth through the process of finding employment, they need to know that when people apply for a job, they'll usually be asked to fill out an application form to answer some questions about themselves, their education and work experience.

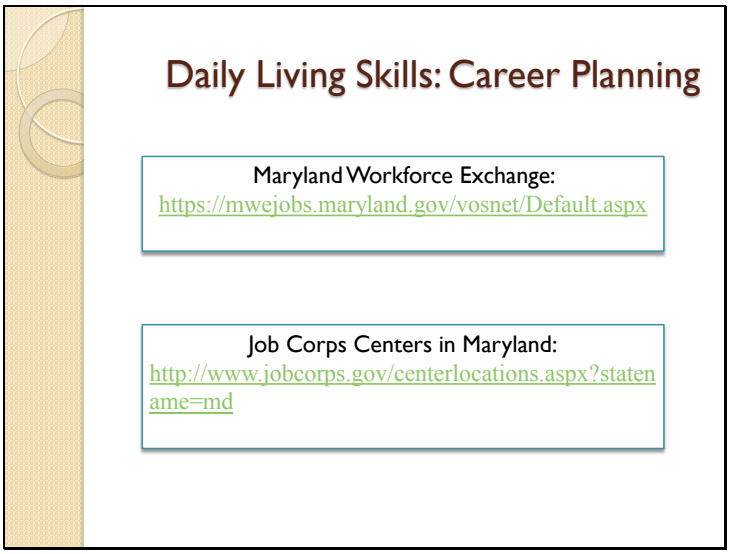
Slide 19



An important part of any job application is the section that asks for references. The youth need to know to make sure that the people they choose know them and can say good things about them. You may help them think through who might be a good reference for them. Previous employers, supervisors, teachers, principals, etc., are often used as references. They will also need to know to always check with the person before they use him/her as a reference.

One exercise you might have them do during this process is to describe qualities that they have other than work experience which would be important to a potential employer.

Slide 20



The following websites are wonderful sources of information, not only for job listings, but other employment help as well:
Maryland Workforce Exchange:
https://mwejobs.maryland.gov/vosnet/Default.aspx

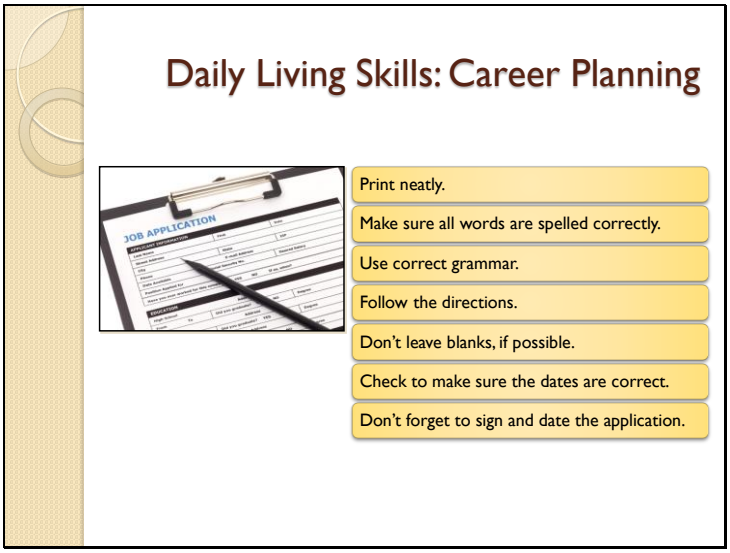
Job Corps Centers in Maryland:
http://www.jobcorps.gov/centerlocations.aspx?statename=md

Slide 21

Once you have helped the youth figure out what kind of jobs they are interested in, as well helped them in the process of identifying jobs to apply for, they will need to fill out job applications. You can help them through this process in a number of ways as well.

First, they need to understand that the process of finding employment can be lengthy. The more employers they contact, the better chance they will have of getting a job.

Slide 22



They will usually be asked to fill out a job application form and later meet with the potential employer (interviewer) to talk about their skills, education, and experience. You can help them understand that their applications represent themselves and, as such, will need to be done well. You can provide them the following tips:

- Print neatly.
- Make sure all words are spelled correctly.
- Use correct grammar.
- Follow the directions.
- Don't leave blanks, if possible.
- Check to make sure the dates are correct.
- Don't forget to sign and date the application

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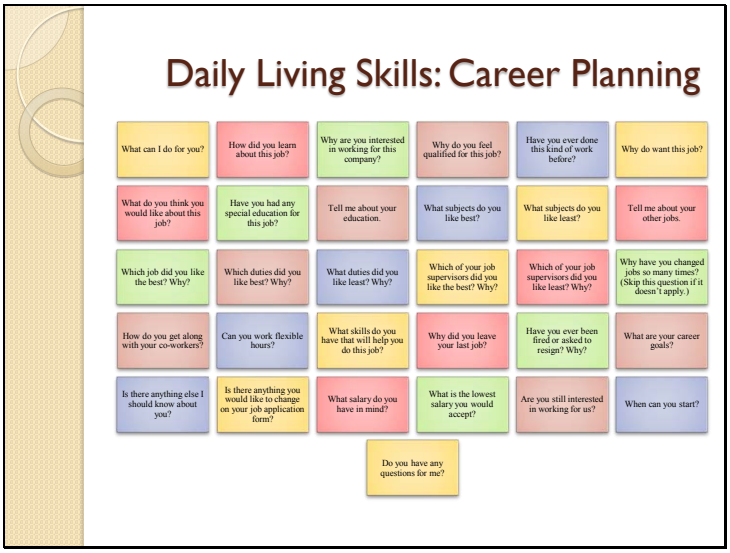

They will also need to be prepared for the interview process. You can help them by role-playing with them. You can be the interviewer and they can practice answering questions such as the following:

- What can I do for you?
- How did you learn about this job?
- Why are you interested in working for this company?
- Why do you feel qualified for this job?
- Have you ever done this kind of work before?
- Why do want this job?
- What do you think you would like about this job?
- Have you had any special education for this job?
- Tell me about your education.
- What subjects do you like best?
- What subjects do you like least?
- Tell me about your other jobs.
- Which job did you like the best? Why?
- Which duties did you like best? Why?
- What duties did you like least? Why?
- Which of your job supervisors did you like the best? Why?
- Which of your job supervisors did you like least? Why?
- Why have you changed jobs so many times? (Skip this question if it doesn't apply.)
- How do you get along with your co-workers?

- Can you work flexible hours?
- What skills do you have that will help you do this job?
- Why did you leave your last job?
- Have you ever been fired or asked to resign? Why?
- What are your career goals?
- Is there anything else I should know about you?
- Is there anything you would like to change on your job application form?
- What salary do you have in mind?
- What is the lowest salary you would accept?
- Are you still interested in working for us?
- When can you start?
- Do you have any questions for me?

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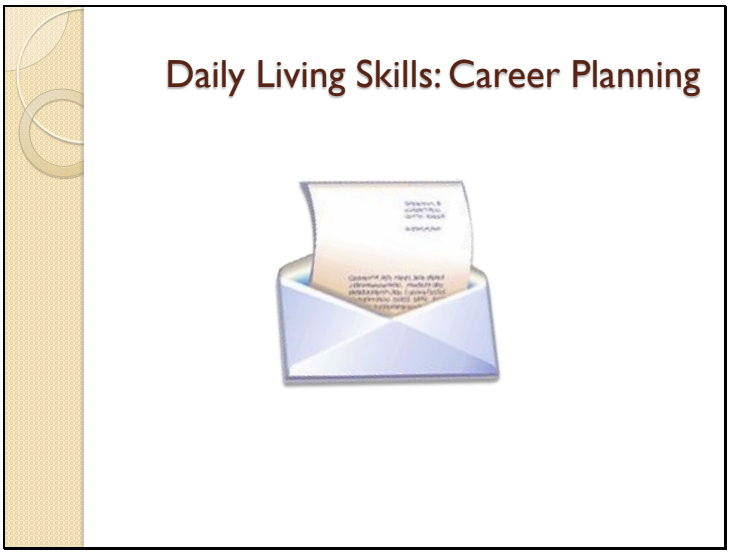
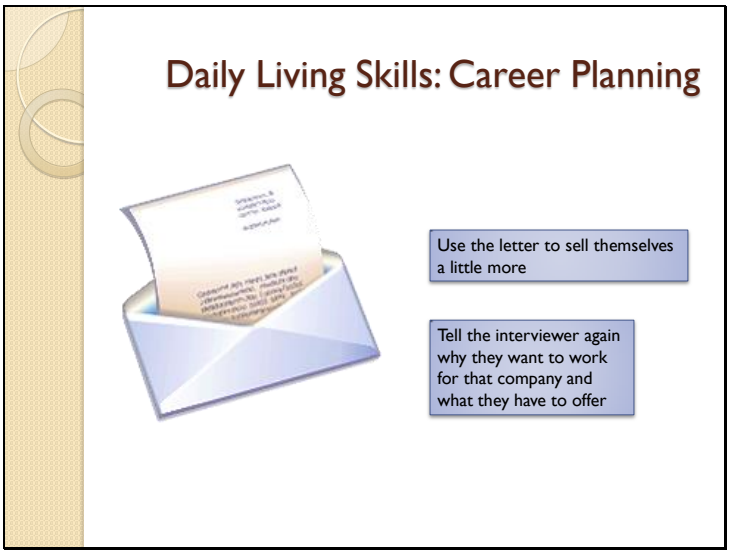


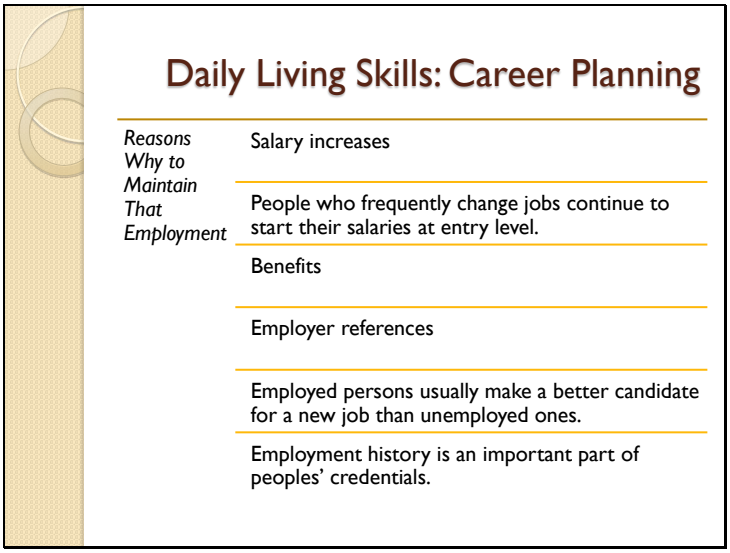
You might also help them with a follow-up thank you letter if they have been interviewed. You can explain to the youth that it is important to send a thank you letter following their interviews to express their appreciation to the interviewer for talking with them. In addition, their letter will remind the interviewer that they are still very interested in the job and it keeps their names in the interviewer's mind until a decision is made.

Slide 25



The follow-up letter will also give them the opportunity to answer questions they needed more time to think about and could not answer during the interview. You may point out that the youth can use the letter to sell themselves a little more, as well take the time to tell the interviewer once again why they want to work for that company and what they have to offer.

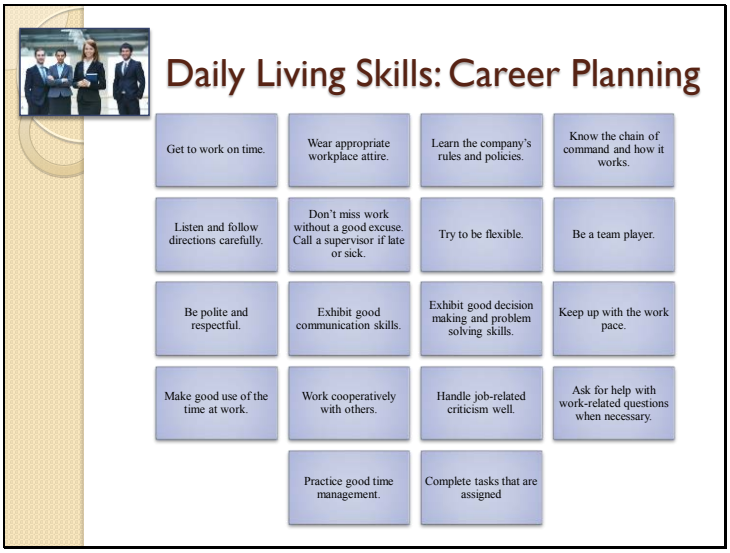
Slide 26



Once a youth has a job, it is important for them to be able to keep that job. There are a number of reasons why it is important to maintain that employment. You may review these with the youth:

- Salary increases usually come with length of time employed.
- People who frequently change jobs continue to start their salaries at entry level.
- Benefits such as vacations, sick pay, tuition payment plans, promotional opportunities, and pension plans may only be available after an employee completes a specific amount of time on the job. These benefits usually increase with the length of time employed.
- Employer references are an important part of future job searches; being fired from a job can limit future employment opportunities.
- Employed persons usually make a better candidate for a new job than unemployed ones. (Employers tend to be suspicious of gaps in an employment record.)
- Employment history is an important part of peoples' credentials. Employers expect job changes for advancement in position, salary increases, and in order to develop new skills.

Slide 27

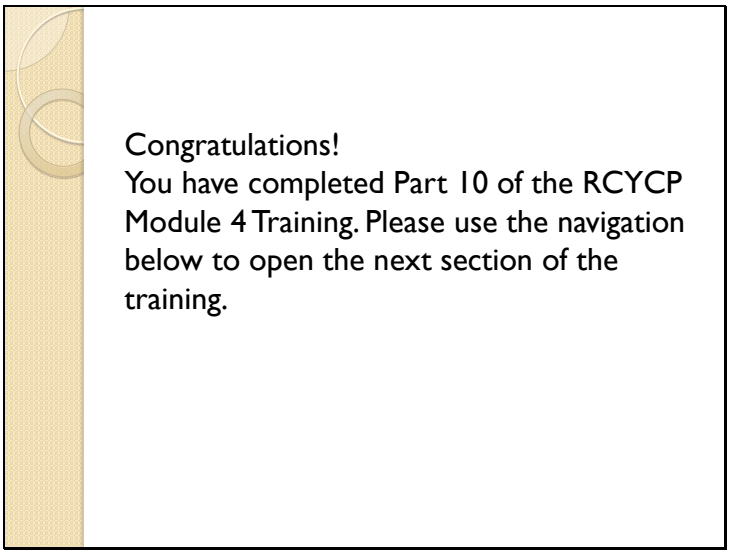


So in order to maintain employment, people need to conduct themselves appropriately at work. You might ask the youth to brainstorm the things/qualities that are important to maintaining a job. In doing this activity you are helping them to think more about themselves as professionals. Here are some things that can be mentioned:

- Get to work on time.
- Wear appropriate workplace attire.
- Learn the company's rules and policies. (For example, how long is the lunch period?)
- Know the chain of command and how it works.
- Listen and follow directions carefully. If there are any questions about duties, don't hesitate to ask a supervisor.
- Don't miss work without a good excuse. Call a supervisor if late or sick.
- Try to be flexible. An employee who is willing to learn new tasks or to help out in a crisis might be the employee who receives a raise or a promotion.
- Be a team player.
- Be polite and respectful.
- Exhibit good communication skills.
- Exhibit good decision making and problem solving skills.
- Keep up with the work pace.
- Make good use of the time at work.
- Work cooperatively with others.
- Handle job-related criticism well.
- Ask for help with work-related questions when necessary.

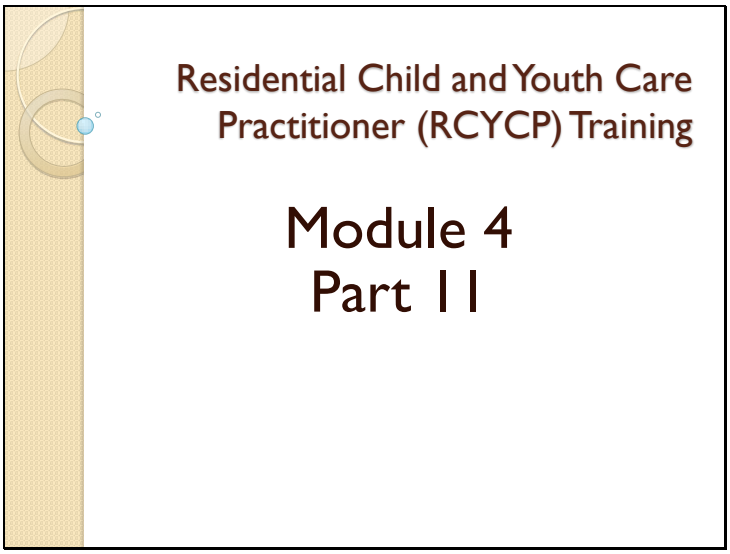
- Practice good time management.
- Complete tasks that are assigned.

Slide 28



Congratulations! You have completed Part 10 of the RCYCP Module 4 Training. Please use the navigation below to open the next section of the training.

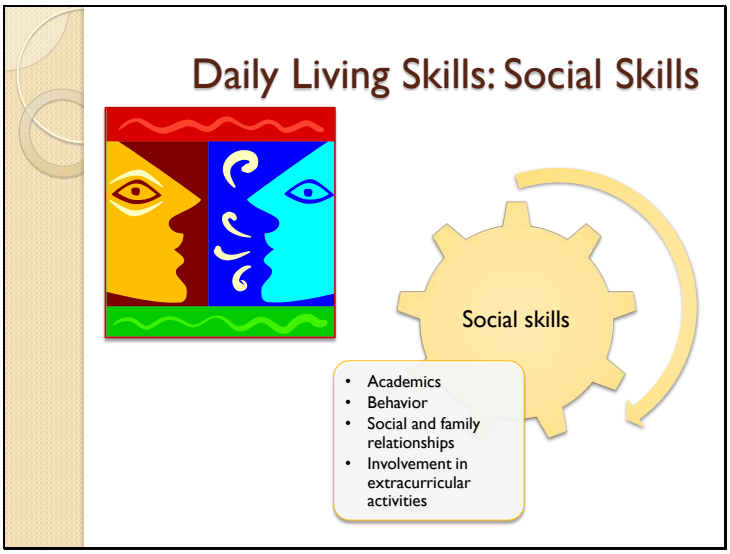
Slide 2



Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 4 Part 11 of the Residential Child and Youth Care Practitioner Training.

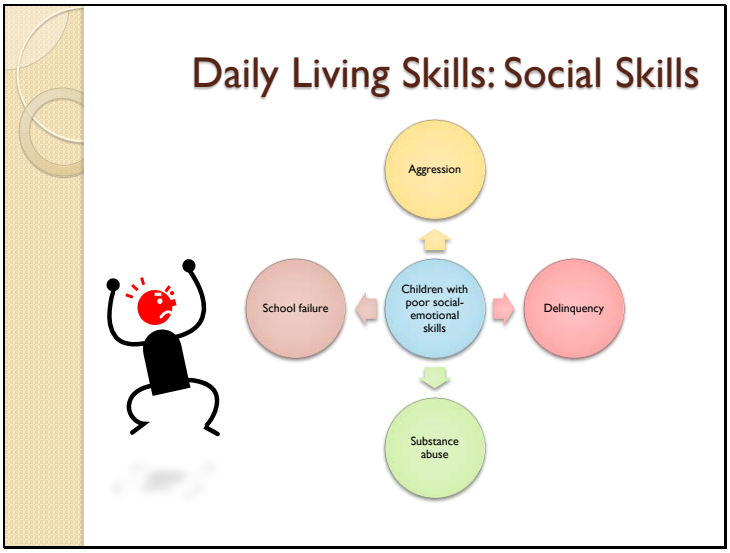
Slide 3



Daily Living Skills: Social Skills

Good social skills are critical for youth if they are to be successful in life. Having good social skills enables youth to make good choices and to behave in successful ways in different situations. Social skills impact academic performances, behavior, social and family relationships, and involvement in extracurricular activities.

Slide 4



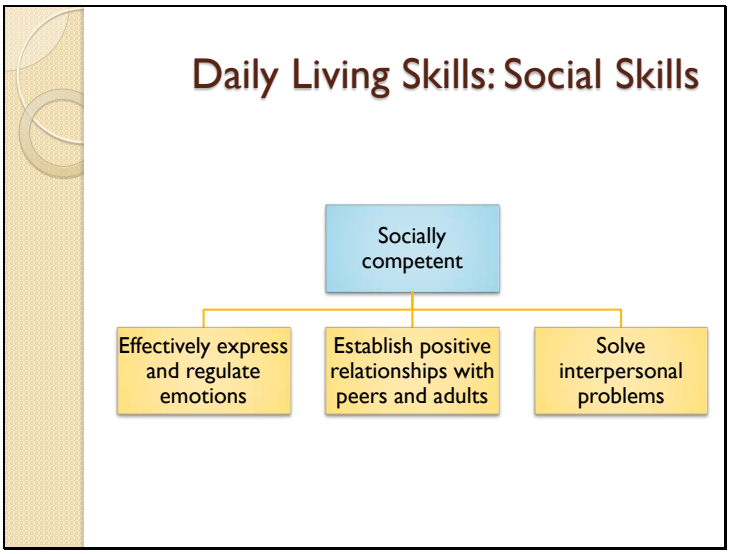
Social skills are extremely important if one is to get along at school, at home, in the workplace, and in social contexts. Individuals with poor social skills experience difficulties in interpersonal relationships with parents, peers, teachers, and other adults. They tend to evoke highly negative responses from others that lead to high levels of peer rejection, which then increase their risk for depression, aggression, and anxiety (NASP, 2002). Research indicates that children with poor social-emotional skills are at increased risk for:

- Aggression
- Delinquency
- Substance abuse
- School failure

Slide 6

So what are social skills? There is no universal definition, but having socials skills can be thought of as having the ability to generate skilled behavior according to rules and goals and in response to social feedback. Socially skilled individuals can adapt well to their environment – avoiding both verbal and physical conflict through communication with others. Inappropriate interpersonal behaviors signal social skills problems or deficits.

Slide 7



In order to be socially competent an individual needs to be able to:

- Effectively express and regulate emotions
- Establish positive relationships with peers and adults
- Solve interpersonal problems

Slide 8

In order to accomplish this social competence, youth must have:

- Self-awareness
- Social awareness
- Self-management
- Relationship skills
- Responsible decision making

Let's go over what these are.

Slide 9

Self-awareness:
In preschool children self-awareness includes recognizing one's own basic emotions (being happy, sad, angry).
In elementary aged children self-awareness also includes the ability to accurately label one's emotions and understand that feelings can vary in intensity.

Slide 10

Social awareness:
In preschool children social awareness involves understanding other's thoughts and feelings and demonstrating empathy.
In elementary school children social awareness involves recognizing similarities and differences among people, but also learning to recognize verbal and physical cues that identify how others feel.

Slide 11

Self-management:
In preschool children self-management includes the development and utilization of emotion regulation skills to manage their emotions – for example, learning to calm oneself down when upset about something.
In elementary school children self-management skills extend to the ability to understand the steps involved in establishing and working toward goals. For example, a skilled child may think, "I want to be able to play games with the other kids during recess – now I have to figure out how to approach them and ask if I can play."

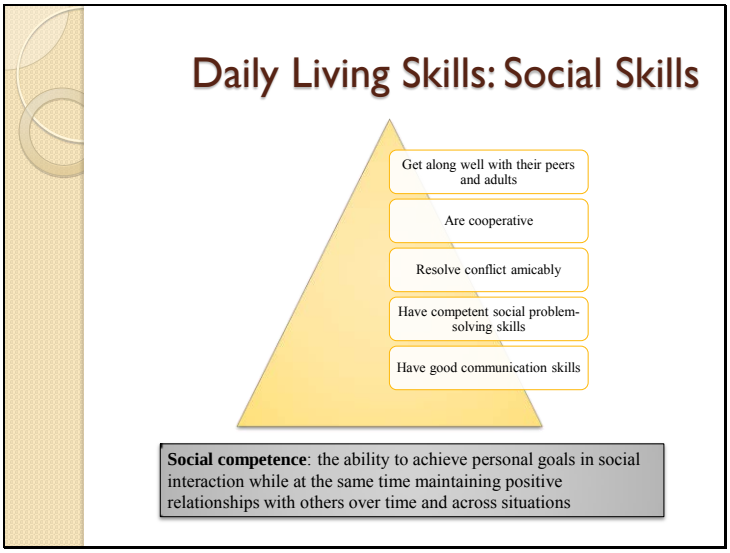
Slide 12

Relationship skills:
Relationship skills are those that are necessary to build positive relationships with both peers and adults.
At the preschool level this includes skills such as cooperation and sharing.
At the elementary age children should be able to identify and implement strategies for establishing and maintaining friendships.

Slide 13

Responsible decision-making:
For preschoolers this includes the skills for solving common social problems such as waiting for something or having something taken away.
For elementary-aged children, decision making requires skills to recognize problematic interpersonal situations and to generate and enact positive solutions to resolve the problem.

Slide 14

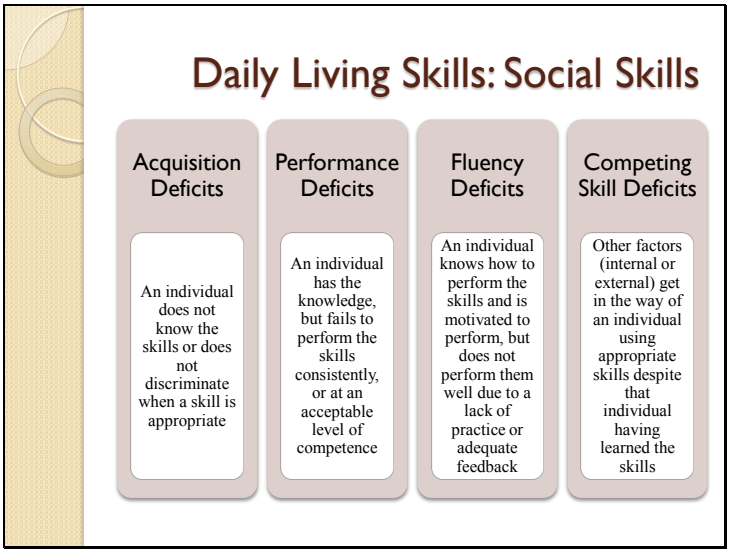


Youth who exhibit positive social-emotional development are those who:

- Get along well with their peers and adults
- Are cooperative
- Resolve conflict amicably
- Have competent social problem-solving skills
- Have good communication skills

Social competence is: “the ability to achieve personal goals in social interaction while at the same time maintaining positive relationships with others over time and across situations” (Hair, Jager, & Garrett, 2002).

Slide 15



So how do kids develop social skills? Most kids learn social skills from their parents, as well as through their everyday interactions with other kids and adults. In many cases, however, youth may experience difficulty performing one or more skills.

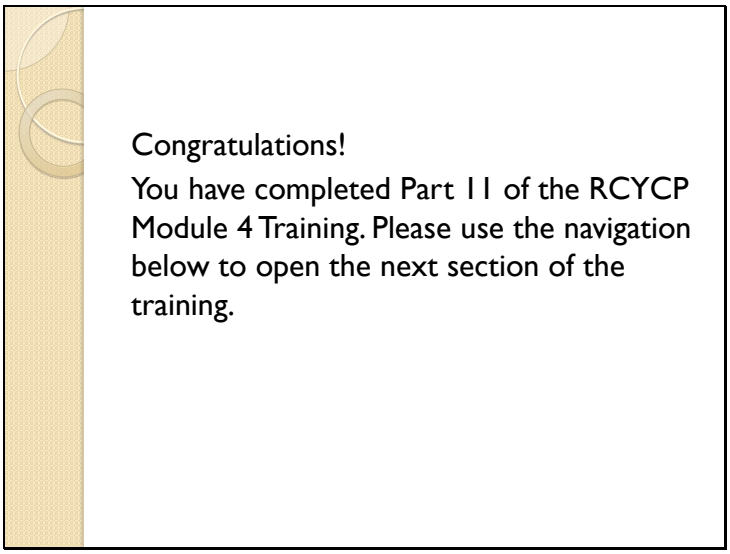
1.) In some cases this deficit is due to a lack of knowledge – an individual does not know the skills or does not discriminate when a skill is appropriate (acquisition deficits) – for example, wants to play with others, but doesn't know how to engage others.

2.) In some cases, an individual has the knowledge, but fails to perform the skills consistently, or at an acceptable level of competence (performance deficits) – for example, consistently raising hand in class – not blurting out.

3.) In some cases, an individual knows how to perform the skills and is motivated to perform, but does not perform them well due to a lack of practice or adequate feedback (fluency deficits) – for example, an individual confronted by a bully, but has not practiced responding.

4.) In some cases other factors (internal or external) get in the way of an individual using appropriate skills despite that individual having learned the skills (competing skill deficits or behaviors) – for example, anxiety prevents use of a skill.

Slide 17



Congratulations! You have completed Part 11 of the RCYCP Module 4 Training. Please use the navigation below to open the next section of the training.

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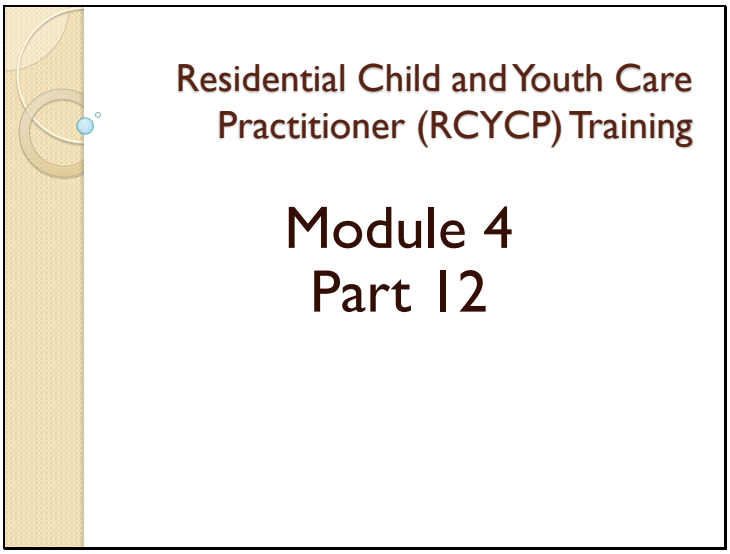


Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 4 of the Residential Child and Youth Care Practitioner Training.

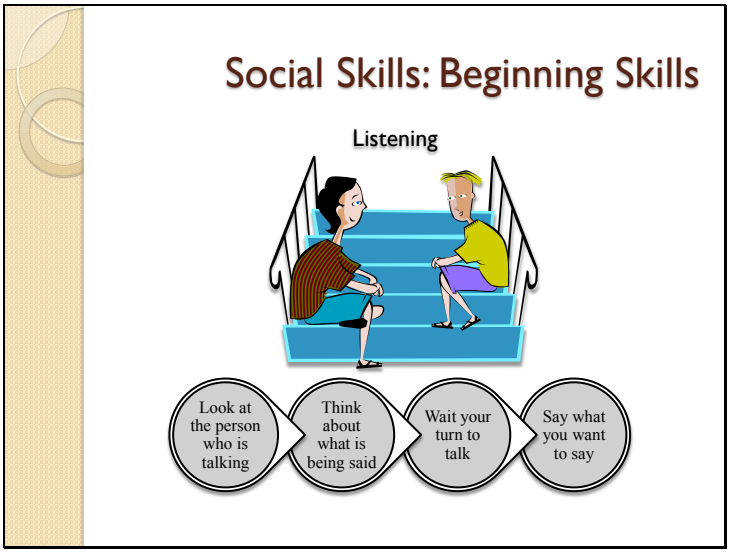
Slide 3

Social Skills: Beginning Skills

Now let's look at specific social skills.

In working with youth in residential care, you may notice that many of the youth, if not all, can use some help with their social skills. Your role as a counselor is to model proper social skills, as well as help youth to learn and master the skills so that they will be successful in their interactions with others. Let's start with beginning social skills and then we will review more advanced skills, skills for dealing with feelings, skill alternatives to aggression, and skills for dealing with stress.

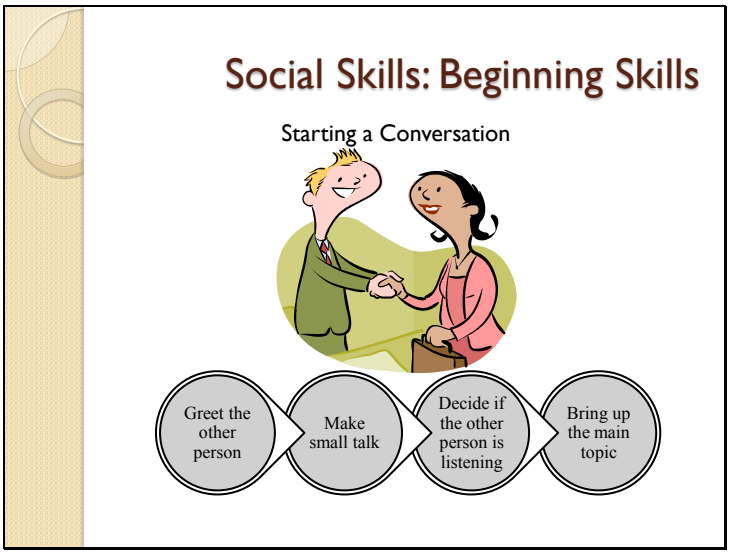
Slide 4



Listening

1. Look at the person who is talking (face the person; establish eye contact)
2. Think about what is being said (this may be shown by nodding or saying “mmm-hmmm”)
3. Wait your turn to talk (Don’t fidget; don’t shuffle your feet)
4. Say what you want to say (Ask questions; express feelings, express your ideas)

Slide 5



Starting a Conversation

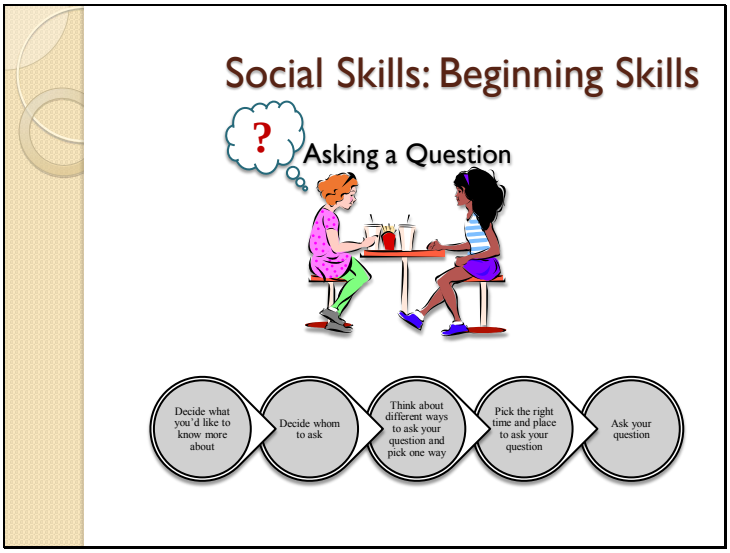
1. Greet the other person (Say “hi”; shake hands; choose the right time and place)
2. Make small talk (Talk about sports, the weather, school events and, so forth)
3. Decide if the other person is listening (Check if the other person is listening: looking at you, nodding, saying “mm-hmmm”
4. Bring up the main topic.

Slide 6

Having a Conversation

1. Say what you want to say.
2. Ask the other person what s/he thinks.
3. Listen to what the other person says (using the steps for the listening skill).
4. Say what you think (Respond to the other person; add new information; ask questions).
5. Make a closing remark (You can discuss types of closing remarks. Steps 1-4 can be repeated many times before Step 5 is done).

Slide 7



Asking a Question

1. Decide what you'd like to know more about (ask about something you don't understand, something you didn't hear, or something confusing).
2. Decide whom to ask (think about who has the best information on a topic; consider asking several people).
3. Think about different ways to ask your question and pick one way (Think about wording; raise your hand; ask in a way that is not challenging or threatening).
4. Pick the right time and place to ask your question (wait for a pause; wait for privacy).
5. Ask your question.

Slide 8

Saying Thank You

1. Decide if the other person said or did something that you want to thank him/her for (it may be a compliment, favor, or gift).
2. Choose a good time and place to thank the other person (this is a quiet time, a private place, or other time and place where you are sure you will have the other person's attention).
3. Thank the other person in a friendly way (express thanks with words, a gift, a letter, or do a return favor).
4. Tell the other person why you are thanking him/her.

Slide 9

Introducing Yourself

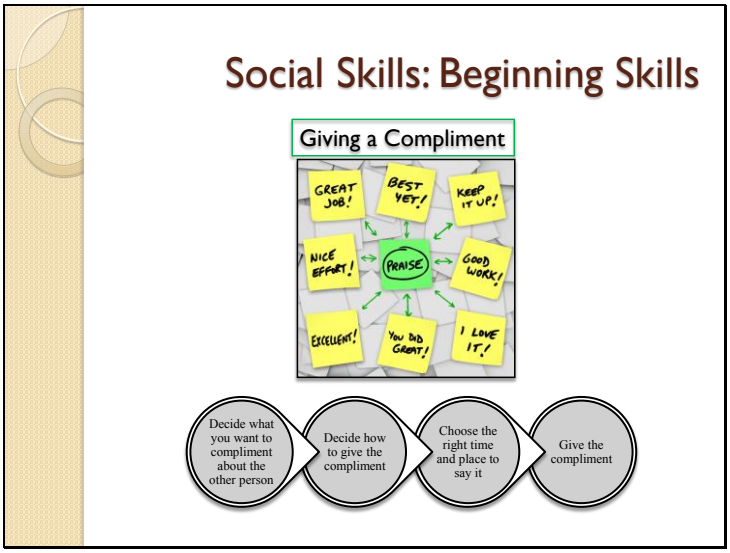
1. Choose the right time and place to introduce yourself.
2. Greet the other person and tell your name (shake hands if appropriate).
3. Ask the other person his/her name if you need to.
4. Tell or ask the other person something to help start your conversation (tell something about yourself; comment on something you both have in common; ask a question).

Slide 10

Introducing Other People

1. Name the first person and tell him/her the name of the second person (speak clearly and loudly enough so that the names are heard by both people).
2. Name the second person and tell him/her the name of the first person.
3. Say something that helps the two people get to know each other (mention something they have in common; invite them to talk or do something with you; say how you know each of them).

Slide 11



Giving a Compliment

1. Decide what you want to compliment about the other person (it may be the person's appearance, behavior, or another accomplishment).
2. Decide how to give the compliment (consider the wording and ways to keep the other person and yourself from feeling embarrassed).
3. Choose the right time and place to say it (it may be a private place or a time when the other person is unoccupied).
4. Give the compliment (be friendly and sincere).

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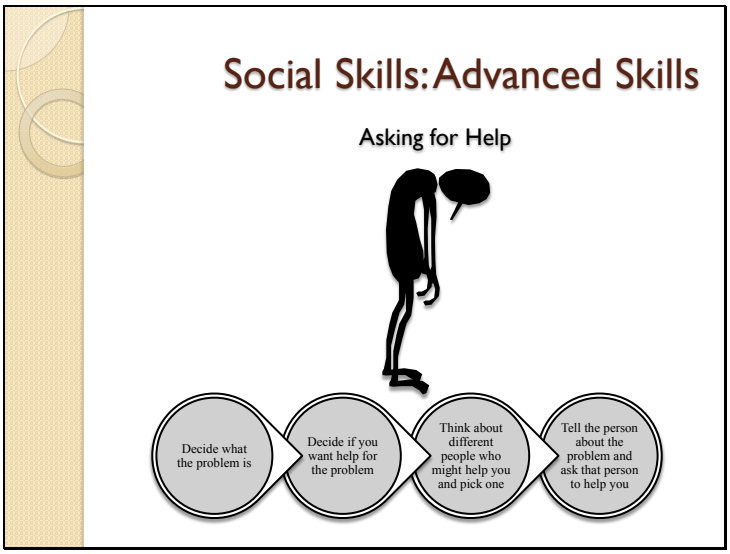
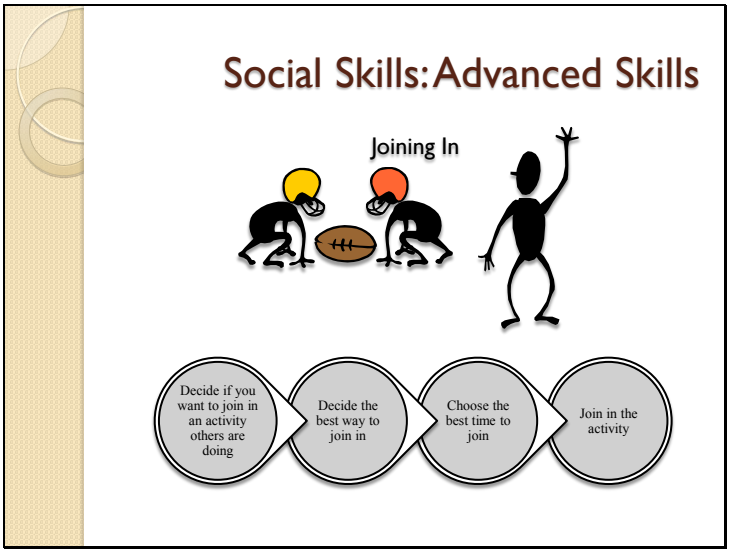


Social Skills: Advanced Skills

Now let's turn to the more advanced skills such as:

Asking for Help
1. Decide what the problem is (be specific: who and what are contributing to the problem; what is its effect on you?)
2. Decide if you want help for the problem (figure out if you can solve the problem alone).
3. Think about different people who might help you and pick one (consider all possible helpers and choose the best one).
4. Tell the person about the problem and ask that person to help you (if the person wants to help you but is unable to do so at the moment, ask the person when a good time would be).

Slide 13



Joining In

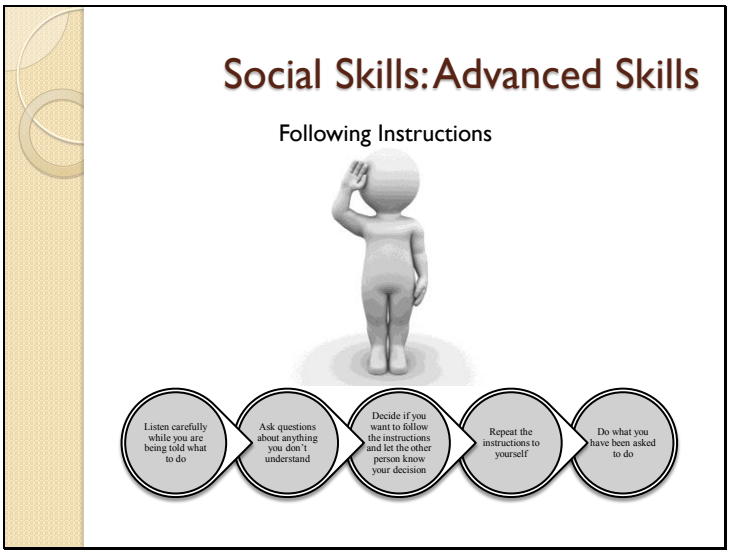
1. Decide if you want to join in an activity others are doing (check the advantages and disadvantages. Be sure you want to participate in and not disrupt what others are doing).
2. Decide the best way to join in (you might ask, apply, start a conversation, or introduce yourself).
3. Choose the best time to join (good times are usually during a break in the activity or before the activity gets started).
4. Join in the activity.

Slide 14

Giving Instructions

1. Decide what needs to be done (it might be a chore or a favor).
2. Think about the different people who could do it and choose one.
3. Ask the person to do what you want done (tell the person how to do it when the task is complex).
4. Ask the other person if he/she understands what to do.
5. Change or repeat your instructions if you need to (this step is optional).

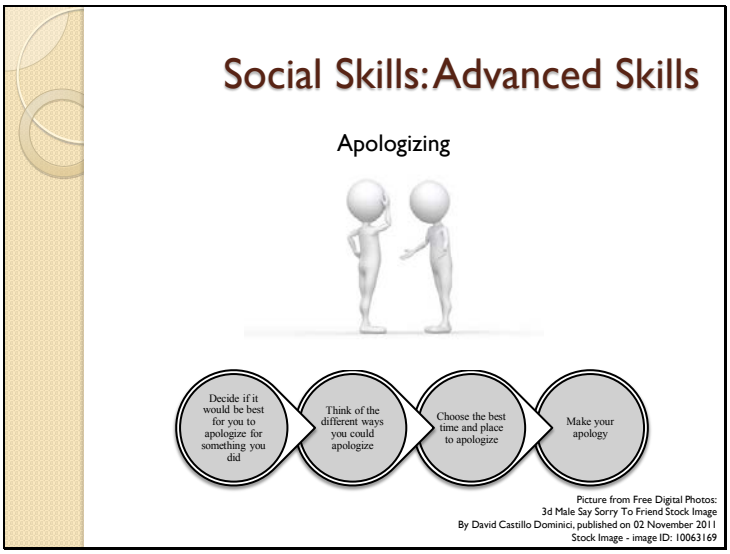
Slide 15



Following Instructions

1. Listen carefully while you are being told what to do (take notes if necessary; nod your head; say “mm-hmm”).
2. Ask questions about anything you don’t understand (the goal is making instructions more specific, more clear.)
3. Decide if you want to follow the instructions and let the other person know your decision (think about the positive and negative consequences of following the instructions).
4. Repeat the instructions to yourself (do this in your own words).
5. Do what you have been asked to do.

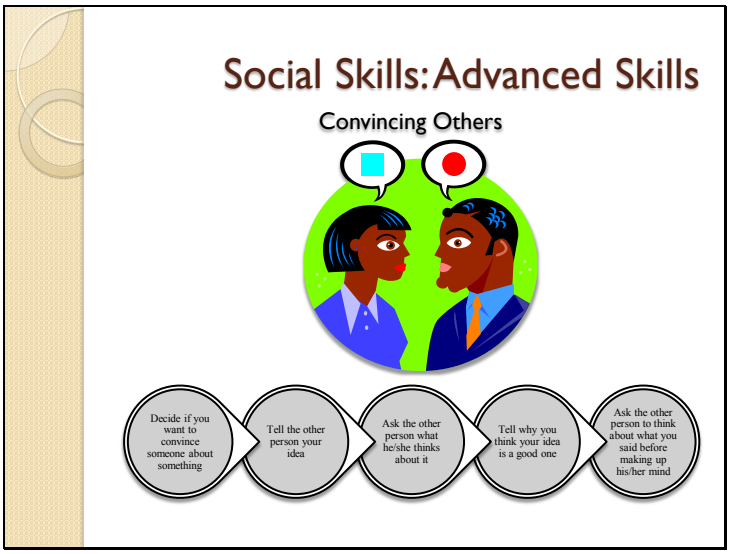
Slide 16



Apologizing
1. Decide if it would be best for you to apologize for something you did (you might apologize for breaking something, making an error, interrupting someone, or hurting someone's feelings).
2. Think of the different ways you could apologize (say something; do something; write something).
3. Choose the best time and place to apologize (do it as privately and as quickly as possible after creating the problem).
4. Make your apology (this might include an offer to make up for what happened).

Picture from Free Digital Photos:
3d Male Say Sorry To Friend Stock Image
By David Castillo Dominici, published on 02 November 2011
Stock Image - image ID: 10063169

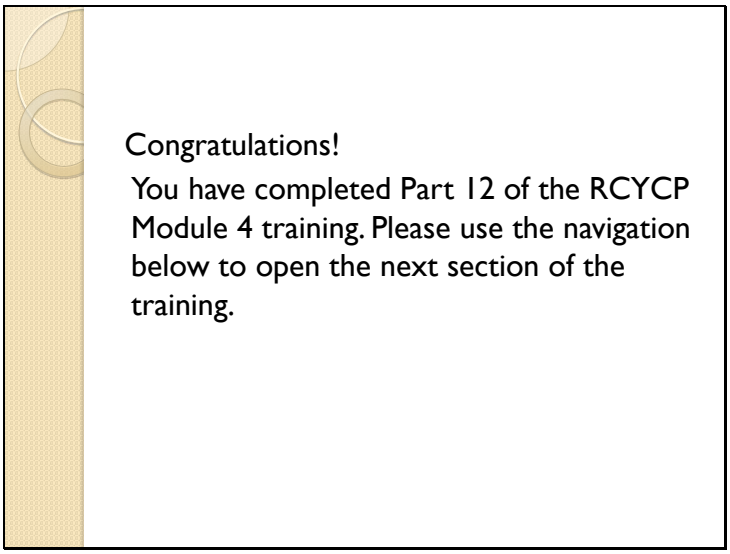
Slide 17



Convincing Others

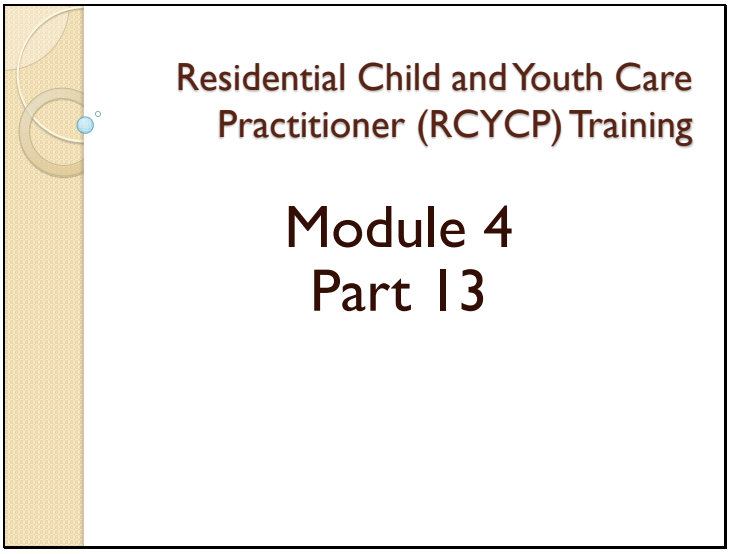
1. Decide if you want to convince someone about something (it might be doing something your way, going someplace, interpreting events, or evaluating ideas).
2. Tell the other person your idea (focus on both content of ideas and feeling about point of view).
3. Ask the other person what he/she thinks about it (this requires the listening skill).
4. Tell why you think your idea is a good one (try your best to be fair, “get into the other person’s shoes”).
5. Ask the other person to think about what you said before making up his/her mind (check on the other person’s decision at a later point in time).

Slide 18



Congratulations! You have completed Part 12 of the RCYCP Module 4 training. Please use the navigation below to open the next section of the training.

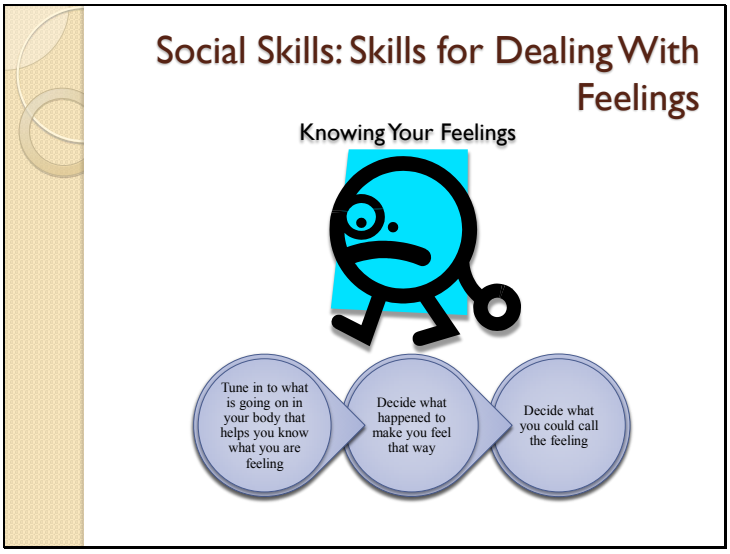
Slide 2



Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 4, Part 13 of the Residential Child and Youth Care Practitioner Training.

Slide 3



Social Skills: Skills for Dealing With Feelings

Let's move on now to skills for dealing with feelings.

Knowing Your Feelings:
1. Tune in to what is going on in your body that helps you know what you are feeling (some cues are blushing, butterflies in your stomach, tight muscles, etc.).
2. Decide what happened to make you feel that way (focus on outside events such as a fight, a surprise, etc.).
3. Decide what you could call the feeling (possibilities are anger, fear, embarrassment, joy, happiness, sadness, disappointment, frustration, excitement, anxiety, etc.).

Slide 4

Expressing Your Feelings:

1. Tune in to what is going on in your body.
2. Decide what happened to make you feel that way.
3. Decide what you are feeling (possibilities are happy, sad, in a bad mood, nervous, worried, scared, embarrassed, disappointed, frustrated, etc.).
4. Think about the different ways to express your feeling and pick one (consider prosocial alternatives such as talking about a feeling, doing a physical activity, telling the object of the feeling about the feeling, walking away from emotional situations, or delaying action. Consider how, when, where, and to whom the feeling could be expressed).

Slide 5

Understanding the Feelings of Others:

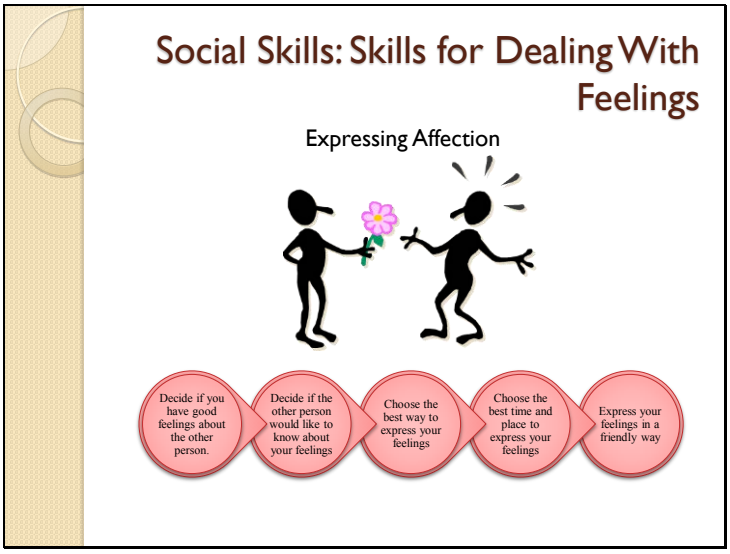
1. Watch the other person (notice tone of voice, posture, and facial expression).
2. Listen to what the other person is saying (try to understand the content).
3. Figure out what the person might be feeling (he/she may be angry, sad, anxious, for example)
4. Think about ways to show you understand what he/she is feeling (you might tell him/her, touch him/her, or leave the person alone).
5. Decide on the best way and do it.

Slide 6

Dealing with Someone Else's Anger:

1. Listen to the person who is angry (don't interrupt; stay calm).
2. Try to understand what the angry person is saying and feeling (ask questions to get explanations of what you don't understand; restate them to yourself).
3. Decide if you can say or do something to deal with the situation (think about ways of dealing with the problem. This may include just listening, being empathic, doing something to correct the problem, ignoring it, or being assertive).
4. If you can, deal with the other person's anger.

Slide 7



Expressing Affection:

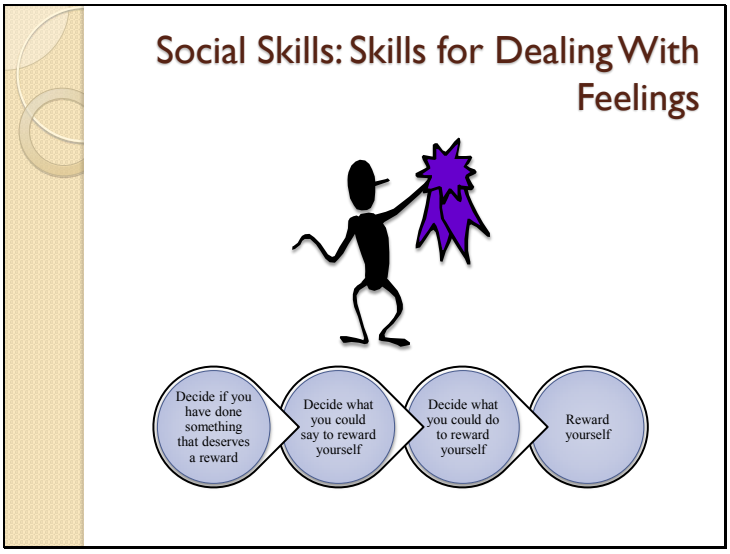
1. Decide if you have good feelings about the other person.
2. Decide if the other person would like to know about your feelings (consider the possible consequences – e.g., happiness, misinterpretation, embarrassment, encouragement of friendship).
3. Choose the best way to express your feelings (do something, say something, give gift, send card, telephone, offer invitation).
4. Choose the best time and place to express your feelings (minimize distractions and possible interruptions).
5. Express your feelings in a friendly way.

Slide 8

Dealing with Fear:

1. Decide if you are feeling afraid (use the skill "knowing your feelings).
2. Think about what you might be afraid of (think about alternative possibilities and choose the most likely one).
3. Figure out if the fear is realistic (is the feared object really a threat? You may need to check this out with another person or may need more information).
4. Take steps to reduce your fear (you might talk with someone, leave the scene, or gradually approach the frightening situation).

Slide 9



Rewarding Yourself:

1. Decide if you have done something that deserves a reward (it might be something you have succeeded at or some area of progress).
2. Decide what you could say to reward yourself (use praise, approval, or encouragement).
3. Decide what you could do to reward yourself (you might buy something, go someplace, or increase or decrease an activity).
4. Reward yourself (say and do it).

Slide 10

Now we begin skill alternatives to aggression.

Asking Permission:
1. Decide what you would like to do for which you need permission (ask if you want to borrow something or request a special privilege).
2. Decide whom you have to ask for permission (ask the owner, manager, or teacher).
3. Decide how to ask for permission (ask out loud; ask privately; ask in writing).
4. Pick the right time and place.
5. Ask for permission.

Slide 11

Sharing Something:

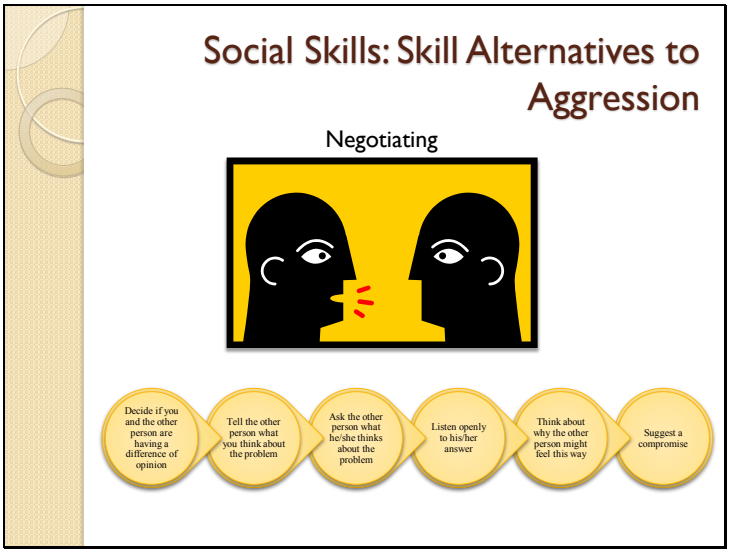
1. Decide if you might like to share some of what you have (divide the item between yourself and the other person or allow the other to use the item).
2. Think about how the other person might feel about your sharing (he/she might feel pleased, indifferent, suspicious, or insulted).
3. Offer to share in a direct and friendly way (make the offer sincere, allowing the other to decline if he/she wishes).

Slide 12

Helping Others:

1. Decide if the other person might need and want your help (think about the needs of the other person; observe).
2. Think of the ways you could be helpful.
3. Ask the other person if he/she needs and wants your help (make the offer sincere, allowing the other to decline if he/she wishes).
4. Help the other person.

Slide 13



Negotiating:

1. Decide if you and the other person are having a difference of opinion (are you getting tense or arguing?)
2. Tell the other person what you think about the problem (state your own position and your perception of the other's position).
3. Ask the other person what he/she thinks about the problem.
4. Listen openly to his/her answer.
5. Think about why the other person might feel this way.
6. Suggest a compromise (be sure the proposed compromise takes into account the opinions and feelings of both persons).

Slide 14

Using Self-Control:

1. Tune in to what is going on in your body that helps you know you are about to lose control of yourself (are you getting tense, angry, hot, fidgety?)
2. Decide what happened to make you feel this way (consider both outside events and "internal" events (thoughts)).
3. Think about ways in which you might control yourself (slow down; count to 10; breathe deeply; assert yourself; leave; do something else).
4. Choose the best way to control yourself and do it.

Slide 15

Standing Up for Your Rights:

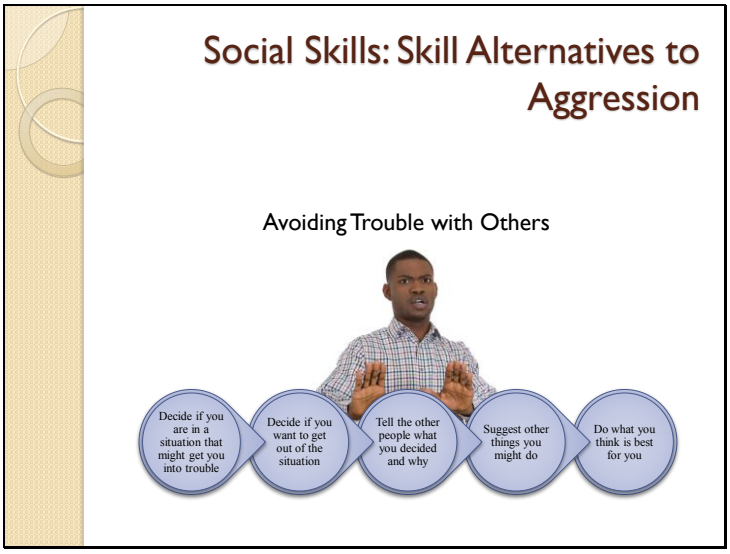
1. Pay attention to what is going on in your body that helps you know that you are dissatisfied and would like to stand up for yourself (some cues are tight muscles, butterflies in your stomach, and so forth).
2. Decide what happened to make you feel dissatisfied (are you being taken advantage of, ignored, mistreated, or teased?)
3. Think about ways in which you might stand up for yourself and choose one (seek help; say what is on your mind; get a majority opinion; choose the right time and place).
4. Stand up for yourself in a direct and reasonable way.

Slide 16

Responding to Teasing:

1. Decide if you are being teased (are others making jokes or whispering?)
2. Think about ways to deal with the teasing (gracefully accept it; make a joke of it; ignore it).
3. Choose the best way and do it (when possible, avoid alternatives that foster aggression, malicious counter-teasing, and withdrawal).

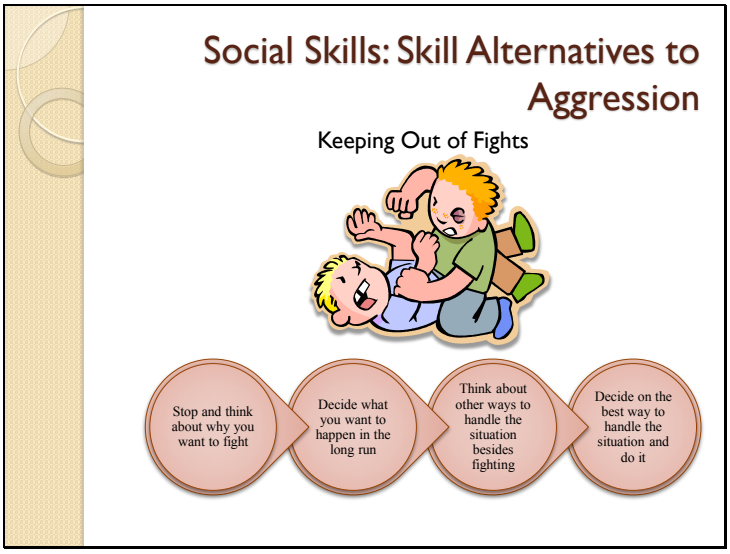
Slide 17



Avoiding Trouble with Others:

1. Decide if you are in a situation that might get you into trouble (examine immediate and long-range consequences).
2. Decide if you want to get out of the situation (consider risks versus gains).
3. Tell the other people what you decided and why.
4. Suggest other things you might do (consider prosocial alternatives).
5. Do what you think is best for you.

Slide 18



Keeping Out of Fights:

1. Stop and think about why you want to fight.
2. Decide what you want to happen in the long run (what is the long-range outcome?).
3. Think about other ways to handle the situation besides fighting (you might negotiate, stand up for your rights, ask for help, or pacify the person).
4. Decide on the best way to handle the situation and do it.

Slide 19

The final skills cover dealing with stress.

Making a Complaint:
1. Decide what your complaint is (what is the problem?)
2. Decide whom to complain to (who can resolve it?)
3. Tell that person your complaint (consider alternative ways to complain – for example, politely, assertively, privately).
4. Tell that person what you would like done about the problem (offer a helpful suggestion about resolving the problem).
5. Ask how he/she feels about what you've said.

Slide 20

Answering a Complaint:

1. Listen to the complaint (listen openly).
2. Ask the person to explain anything you don't understand.
3. Tell the person that you understand the complaint (rephrase; acknowledge the content and feeling).
4. State your ideas about the complaint, accepting the blame if appropriate.
5. Suggest what each of you could do about the complaint (you might compromise, defend your position, or apologize).

Picture from: Free Digital Photos
Boss Complaining Stock Image
By jesadaphorn, published on 09 February 2014
Stock Image - image ID: 100234932

Slide 21

Being a Good Sport:

1. Think about how you did and how the other person did in the game you played.
2. Think of a true compliment you could give the other person in his/her game (say "good try," "congratulations," or "getting better").
3. Think about his/her reactions to what you might say (the reaction might be pleasure, anger, or embarrassment).
4. Choose the compliment you think is best and say it.

Slide 22

Dealing with Embarrassment:

1. Decide if you are feeling embarrassed.
2. Decide what happened to make you feel embarrassed.
3. Decide on what will help you feel less embarrassed and do it (correct the cause; minimize it; ignore it; distract others; use humor; reassure yourself).

Slide 23

Dealing with Being Left Out:

1. Decide if you are being left out (are you being ignored or rejected?).
2. Think about why the other people might be leaving you out of something.
3. Decide how you could deal with the problem (you might wait, leave, tell the other people how their behavior affects you, or ask to be included).
4. Choose the best way and do it.

Slide 24

Standing Up for a Friend:

1. Decide if your friend has not been treated fairly by others (has your friend been criticized, teased, or taken advantage of?)
2. Decide if your friend wants you to stand up for him/her.
3. Decide how to stand up for your friend (you might assert his/her rights, explain, or apologize).
4. Stand up for your friend.

Slide 25

Responding to Persuasion:

1. Listen to the other person's ideas on a topic (listen openly; try to see the topic from the other person's viewpoint)
2. Compare what he/she said with what you think (agree; disagree; modify; postpone a decision).
3. Decide what you think about the topic (distinguish your own ideas from the ideas of others).
4. Decide which idea you like better and tell the other person about it.

Slide 26

Responding to Failure:

1. Decide if you have failed at something (the failure may be interpersonal, academic, or athletic).
2. Think about why you failed (it could be due to skill, motivation or luck. Include personal reasons and circumstances).
3. Think about what you could do to keep from failing another time (evaluate what is under your control to change: If a skill problem, practice; if motivation, increase effort; if circumstances, think of ways to change them).
4. Decide if you want to try again.
5. Try again using your new idea.

Slide 27

Dealing with Contradictory Messages:

1. Decide if someone is telling you two opposite things at the same time (this could be in words, in nonverbal behavior, or in saying one thing and doing another).
2. Think of ways to tell the other person that you don't understand what he/she means (confront the person; ask).
3. Choose the best way to tell the person and do it.

Slide 28

Dealing with an Accusation:

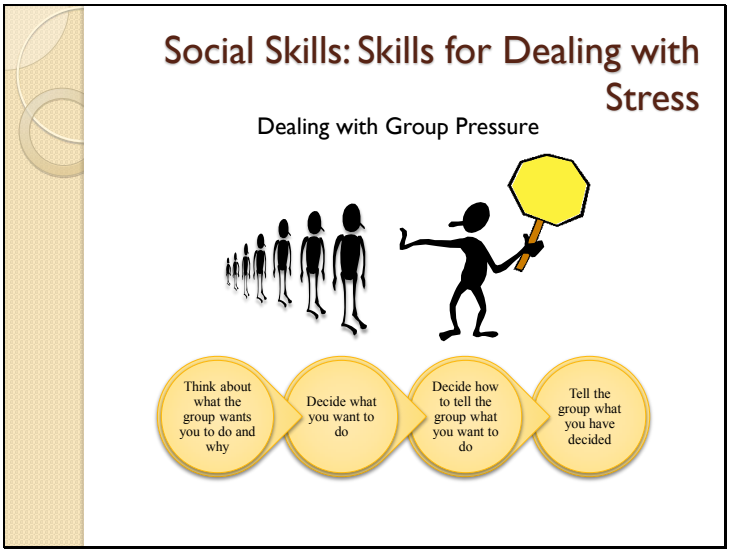
1. Think about what the other person has accused you of (is the accusation accurate or inaccurate?)
2. Think about why the person might have accused you (have you infringed on his/her rights or property? Has a rumor been started by someone else?)
3. Think about ways to answer the person's accusation (deny it; explain your own behavior; correct the other person's perceptions; assert yourself; apologize; offer to make up for what happened).
4. Choose the best way and do it.

Slide 29

Getting Ready for a Difficult Conversation:

1. Think about how you will feel during the conversation (you might be tense, anxious, or impatient).
2. Think about how the other person will feel (he/she may feel anxious, bored, or angry).
3. Think about different ways you could say what you want to say.
4. Think about what the other person might say back to you.
5. Think about any other things that might happen during the conversation (repeat steps 1-5 at least twice, using different approaches to the situation).
6. Choose the best approach you can think of and try it.

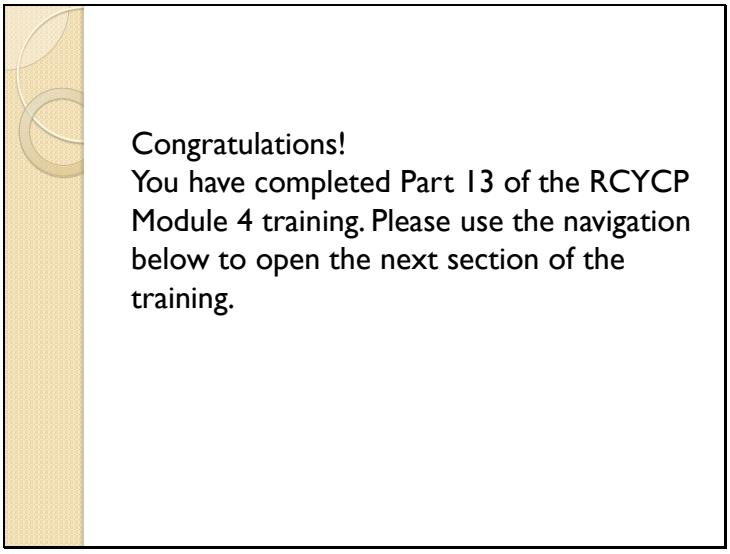
Slide 30



Dealing with Group Pressure:

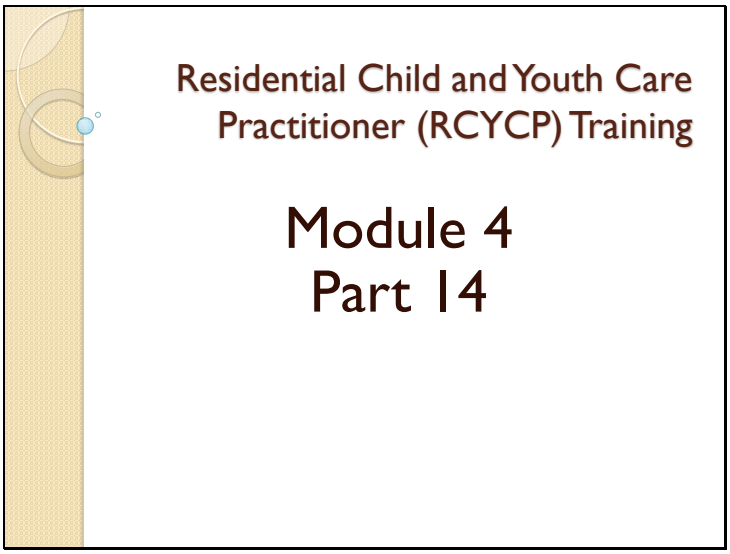
1. Think about what the group wants you to do and why (listen to other people; decide what the real meaning is; try to understand what is being said).
2. Decide what you want to do (yield; resist; delay; negotiate).
3. Decide how to tell the group what you want to do (give reasons; talk to one person only; delay; assert yourself).
4. Tell the group what you have decided.

Slide 32



Congratulations!
You have completed Part 13 of the RCYCP Module 4 training. Please use the navigation below to open the next section of the training.

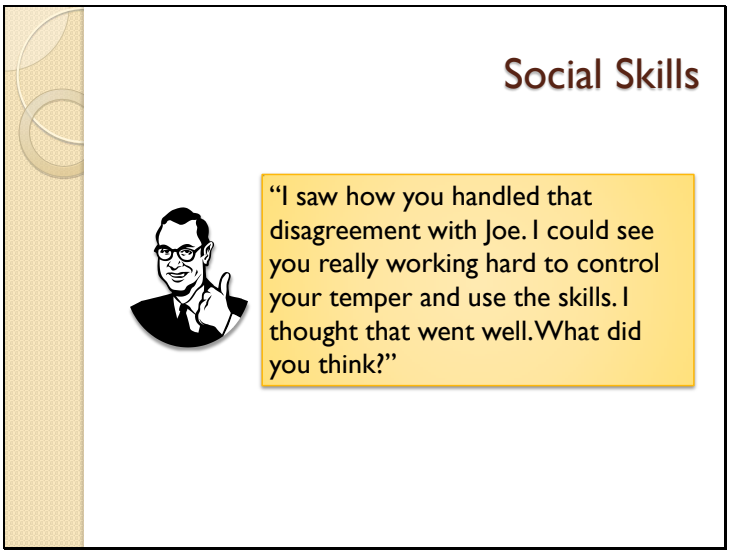
Slide 2



Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 4, Part 14 of the Residential Child and Youth Care Practitioner Training.

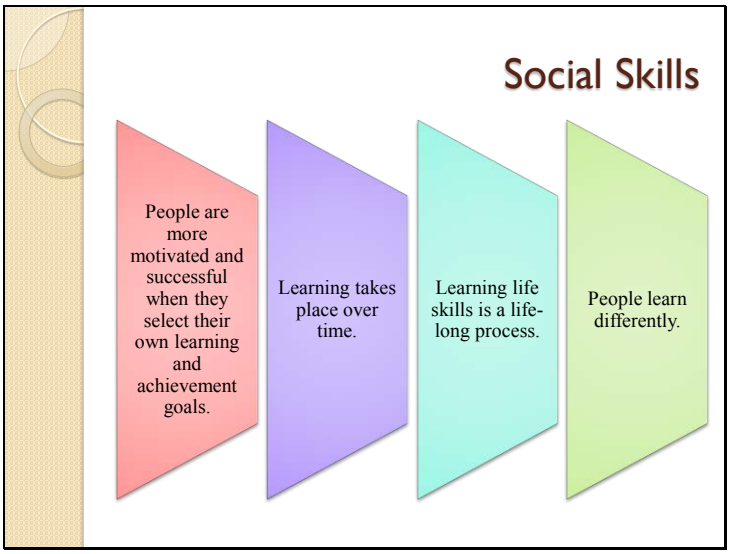
Slide 3



Social Skills

As residents learn the skills and feel comfortable using them in interactions with others, you as an RCYCP can provide positive feedback and reinforcement – for example, you might say, "I saw how you handled that disagreement with Joe. I could see you really working hard to control your temper and use the skills. I thought that went well. What did you think?" These discussions can also continue to help residents learn and master the skills.

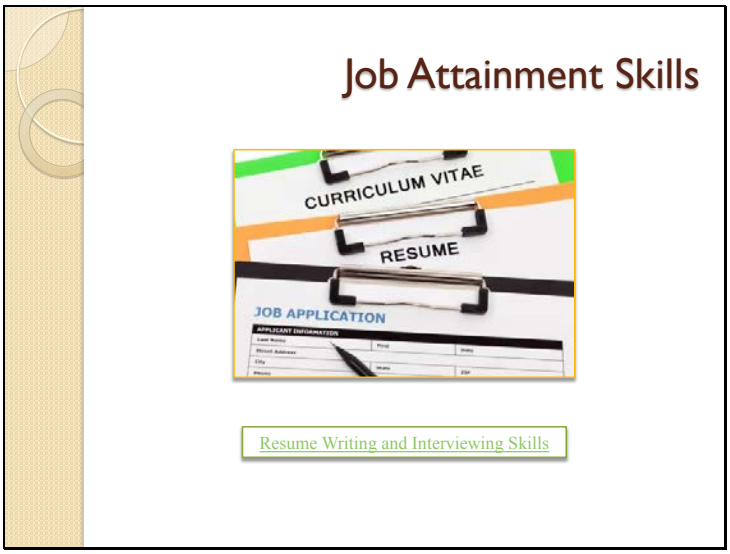
Slide 4



Some things to remember when you are working with youth on social and life skills are that:

- People are more motivated and successful when they select their own learning and achievement goals.
- That learning takes place over time and people progress through a series of stages or levels as learning takes place.
- That learning life skills is a life-long process and so it is to be expected that individuals will not achieve 100% mastery in all of the life skills domains.
- That People learn differently based on their different learning styles: visual learners like to see things and are aided by such things as flip charts, videos, pictures, and handouts. Auditory learners like to hear and talk about things and find that small group discussions, music, and mini-lectures promote learning. Kinesthetic learners like to feel things and prefer “hands-on” activities, simulations, and games that involve movement.

Slide 6



Job Attainment Skills

Resume writing and interviewing is an important skill for the youth in residential care. You may be called upon to help these youth put together a resume and prepare for interviews. Howard County Public School System has put together a very informative and helpful packet about these important endeavors. It is linked here for you to read through and refer youth to when you are working with them.

https://www.dropbox.com/s/2evdhwbcveqvhfu/eng_resumewriting.pdf?dl=0

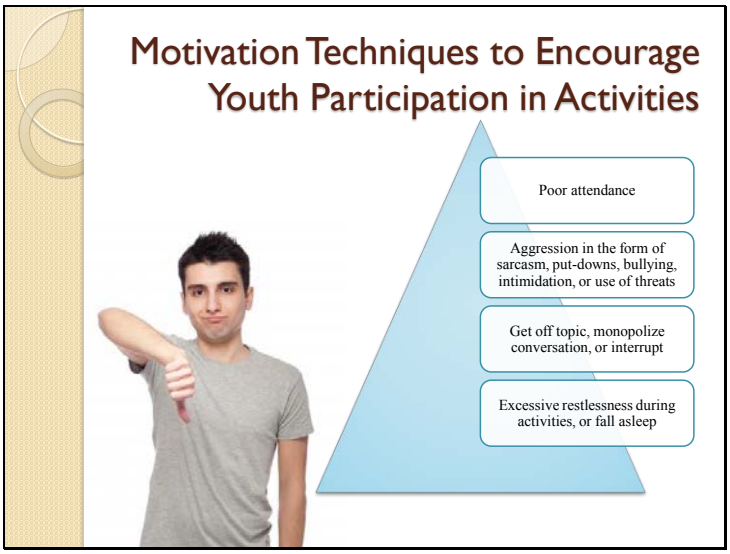
Picture from Free Digital Photos: Job Interview Stock Photo
By phasinphoto, published on 18 March 2014
Stock Photo - image ID: 100248987

Slide 7

Developmentally Appropriate Activities and Recreation

To reiterate material from Module 2, it is important when working with youth that you are conscious of what are developmentally appropriate activities and recreation. That is to say, for example, that you would not take young children to a movie that is not appropriate to their age group. Imagine taking 6 year olds to see the Hunger Games. This activity would not be appropriate. Similarly, for example, it would not be appropriate to take teenagers to the library to listen to the "storybook lady." It is also important to remember that chronological age does not necessarily equal developmental age. Use your good judgment here, as well as follow the guidelines for your residential facility.

Slide 8



Motivation Techniques to Encourage Youth Participation in Activities

Despite your good intentions, the youth that you work with may not be motivated to learn life skills or social skills. You may then encounter some resistance. For example:

- They may not wish to attend activities
- Or they attend only sometimes.
- They might not think something is important or relevant.
- They may actively resist attending (participation, but not as instructed, passive-aggressive isolation, negativism, refusal, disruptiveness).
- There might be some aggression in the form of sarcasm, put-downs, bullying, intimidation, or use of threats.
- They may get off topic, monopolize conversation, or interrupt.
- Excessive restlessness during activities, or falling asleep are good indicators that motivation is lacking.

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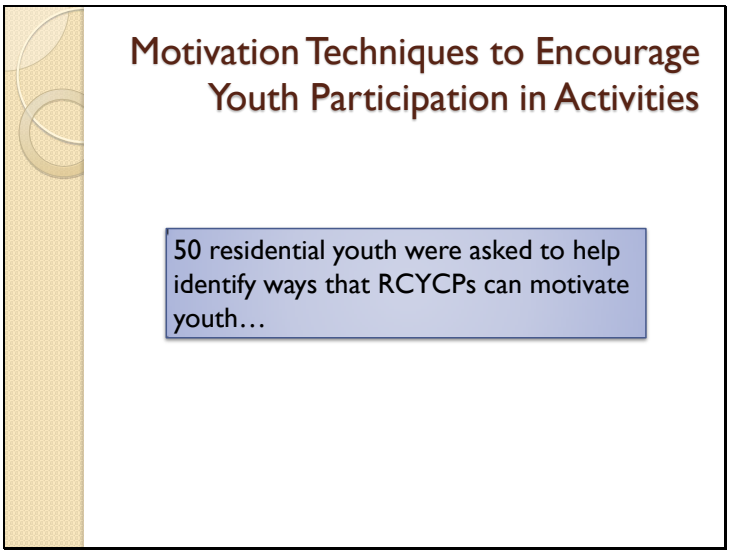
By artur84, published on 22 March 2013
Stock Photo - image ID: 100149562

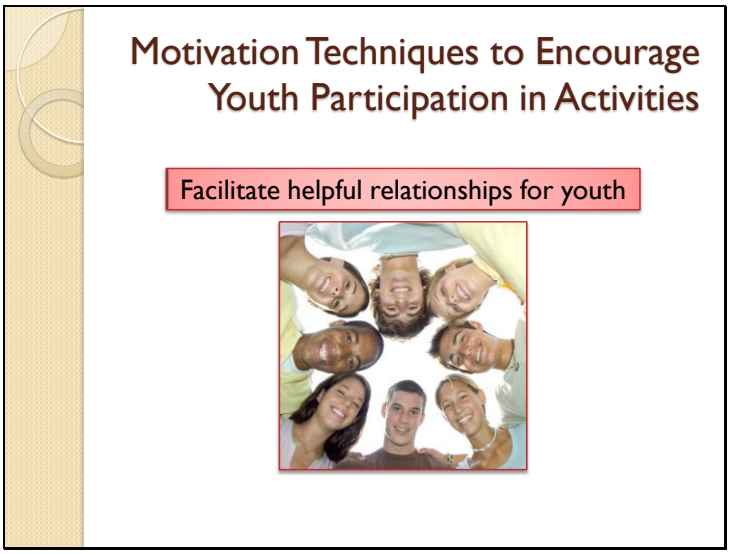
Slide 9



So what do you do? Motivating people can be difficult.

Building Bridges Initiative conducted a study of promoting youth engagement in residential settings and in doing so interviewed more than 50 youth in such residential settings. These youth were asked to use their personal experiences of life in residential care to help researchers identify ways that RCYCPs can effectively motivate youth to participate or “engage” in the processes and activities of residential care. Six key themes emerged from the feedback.

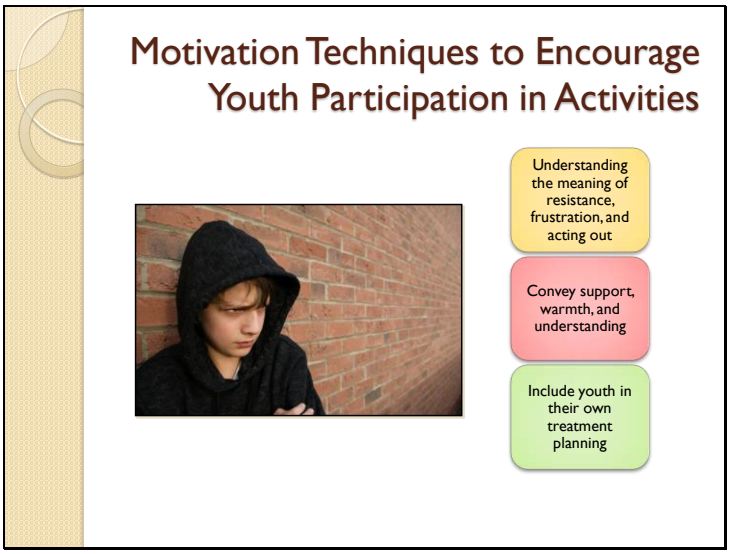
Slide 10



1. Facilitate Helpful Relationships for Youth:

The youth reported how crucial it is for them to have people that they can trust and who provide them support, especially during challenging times. They emphasized how difficult residential placement can be, and that many of them do not have the benefits of supportive relationships with friends or family. RCYCPs like you have the opportunity to provide that support, take interest in the youth, and become caring, consistent mentors for them. Additionally, the youth noted that it is extremely helpful to them when counselors help facilitate positive relationships among all of the youth. These positive relationships that are cultivated are one of the most important components in motivating youth to participate in the activities in residential care.

Slide 11

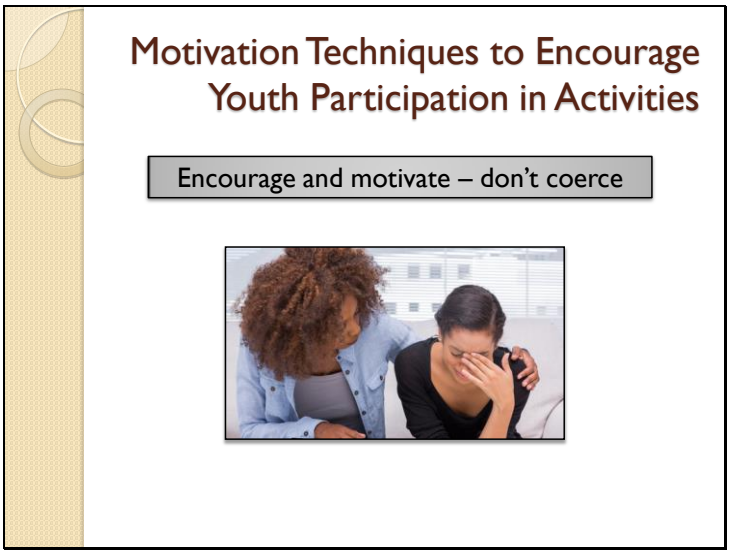


2. Understand the Meaning of Resistance, Frustration, and Acting Out:
The youth in this study felt that it was incredibly important for RCYCPs to understand where they are coming from and why they might be acting out. They felt like their behaviors are often poorly understood and so then handled badly by the RCYCPs, thereby decreasing the youth's desire to participate in activities. The youth discussed how their past traumatic experiences make it extremely difficult for them to trust people – especially providers (like RCYCPs) and that "acting out" is an expression of this. They talked how they often feel scared, alone, isolated, and confused when they are in residential placements. These feelings then make them feel frustrated and hopeless about the future, and that there is no end to their placement – that it will go on indefinitely. As a result of these negative feelings, youth disengage completely from the process, or act out in other ways. The youth report that the most helpful thing RCYCPs can do to manage these behaviors, as well as re-engage the youth, is to convey support, warmth, understanding, and allow youth the time they need to gather their thoughts and express themselves. Additionally, the youth mentioned that being included in their own treatment planning can also help to keep them motivated and engaged.

Slide 12

3. Create Opportunities for Peer Support:
In addition to support from RCYCPs, residential youth emphasized the importance of having peer support as a way to keep them engaged in the activities and processes of residential care. The youth though it would be especially helpful to have peers who are in a position to understand and empathize with each other, as they often have similar lived experiences and understand the emotions associated with placement firsthand.

Slide 13



4. Encourage and Motivate – Don't Coerce:

The youth in this study emphasized how important it is for them to not feel pressured or coerced into participation. They noted that when they are pressured or coerced they are much less likely to want to participate. Rather, they want to feel free to make choices. They want RCYCPs to be supportive, encouraging, and patient with them – taking time to explain why participation in activities is good for them. To some extent the youth would like the staff to "not give up on them," however, when they need space, the youth request that RCYCPs be patient and give them space.

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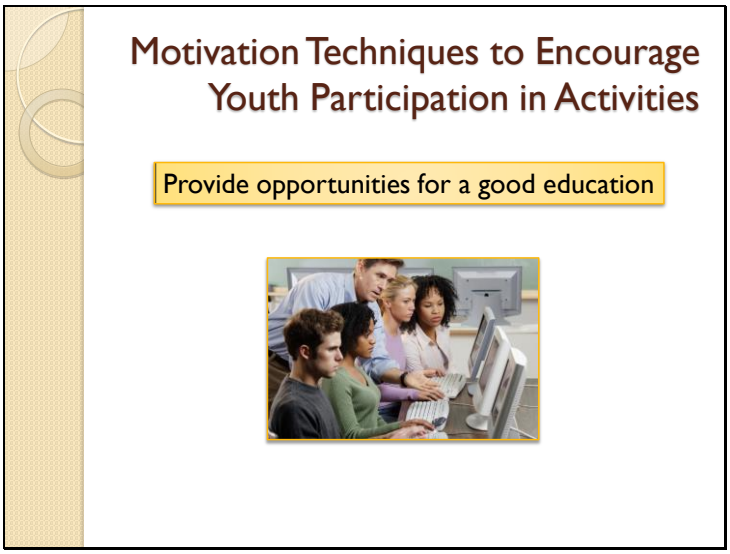

5. Provide Opportunities for a Good Education:
Another way the youth report that RCYCPs can motivate them is by providing opportunities for a good education. They reported feeling frustrated by the quality of educational services that they received in residential care – that it was both ineffective and below their standards and because of that kept them disengaged. Instead the youth requested that they be given placement tests so that they are able to work at the right levels. They also wanted educationally enriching activities, such as SAT preparation courses, to motivate and engage them.

Slide 15

6. Ensure Fairness and Safety:
One of the significant problems affecting engagement and motivation by youth in residential care is favoritism. According to the youth, RCYCPs often engage in favoritism by offering privileges to some youth but not to others. This form of favoritism serves to undermine staff-youth relationships and create negativity on the part of the youth. This then leads to disengagement and a lack of motivation to participate in residential activities and programs. The youth suggest, instead, that RCYCPs work hard to treat all youth equally and avoid "playing favorites."

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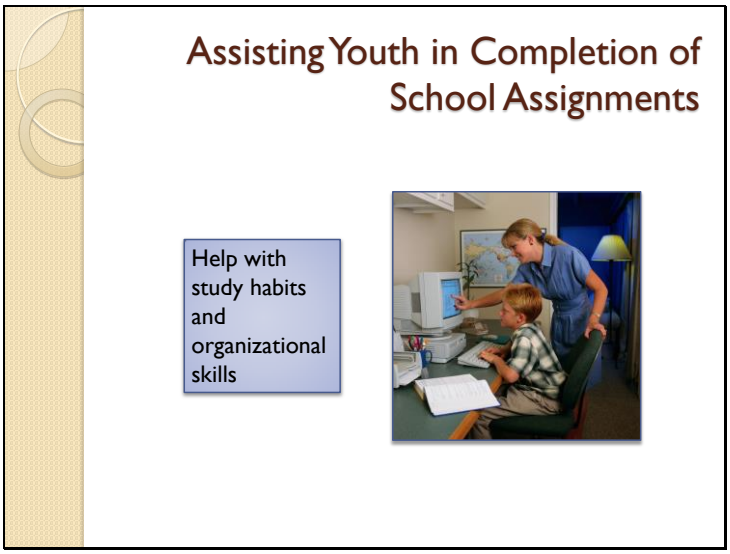

Assisting Youth in Completion of School Assignments

Part of your job as an RCYCP is to help youth succeed in school. One way to do that is to help them with their study habits and organizational skills. As was discussed during life skills, helping them identify the factors that matter the most to them in terms of their success. How do they study best? How can they keep track of the things they need to do for school? How do they come up with a plan and timeline for getting their work done? You may also be helpful to them in finding resources (such as library materials) to complete their assignments.

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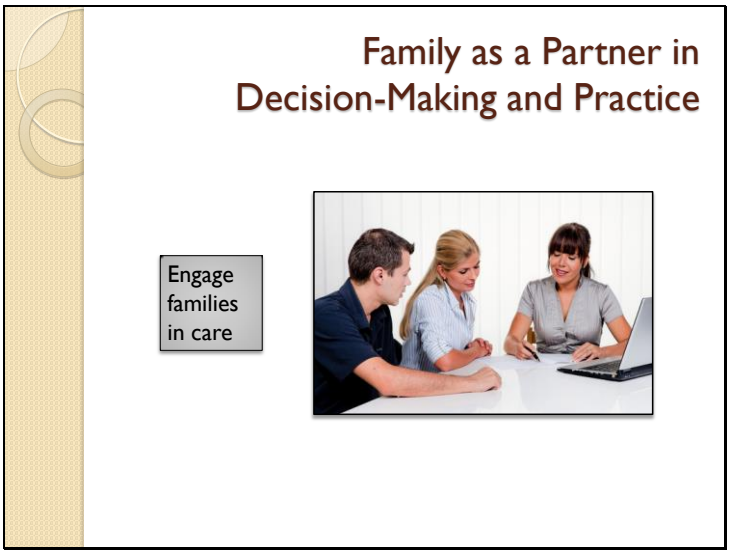

Family as a Partner in Decision-Making and Practice

In order for residential programs to be able to effectively help children and youth, RCYCPs need to engage and involve families in that care. Specifically, that includes activities such as involving families in the planning and delivery of treatment, as well as maximizing family involvement in the transition from residential services to after-care support. This might mean parents/caretakers being involved in planning and decision-making, education and skill-building, relationship-building/recreation, involvement in direct clinical services, transition planning, and provision of after-care supports.

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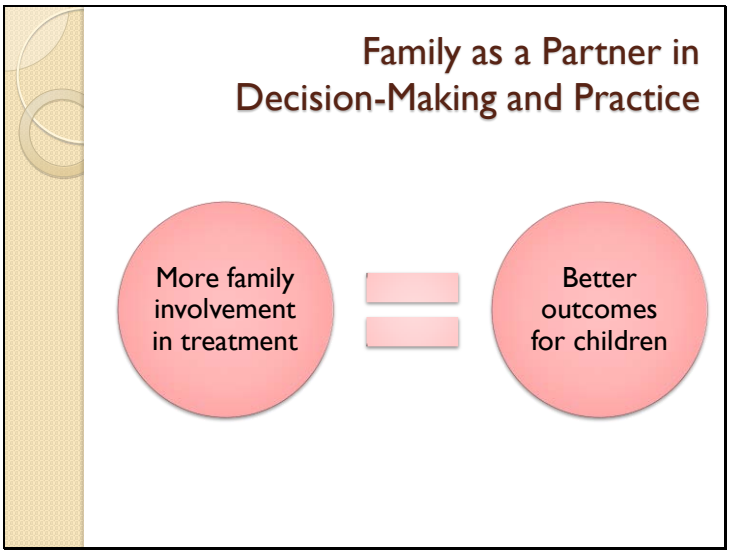
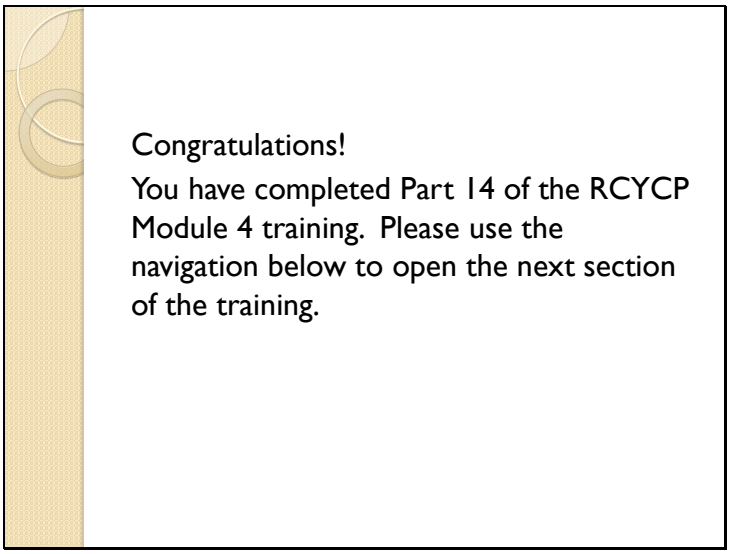


Review of the research displays the strong positive connection between family involvement and outcomes for children in residential care treatment. Most effective treatments for youth require some level of caregiver involvement.

Unfortunately, getting parents and caregivers involved in treatment can be extremely difficult. Research shows that even when parents are initially motivated to attend, 15-35% of parents fail to show up for first appointments. Additionally, the dropout rate for parent/caregiver involvement may be as high as 60%.

Before we discuss some strategies to engage families in treatment, let's talk about some of the barriers to family and caregiver participation in decision-making and practice.

Slide 20



You have completed Part 14 of the RCYCP Module 4 training. Please use the navigation below to open the next section of the training.

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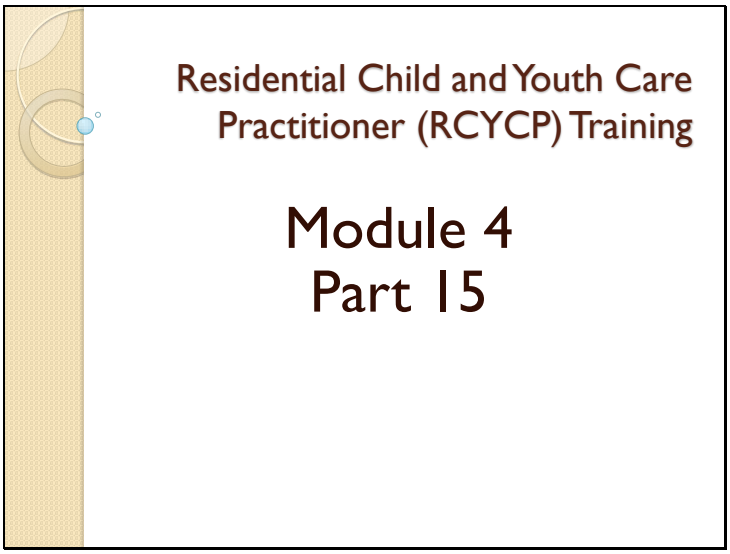

Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 4, Part 15 of the Residential Child and Youth Care Practitioner Training.

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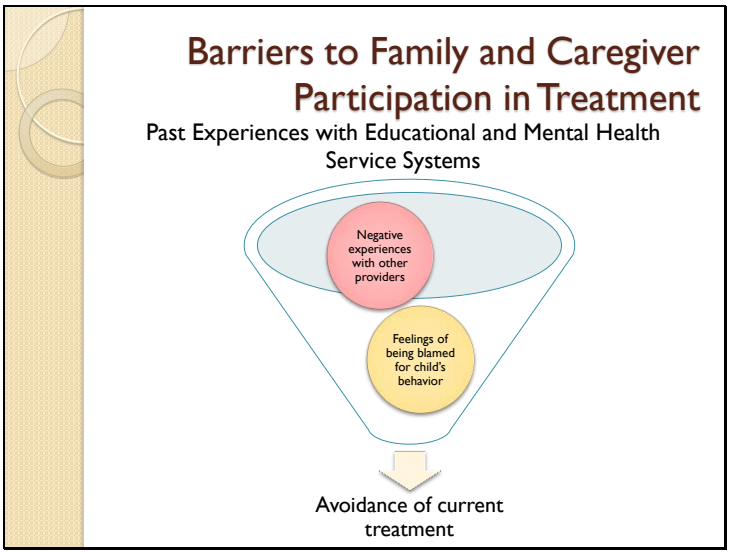
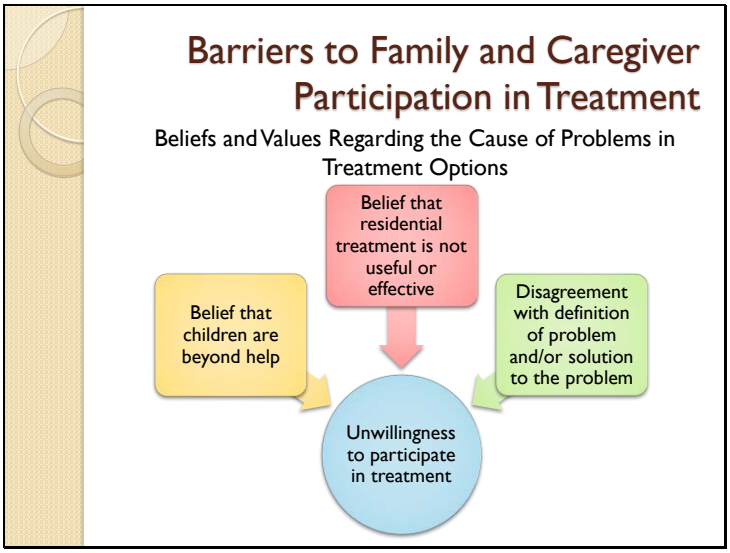


Barriers to Family and Caregiver Participation in Treatment

One barrier is past experiences with educational and mental health service systems.

When youth enter residential treatment, their parents/caregivers have likely had many interactions with different service providers, and this history will influence their decisions, behavior, and participation with residential treatment providers. If they have had negative experiences with other mental health service providers, they are unlikely to want to participate in any way with their child/youth's treatment in residential care. For example, if parents feel that they have been blamed for their child's behaviors in the past by other service providers then they will probably avoid being involved in the current treatment. They will stay at a distance.

Slide 4



Another barrier has to with beliefs and values regarding cause of problems and treatment options.

Parents and caregivers may believe that their children are beyond help, or that residential treatment is not useful or effective in treating their kids. They may disagree with the definition of the problem, or how the problem should be solved. There are many ways in which a parent's or caregiver's beliefs and values can negatively affect their willingness to participate in treatment.

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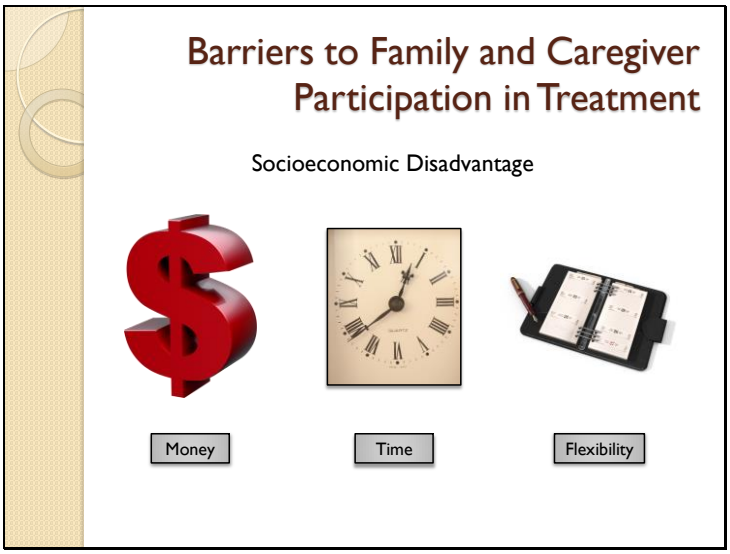
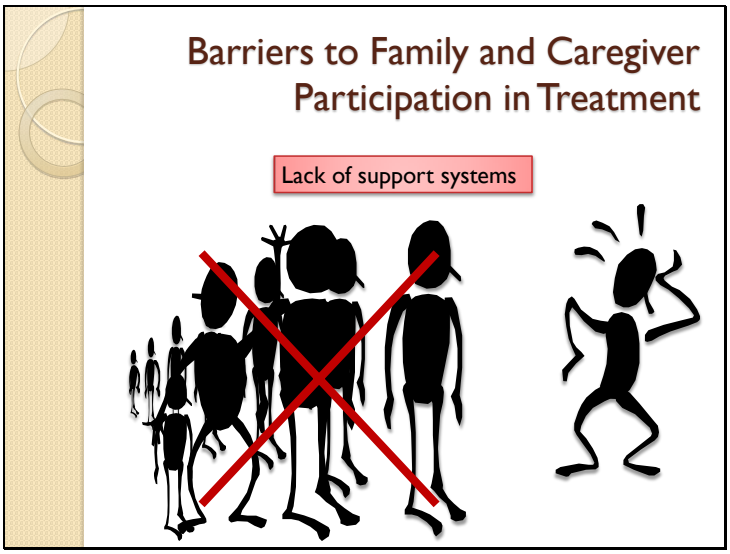


Another barrier to family engagement is socioeconomic disadvantage. Families may not have the economic resources to get or stay involved. For example, parents/caregivers may not have the money, time, or flexibility with work to participate.

Slide 6

Additionally, parent stress and depression can make it difficult for families/caregivers to engage in treatment.

Slide 7



Lack of support systems to help parents/caregivers deal with their other responsibilities (and it is likely that they have many) may make it difficult to participate either consistently or at all in treatment.

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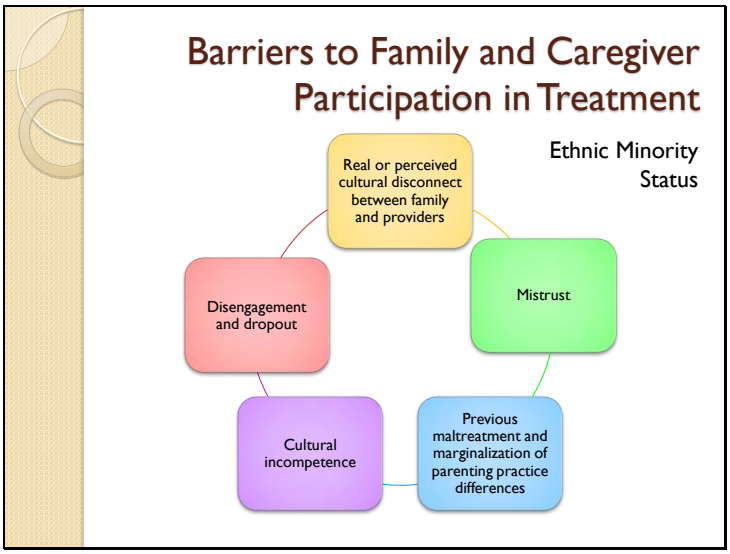
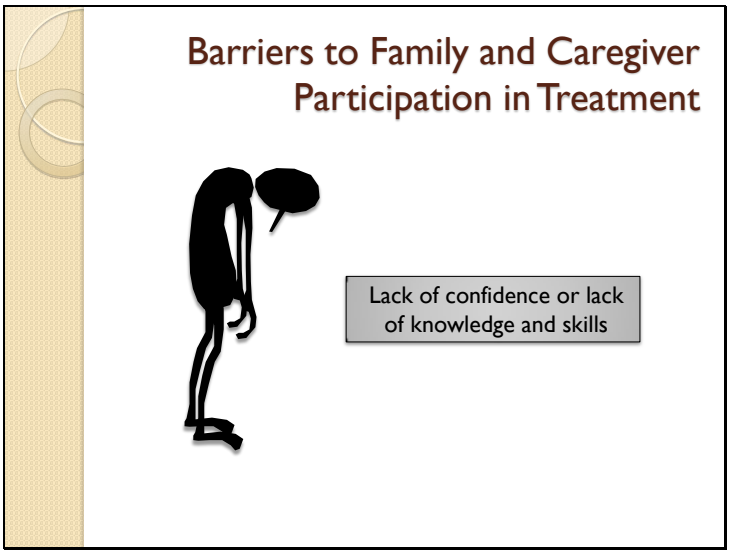


One major barrier to family involvement in residential care is the real or perceived cultural disconnect between the family and the residential providers. If RCYCPs are not knowledgeable and sensitive to cultural differences they may inadvertently alienate parents/caregivers. Research shows that minority-group parents often develop a mistrust for services because of previous maltreatment and marginalization of parenting practice differences (Herman et al., 2011). These culturally incompetent practices can keep parents/caregivers from participating in treatment at the outset, as well as increase the likelihood that they will eventually disengage or drop out of treatment even if they initially participated. This is another reason why cultural competence is crucial to effectively working with youth and their families.

Slide 9

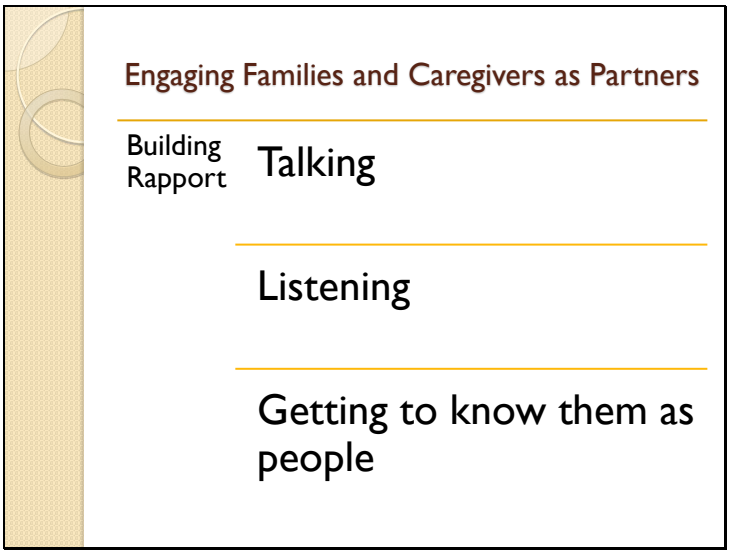


Finally, parents or caregivers are often at a loss as to how to deal with their youth. One of the reasons that residential care is necessary is that their home situations have not been successful in the past.

Parents/caregivers may feel like they have failed, or will continue to fail when it comes to these kids. Their lack of confidence or belief that they lack knowledge or skills can significantly contribute to their hesitation to become involved.

This lack of confidence, or any of the previously listed issues, may contribute to overall resistance to participating in decision-making, and treatment. It is up to you as a residential counselor to become skilled at recognizing these barriers and engaging families as partners.

Slide 11



Engaging Families and Caregivers as Partners

So what, then, are the ways to engage families as partners in the care of their children?

Building rapport is one of the most crucial components of engaging families. It sets the stage for a positive relationship between counselors and families. As an RCYCP you build rapport in several ways, primarily through talking and listening to families, and getting to know them as people. What do they think the problem is? What do they think is needed to address the problem? What have been their previous experiences with mental health providers?

In this way you are developing a collaborative relationship (that notion that we are partners in this process). They are the experts on their family and should be treated as such.

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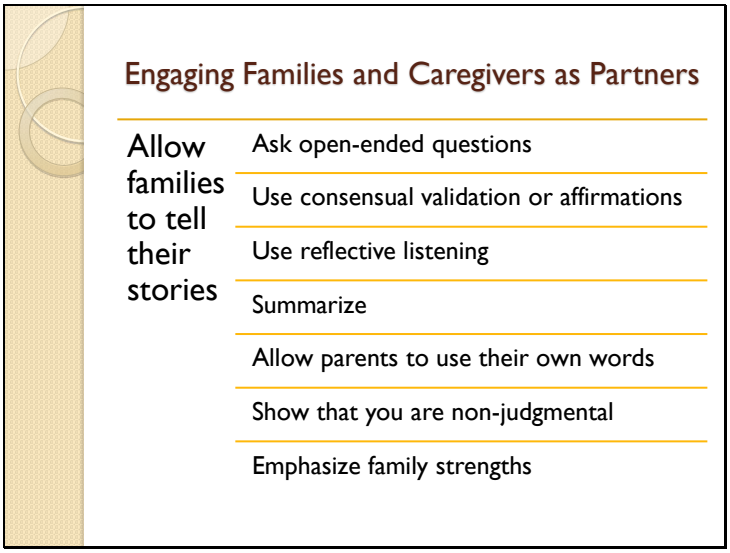

It also includes allowing families to tell their story, and to do so in their own words while you provide an empathic and non-judgmental atmosphere. If you think back to the section on communication, many strategies can be helpful, such as:

- Asking open-ended questions: “tell me more about your concerns . . .”.
- Using consensual validation or affirmations: “I can see how hard you are working on this . . .”.
- Using reflective listening “It makes you angry when . . .”.
- Summarizing “the three things I’m hearing that you really want to change about this situation . . .”.
- Allowing parents to use their own words.
- Showing that you are non-judgmental .
- Emphasizing family strengths.

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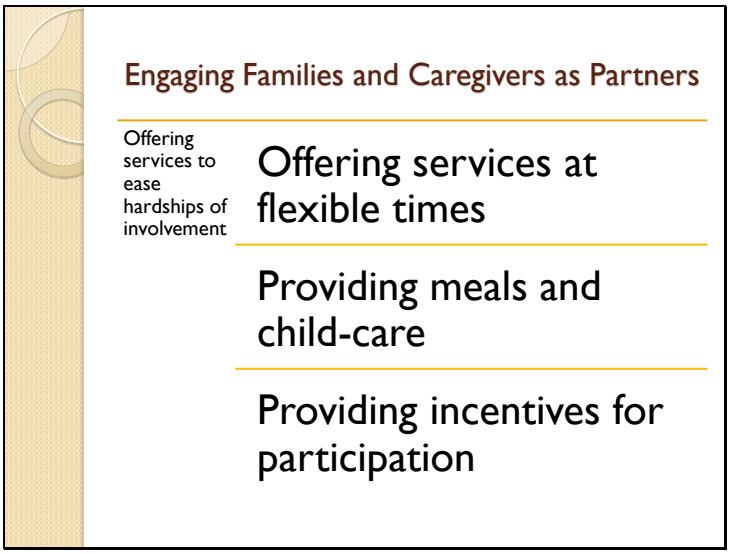


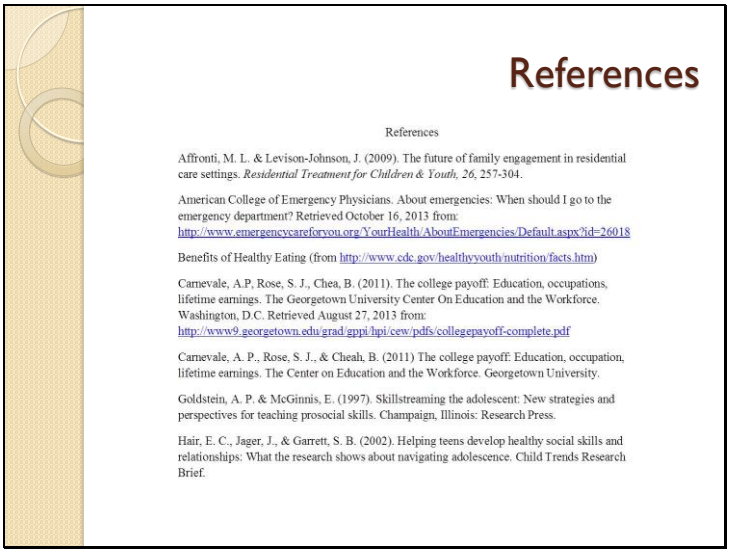
Another way to engage families is by helping families see a high likelihood of benefit of help-seeking relative to cost. That is to say, they need to be able to see the potential for good outcomes from their involvement so that they are willing to overcome any obstacles to becoming involved. A way to accomplish this is by offering services that may ease the hardships of involvement for parents/caretakers such as:

- Offering services at flexible times
- Providing meals and child-care for participation in family-focused interventions
- Providing incentives for participation

Slide 14

Finally, and it should come as no surprise to you given what you have learned so far… Being culturally competent is a MUST.

Slide 15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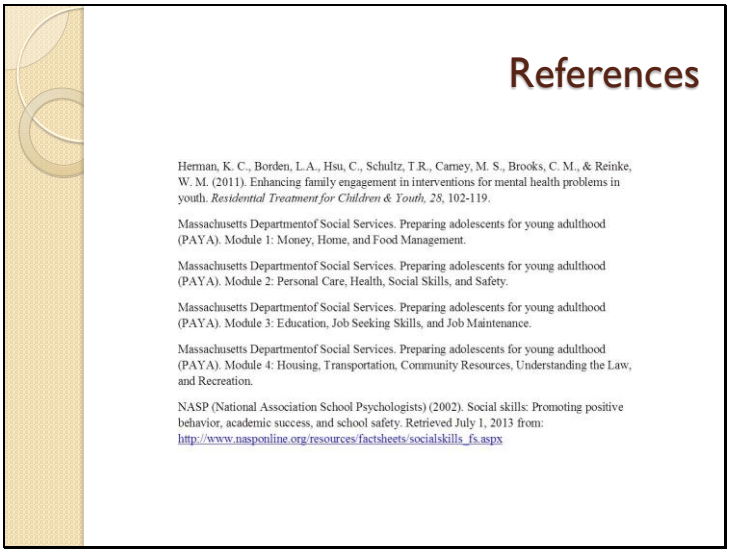
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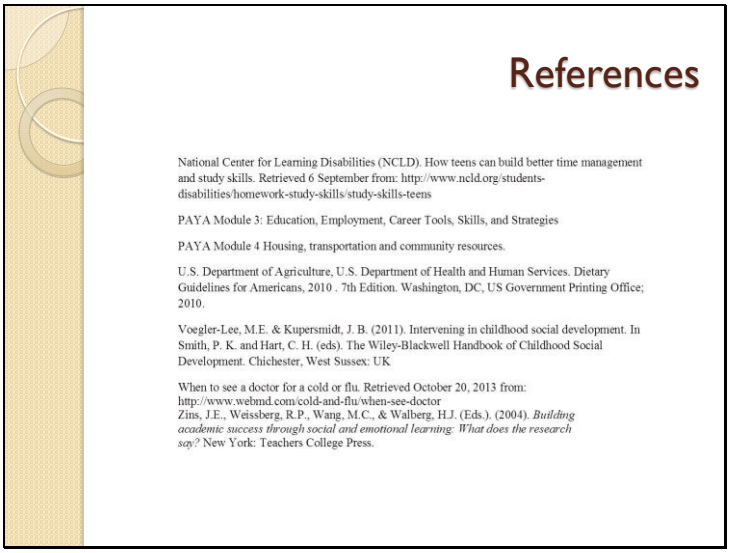
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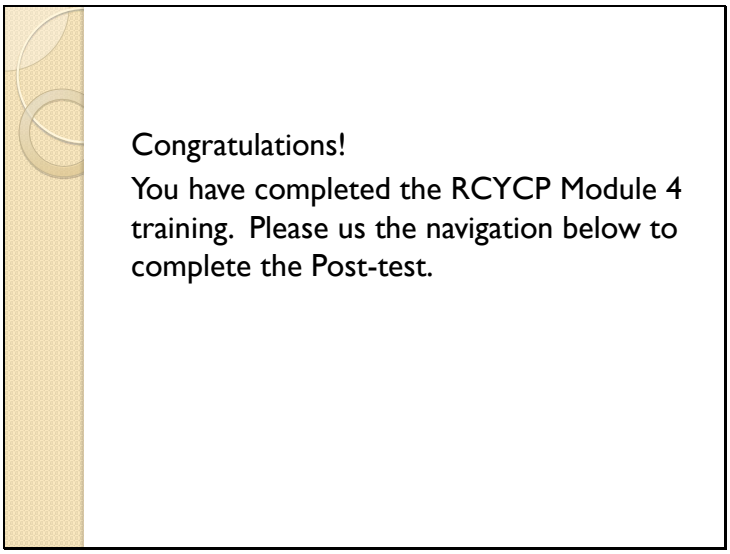

Congratulations! You have completed the RCYCP Module 4 training. Please us the navigation below to complete the Post-test.

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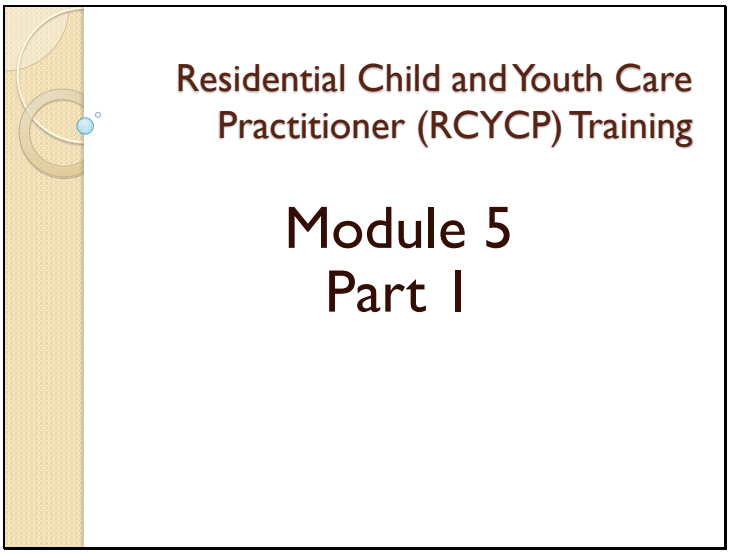

Residential Child and Youth Care Practitioner Training

Welcome to Module 5, Part 1 of the Residential Child and Youth Care Practitioner Training.

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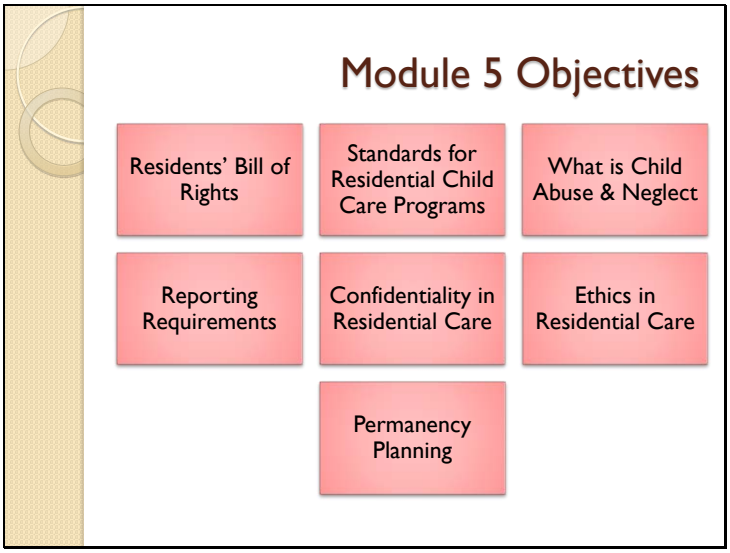

Module 5 Objectives

Module 5 covers information that you need to know about legal and ethical issues pertaining to residential care. In this module you will learn about the following:

- Residents' Bill of Rights
- Standards for Residential Child Care Programs
- Identifying Child Abuse and Neglect
- Reporting Requirements
- Confidentiality in Residential Care
- Ethics in Residential Care, and
- Permanency Planning

Slide 4

Residents' Bill of Rights

Let's begin with Maryland's Code on Residents' Bill of Rights (statute 8-707). According to Maryland law, a youth in residential care has a right:
1. To be treated with fairness, dignity, and respect;

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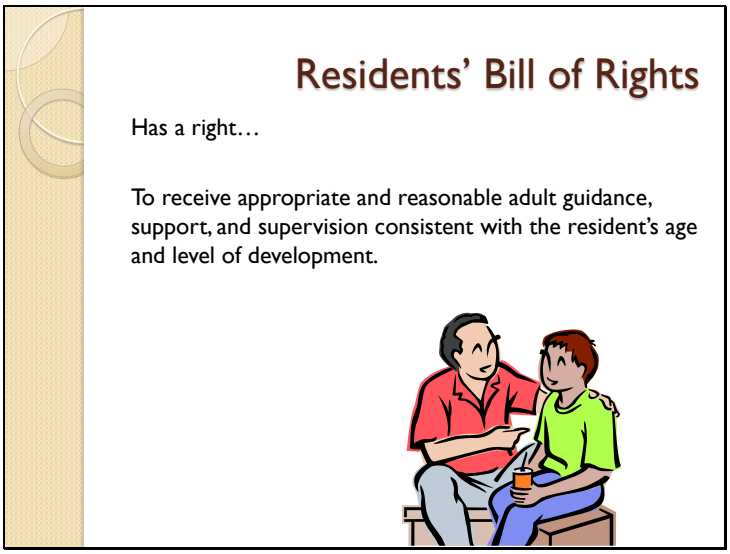

Has a right…

2. To receive appropriate and reasonable adult guidance, support, and supervision, consistent with the resident's age and level of development;

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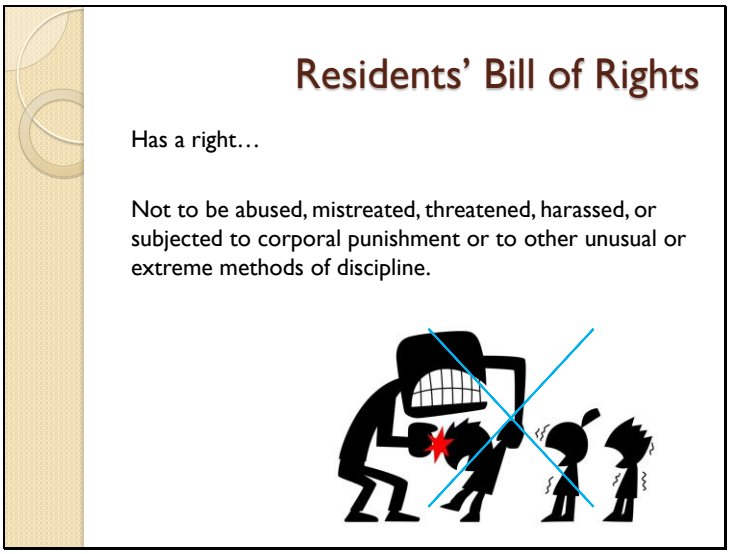

Has a right…

3. Not to be abused, mistreated, threatened, harassed, or subjected to corporal punishment or to other unusual or extreme methods of discipline;

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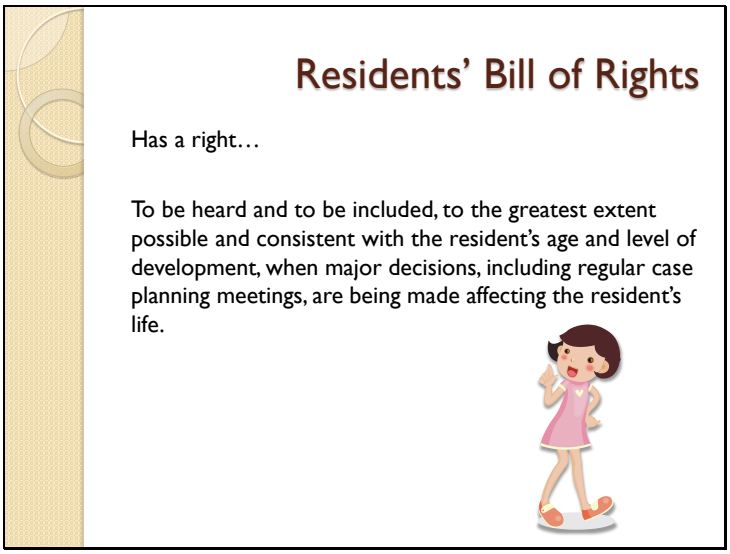

Has a right…

4. To be heard and to be included, to the greatest extent possible and consistent with the resident's age and level of development, when major decisions, including regular case planning meetings, are being made affecting the resident's life.

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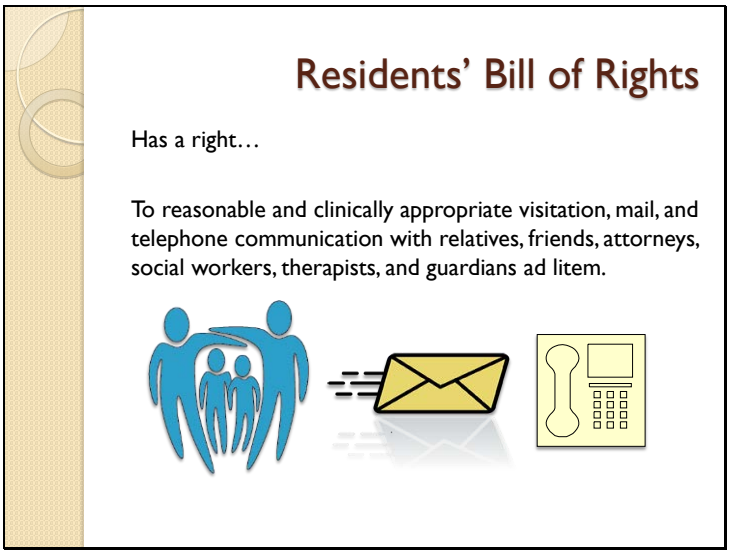

Has a right…

5. To reasonable and clinically appropriate visitation, mail, and telephone communication with relatives, friends, attorneys, social workers, therapists, and guardians ad litem.

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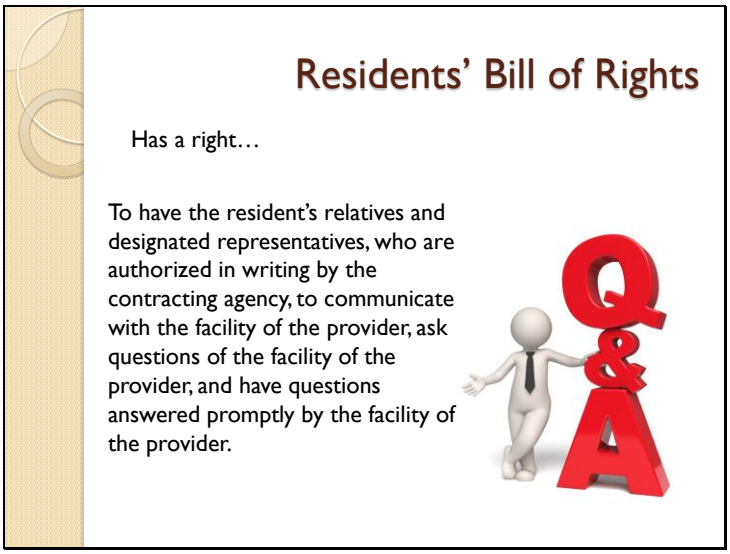
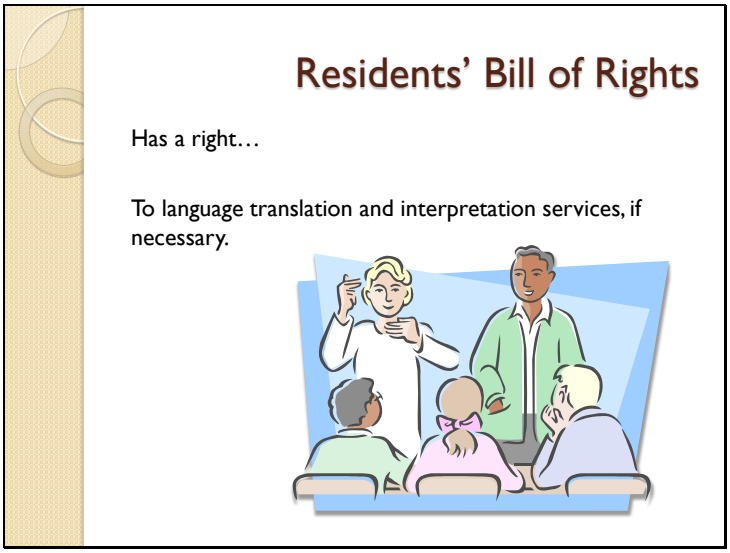


Has a right…

6. To have his or her relatives and designated representatives, who are authorized in writing by the contracting agency, communicate with the facility of the provider, ask questions of the facility of the provider, and have questions answered promptly by the facility of the provider;

Slide 10



Has a right…

7. To language translation and interpretation services, if necessary.

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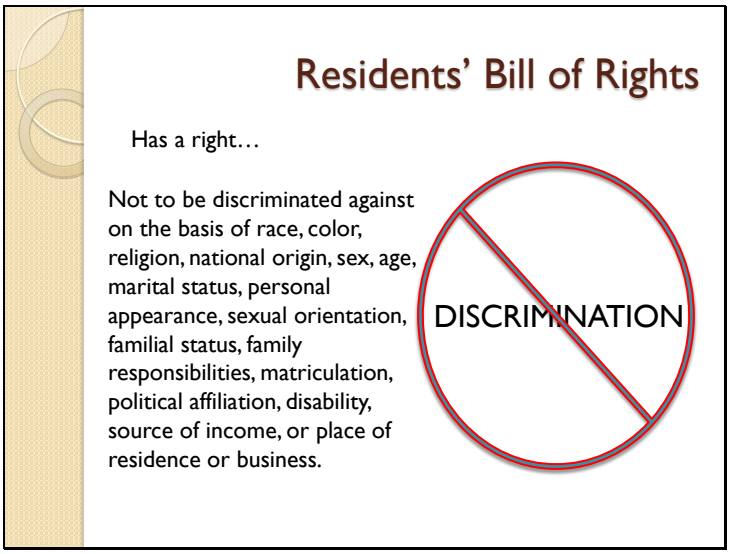
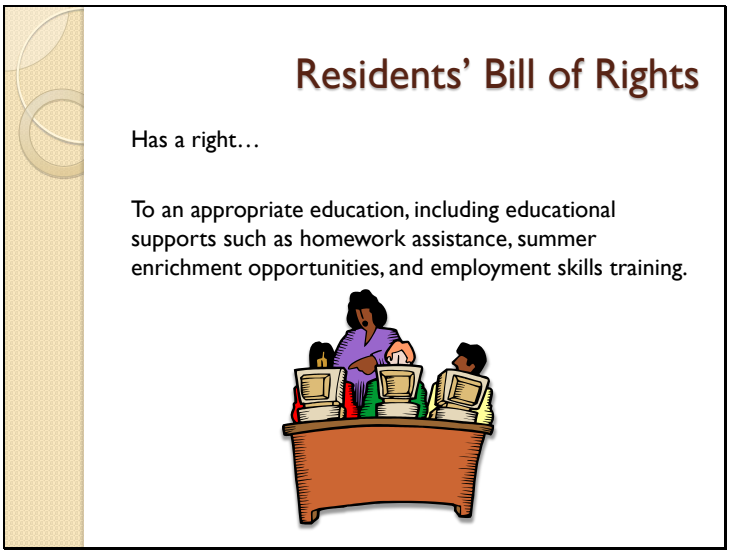


Has a right…

8. Not to be discriminated against on the basis of race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, familial status, family responsibilities, matriculation, political affiliation, disability, source of income, or place of residence or business.

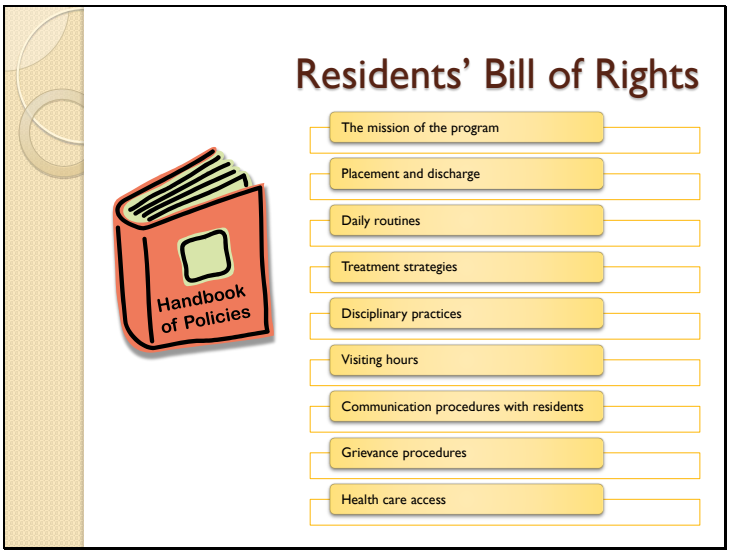
Slide 12



And finally, has a right…

9. To an appropriate education, including educational supports such as homework assistance, summer enrichment opportunities, and employment skills training.

Slide 13



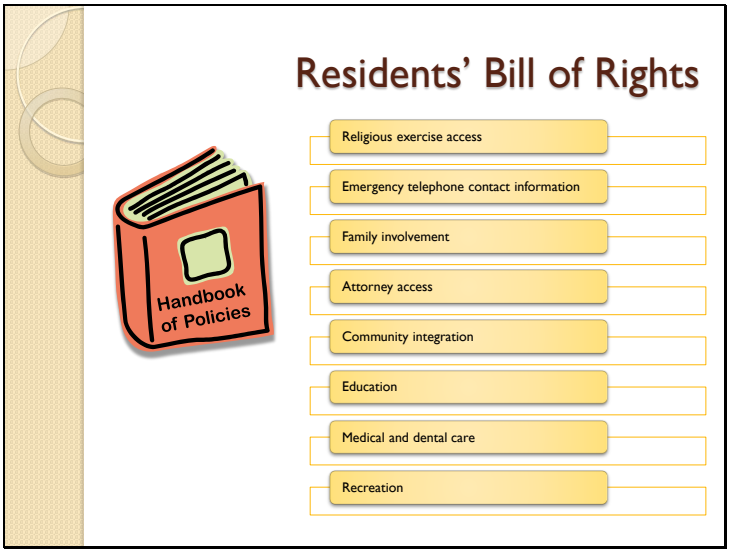
Residents' Bill of Rights

Additionally, Maryland law requires that residential service providers post the Residents' "Bill of Rights" in a conspicuous location at the facility, as well as provide a handbook of policies to residents and their parents or legal guardians.

This handbook includes information on:

- The mission of the program
- Placement and discharge
- Daily routines
- Treatment strategies
- Disciplinary practices
- Visiting hours
- Communication procedures with residents
- Grievance procedures
- Health care access

Slide 14

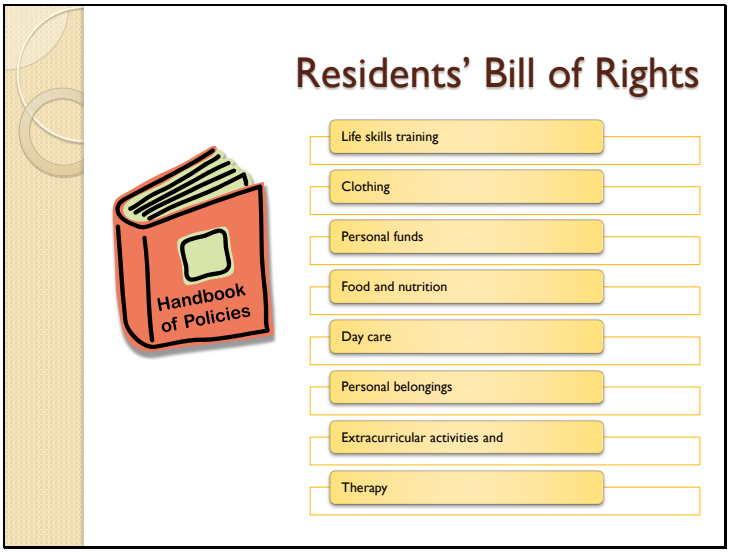


Residents' Bill of Rights

This handbook includes:

- Access to practice their religion
- Emergency telephone contact information
- Family involvement
- Attorney access
- Community integration
- Education
- Medical and dental care, and
- Recreation

Slide 15



Residents' Bill of Rights

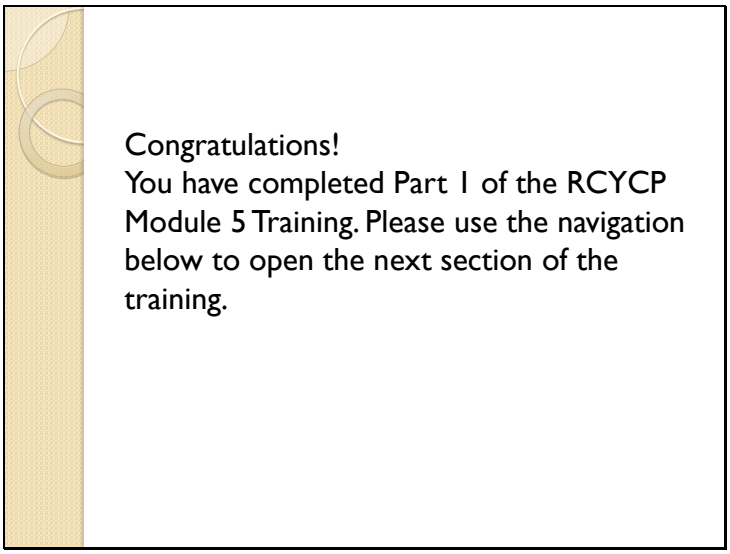
This handbook offers information on:

- Life skills training
- Clothing
- Personal funds
- Food and nutrition
- Day care
- Personal belongings
- Extracurricular activities and
- Therapy

In each child's case file there should be documentation that the child and parent or guardian of that child have received and reviewed the handbook.

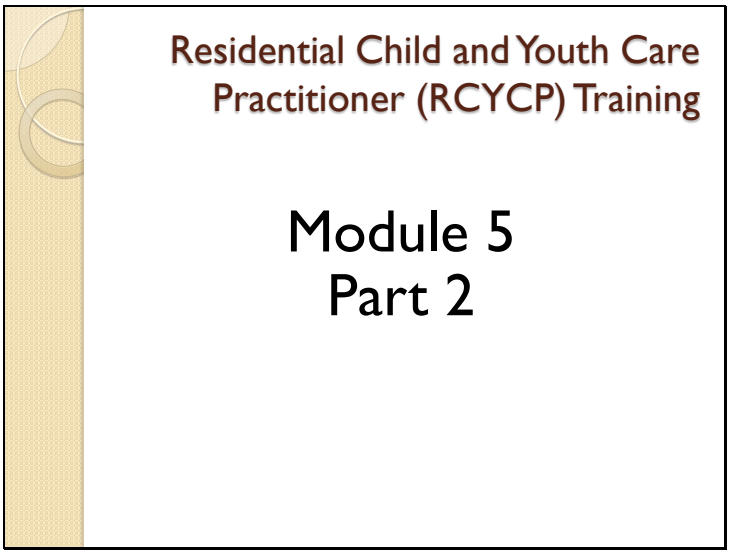
You, as an RCYCP, should have the opportunity to look over your program's handbook of policies and procedures. You should become familiar with the material in the handbook, as it will be important to your role at the agency.

Slide 17



Congratulations! You have completed Part 1 of the RCYCP Module 5 Training. Please use the navigation below to open the next section of the training.

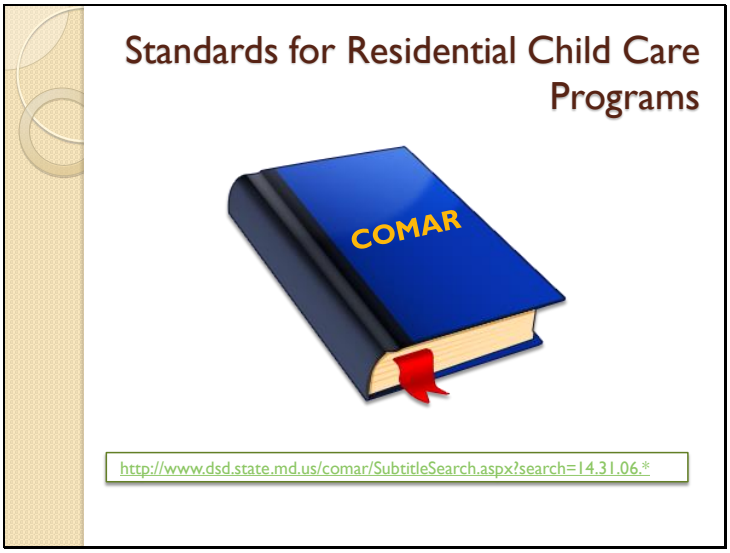
Slide 2



Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 5 Part 2 of the Residential Child and Youth Care Practitioner Training.

Slide 3



Standards for Residential Child Care Programs

As an RCYCP you work for a Residential Child Care Program that is licensed by the state of Maryland, and as such, you and the child care program that employs you are required to comply with a number of legal and ethical standards. You may remember hearing about COMAR in Module 1. COMAR stands for the Code of Maryland Regulations. In this module, you will hear about some additional COMAR standards that are most relevant to your work as an RCYCP. You can download and read through a complete list of the standards by visiting the website provided.

Please note, the term “child” or “children” here refers to all ages of youth in residential care. These terms are used specifically because the Maryland Standards use these terms.

http://www.dsd.state.md.us/comar/SubtitleSearch.aspx?search=14.31.06.*

Slide 5

Standards for Residential Child Care Programs: Personnel Policies

As an RCYCP you should you receive a copy of your program's personnel policies that include information about:

1. Annual performance evaluations.
2. Communicable diseases.
3. Confidentiality of records.
4. Description of job responsibilities.
5. Drug and alcohol free workplace.
6. Employee discipline, suspension, and dismissal.
7. Employee supervision.
8. Grievance procedures for employees.
9. Hiring and recruitment of qualified staff.
10. Hours of work.
11. Organizational chart
12. Orientation and on-going training requirements.
13. Salary and benefits.
14. Vacation and other leave allowances.
15. A prohibition against the employment of any person whose physical or emotional health, notwithstanding any accommodations required by law, would impair that person's ability to protect the health, welfare, and safety of the program's residents, and

16. A prohibition against employment discrimination based on race, color, national origin, religion, creed, age, sex, sexual orientation, marital status, ancestry, or physical or mental disability.

Slide 6

As an RCYCP you will be subject to a criminal background check that is required by law.

Slide 7

Standards for Residential Child Care Programs: Personnel Policies

In addition to the discussion of conduct that has occurred in these modules, your agency will have an established code of conduct that:

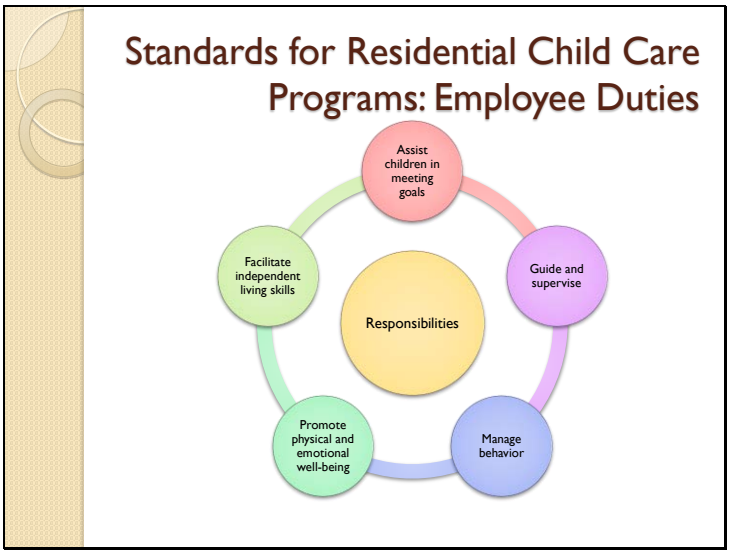
1. Bans sexual harassment or other discrimination against staff and residents, and
2. Requires that all staff (this includes RCYCPs) conduct themselves in a manner appropriate to serving the needs of the program residents.

Slide 8

Your agency is required to maintain adequate staff coverage at all times, based on the time of day, the size and nature of the program, and layout of the physical plant.

When the program administrator is unavailable, s/he is required to appoint a qualified staff member who will then have authority.

Slide 9

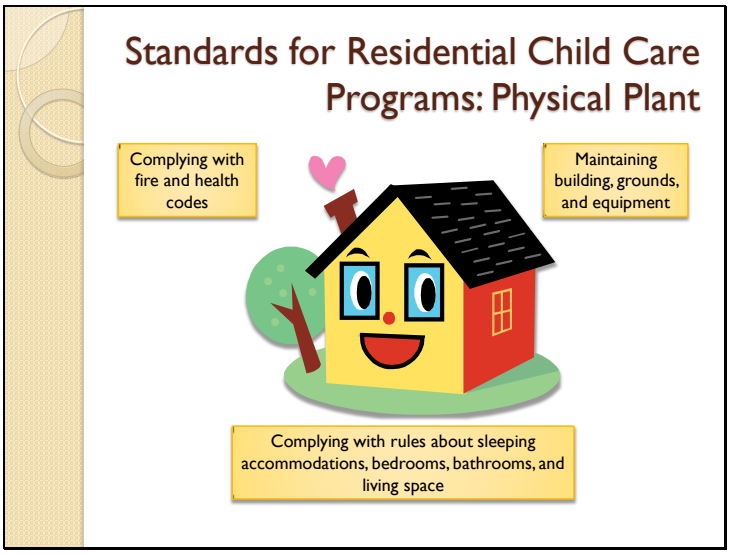


Standards for Residential Child Care Programs: Employee Duties

According to these standards, the responsibilities of Direct Care Staff (such as RCYCPs) are to:

1. Assist the children in meeting the goals and objectives of their individual plans of care
2. Guide and supervise the children in accordance with the Residents' Bill of Rights.
3. Manage the children's behavior.
4. Promote the physical and emotional well-being of the children, and
5. Facilitate the attainment of independent living skills based on the needs of the child.

Slide 11



Standards for Residential Child Care Programs: Physical Plant

Your agency is also required to maintain multiple aspects of the physical plant (essentially the building and property of the residential care facility). Some of the many requirements include:

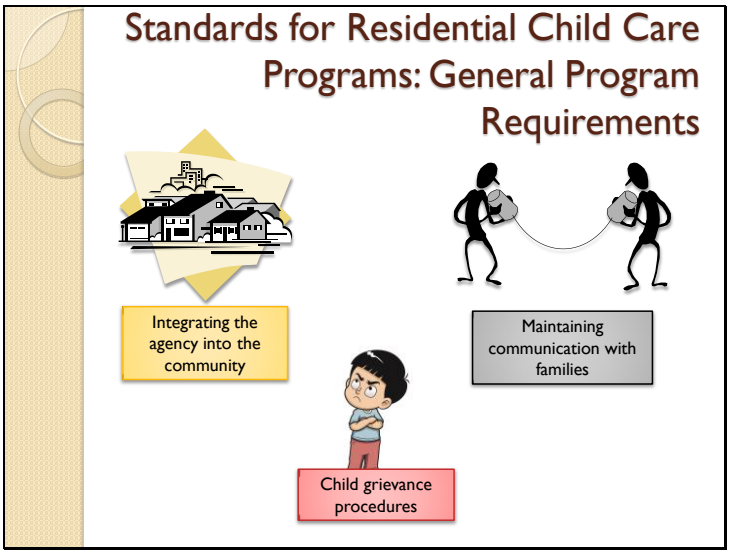
1. Complying with fire and health codes.
2. Maintaining building, grounds, and equipment.
3. Complying with rules about sleeping accommodations, bedrooms, bathrooms, and living space. For example, no more than four children may sleep in a bedroom, and children shall be allowed some discretion in the decorating of sleeping areas.

Slide 12

Standards for Residential Child Care Programs: Emergencies and General Safety

In addition to maintaining the physical plant, your agency will have policies and procedures in place for emergencies and general safety. For example, there will be emergency drills at least monthly, as well as procedures that will be followed before, during, and after an emergency. You will hear more about this topic in Module 6.

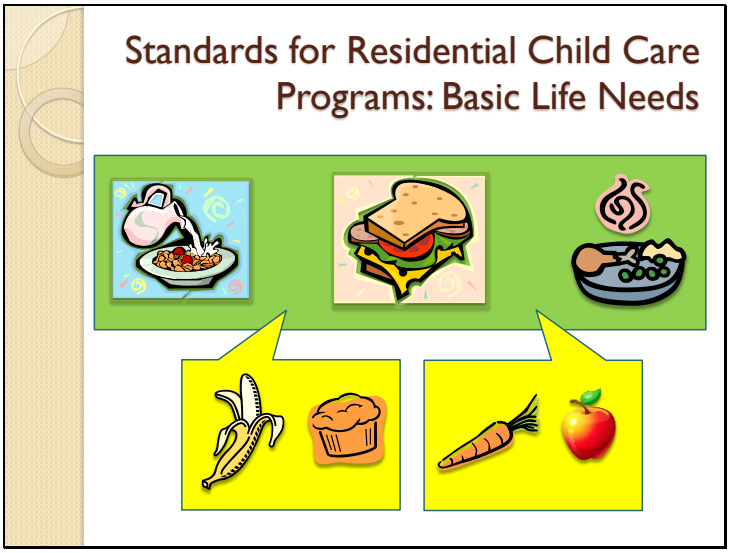
Slide 13



Standards for Residential Child Care Programs: General Program Requirements

General program requirements for all residential care placements include integrating the agency program into the community, maintaining communication with families and others involved in the child's life, as well as having child grievance procedures in place in the event of a problem.

Slide 14



Standards for Residential Child Care Programs: Basic Life Needs

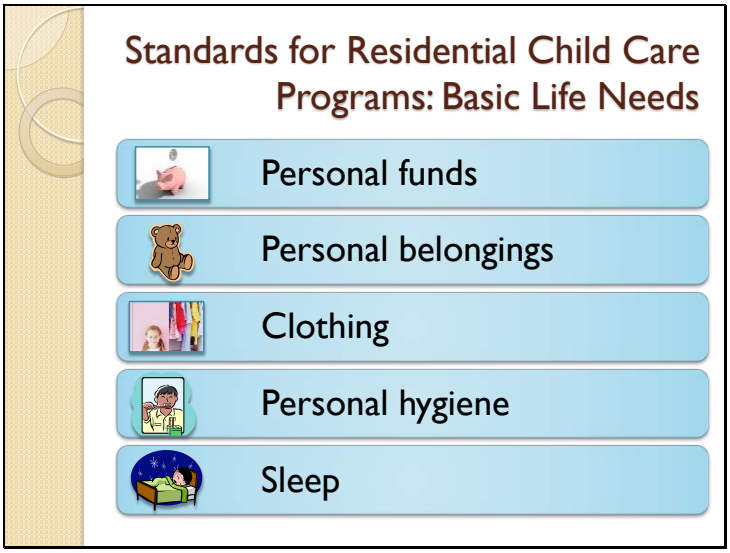
Agencies have a legal responsibilities to meet children's physical needs and well-being.

Among other things, children are provided 3 nutritious meals a day, as well as nutritious between-meal snacks. You will remember from earlier modules about the importance of cultural competence. One of the ways that is incorporated into resident life is through food. Meals are modified as appropriate for religious, cultural, life philosophy, and/or health reasons.

You will notice that if you or other employees are served food from the facility, it will be the same food that is served to the children.

As you will hear again later, it is against the law to force feed or withhold food from a child as a form of discipline.

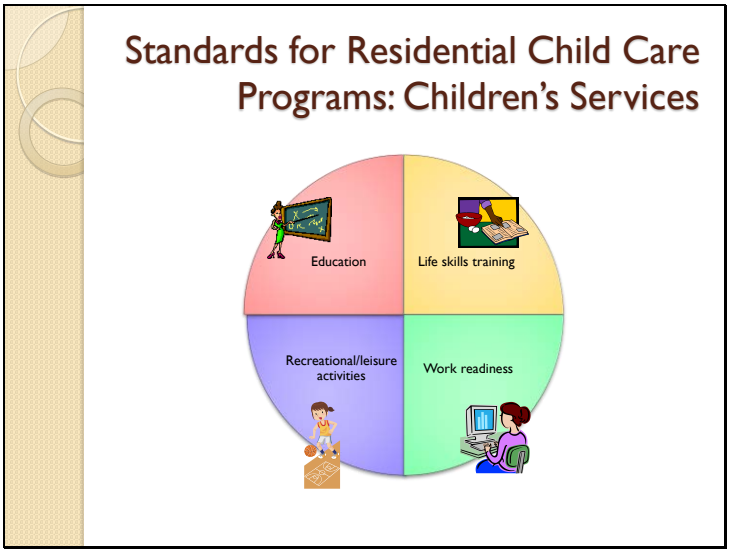
Slide 15



Other requirements of the physical needs and well-being category of regulations include policies regarding:

- Children's personal funds (for example, money that is earned by the child is considered his or her property)
- Personal belongings (for example, allowing a child to possess personal belongings)
- Clothing (for example, allowing a child to be involved in the selection, care, and maintenance of his or her clothing)
- Personal hygiene (for example, each child is provided with culture-specific and gender-specific hygiene products)
- Sleep (for example, children should have the opportunity each night for at least 8 hours of uninterrupted sleep, except in the event of an emergency or drill).

Slide 18



Standards for Residential Child Care Programs: Children's Services

Children in residential care are entitled by Maryland State Standards to receive various types of educational and life services.

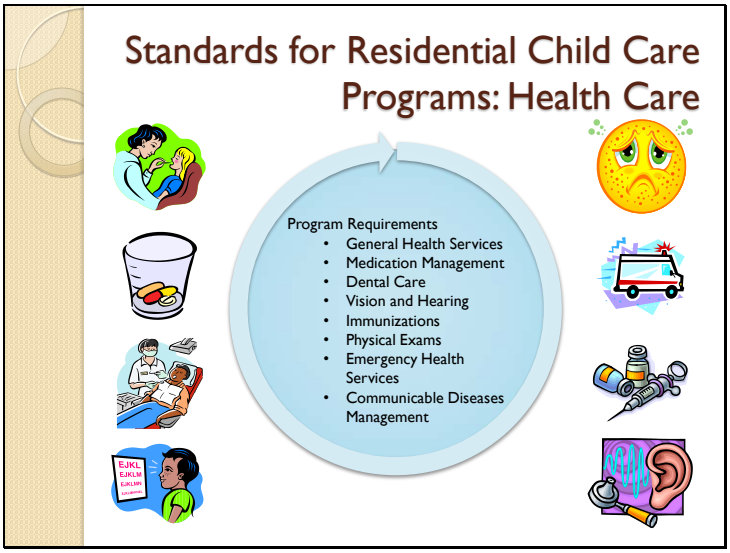
Children in residential care who are of mandatory school age -- that is, between 5 and 16 years of age -- and who have not earned a diploma or certificate of completion, are required to receive appropriate education. Depending on the individual, this might be regular education, special education, or vocational education. Also, children who are above the mandatory school age and who have not received a secondary school diploma or certificate of completion are required to participate in a secondary school education program, a tutoring program for the GED, or a developmentally appropriate vocational skills training program.

In addition to classroom education, children are provided life skills training appropriate to the age and capability of the child. You have heard about these life skills in Module 4.

Similarly, children are trained in work readiness depending on their age and capability.

Finally, children in care are entitled to be provided with recreational and leisure activities based on needs, interests, and group composition that include both indoor and outdoor types, as well as in the program and the community.

Slide 20



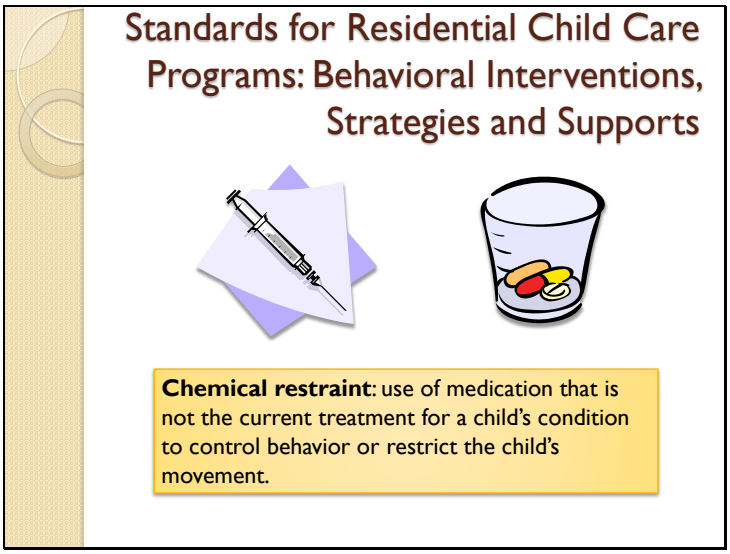
Standards for Residential Child Care Programs: Health Care

There are a number of different program requirements for health care for the children in residential care. These have to do with:

- General health services (for example, having a written plan in place for the health and mental health care of the residents).
- Medication management (for example, keeping medications locked up).
- Dental care (for example, regular check-ups every 6 months, as well as access to a dentist if the need arises between check-ups).
- Vision and hearing care (for example, arranging for access to vision or hearing care upon the authorization of the child's primary care physician).
- Immunizations (for example, updating immunizations for children who are not up to date).
- Physical exams (for example, having children undergo a physical exam if they have not had one during the prior 12 months, as well as regular check-ups thereafter as determined by the child's medical care provider).
- Emergency health services (for example, having a policy in place for emergency mental health services), and
- Communicable disease management (for example, having a policy in place for isolation in the event of a communicable disease threat).

You will learn the various policies and procedures regarding each of these at your specific site.

Slide 21

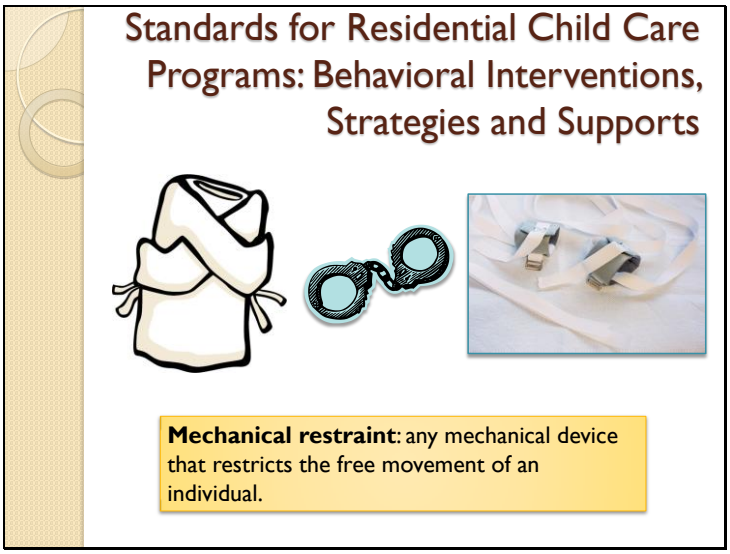


Standards for Residential Child Care Programs: Behavioral Interventions, Strategies and Supports

As part of your on-site training as an RCYCP, you will be trained in state-approved forms of discipline and behavior management techniques, including crisis management and the use of isolation and restraint. For the purposes of this online training, we will cover some important legal points with regard to behavioral interventions. You will learn much more about these in your on-site training.

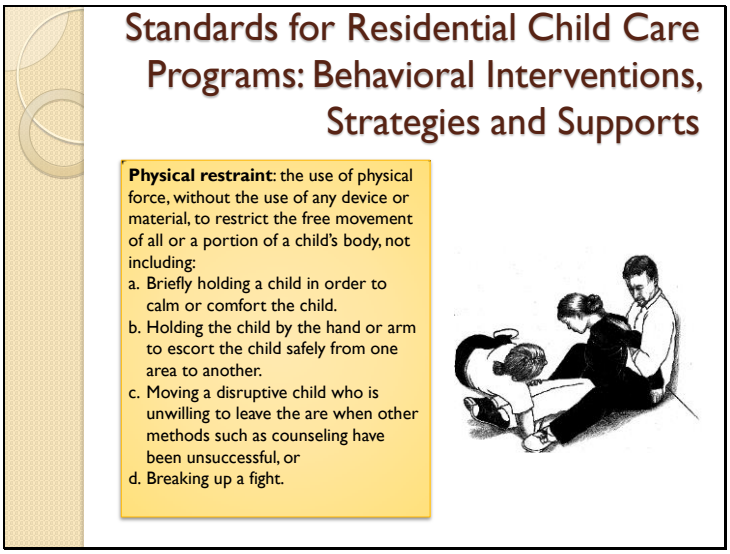
Before we begin, let's go over some terminology:
Chemical restraint means the use of medication that is not the current treatment for a child's condition, to control behavior or restrict the child's movement. For example, a sedative.

Slide 22



Mechanical restraint means any mechanical device that restricts the free movement of an individual. Examples include handcuffs, anklets, wristlets, camisoles, helmets with fasteners, muffs and mitts with fasteners, waist straps, head straps, restraining sheets, and similar devices.

Slide 23



Physical restraint means the use of physical force, without the use of any device or material, to restrict the free movement of all or a portion of a child's body, not including:
a. Briefly holding a child in order to calm or comfort the child;
b. Holding the child by the hand or arm to escort the child safely from one area to another;
c. Moving a disruptive child who is unwilling to leave the area when other methods such as counseling have been unsuccessful; or
d. Breaking up a fight.

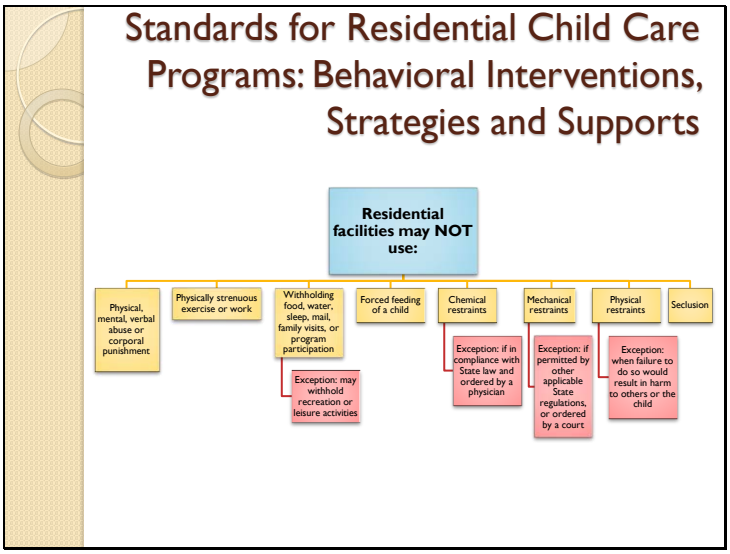
Do not utilize any type of physical restraint until you have been trained at your residential child care facility. As a matter of law, physical restraint is only used when other less restrictive forms of intervention have been attempted or determined to be inappropriate.

Image from: http://www.tact2.com/physicaltraining.html

Slide 24

Seclusion means the confinement of a child alone in a room from which the child is physically prevented from leaving.

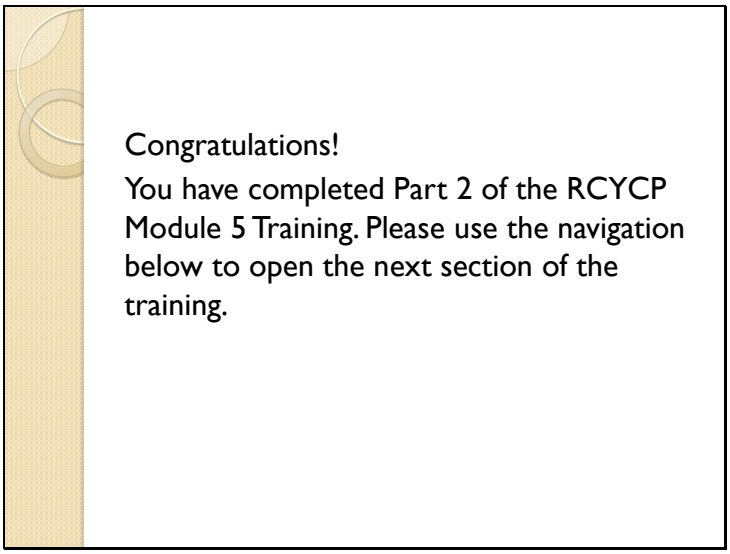
Slide 25



According to Maryland Statutes, residential care facilities may not use the following as disciplinary measures:

1. Physical, mental, and verbal abuse, or corporal punishment.
2. Physically strenuous exercise or work.
3. The withholding of:
    a. Food.
    b. Water.
    c. Sleep.
    d. Mail.
    e. Family visits, or
    f. Program participation other than recreation or leisure activities.
4. Forced feeding of a child.
5. Chemical restraints, unless in compliance with State law and ordered by a physician.
6. Mechanical restraints, except as permitted by other applicable State regulations or ordered by a court.
7. Physical restraint, except when failure to do so would result in harm to others or the child.
8. Seclusion.

Slide 27



Congratulations! You have completed Part 2 of the RCYCP Module 5 Training. Please use the navigation below to open the next section of the training.

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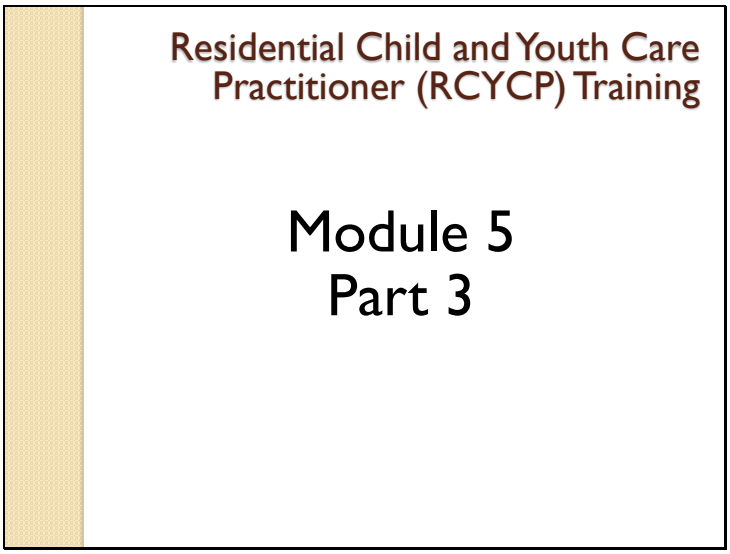
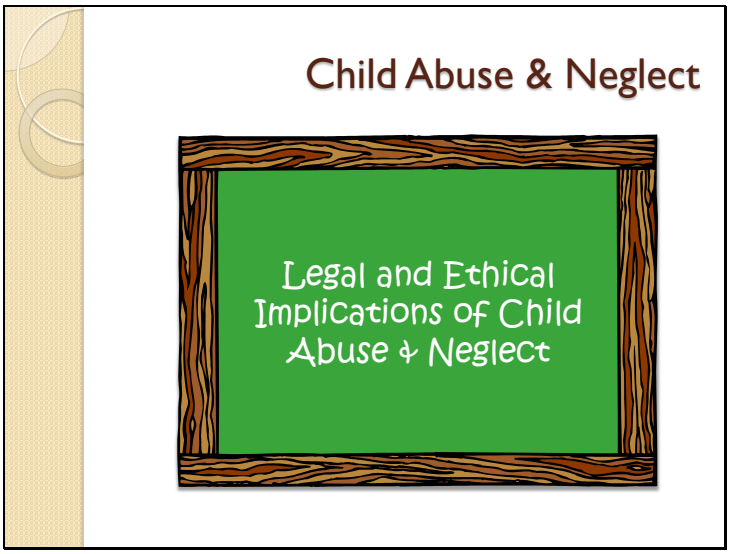


Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 5, Part 3 of the Residential Child and Youth Care Practitioner Training.

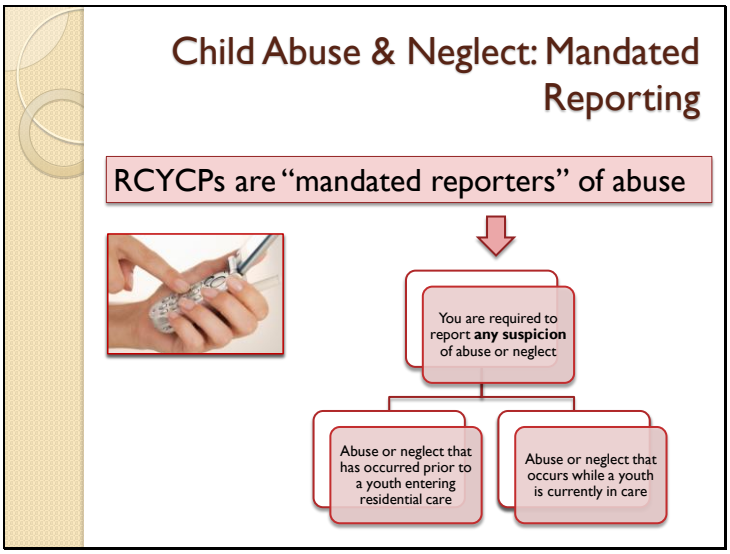
Slide 3



Child Abuse & Neglect

Let's turn now to a discussion of child abuse and neglect. While you will hear more about the impact of abuse and neglect on children in Module 7, the purpose of the discussion in this module is limited to the legal and ethical implications of abuse and neglect on you, as an RCYCP. Let's begin.

Slide 4



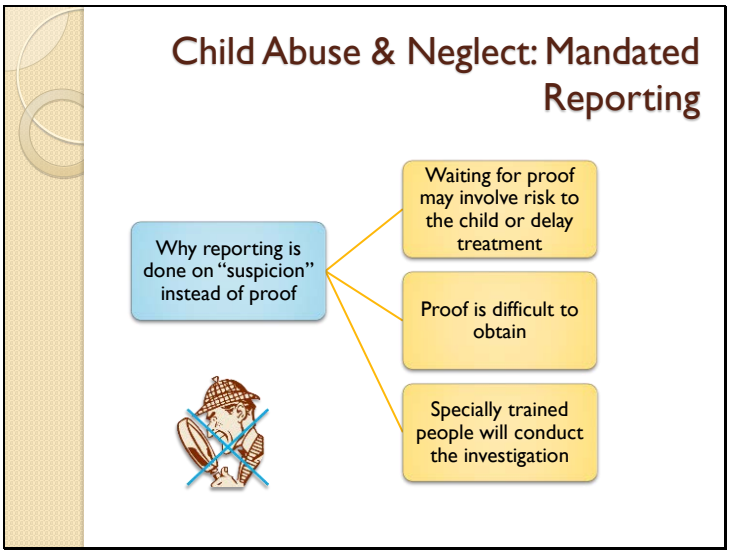
Child Abuse & Neglect: Mandated Reporting

As an RCYCP you are considered a mandated reporter of abuse. So what does that mean? That means that you are required by Maryland State law to report any suspicion of abuse or neglect of the youth at the agency where you work. This includes not only abuse or neglect that has occurred prior to a youth entering residential child care, but also any abuse or neglect that occurs while a youth is currently in care.

Slide 5

You will note that you are mandated to report based on "suspicion" of abuse. This is an important point to understand. Reporting does NOT require PROOF that abuse or neglect has occurred. Incidents are to be reported as soon as they are suspected.

Slide 6

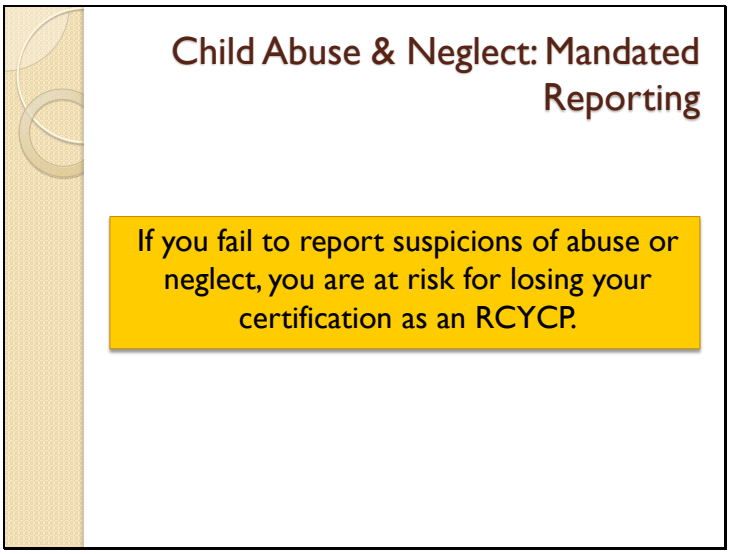


There are a number of reasons why reporting is done based on suspicion and not proof. First, waiting for proof may involve grave risk to the child and delay or prevent necessary treatment or services to all concerned.

Second, proof is often difficult to obtain; witnesses to child abuse and neglect are rare, and the child's testimony may be disbelieved or inadmissible.

Finally, your job is to support the youth with whom you work. Once reported, specially trained people will conduct the investigation.

Slide 7



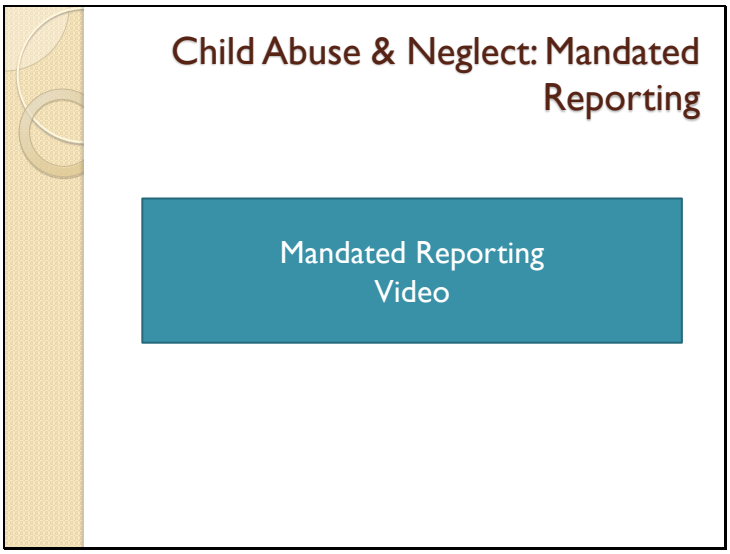
As a mandated reporter, if you fail to report suspicions of abuse or neglect, you are at risk for losing your certification as an RCYCP. The law is in place to protect children and youth in Maryland.

Slide 8

What if you make a mistake and file a report of abuse when there actually isn't abuse?

You may be worried about this happening, but rest assured: Maryland, like many other states with mandated reporting of abuse, has what is called a "good faith" law. If you report your suspicions in good faith (that is to say, you have honest concerns and suspicions of abuse and are not lying or making them up), then you cannot get in trouble for doing so.

Slide 9



Click on the link to see a brief video on mandated reporting (2:08)

http://www.youtube.com/watch?v=LzIWQa46qxQ

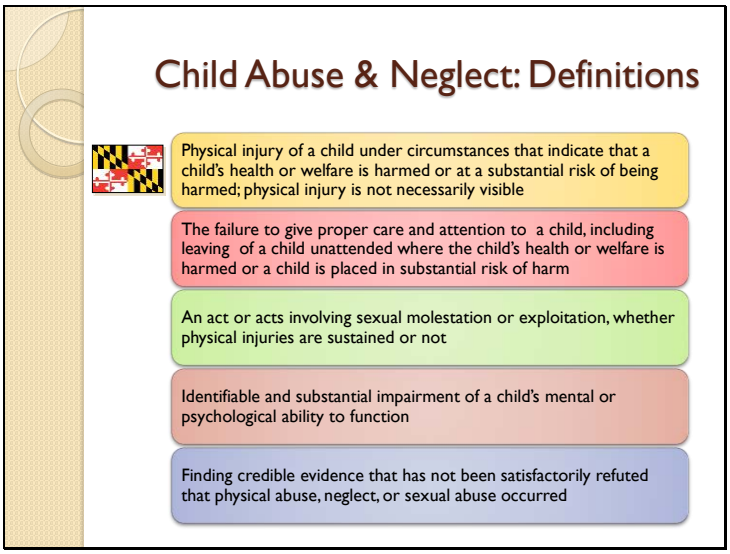
Slide 11

Child Abuse & Neglect: Definitions

So now that you know that as an RCYCP you are a mandated reporter, you need to know what things you need to report.

Let's look at how Maryland defines abuse and neglect.

Slide 12

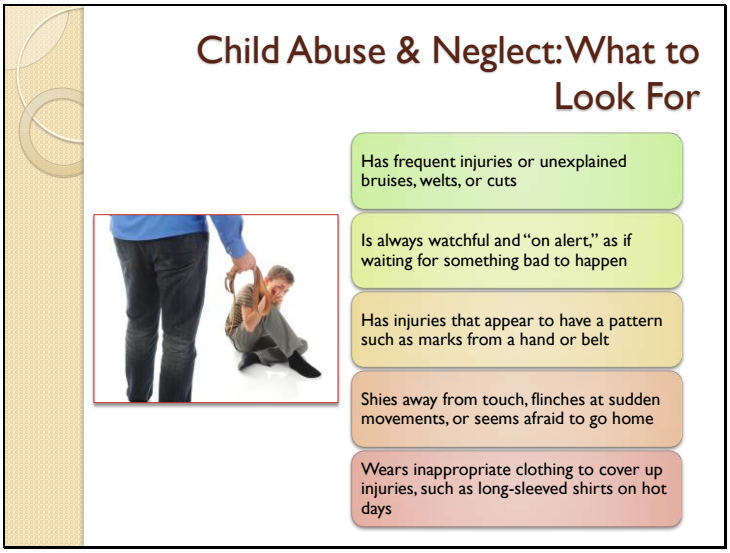


Child abuse and neglect are defined in Maryland as:

- Physical injury of a child under circumstances that indicate that a child's health or welfare is harmed or at substantial risk of being harmed. This physical injury is not necessarily visible.
- The failure to give proper care and attention to a child, including leaving a child unattended where the child's health or welfare is harmed or a child is placed in substantial risk of harm.
- An act or acts involving sexual molestation or exploitation, whether physical injuries are sustained or not.
- Identifiable and substantial impairment of a child's mental or psychological ability to function.
- Finding credible evidence that has not been satisfactorily refuted that physical abuse, neglect or sexual abuse have occurred.

Let's talk now about some things you may notice in children who have been abused or neglected.

Slide 13

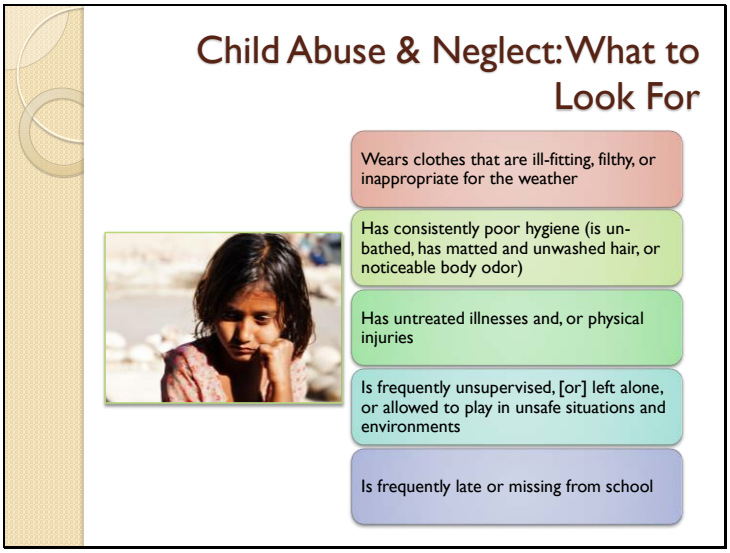


Child Abuse & Neglect: What to Look For

A child might be potentially experiencing physical abuse if he or she:

- Has frequent injuries or unexplained bruises, welts, or cuts
- Is always watchful and "on alert", as if waiting for something bad to happen
- Has injuries that appear to have a pattern, such as marks from a hand or belt
- Shies away from touch, flinches at sudden movements, or seems afraid to go home
- Wears inappropriate clothing to cover up injuries, such as long-sleeved shirts on hot days

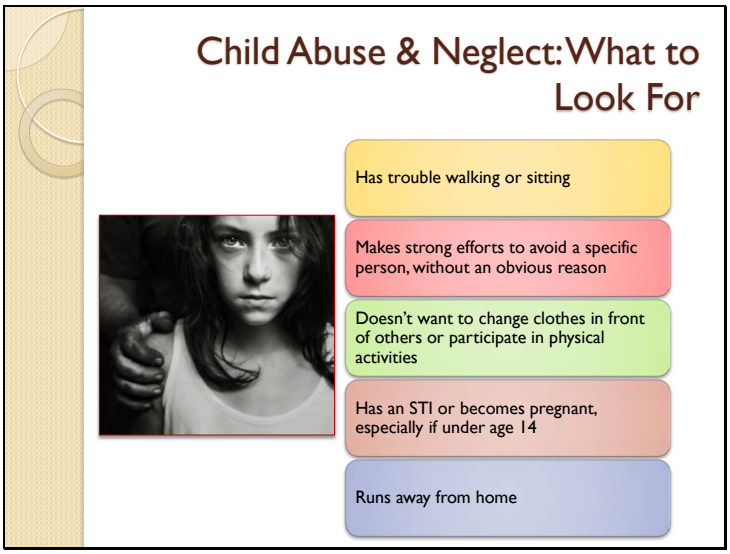
Slide 14



A child might be potentially neglected if he or she:

- Wears clothes that are ill-fitting, filthy, or inappropriate for the weather
- Has consistently poor hygiene (is unbathed, has matted and unwashed hair, or noticeable body odor)
- Has untreated illnesses and/or physical injuries
- Is frequently unsupervised, [or] left alone, or allowed to play in unsafe situations and environments
- Is frequently late or missing from school

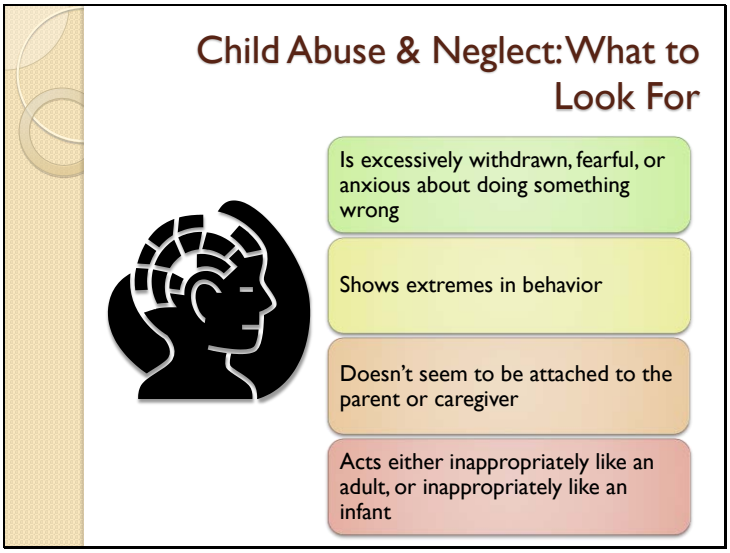
Slide 15



A child might be potentially experiencing sexual abuse if he or she:

- Has trouble walking or sitting
- Makes strong efforts to avoid a specific person, without an obvious reason
- Doesn't want to change clothes in front of others or participate in physical activities
- Has an STI or becomes pregnant, especially if under age 14
- Runs away from home

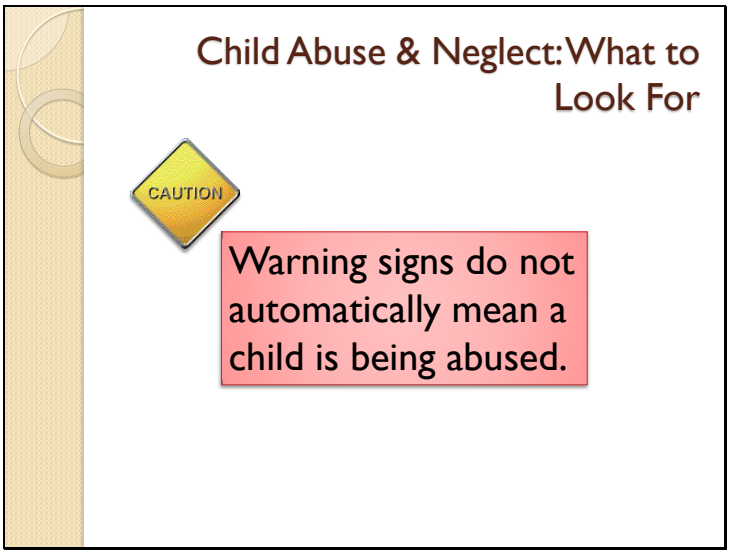
Slide 16



A child might be potentially showing the signs of mental injury if he or she:

- Is excessively withdrawn, fearful, or anxious about doing something wrong
- Shows extremes in behavior (extremely compliant or extremely demanding; extremely passive or extremely aggressive)
- Doesn't seem to be attached to the parent or caregiver
- Acts either inappropriately adult-like (such as taking care of other children) or inappropriately like an infant (such as rocking, thumb-sucking, tantrums)

Slide 18



Warning signs do not automatically mean a child is being abused. However, such signs may draw your attention to the child and the child's situation and reveal additional warning signs.

Slide 19

Identifying Child Abuse & Neglect: Videos

Click on each link to watch a brief video about the signs of abuse and neglect.

- Identifying Child Abuse and Neglect
http://www.youtube.com/watch?v=7O-0OB8Ok6s (3:15)
- Recognizing Child Abuse: Physical Abuse
http://www.youtube.com/watch?v=vKvtkhM1Vrk (3:07)
- Recognizing Child Abuse: Sexual Abuse
http://www.youtube.com/watch?v=RbKJOXDGTpg (2:41)
- Recognizing Child Abuse: Neglect and Emotional Abuse
http://www.youtube.com/watch?v=cLfZXbShgzk (2:41)

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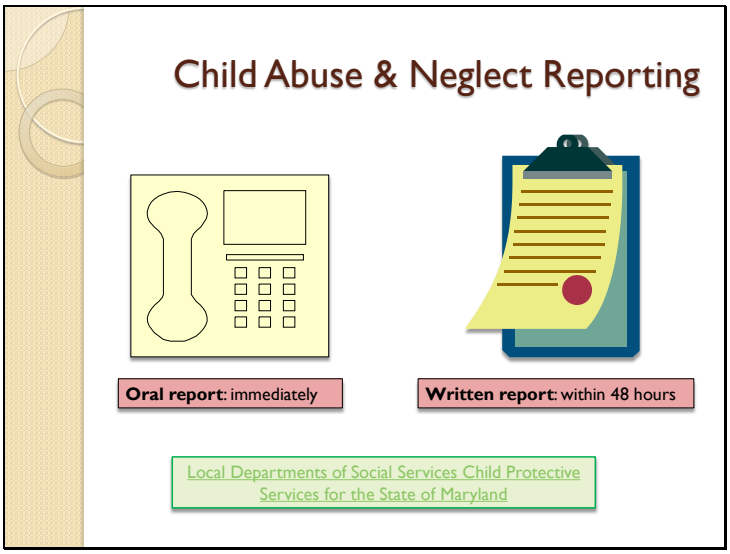


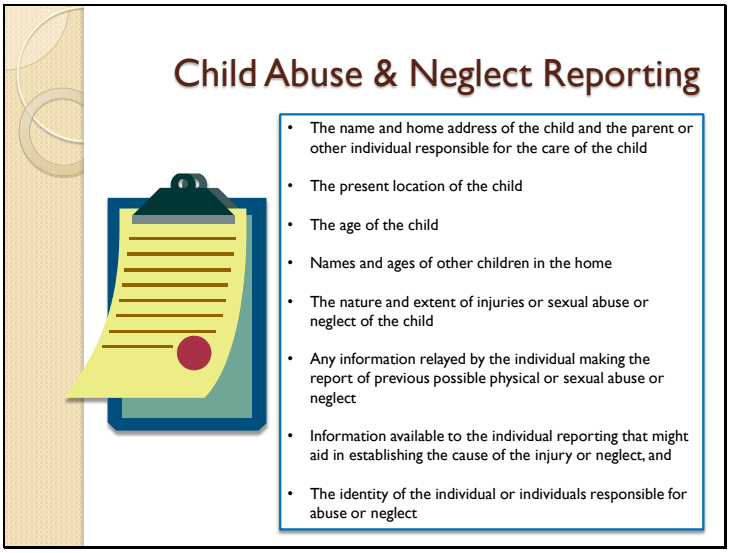
Child Abuse & Neglect Reporting

If you suspect child abuse or neglect, you will need to call in an oral report immediately and follow that up with a written report within 48 hours to a local department of Social Services Child Protective Services for the State of Maryland.

The highlighted link lists phone numbers and addresses by county in Maryland of Social Services Child Protective Services.

- Local Departments of Social Services Child Protective Services for the State of Maryland https://www.dhr.state.md.us/blog/?page_id=4631

Slide 21



A report must include:

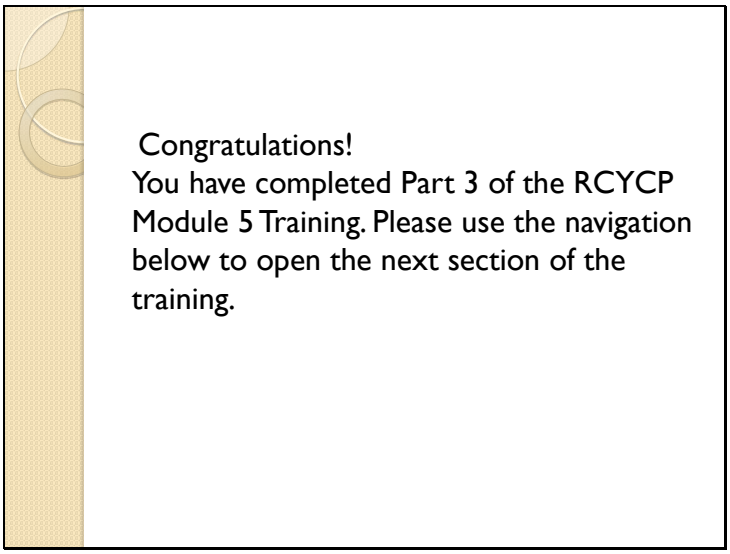
- The name and home address of the child and the parent or other individual responsible for the care of the child
- The present location of the child
- The age of the child
- Names and ages of other children in the home
- The nature and extent of injuries or sexual abuse or neglect of the child
- Any information relayed by the individual making the report of previous possible physical or sexual abuse or neglect
- Information available to the individual reporting that might aid in establishing the cause of the injury or neglect, and
- The identity of the individual or individuals responsible for abuse or neglect

It may be that you do not know all of the information that is requested. If this is the case, the report should be filed with as much information as you know. The person to whom you make the report may give you further guidance.

Slide 22

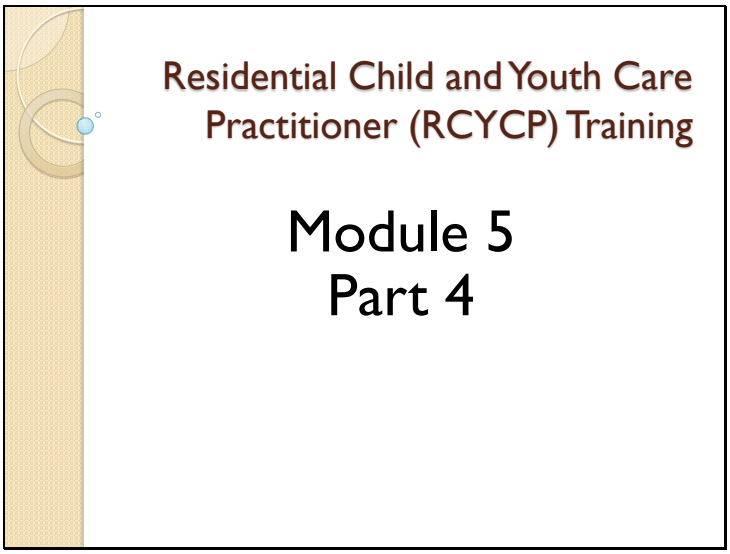
In addition to filing a report with the local Department of Social Services Child Protective Services, you will also need to notify your program supervisor or administrator of the abuse report so that she or he can file the necessary report with the licensing agency.

Slide 24



Congratulations! You have completed Part 3 of the RCYCP Module 5 Training. Please use the navigation below to open the next section of the training.

Slide 2



Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 5, Part 4 of the Residential Child and Youth Care Practitioner Training.

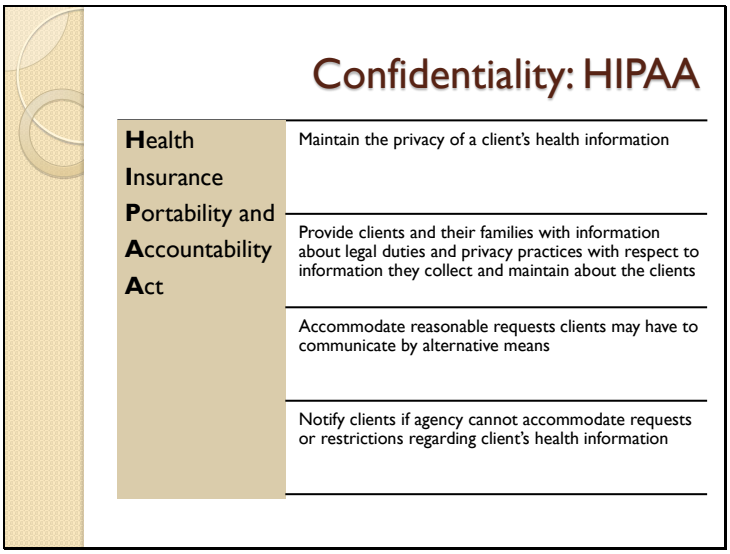
Slide 3

Confidentiality

Let's talk about confidentiality now. As an RCYCP you are in a position to know a lot of very sensitive information about youth and their families. With few exceptions, this information is confidential and subject to national laws regarding protected health information such as HIPAA, as well as the laws of the State of Maryland, specifically COMAR (Code of Maryland) regulations.

Let's begin with HIPAA.

Slide 4



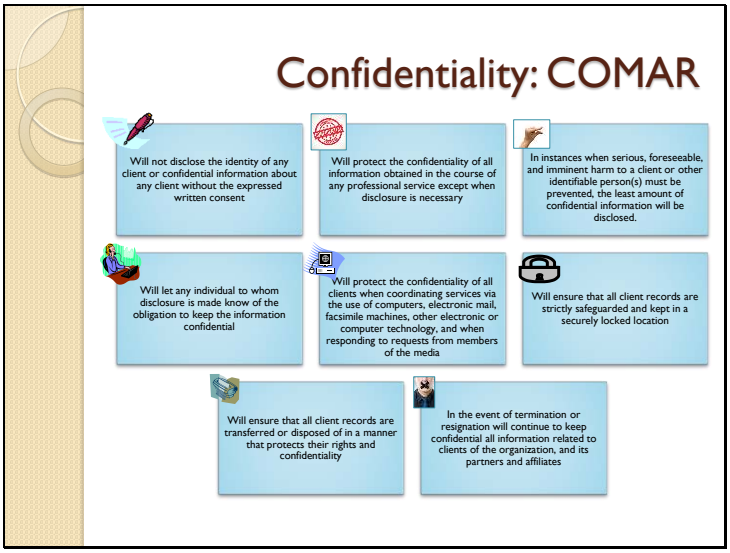
Confidentiality: HIPAA

HIPAA stands for Health Insurance Portability and Accountability Act of 1996. It establishes the framework for nationwide security standards that protect health information privacy. You may recognize HIPAA from the forms that you are required to fill out when you get medical treatment of any kind.

HIPAA requires residential child care providers to:

- Maintain the privacy of a client's health information.
- Provide clients and their families with information about legal duties and privacy practices with respect to information they collect and maintain about the clients.
- Accommodate clients' reasonable requests to communicate health information by alternative means or at alternative locations, and
- Notify clients if any agency cannot accommodate requests or restrictions regarding that client's health information.

Slide 5



Confidentiality: COMAR

In addition to HIPAA, residential youth care providers and RCYCPs must follow confidentiality requirements established in COMAR regulations for the state of Maryland. Specifically, providers and RCYCPS:

1. Will not disclose the identity of any client or confidential information about any client without the expressed written consent of the person or someone legally authorized to consent on the person's behalf.
2. Will protect the confidentiality of all information obtained in the course of any professional service except when disclosure is necessary, for example, in reporting abuse or neglect. In instances when serious, foreseeable, and imminent harm to a client or other identifiable person must be prevented, the least amount of confidential information directly relevant to achieve the desired purpose will be disclosed.
3. Will let any individual to whom disclosure is made know of the obligation to keep the information confidential.
4. Will protect the confidentiality of all clients when coordinating services by using computers, electronic mail, facsimile machines, other electronic or computer technology, and when responding to requests from members of the media.
5. Will ensure that all client records are strictly safeguarded and kept in a securely locked location.

6. Will ensure that all client records are transferred or disposed of in a manner that protects their rights and confidentiality, and
7. In the event of termination or resignation will continue to keep confidential all information related to clients of the organization, and its partners and affiliates

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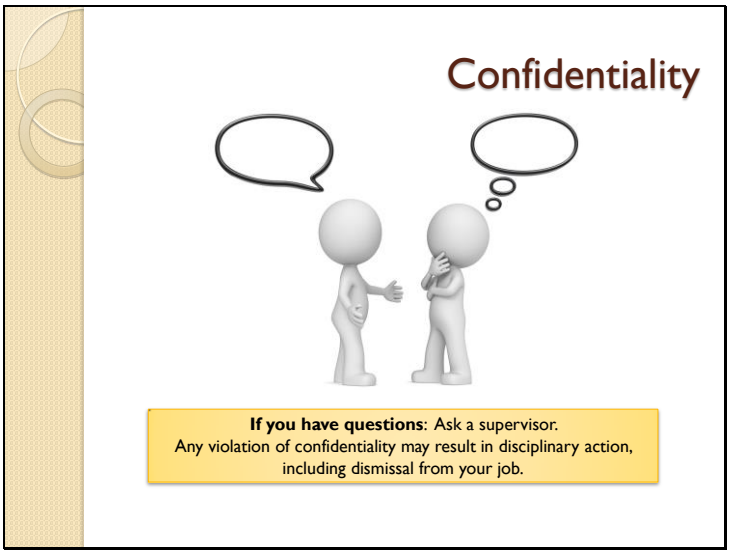

Confidentiality

Your specific agency may have additional confidentiality policies and procedures that will be provided to you during your orientation or training. You should be familiar with these policies and procedures. If you have questions about confidentiality or whether or not it's OK to disclose certain information, be sure to ask a supervisor before disclosing any information. Any violation of confidentiality may result in disciplinary action, including dismissal from your job.

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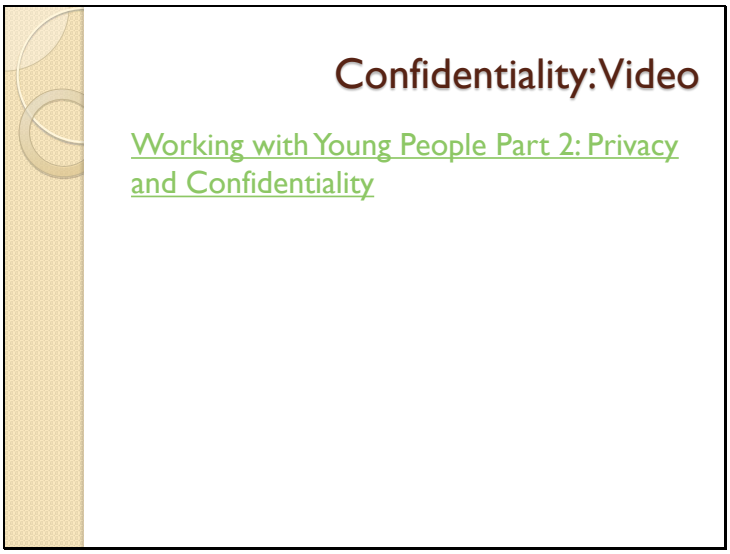
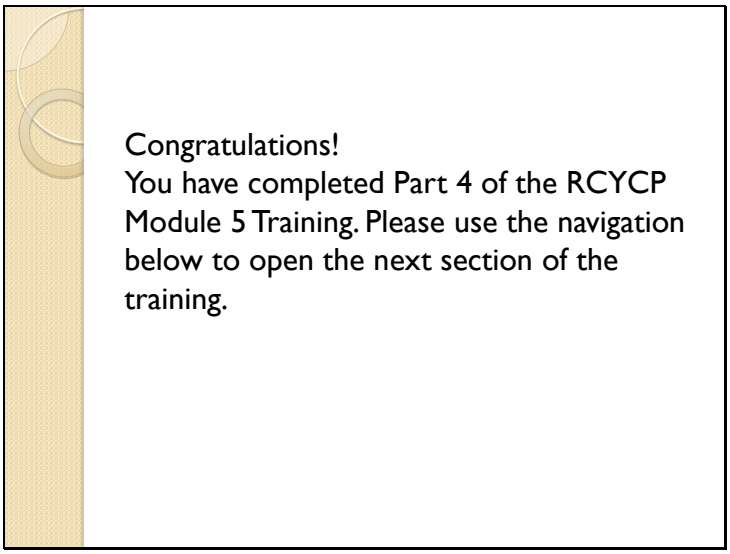


Confidentiality: Video

Click on the link to watch a short video on confidentiality.

Working with Young People Part 2: Privacy and Confidentiality
http://www.youtube.com/watch?v=tqJ_yyKm12k (5:55)

Slide 9



Congratulations! You have completed Part 4 of the RCYCP Module 5 Training. Please use the navigation below to open the next section of the training.

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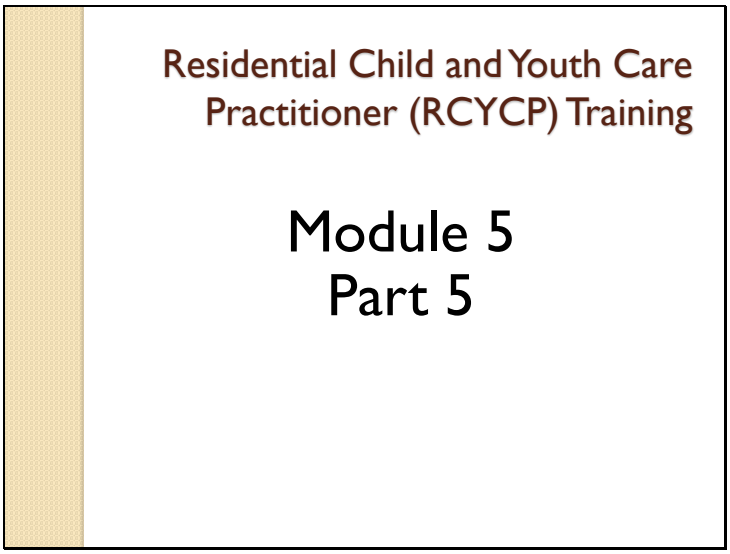
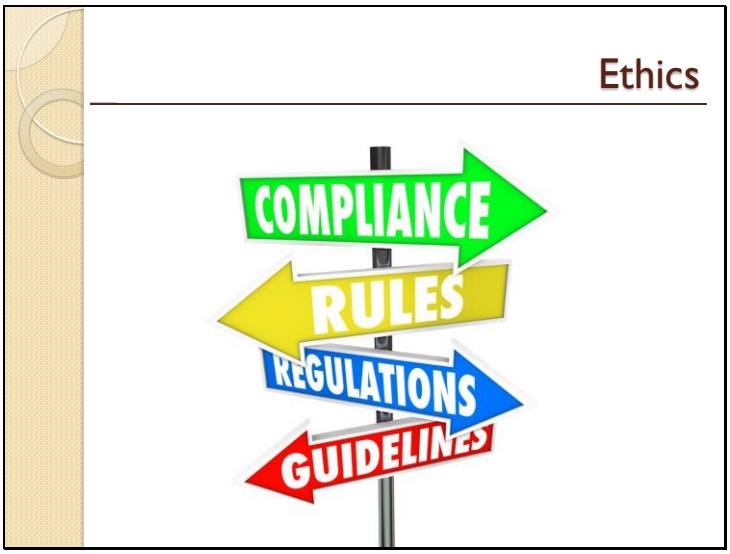


Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 5, Part 5 of the Residential Child and Youth Care Practitioner Training.

Slide 3



Ethics

You have now learned about the legal responsibilities that you have as an RCYCP. As you learned in Module 1, you have a great many ethical responsibilities as well. Here is a brief recap of those responsibilities.

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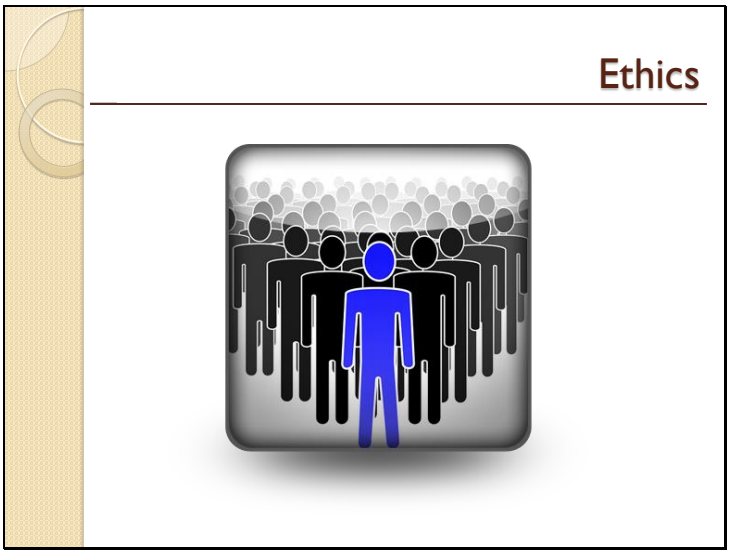
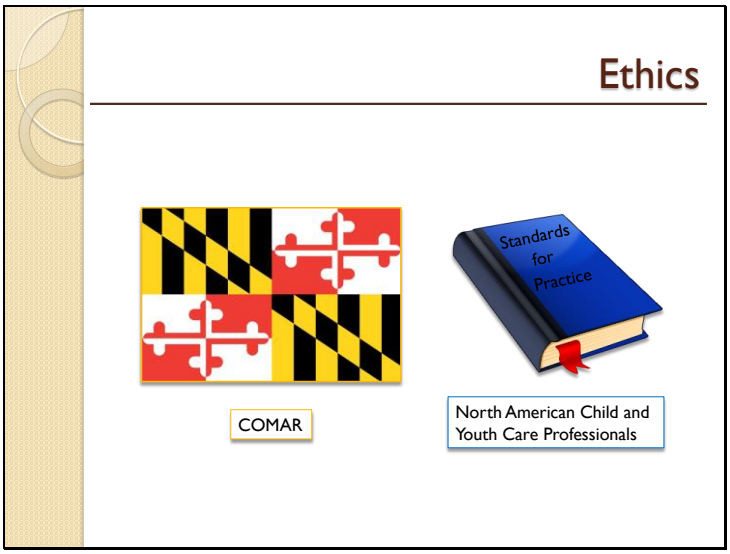


Working with children and adolescents in residential care is both a privilege and a responsibility. It is a privilege because you have the opportunity to make a significant difference in the lives of these youth, and a responsibility because you are entrusted to safeguard the health and well-being of a unique and vulnerable group of kids. They have little power over their lives, and few skills for protecting and caring for themselves. As an adult, you have the power to do great good, or in some unfortunate cases, great harm. Because of this power differential, and the complexity of the role of caregiver to this population, ethical guidelines are in place to protect youths and the professionals who care for them.

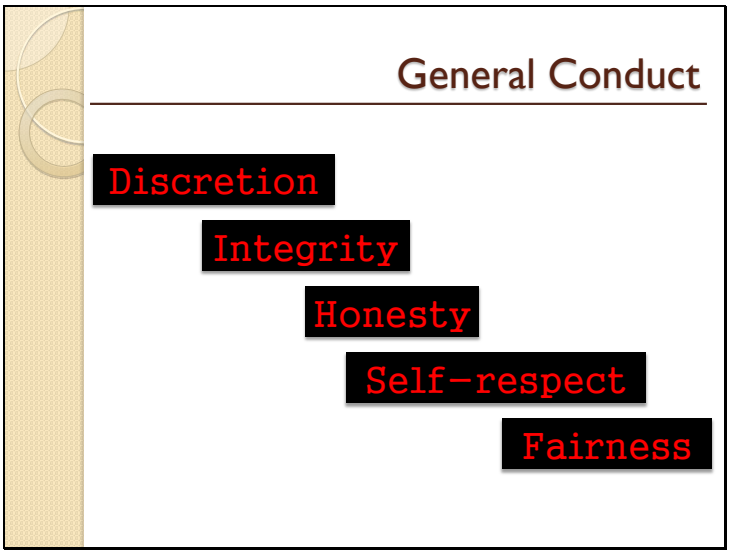
Slide 5



You will remember that as an RCYCP ,you are held to 2 sets of ethical standards:
1. COMAR (the Code of Maryland Regulations), and
2. The Standards for Practice of North American Child and Youth Care Professionals

Let's review these briefly. We will start with COMAR.

Slide 6

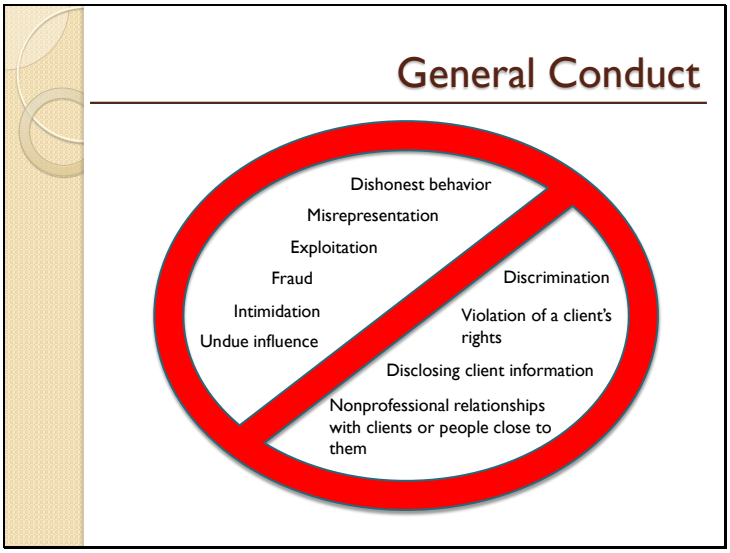


General Conduct

As an RCYCP you should:

- Function with discretion and integrity in relationships with other health professionals.
- Carry out all duties with honesty, integrity, self-respect, and fairness.
- Report any unethical conduct by another RCYCP or administrator to the Board.
- Inform the Board if someone is misrepresenting him or herself as being certified when she or he is not.

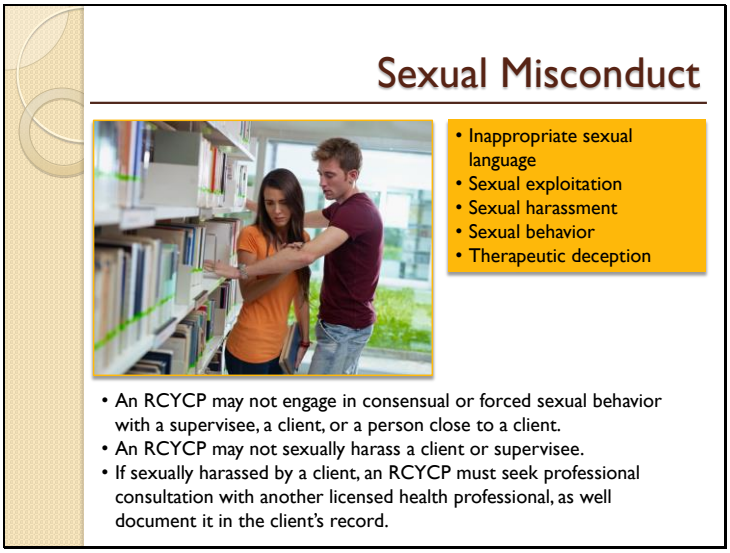
Slide 7



The RCYCP may not:

- Participate in, or condone, dishonest behavior of any kind.
- Misrepresent his/her professional qualifications or experience.
- Exploit a relationship with a client for personal gain.
- Engage in solicitation that amounts to fraud, intimidation, or undue influence.
- Practice, condone, or facilitate discrimination on the basis of race, color, sex, sexual orientation, age, religion, national origin, marital status, political belief, disability, or other preference or personal characteristic, condition or status.
- Engage or participate in an action that violates or diminishes the civil or legal rights of a client.
- Share information given to you in confidence by a client without his or her express permission unless it involves danger to self or another individual, or for a compelling professional reason.
- Enter into a nonprofessional, social, or dual relationship with a client, or an individual that has a close personal relationship with a client.

Slide 8



Sexual Misconduct

With regard to sexual misconduct the RCYCP may not engage in sexual misconduct with a client or a supervisee. Sexual misconduct includes, but is not limited to:

- Inappropriate sexual language
- Sexual exploitation
- Sexual harassment
- Sexual behavior and,
- Therapeutic deception (suggesting that sexual contact, activity, or disclosure is part of the client's therapy or treatment).

The RCYP may not engage in either consensual or forced sexual behavior with:

- A client
- A supervisee
- An individual with whom the client has a close personal relationship if there is risk of exploitation or potential harm to the client.

With regard to sexual harassment, the RCYCP :

- May not sexually harass a client or supervisee.
- If sexually harassed by a client, the RCYCP must seek professional consultation with another licensed health professional, as well document it in the client's record.

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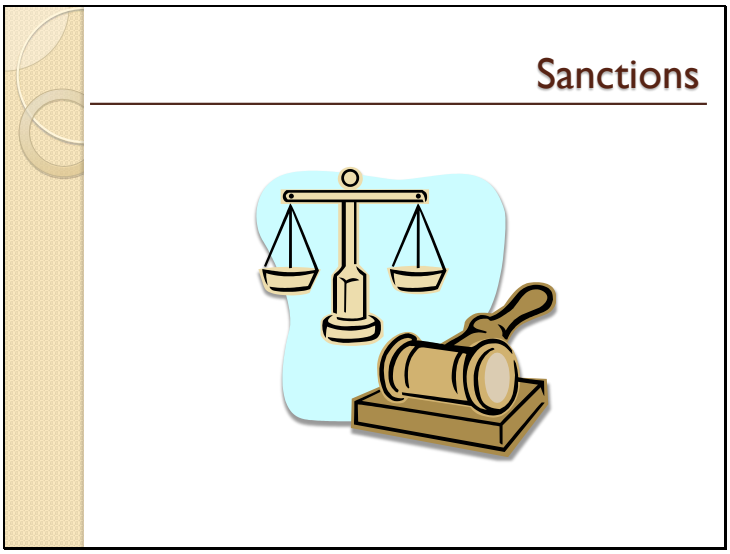


Sanctions

An RCYCP is also subject to sanctions for violating any provisions of the:

- Law pertaining to the profession of residential child and youth care.
- Regulations of the Board that pertain to RCYCPs.

For additional information on sanctions, re-hearings, and appeals, please visit the website and read through the COMAR regulations.

Slide 11

Standards for Practice of North American Child and Youth Care Professionals
In addition to the COMAR regulations, you are ethically bound to the Standards for Practice of North American Child and Youth Care Professionals.

Click on the different sections to hear the standards.

Responsibility to the client : Above all else, do not harm the child, youth, or family. That means not being disrespectful, degrading, dangerous, exploitive, intimidating, psychologically damaging or physically harmful to clients. This includes maintaining proper boundaries between yourself and your clients – a relationship that is professional, respectful, and appropriate. Sexual intimacy with a client or the family member of a client is unethical. You respect the privacy of clients and keep information confidential unless otherwise specified. It also means ensuring that you are sensitive and non-discriminatory toward clients. Your professional responsibility is to the client and you should always be advocating for the client's best interest. Finally, in your responsibility toward clients and families, you must recognize and respect the differences in the life circumstances of clients and their families, as well as the differences in the needs of the clients and their families.

Responsibility for Self: As an RCYCP you are responsible for maintaining the highest standards of professional conduct. You take responsibility for your professional knowledge and abilities. That means that you maintain your competency – getting training, education, supervision, experience, and guidance as needed. You must be aware of your own values and their

implication for practice. It also means that you maintain your physical and emotional well-being so that you are the best professional that you can be.

Responsibility to the Employing Organization: As an RCYCP you have made a commitment to help the youth with whom you work. You have also made commitments to the organization that hired you, and as such, you must respect those commitments. As an employee you must treat colleagues with respect, courtesy, fairness, and good faith. And while your colleague's clients are not your own, it goes without saying that you must relate to the clients of colleagues with professional consideration as well.

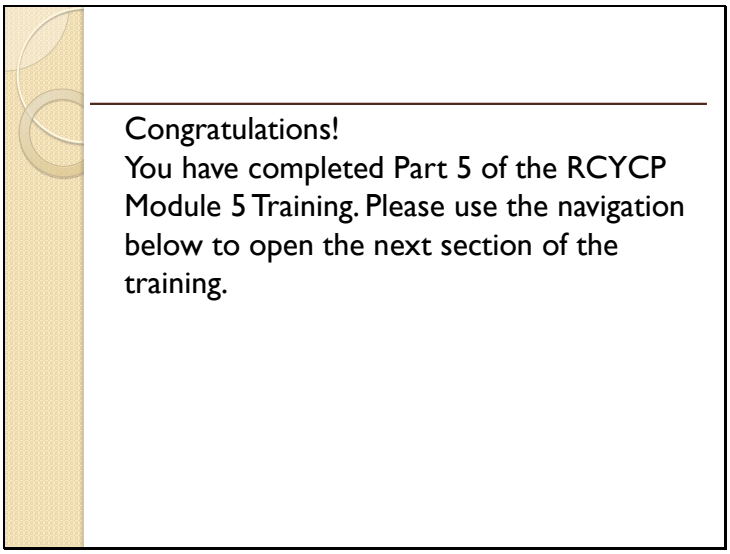
Responsibility to the Profession: As an RCYCP your responsibility to the profession requires you to practice ethically, such that you are guided in your professional practice by these standards, as well as those set out by COMAR. In addition to your own professionalism, your responsibility to the profession means that you report ethical violations by others when you are aware of them. It also means collaborating with colleagues to provide the best possible outcomes for the youth with whom you work.

Responsibility to Society: As an RCYCP you have a responsibility to society on a broader level by promoting understanding and facilitating acceptance of diversity in society. You give back to society in other ways as well, for example, by demonstrating the standards of this Code with students and volunteers.

You may click on the link on the link at the bottom of the page to see the complete document:

http://www.acycp.org/standards/CYC%20Ethics%20Code%20Rev%209.2009.pdf

Slide 12



Congratulations! You have completed Part 5 of the RCYCP Module 5 Training. Please use the navigation below to open the next section of the training.

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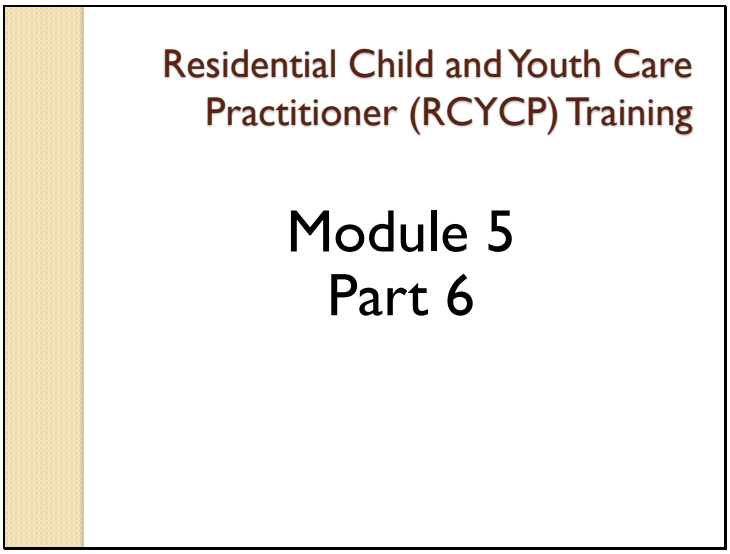
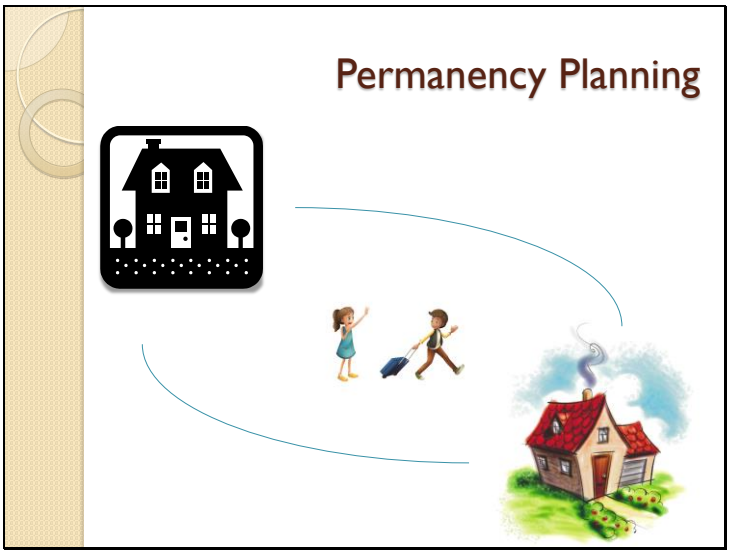


Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 5, Part 6 of the Residential Child and Youth Care Practitioner Training.

Slide 3

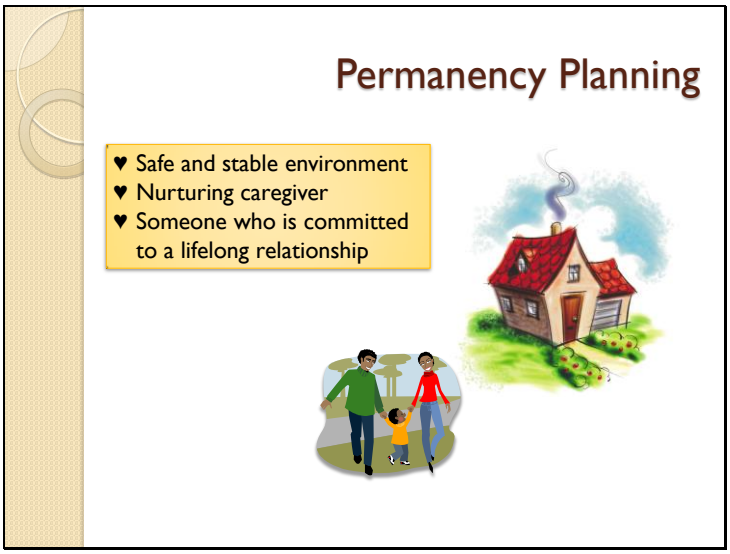


Permanency Planning

Let's talk now about permanency planning.

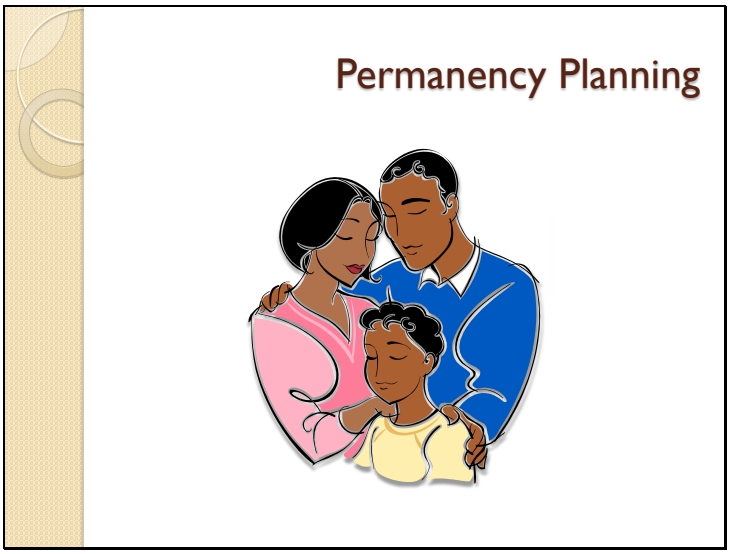
One of the goals of the State in working with youth in residential care is to have a permanency plan in place. What that means is having a plan that specifies where and with whom the child will live after residential care.

Slide 4



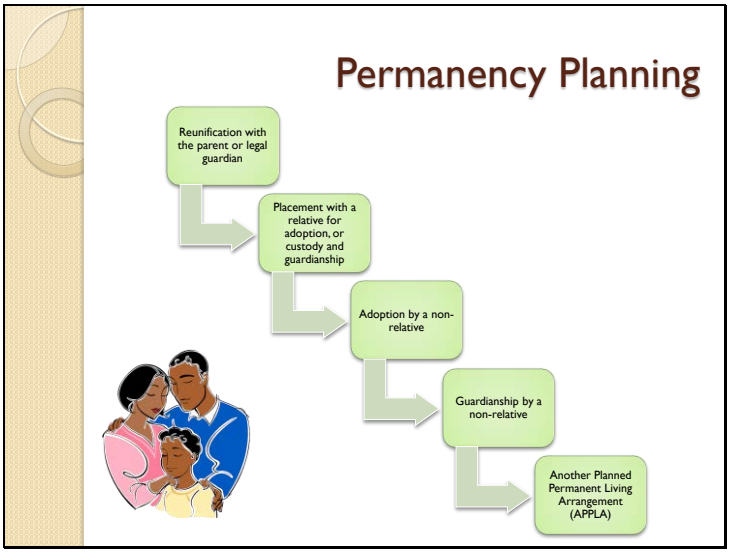
The goal of permanency planning is to provide a child with a safe, stable environment in which to grow up, while in the care of a nurturing caregiver, who is committed to a lifelong relationship with that child. Rather than letting a youth float adrift through the system without a lifeline, permanency planning attempts to secure a healthy and permanent home for each child as soon as possible.

Slide 5



If you recall from the developmental module, children and adolescents need to develop secure attachment relationships with trusted adult caregivers. Permanency planning is designed to do that.

Slide 6

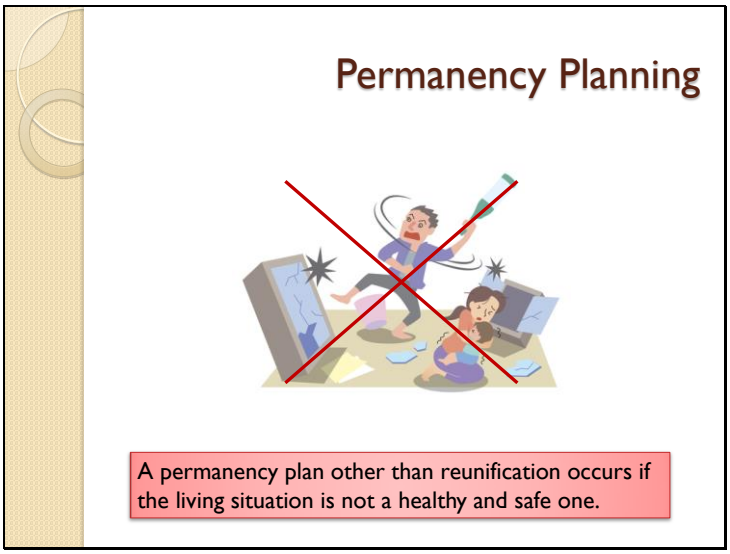


In Maryland, the state recognizes that reunification with a parent after out-of-home care is ideal if the living situation is a healthy and safe one. Services provided to both a child and his/her family during an out-of-home placement are designed to make reunification possible. When reunification with the parent or guardian is not possible, the State works hard to develop and implement a plan in the best interests of the child that provides a planned, permanent living arrangement for the child who cannot be reunified.

Maryland prioritizes the following living arrangements in the following order of preference:

1. Reunification with the parent or legal guardian
2. Placement with a relative for adoption, or custody and guardianship
3. Adoption by a non-relative
4. Guardianship by a non-relative, or
5. Another Planned Permanent Living Arrangement (referred to as APPLA)

Slide 7



Reunification is not always ideal, however. There are a number of different reasons that the permanency plan for children and adolescents is something other than reunification. The guiding principle for the state in determining a permanency plan is what is in the best interest of the child. That is to say, the state looks at whether or not being reunified with the family is in the best interest of the child.

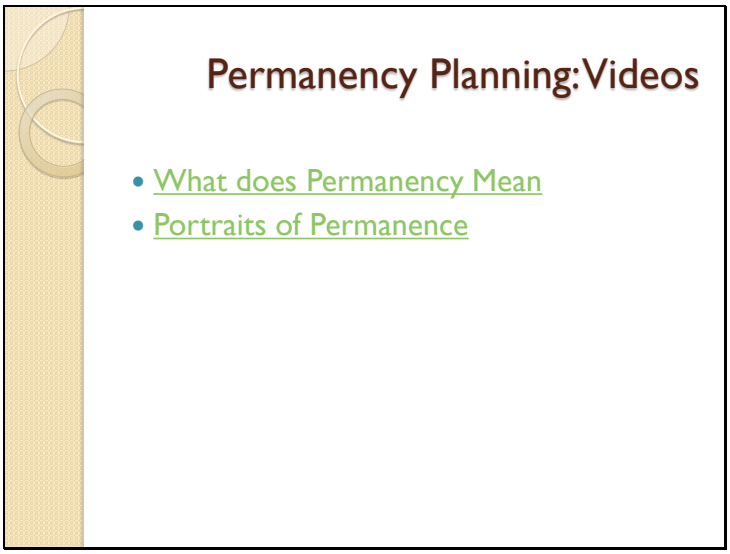
For example, a permanency plan other than reunification may occur if there is ongoing physical, sexual, or emotional abuse in a family. In this type of situation the state makes a determination that reunification is not in the best interest of the child and a permanency plan for another type of living arrangement is designated.

Slide 8

The process for a permanency plan is a complicated one that can go on for an extended period of time. For example, a child can be removed from a family because there is abuse. Over time and with treatment, the state may decide that a family has fixed their problems and may be an okay place to which a child can return. What you need to know as an RCYCP is that the permanency planning that is done, is done outside of your agency. It is entirely likely that you will not know what the permanency plan is for any of the youth with whom you work. The youth may not know either, or they might think they know, or they might know, or they might know, but then the plan changes. There are a number of different possibilities. What is known, however, is that the permanency plan process can create anxiety for the youth. Your job in working with the youth is to use your reflective listening skills when they are anxious about what is happening with their permanency plan. Talk to them and empathize with them. It is not your job to discuss specifics about a permanency plan with any youth, nor is it a good idea given how permanency plans can change periodically. It would be detrimental to give incorrect information to a youth; information that is likely to have a significant emotional impact on him/her.

If you have questions or concerns about a youth's permanency plan, or how to handle discussions with a particular youth, it is important to consult your supervisor or the program administrator.

Slide 11



Permanency Planning: Videos

Click on each link to see a video about permanency.

What Does Permanency Mean: http://www.youtube.com/watch?v=nb_xGcttdIk (6:07)

Portraits of Permanence: http://www.youtube.com/watch?v=dNf7sE2OaJA (14:08)

Slide 12

References

COMAR Title 10: Subtitle 57: Chapter 5: Code of Ethics. Available from: http://www.dsd.state.md.us/comar/

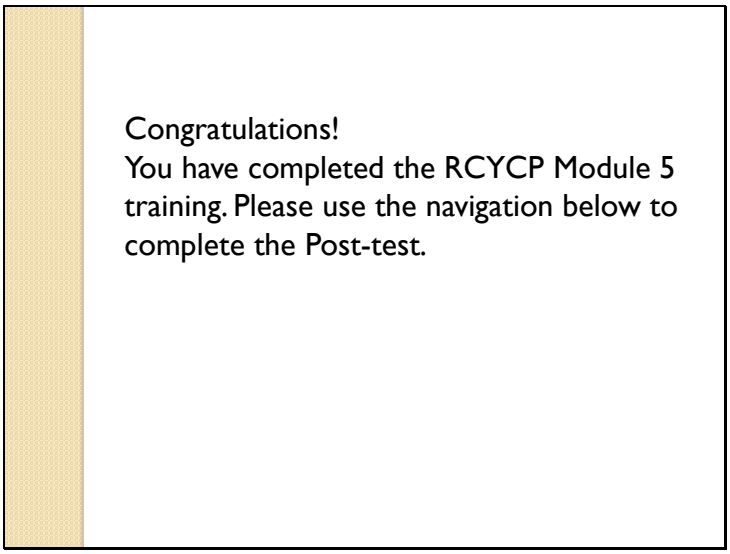
COMAR Title 14: Subtitle 31: Chapter 6: Standards for Residential Child Care Programs. Available from: http://www.dsd.state.md.us/comar/

Maryland Department of Human Resources: Mandated Reporters. Available from: https://www.dhr.state.md.us/blog/?page_id=3992

Resident's Bill of Rights: 2013 Maryland Code Title 8: Subtitle 7: Section 8-707

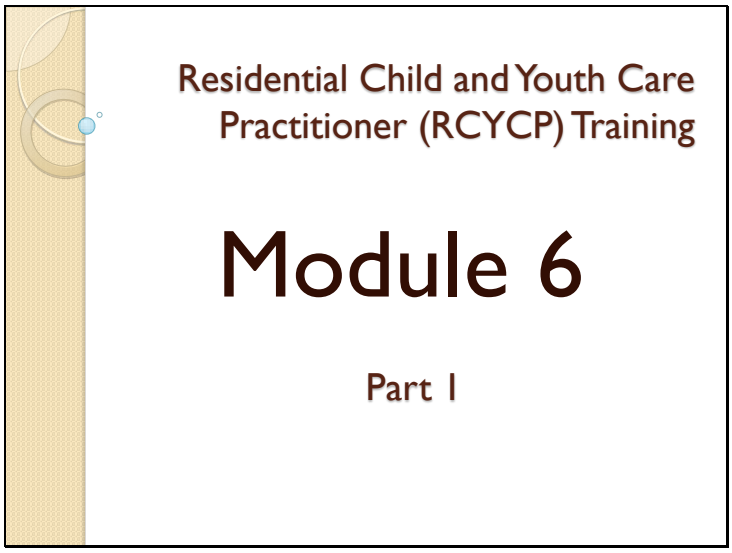
Standards for Practice of North American Child and Youth Care Professionals: Available from: http://www.pitt.edu/~mattgly/CYCethics.html

Slide 13



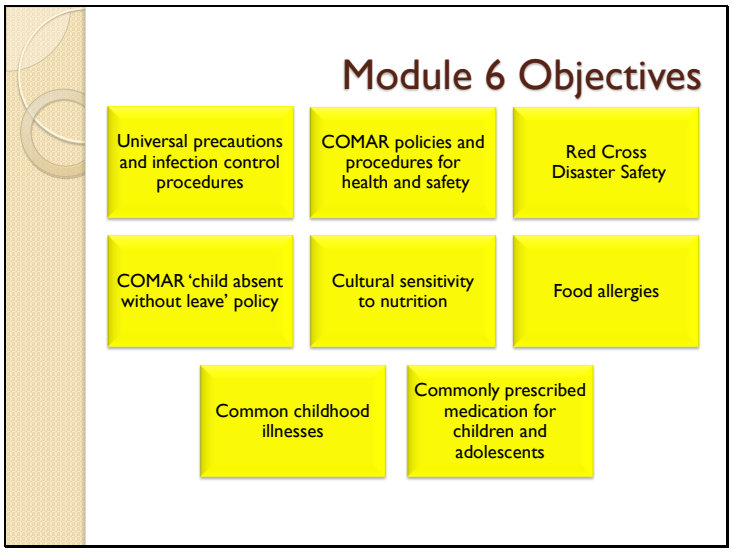
Congratulations! You have completed the RCYCP Module 5 training. Please use the navigation below to complete the Post-test.

Slide 1



Residential Child and Youth Care Practitioner (RCYCP) Training
Welcome to Module 6, Part 1 of the Residential Child and Youth Care Practitioner Training.

Slide 2

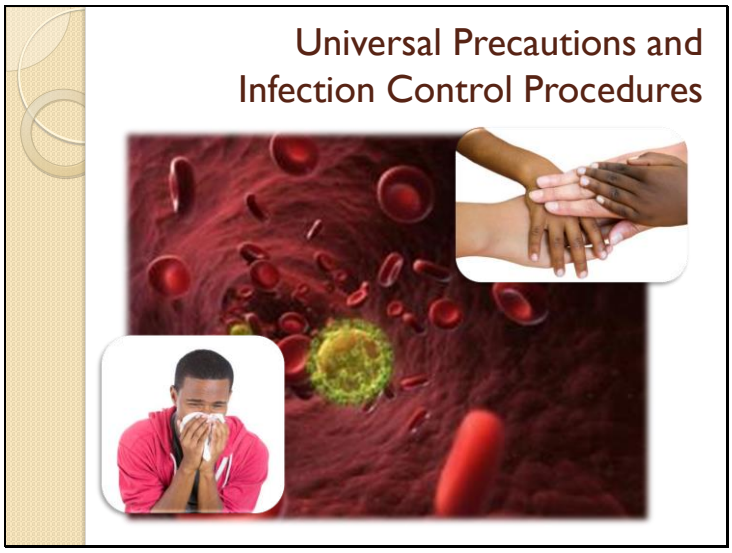


In this module you will learn about:
- Universal precautions and infection control procedures
- COMAR policies and procedures for health and safety
- Red Cross Disaster Safety
- COMAR "child absent without leave" policy
- Cultural sensitivity to nutrition
- Food allergies
- Common childhood illnesses
- Most commonly prescribed medication for children and adolescents

For the purposes of this module, residential child and youth care facilities may be referred to as facilities or agencies.

As a reminder, whenever COMAR is mentioned in this training, it is referring to COMAR 14.31.06 – The Standards for Residential Child Care Programs.

Slide 3



When spending time in a setting where you interact with many different people, the chance of getting sick or getting others sick can increase greatly. This is especially true in health care environments, where you can come in contact with people with a wide variety of different health histories. Some might have more common illnesses such as a cold or flu, while others might have much more severe concerns such as Hepatitis B, Hepatitis C, or HIV/AIDS. In fact, some people do not even know that they have such an illness, which might be transmitted through the air (like through a sneeze), by touch (like a handshake), or by the exchange of bodily fluids (like saliva, semen, or blood).

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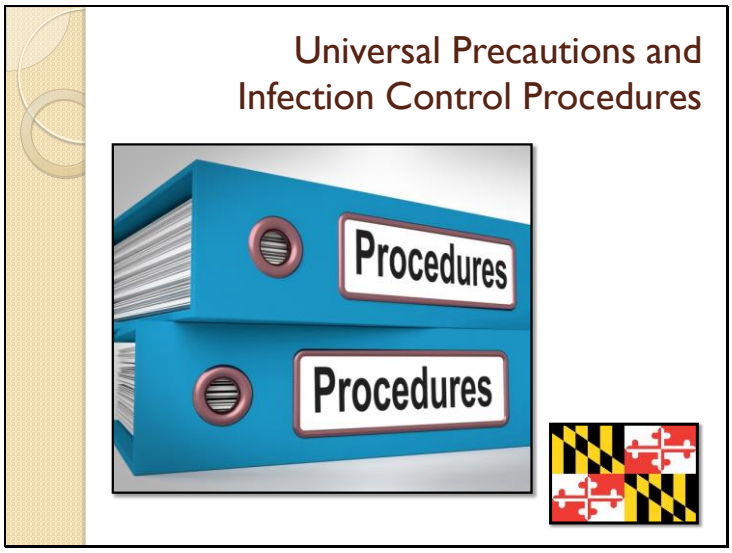

In order to protect health care workers and residents against the spread of a wide variety of infections and diseases, known and unknown, a set of general practices has been developed. These are called Universal Precautions. All RCYCPs in the state of Maryland receive initial and annual trainings that cover this material. Because you will receive additional training on this topic, this module will cover only the basics.

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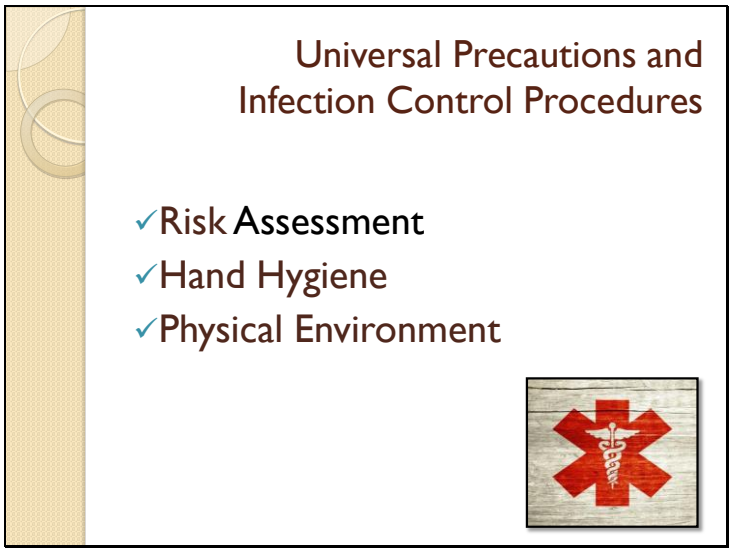
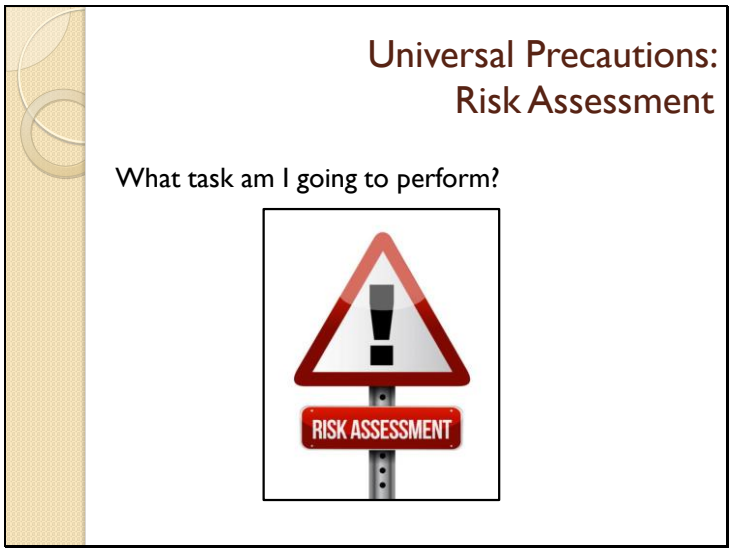


Let's begin. Although universal precautions are typically used in medical environments, they have direct relevance to residential environments as well. Universal precautions can be broken into the following categories:

- Risk Assessment
- Hand Hygiene
- Physical Environment

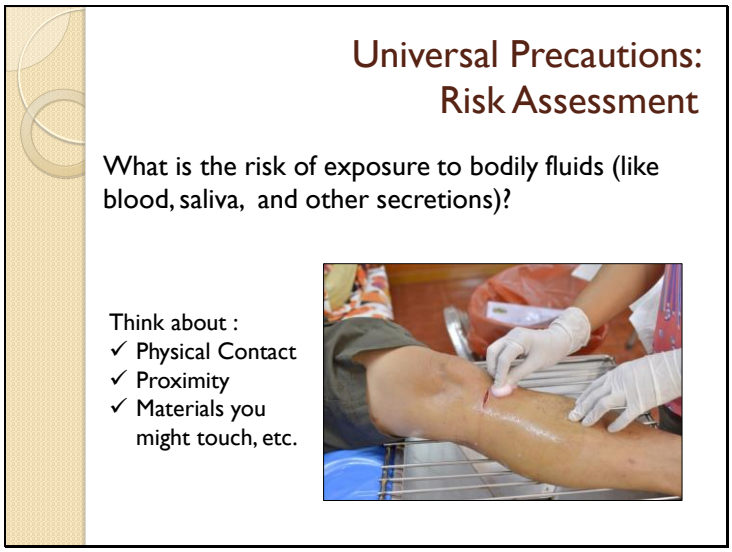
Slide 6



Let's begin with Risk Assessment
Before you have any interaction with a resident, you should conduct a quick risk assessment to evaluate the risk of infection or disease transmission. This can be accomplished by asking several questions:
Question 1: What task am I going to perform?

Be sure to think through what you are about to do with as much detail as possible. This process will become easier, and even automatic, as you gain more experience with different tasks in the residential care setting. For example, if you are helping a youth who has fallen and skinned his or her knee, think about the procedure you should follow.

Slide 7



Question 2: What is the risk of exposure to bodily fluids, like blood, saliva, and other secretions?

Other than your immediate physical safety, exposure is the most important aspect of the risk assessment. Be sure to think through all the physical parts of the actions you will need to take – physical contact, proximity (how close you are), materials you might touch that contain bodily fluids, and so forth. For example, if you are helping a youth with a skinned knee, are you in a situation where you might come into contact with blood?

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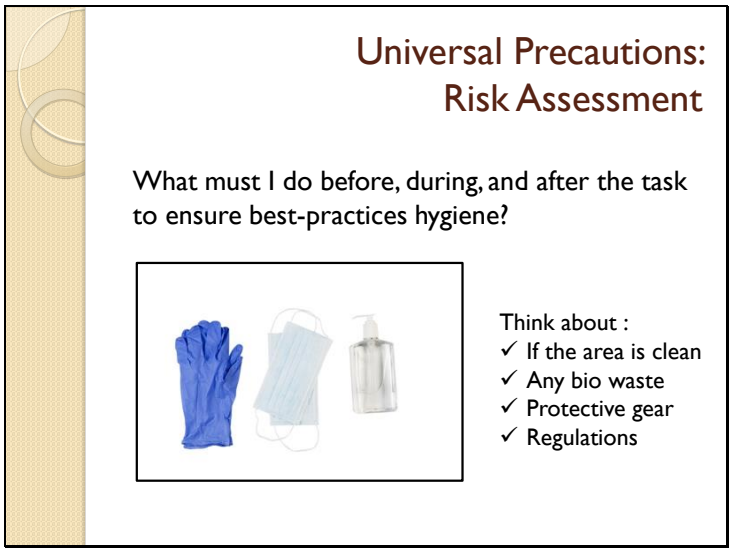
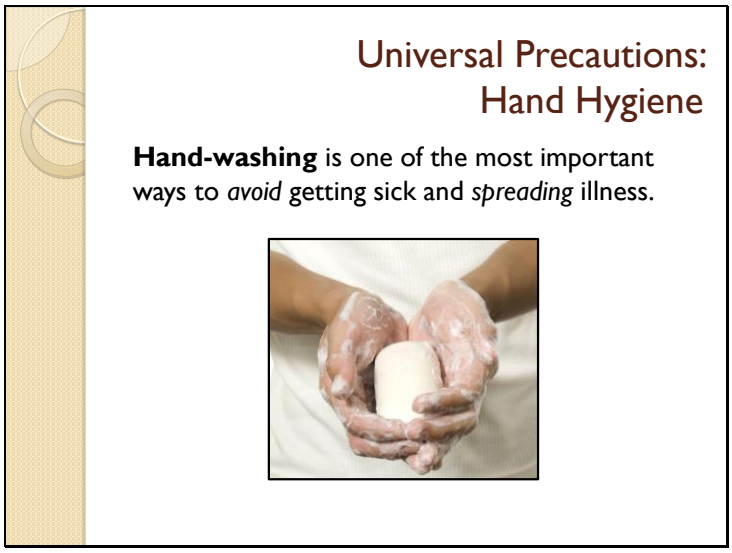


Question 3: What must I do before, during, and after the task to ensure best-practices hygiene?

An obvious answer to this question is thorough hand washing. You should be thinking through other hygiene-related tasks as well. For example, do you need to clean the area? Will there be biological waste that you will need to dispose of (like bandages or tissues)? Will you need any personal protective equipment to reduce the risk of exposure, like gloves or a mask? Are there any other regulations required by your residential facility?

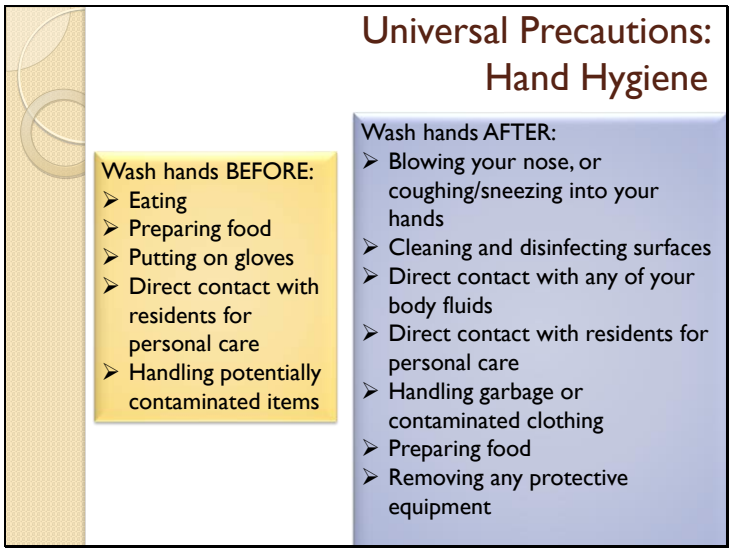
Slide 9



Let's talk about hand hygiene now.

One of the best ways to prevent the spread of infection and disease is to maintain good personal hygiene habits. An obvious example of this is coughing and sneezing into a tissue. Perhaps even more basic, however, is hand washing. As much as we might take hand washing for granted, it is in fact one of the most important ways to avoid getting sick and spreading illness. The key is to know when and how to wash.

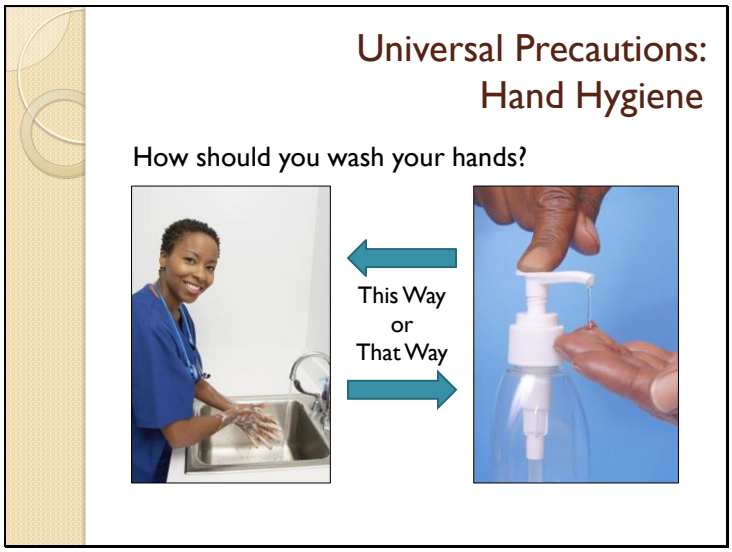
Slide 10



When do you need to wash hands?
Before:
- Eating
- Preparing food
- Putting on gloves
- Having direct contact with residents for personal care
- Handling potentially contaminated items (such as dirty clothes or bandages)

After:
- Blowing your nose, or coughing/sneezing into your hands
- Cleaning and disinfecting surfaces
- Direct contact with any of your own body fluids (like when using the bathroom)
- Direct contact with residents for personal care
- Handling garbage or contaminated clothing
- Preparing food
- Removing any personal protective equipment (such as gloves or masks)

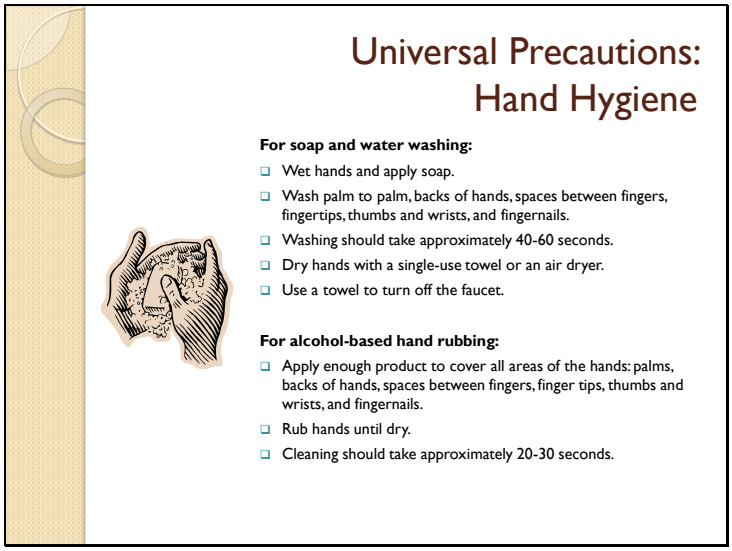
Slide 11



How should you wash your hands?

Good hand hygiene can be practiced with soap and water or with an alcohol-based hand rub. Before starting, make sure that there is soap and single-use towels (or air dryers), or alcohol-based hand rub near the point of care.

Slide 12



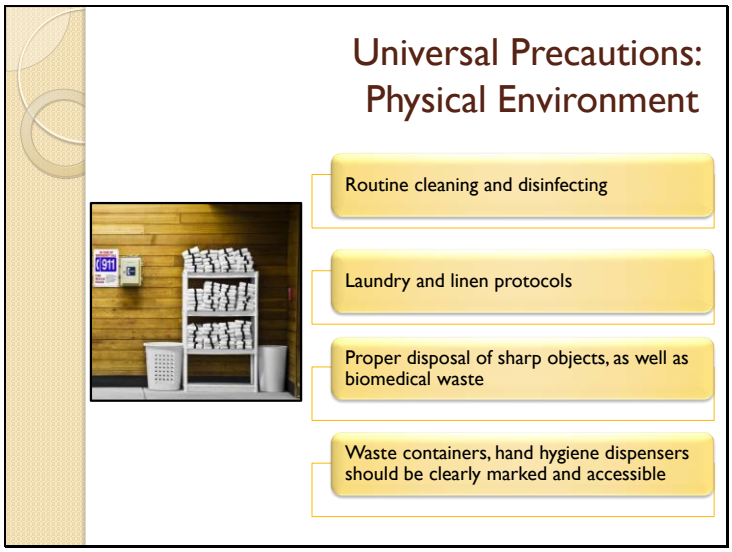
Let's review proper hand washing:
●Wet hands and apply soap.
●Wash palm to palm, backs of hands, spaces between fingers, fingertips, thumbs and wrists, and finger nails.
●Washing should take approximately 40-60 seconds.
●Dry hands thoroughly with a single-use towel or an air dryer.
●Use a towel to turn off the faucet.

For alcohol-based hand rubbing:
●Apply enough product to cover all areas of the hands: palms, backs of hands, spaces between fingers, finger tips, thumbs and wrists, and fingernails.
●Rub hands until dry.
●Cleaning should take approximately 20-30 seconds.

Slide 13

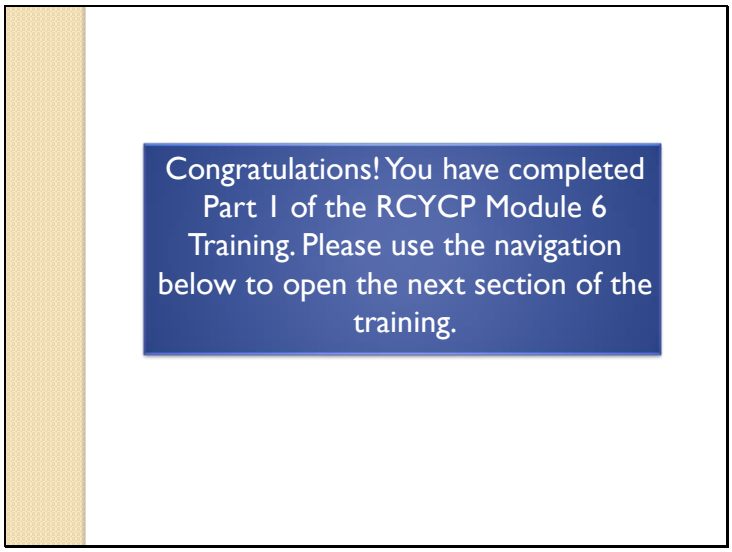
Click on the link to watch a short video on hand washing from the Centers for Disease Control and Prevention: "Proper Hand Washing as approved by CDC."
http://www.youtube.com/watch?v=z87EIgmssBQ

Slide 15



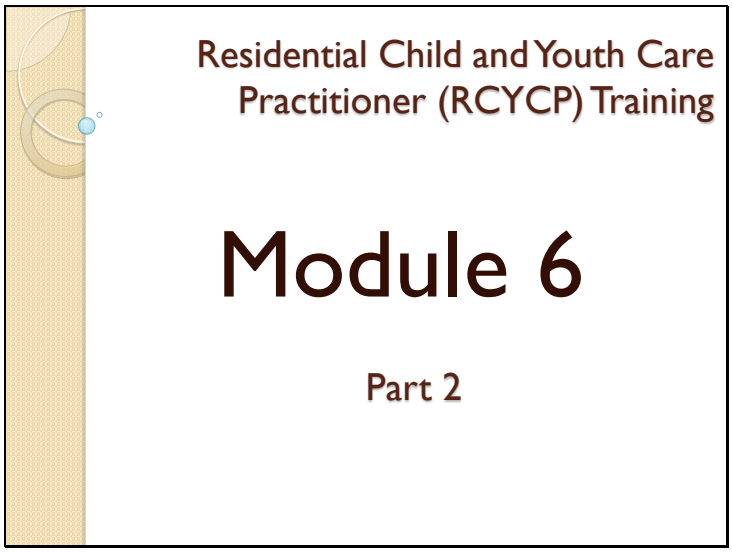
Let's talk about the physical environment now.
In order to maintain a physical environment that minimizes the spread of infection and disease, the following must be in place:
●All work areas and equipment should be properly cleaned and disinfected on a routine basis.
●Protocols should be in place and followed for handling laundry and linens.
●There should be proper disposal of waste, such as needles and other sharp objects, as well as other biomedical waste, such as bloody bandages.
●Waste containers and hand hygiene product dispensers should be clearly marked and easily accessible.

Slide 16



Congratulations! You have completed Part 1 of the RCYCP Module 6 Training. Please use the navigation below to open the next section of the training.

Slide 1



Residential Child and Youth Care Practitioner (RCYCP) Training
Welcome to Module 6, Part 2 of the Residential Child and Youth Care Practitioner Training.

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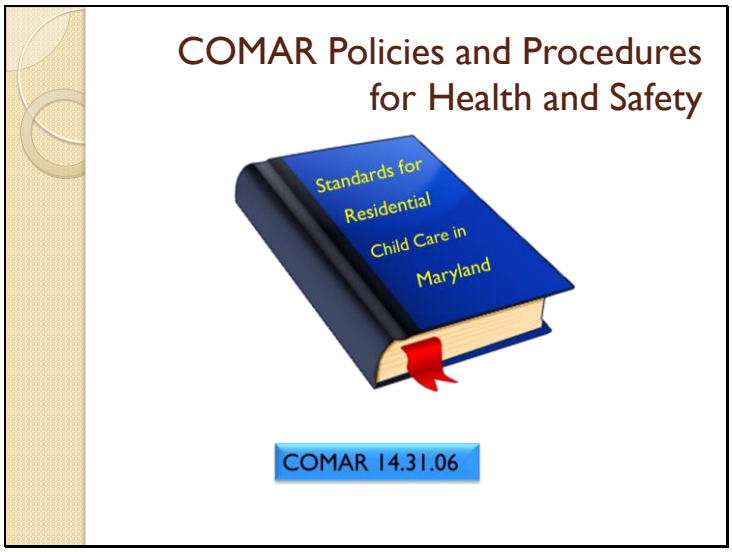

COMAR Policies and Procedures for Health and Safety

Let's now turn to a discussion of policies and procedures for health and safety issues. As you learned in Module 5, COMAR 14.31.06 has a number of regulations in place for residential child and youth care facilities that are designed to keep your facility healthy and safe for residents and staff. We will go over them now broadly. For more details, please be sure to familiarize yourself with COMAR's regulations, along with any policies and procedures on health and safety that are specific to your agency.

Slide 3

Your agency is required to comply with all aspects of COMAR, in addition to other federal and state laws, as well as local building, fire, and health codes. Some examples resulting from these requirements include:

- sound building construction
- well-maintained playground and other recreational equipment
- working fire extinguishers
- slip-proof surfaces
- proper ventilation

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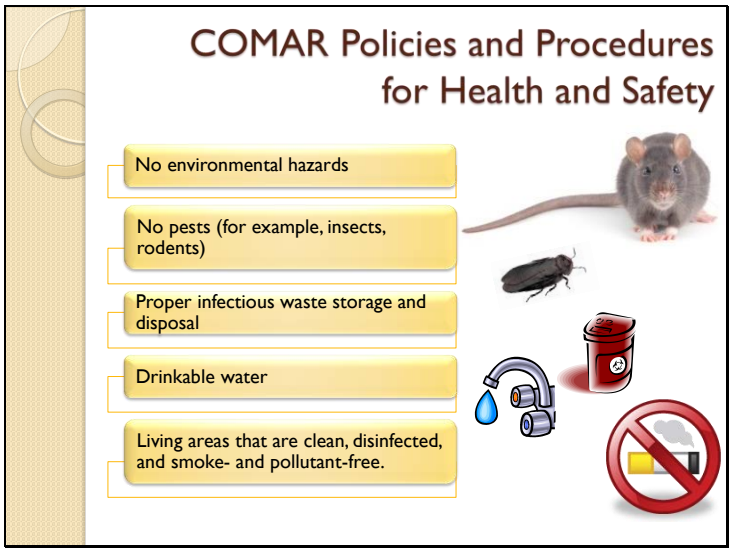
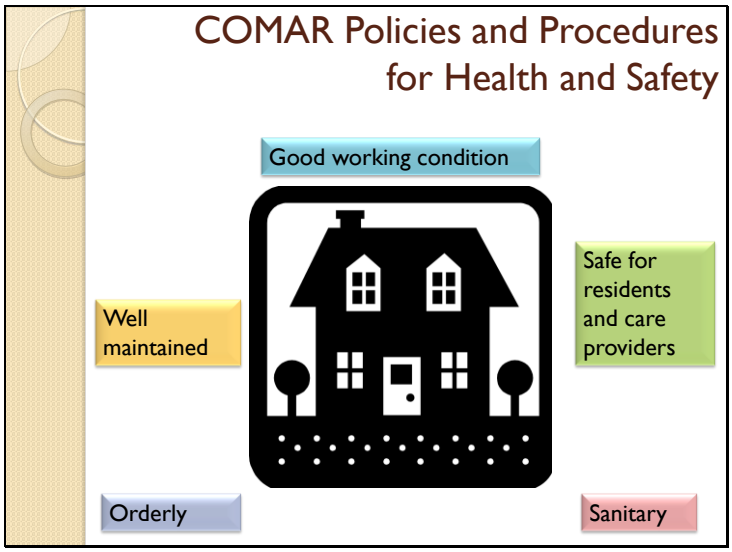


Other examples resulting from these requirements include, but are not limited to:

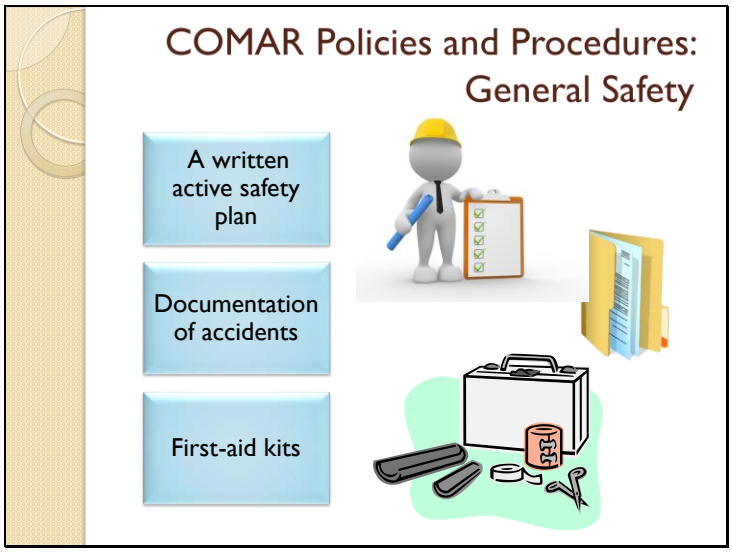
- no environmental hazards, such as lead paint, asbestos, & radon
- no pests, such as insects and rodents
- proper infectious waste storage and disposal
- drinkable water
- and living areas that are clean, disinfected, and smoke- and pollutant-free.

Slide 5



In sum, the residential child and youth care facility must be in good working condition, well maintained, orderly, sanitary, and above all, safe for its residents and care providers.

Slide 6

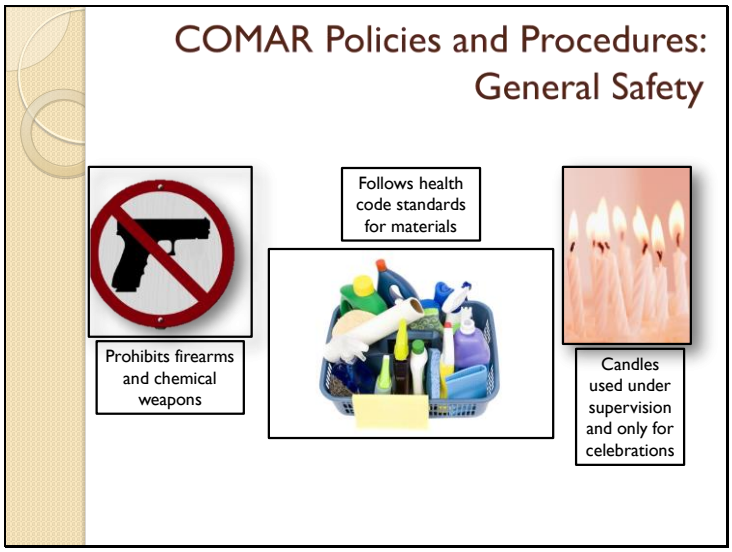


In addition to regulations related to health and safety of the physical plant (that is to say, the agency buildings and property), there are a number of regulations related to general safety and emergencies.

In terms of general safety, COMAR requires that your facility:

- Has a written active safety plan
- Documents accidents
- Has first-aid kits that are appropriate to the size and nature of your program

Slide 7

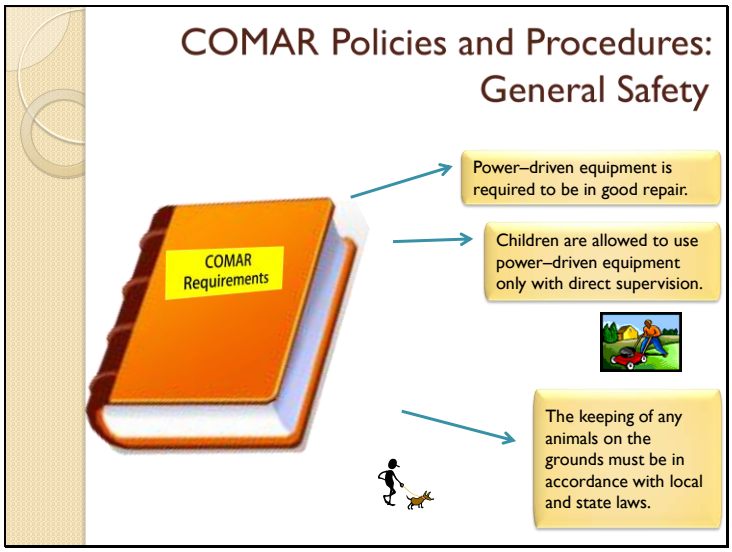


COMAR Policies and Procedures: General Safety

COMAR policies require that your facility:

- Prohibits firearms and chemical weapons on the grounds or within the physical plant
- Follows appropriate health code standards for any poisonous, toxic, or flammable materials
- Prohibits the use of candles, except under the supervision of staff for use during celebrations

Slide 8



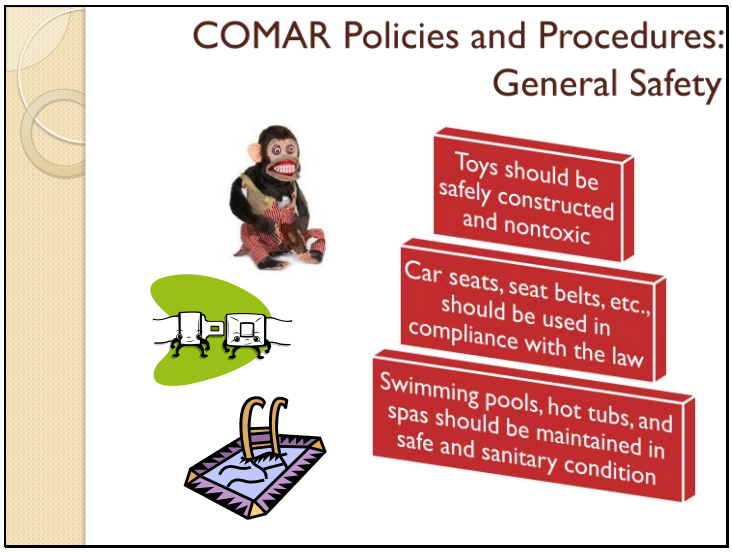
COMAR also requires that your facility:

●Keeps power-driven equipment in safe and good repair

●Ensures that power-driven equipment is used by children only under the direct supervision of an employee and in accordance with the law

●And ensures that, if animals are kept on the grounds or in the facilities, they are kept in accordance with local ordinances or state laws

Slide 9



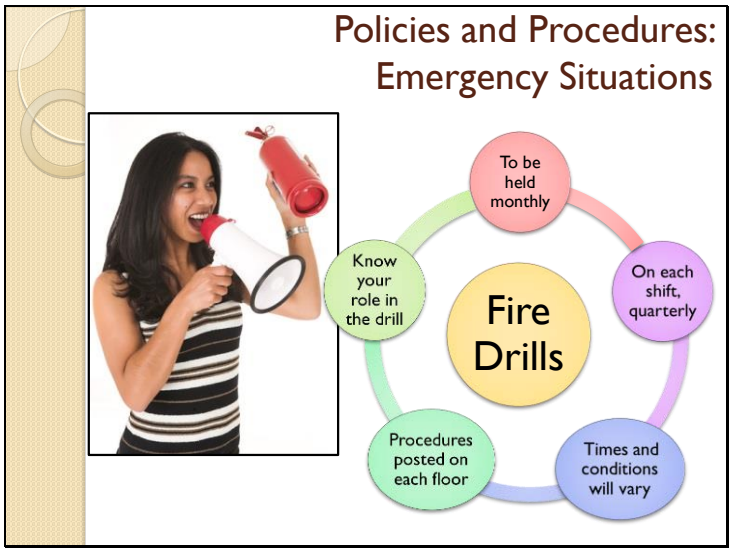
Other general safety regulations cover:

●Toys and equipment: for example, toys used should be safely constructed and nontoxic

●Transportation: for example, federal and State laws on child restraint should be complied with (that is to say, car seats, seat belts, etc., should be used in accordance with the child's age and weight), and the person driving should be licensed to operate the vehicle

●Swimming pools, hot tubs, and spas: for example, pools, hot tubs, and spas should be maintained in safe and sanitary condition

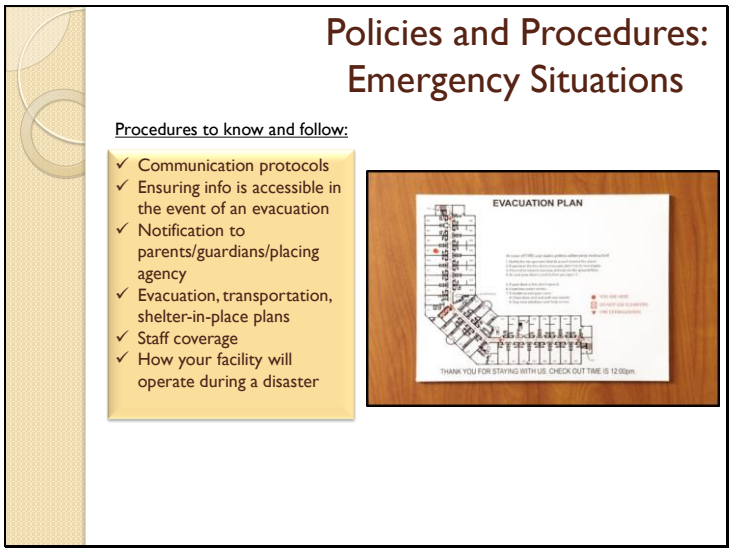
Slide 10



Policies and Procedures: Emergency Situations
In addition to general safety, your facility has policies and procedures in place to deal with emergency situations.

Fire drills
Your agency should hold emergency fire drills at least monthly and a drill for each shift at least quarterly. Some of these drills will occur at unexpected times and under varying conditions. Evacuation procedures should be posted in conspicuous places on each floor of your facility. You should be familiar with these procedures, as well as your role in a drill. For example, you need to know how residents are evacuated, and where people meet to determine that all residents are out of danger.

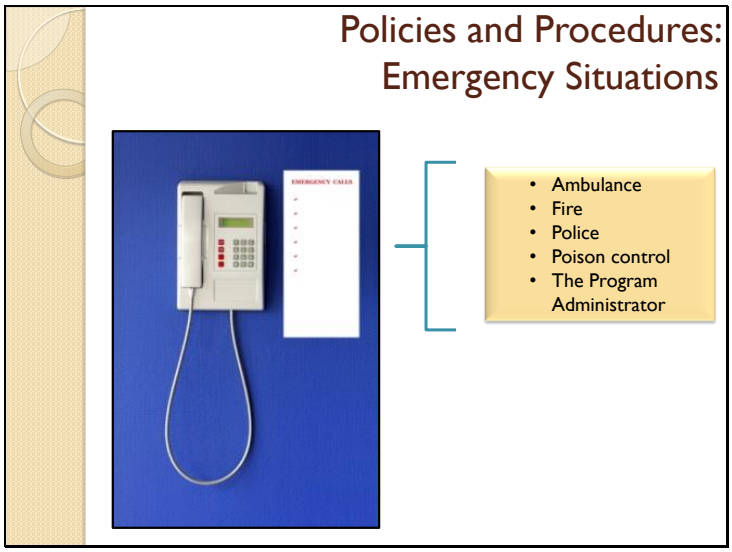
Slide 11



Emergency Plan: Your agency has an emergency plan in place for emergencies and disasters. You, as an RCYCP, should be familiar with this information. It includes:

- Communication protocols
- Ensuring that important information is immediately accessible in the event of an evacuation
- Notification to parents/guardians/placing agency regarding the action taken concerning the safety and well-being of the children
- Evacuation, transportation, shelter-in-place plans
- Staff coverage, and
- How your facility will operate during a disaster

Slide 13



Your agency should also have a posted list of emergency numbers next to all telephones. The list should include numbers for:

- Ambulance
- Fire
- Police
- Poison control, and
- The Program Administrator

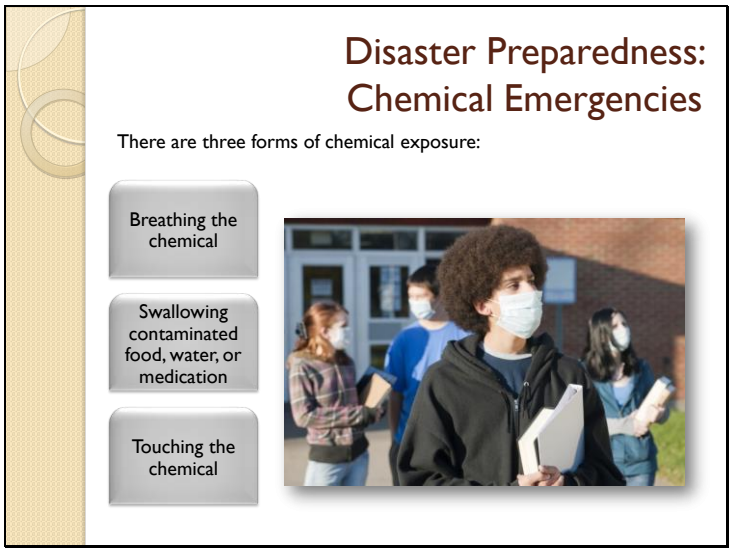
Slide 14

Disaster Preparedness

The following section is devoted to **disaster preparedness**. The information covered in this module comes directly from the Red Cross and is geared toward helping individuals ensure their safety during a disaster. You, as an RCYCP, should be familiar with this information; however, you also should be familiar with your agency's own specific disaster policies and procedures, because they might vary somewhat from the general information covered here.

Material is directly From: Red Cross: http://www.redcross.org/prepare/disaster

Slide 15



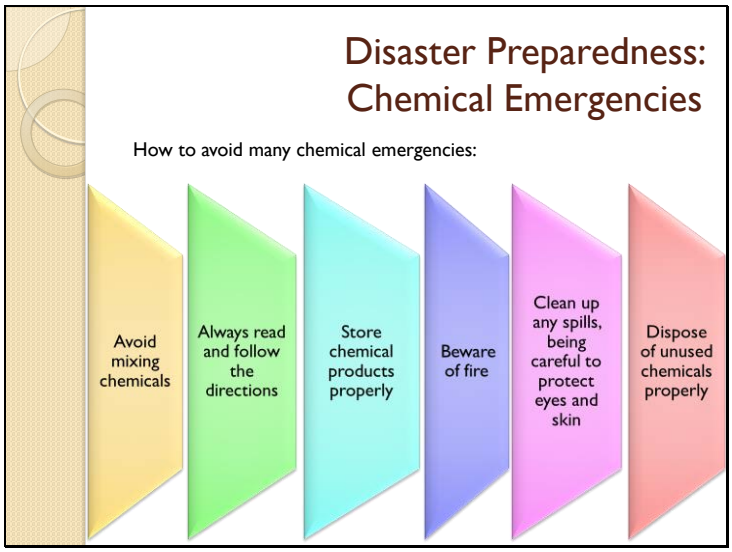
Disaster Preparedness: Chemical Emergencies

Harmful and potentially harmful chemicals are found everywhere – in kitchens, medicine cabinets, basements, and garages. Most chemical accidents occur in people's own homes and they can be prevented.

People can be exposed to harmful chemicals even though they might not be able to see or smell anything unusual. There are three ways they can be exposed:

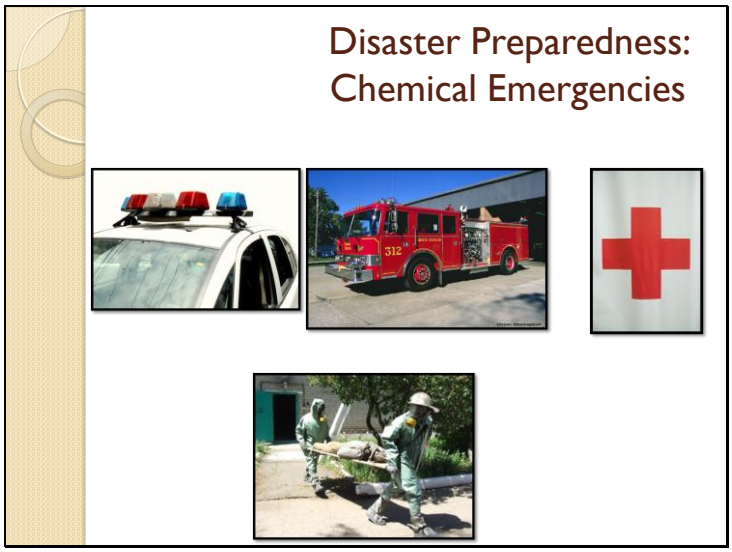
- Breathing the chemical;
- Swallowing contaminated food, water, or medication; and
- Touching the chemical, or coming into contact with clothing or other items that have touched the chemical.

Slide 16



Fortunately, you can take a few simple precautions to help avoid many chemical emergencies.
●Avoid mixing chemicals. Even common household products like ammonia and bleach can, when used in combination, create toxic gases.
●Always read and follow the directions when using a new product. Some products should not be used in small, confined spaces to avoid inhaling dangerous vapors. Other products should not be used without gloves and eye protection to help prevent direct contact with harmful chemicals.
●Store chemical products properly. Non-food products should be stored tightly closed in their original containers so people can always identify the contents of each container and how to properly use the product.
●Beware of fire. Never smoke while using household chemicals. Don't use hair spray, cleaning solutions, paint products, or pesticides near an open flame, including gas stoves, pilot lights, lighted candles, fireplaces, and wood burning stoves. Vapor particles in the air could catch fire or explode.
●Clean up any spills immediately with clean rags, being careful to protect eyes and skin. Allow the fumes in the rags to evaporate outdoors in a safe place, then wrap them in a newspaper and place the bundle in a sealed plastic bag. Dispose of these materials with the trash. Make sure fire extinguishers are handy.
●Dispose of unused chemicals properly. If there are questions about how to dispose of a chemical, call facility administrators or the local environmental or recycling agency to learn the proper method of disposal.

Slide 17



The many organizations that help a community in an emergency, such as (1)police, fire, and sheriff's departments, (2)the American Red Cross, and government agencies, (3)all coordinate their activities through the local office of emergency management. (4)In many areas, there are local Hazardous Materials, or Haz-Mat, Teams, who are trained to respond to chemical accidents. If an accident involving hazardous materials occurs, those who are potentially affected will be notified by the authorities regarding what steps to take.

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The most common home chemical emergencies involve children ingesting medicine outside of supervised treatment.

●Keep all medicines, cosmetics, cleaning products, and other household chemicals out of sight and out of reach of children.

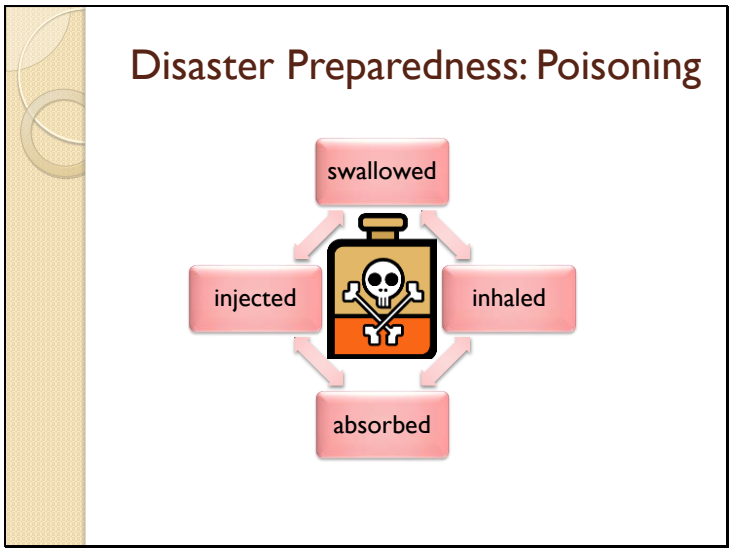
●Keep medications in the containers they came in. Make sure they are kept out of children's reach and locked up.

●Medication should be used only as directed.

●Be aware of the possible side effects and any possible interactions with other medications someone else is taking. Ask a health care provider or pharmacist if there are any questions.

●Never use another person's prescribed medications or medications that have expired.

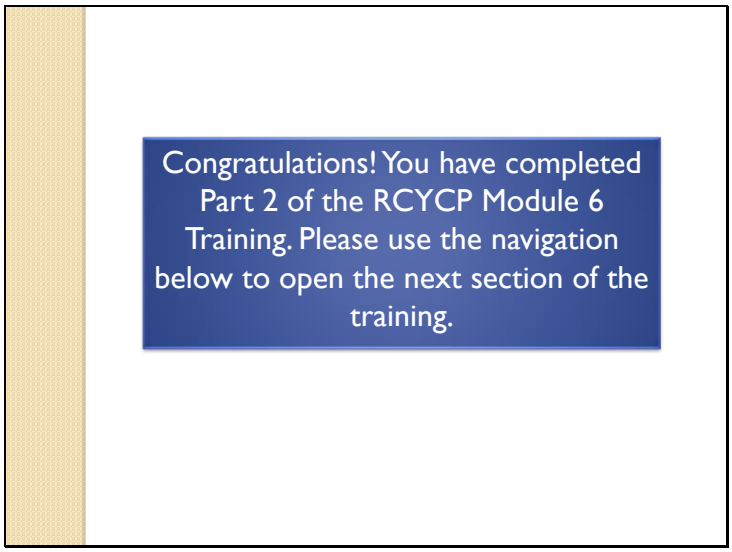
Slide 19



Disaster Preparedness: Poisoning
As you have recently learned, the most common chemical emergency involves children ingesting medicines. Let's take a moment and discuss poisoning since it is so closely related to chemical emergencies.

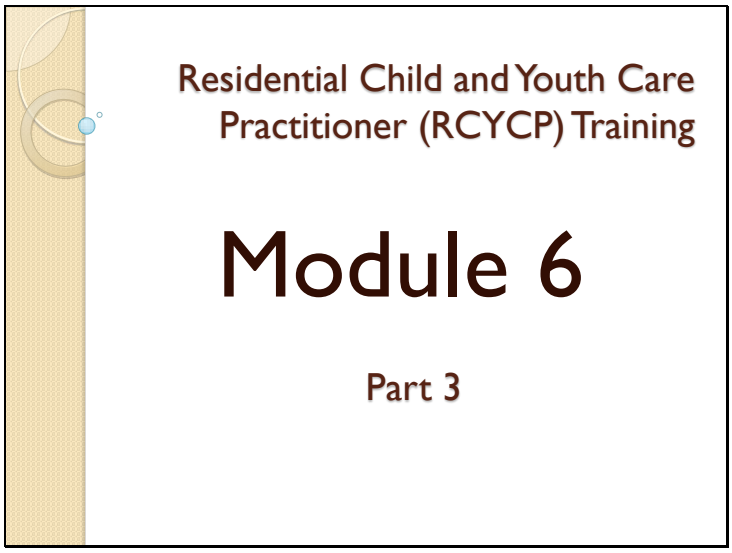
More than 2 million poisonings are reported each year across the country. **Poisons can be swallowed, inhaled, absorbed, or injected.**

Slide 21



Congratulations! You have completed Part 2 of the RCYCP Module 6 Training. Please use the navigation below to open the next section of the training.

Slide 1



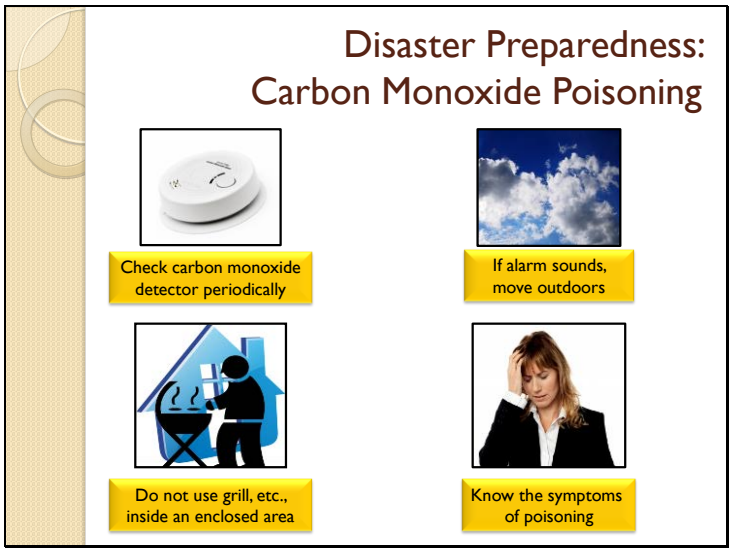
Residential Child and Youth Care Practitioner (RCYCP) Training
Welcome to Module 6, Part 3 of the Residential Child and Youth Care Practitioner Training.

Slide 2

Disaster Preparedness: Chemical Emergencies
If someone in your facility does eat or drink a non-food substance, find the container it came out of immediately and take it with you to the phone. Call the Poison Control Center (1-800-222-1222), or Emergency Medical Services (EMS), or 9-1-1, or call the operator, and tell them exactly what the person ingested.

Follow their instructions carefully. Please be aware that the first aid advice found on the container may not be appropriate. Do not give anything by mouth until you have been advised by medical professionals.

Slide 3



Disaster Preparedness: Carbon Monoxide Poisoning
Carbon monoxide poisoning is another danger that you should be prepared for. Your facility should have carbon monoxide detectors present and in good working order. It's good to be in the habit of periodically checking both carbon monoxide detectors and smoke detectors, and changing the batteries at least twice a year.

If the carbon monoxide alarm sounds, move quickly to a fresh air location outdoors or to an open window or door.

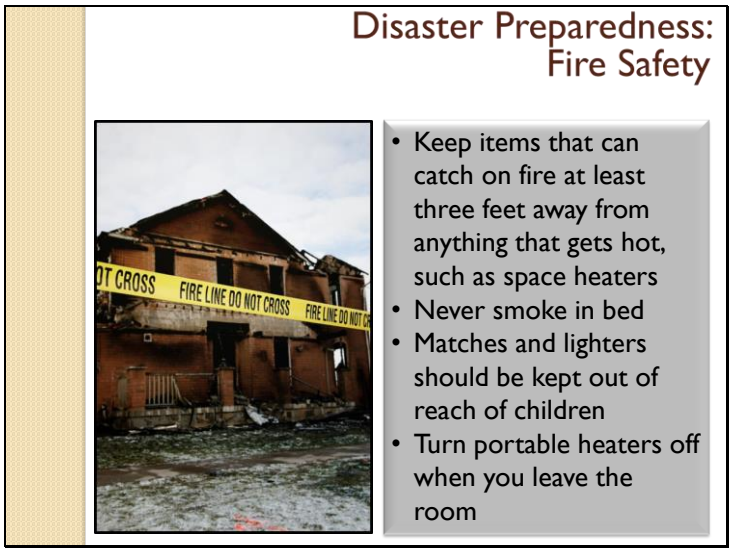
In order to help prevent carbon monoxide poisoning, never use a generator, grill, camp stove or other gasoline, propane, natural gas or charcoal-burning device inside a facility, home, garage, basement, or any partially enclosed area.

Know the symptoms of carbon monoxide poisoning: headache, dizziness, weakness, nausea, vomiting, sleepiness, and confusion. If you suspect carbon monoxide poisoning, get outside to fresh air immediately and then call 9-1-1.

Slide 4

Disaster Preparedness: Fire Safety
Now let's turn to another type of emergency that every facility should be prepared for: fires. Your facility should have a fire escape plan in place, and all staff and residents should be familiar with that plan. Smoke alarms should be present and working at your facility.

Slide 5



The most effective way to protect yourself and your site from fire is to identify and remove fire hazards. Here are some other rules that staff and residents should follow:

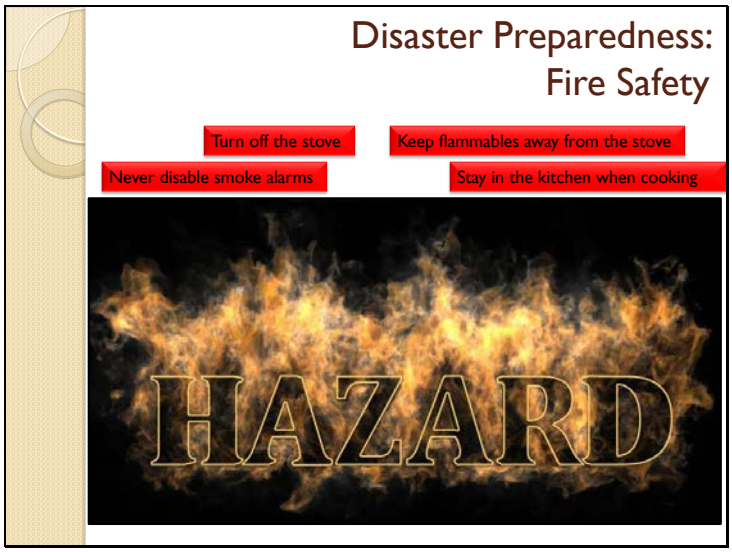
●Keep items that can catch on fire at least three feet away from anything that gets hot, such as space heaters.

●Never smoke in bed.

●Matches and lighters should be kept out of reach of children.

●Turn portable heaters off when you leave the room.

Slide 6

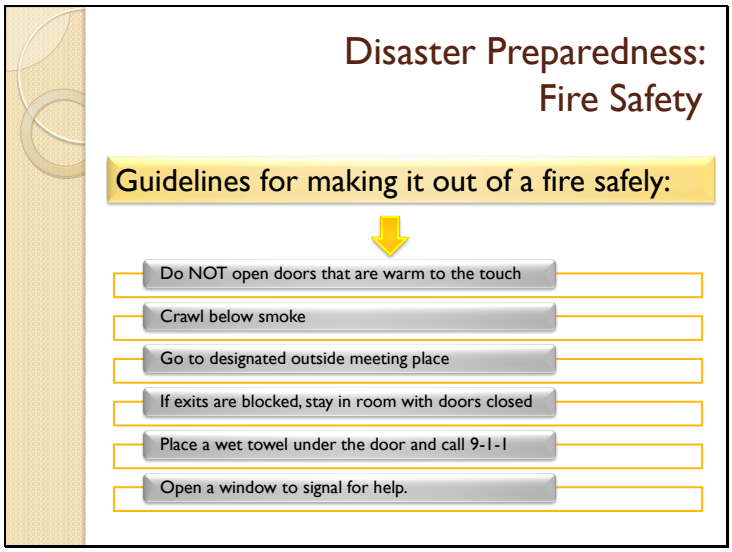


Staff and residents should also be aware of the following:
●Never disable smoke alarms.
●Stay in the kitchen when frying, grilling, or broiling food. If you leave the kitchen, even for a short period of time, turn off the stove.
●Stay in the facility while simmering, baking, roasting or boiling food. Check it regularly and use a timer to remind you that food is cooking.
●Keep anything that can catch fire—like pot holders, towels, plastic and clothing— away from the stove.

Slide 7

If a fire should occur at your facility, the most important thing you can do is GET OUT, STAY OUT, and CALL for help. Once you have exited, do not go back inside, or allow others to do so. A fire can be unpredictable, and even a minor fire can turn deadly in a matter of seconds.

Slide 8



Here are a few other guidelines for making it out of a fire safely:

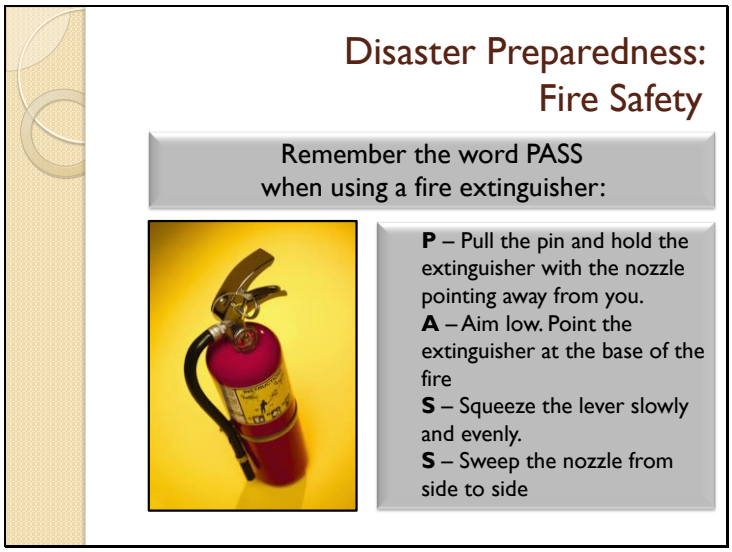
●If closed doors or handles are warm, use your second way out. Never open doors that are warm to the touch.

●Crawl below smoke.

●Go to a designated outside meeting place and then call for help.

●If smoke, heat, or flames block your exit routes, stay in the room with doors closed. Place a wet towel under the door and call the fire department or dial 9-1-1. Open a window and wave a brightly colored cloth or flashlight to signal for help.

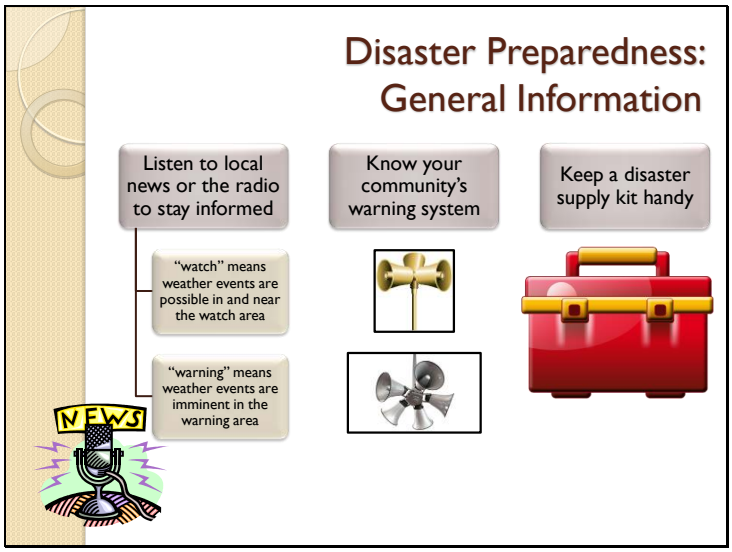
Slide 9



Use Caution with Fire Extinguishers. Remember the word PASS when using a fire extinguisher:

- P – Pull the pin and hold the extinguisher with the nozzle pointing away from you.
- A – Aim low. Point the extinguisher at the base of the fire.
- S – Squeeze the lever slowly and evenly.
- S – Sweep the nozzle from side to side.

Slide 10



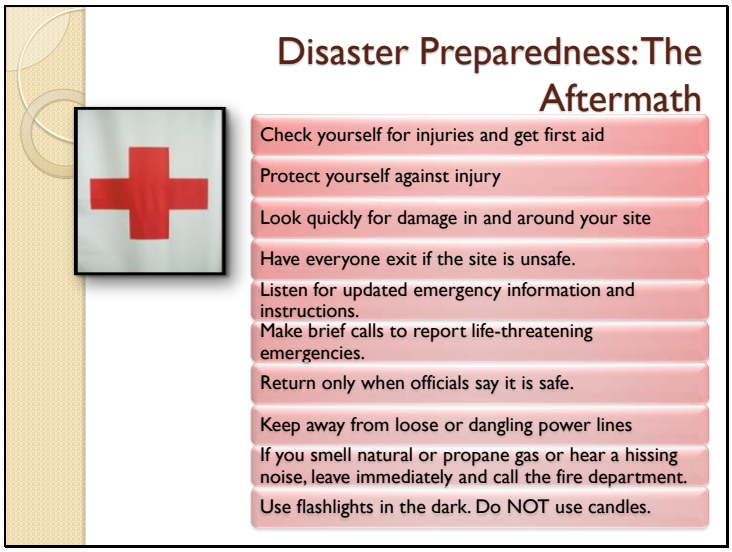
Disaster Preparedness: General Information
Let's switch gears and talk about weather-related disaster preparedness. Before we discuss specific weather related disasters, let's go over general disaster preparedness information – that is, information that is important no matter what the type of disaster. After that, you will hear information that is specific to certain weather events.

General Disaster Preparedness:
Anytime there is an impending weather-related disaster it is important to take the appropriate steps to stay safe.
During any storm, listen to local news or the radio to stay informed about watches and warnings.
●The term "watch," such as "winter storm watch", means weather events are possible in and near the watch area.
●The term "warning," such as "winter storm warning," means weather events are imminent in the warning area.
Know your community's warning system. Communities have different ways of warning residents about weather events, with many having sirens intended for outdoor warning purposes. Click on the siren icons for examples.
Also, keep a disaster supply kit handy.

Slide 11

Recommended Disaster Supplies
Recommended disaster supplies include:
●Water—at least a 3-day supply; one gallon per person per day
●Food—at least a 3-day supply of non-perishable, easy-to-prepare food
●Flashlight
●Battery-powered or hand-crank radio
●Extra batteries
●A first-aid kit and medications (7-day supply) and any needed medical items like hearing aids with extra batteries, glasses, contact lenses, syringes, etc.
●Multipurpose tool
●Sanitation and personal hygiene items
●Copies of personal documents (medication list and pertinent medical information, proof of address, deed/lease to home, passports, birth certificates, insurance policies)
●Cell phone with chargers
●Emergency contact information
●Extra cash
●Emergency blanket
●Map(s) of the area
●Baby supplies (bottles, formula, baby food, diapers) if applicable
●Pet supplies (collar, leash, ID, food, carrier, bowl) if applicable
●Tools/supplies for securing your home
●Extra set of car keys and house keys
●Extra clothing, hat and sturdy shoes
●Clothes specific to the season and type of disaster such as rain gear, warm coats, gloves or mittens, hats, boots and extra blankets, and warm clothing
●Insect repellent and sunscreen if relevant

Slide 12



Disaster Preparedness: The Aftermath

During, or in the aftermath of a disaster, the following Red Cross guidelines are important:

●Check yourself for injuries and get first aid, if necessary, before helping injured or trapped persons.

●Protect yourself against injury from broken objects.

●Look quickly for damage in and around your site, and have everyone exit if the site is unsafe.

●Listen to a portable, battery-operated, or hand-crank radio for updated emergency information and instructions.

●Check the telephones in your workplace to see if you can get a dial tone. Make brief calls to report life-threatening emergencies.

●If you have been forced to evacuate your area, return only when officials say it is safe.

●Keep away from loose or dangling power lines and report them immediately to the power company.

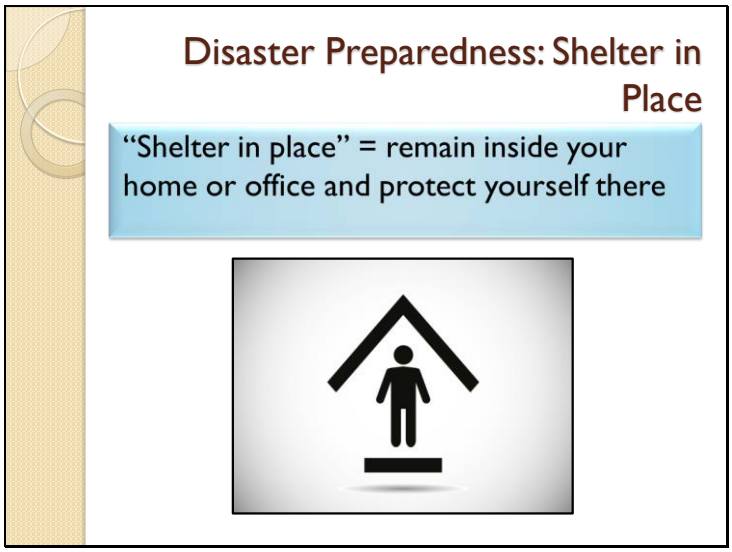
●If you smell natural or propane gas or hear a hissing noise, leave immediately and call the fire department.

●Use flashlights in the dark. Do NOT use candles.

Slide 13

●Avoid drinking or preparing food with tap water until you are sure it's not contaminated.
●Check refrigerated food for spoilage. If in doubt, throw it out.
●Wear protective clothing and be cautious when cleaning up to avoid injury.
●Obey evacuation orders. Avoid flooded roads and washed out bridges.
●Stay out of any building that has water surrounding it.
●Never drive through a flooded roadway. You cannot predict how deep the water may be.
●Help people who may require special assistance, such as infants, children and the elderly or disabled.
●Check your disaster supplies. Replace or restock as needed.

Slide 14

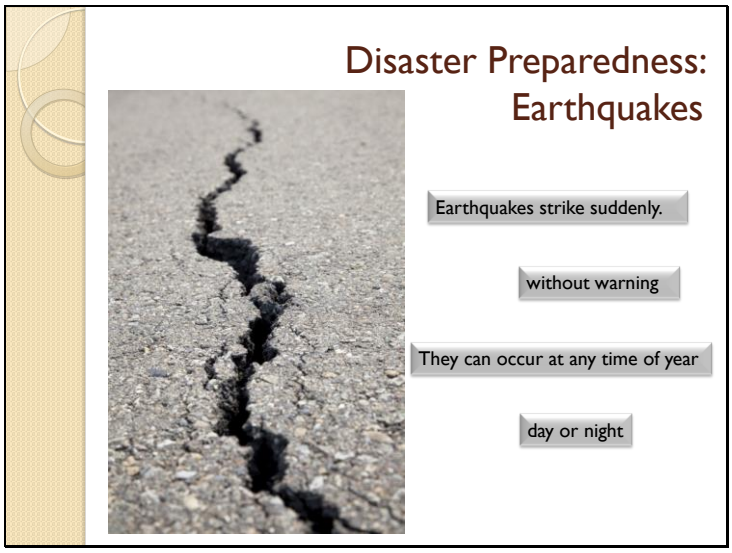


Disaster Preparedness: Shelter in Place
Your local authorities will provide you with the most accurate information specific to an event in your area. Staying tuned to local radio and television, and following their instructions is your safest choice.

If you are advised by local officials to "shelter in place," they mean you are to remain inside your home or office and protect yourself there. Pay attention to news and radio reports for further information. Local officials may call for evacuation in specific areas at greatest risk in your community.

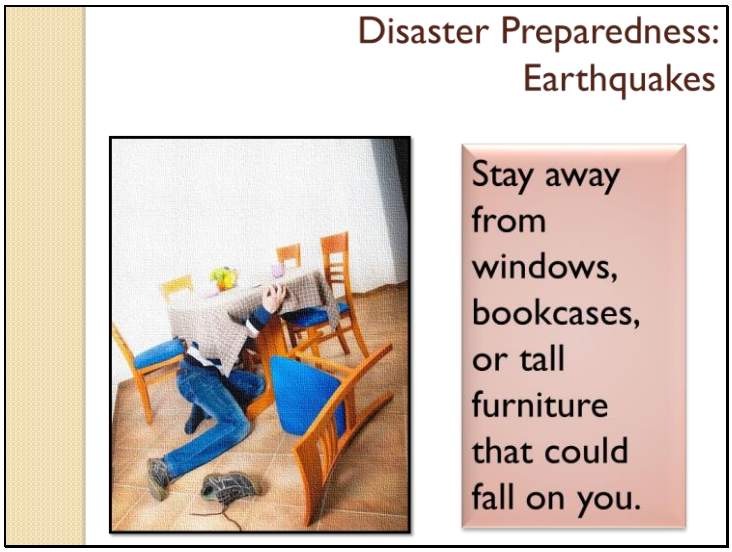
Now that you have heard the general guidelines, let's focus on specific weather-related events.

Slide 15



Disaster Preparedness: Earthquakes
An earthquake is a sudden, rapid shaking of the earth caused by the breaking and shifting of rock beneath the earth's surface. Earthquakes strike suddenly, without warning, and they can occur at any time of the year, day or night.

Slide 16



Become aware of fire evacuation and earthquake safety plans for all of the buildings you occupy regularly.

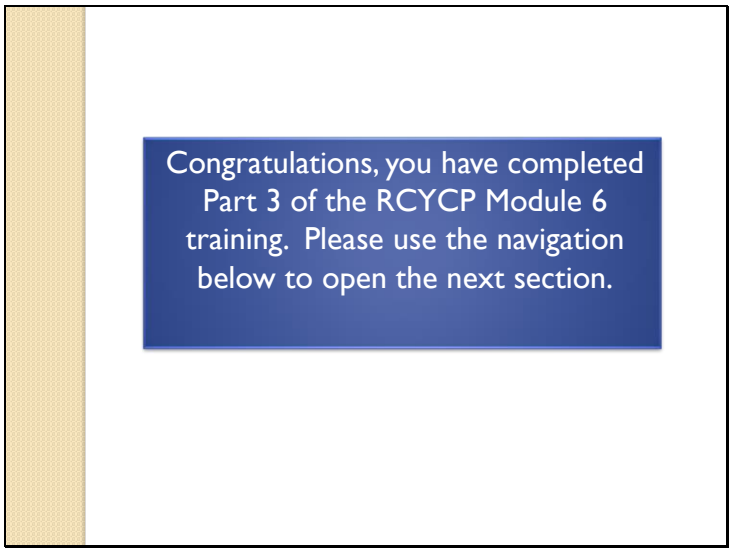
Pick safe places in each room of the buildings you frequent. (1)A safe place could be under a piece of furniture or against an interior wall. Stay away from windows, bookcases or tall furniture that could fall on you.

Slide 17

If You Are Inside When the Shaking Starts...

- Drop, cover, and hold on. Move as little as possible.
- Stay away from windows to avoid being injured by shattered glass.
- Stay indoors until the shaking stops and you are sure it is safe to exit. When it is, use stairs rather than the elevator in case of aftershocks, power outages, or structural damage.
- Be aware that fire alarms and sprinkler systems frequently go off in buildings during an earthquake, even if there is no fire.

Slide 18



Congratulations! You have completed Part 3 of the RCYCP Module 6 Training. Please use the navigation below to open the next section of the training.

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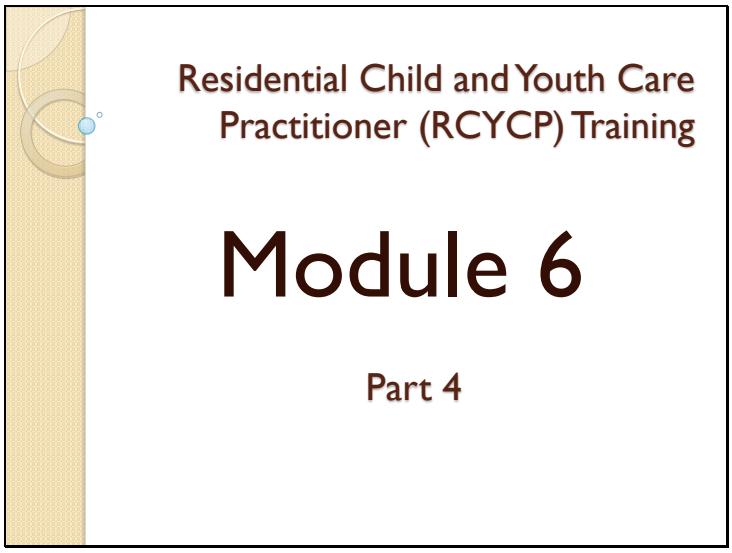
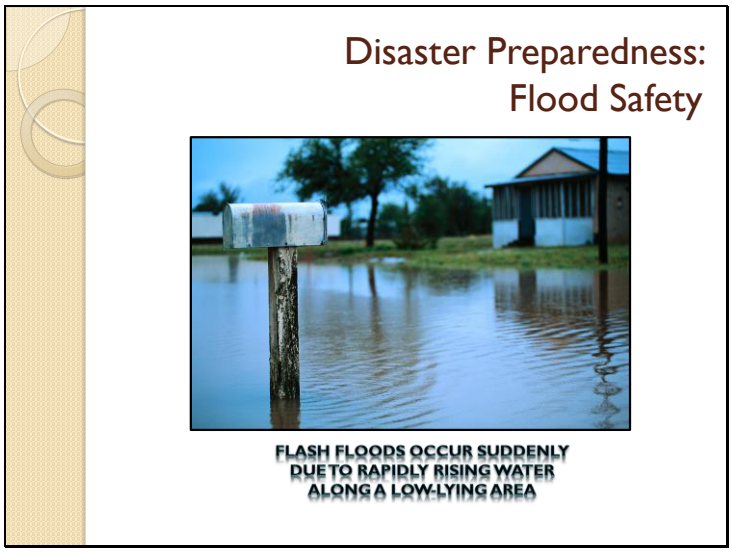


Residential Child and Youth Care Practitioner (RCYCP) Training
Welcome to Module 6, Part 4, of the Residential Child and Youth Care Practitioner Training.

Slide 2



Disaster Preparedness: Flood Safety
Floods are among the most frequent and costly natural disasters.

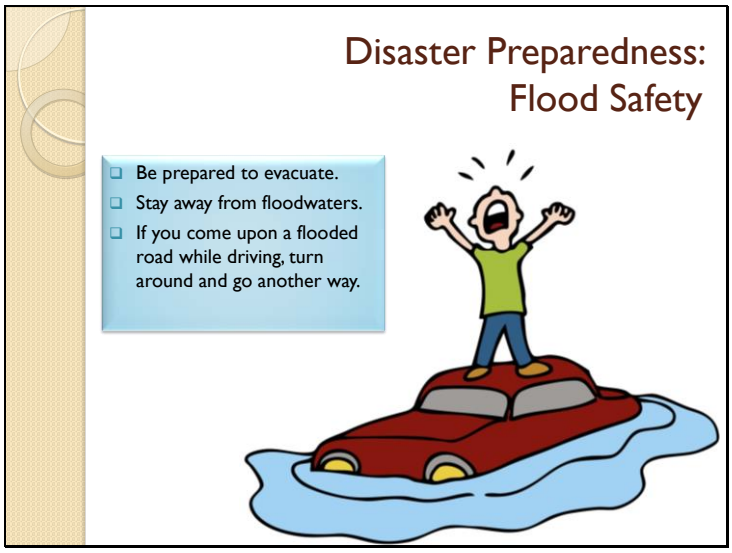
Conditions that cause floods include heavy or steady rain for several hours or days that saturates the ground. Flash floods occur suddenly due to rapidly rising water along a stream or low-lying area.

You will likely hear weather fore casters use these terms when floods are predicted in your community:

Flood/Flash Flood Watch—Flooding or flash flooding is possible in your area.

Flood/Flash Flood Warning—Flooding or flash flooding is already occurring or will occur soon in your area.

Slide 3



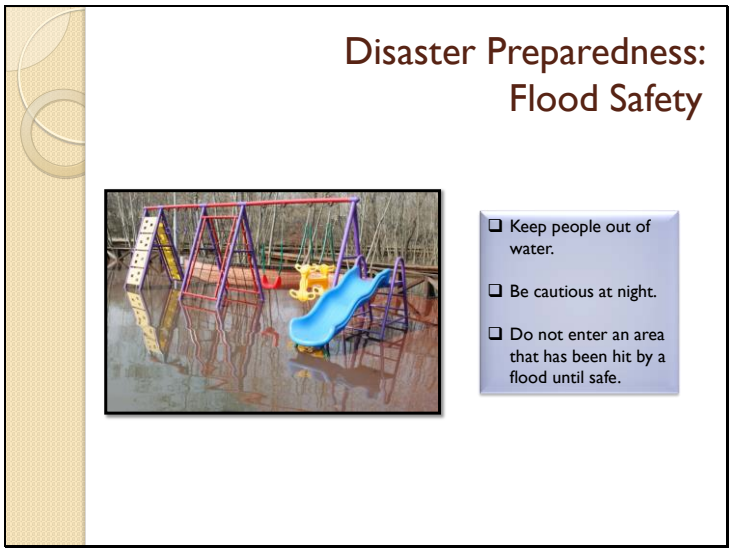
In the event of flooding in your area:

●Be prepared to evacuate at a moment's notice.

●Stay away from floodwaters. If you come upon a flowing stream where water is above your ankles, stop, turn around and go another way. Six inches of swiftly moving water can sweep you off of your feet.

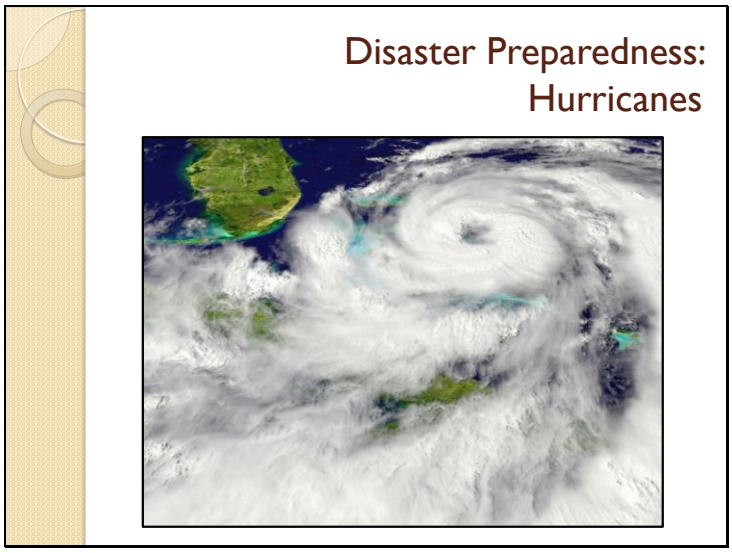
●If you come upon a flooded road while driving, turn around and go another way. If you are caught on a flooded road and waters are rising rapidly around you, get out of the car quickly and move to higher ground. Most cars can be swept away by less than two feet of moving water.

Slide 4



●Keep people out of the water. People can be curious and often lack judgment about running water or contaminated water.
●Be especially cautious at night when it is harder to recognize flood danger.
●Do not enter an area that has been hit by a flood unless officials have declared the area safe.
●Keep kids and animals away from hazardous sites and floodwater.

Slide 5



Disaster Preparedness: Hurricanes
Hurricanes are strong storms that can be life-threatening as well as cause serious property-threatening hazards such as flooding, storm surge, high winds and tornadoes.

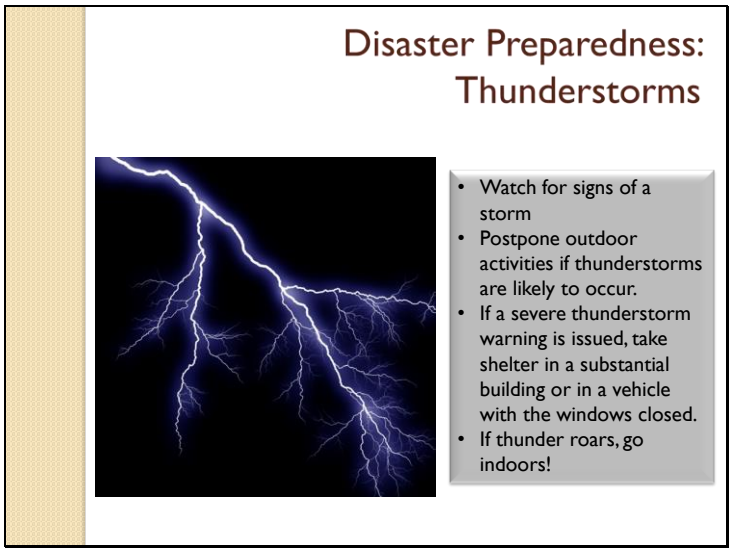
Your facility should have a hurricane evacuation plan in place. Make sure you are familiar with this plan.

Slide 6

Disaster Preparedness: Thunderstorms

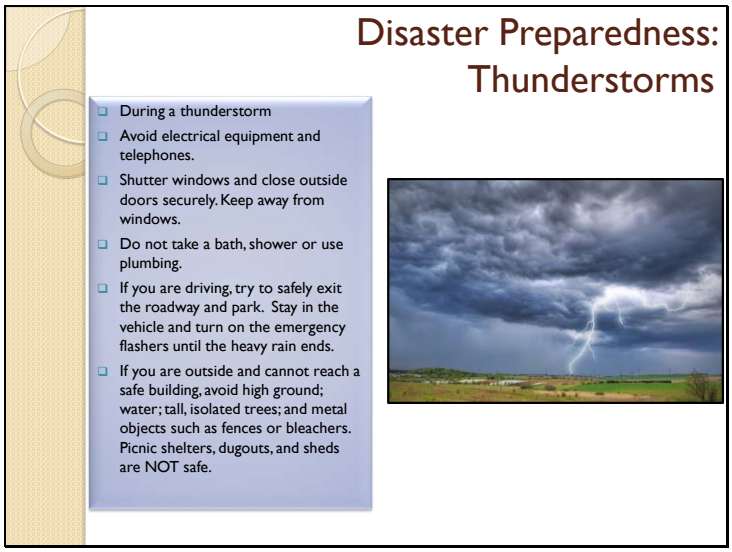
A thunderstorm is considered severe if it produces hail at least 1 inch in diameter or has wind gusts of at least 58 miles per hour. Every thunderstorm produces lightning, which kills more people each year than tornadoes or hurricanes. Heavy rain from thunderstorms can cause flash flooding, and high winds can damage homes and blow down trees and utility poles, causing widespread power outages.

Slide 7



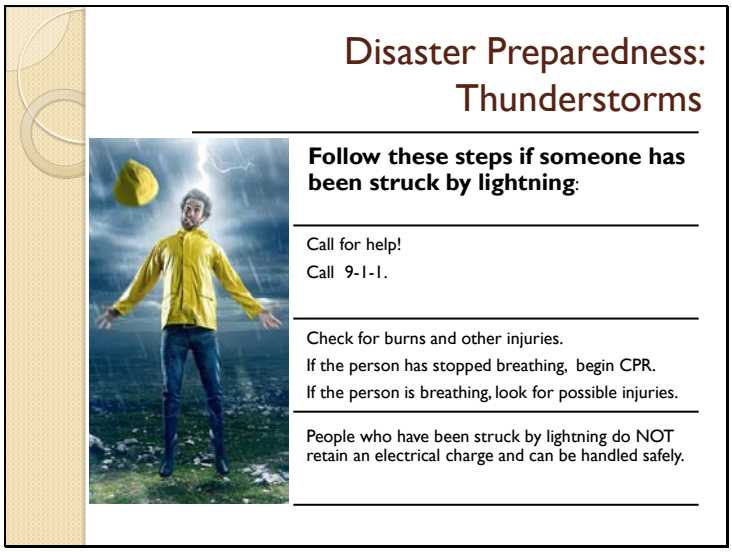
Be prepared for thunderstorms and severe weather:
●Watch for signs of a storm, like darkening skies, lightning flashes or increasing wind.
●Postpone outdoor activities if thunderstorms are likely to occur. Many people struck by lightning are not in the area where rain is occurring.
●If a severe thunderstorm warning is issued, take shelter in a substantial building or in a vehicle with the windows closed. Get out of mobile homes that can blow over in high winds.
●If you can hear thunder, you are close enough to be in danger from lightning. If thunder roars, go indoors! The National Weather Service recommends staying inside for at least 30 minutes after the last thunder clap.

Slide 8



●Avoid electrical equipment and telephones. Use battery-powered TVs and radios instead.
●Shutter windows and close outside doors securely. Keep away from windows.
●Do not take a bath, shower or use plumbing.
●If you are driving, try to safely exit the roadway and park. Stay in the vehicle and turn on the emergency flashers until the heavy rain ends. Avoid touching metal or other surfaces that conduct electricity in and outside the vehicle.
●If you are outside and cannot reach a safe building, avoid high ground; water; tall isolated trees; and metal objects such as fences or bleachers. Picnic shelters, dugouts, and sheds are NOT safe.

Slide 9



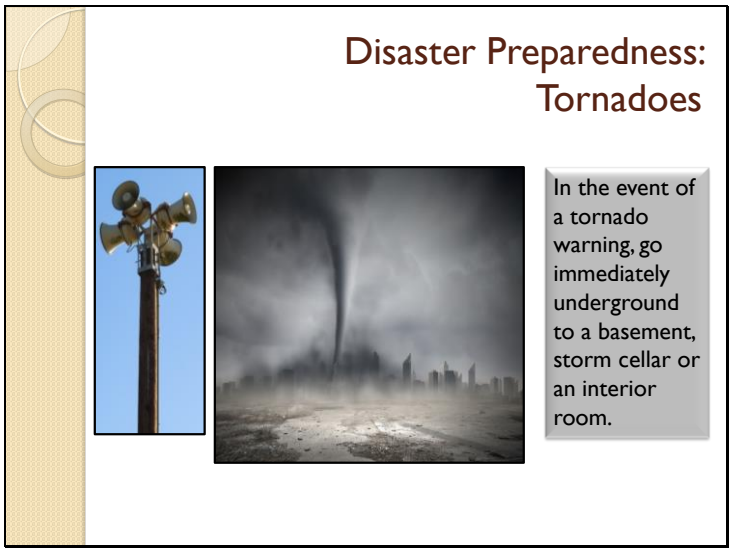
If Lightning Strikes
Follow these steps if someone has been struck by lightning:
●Call for help. Call 9-1-1 or the local emergency number. Anyone who has sustained a lightning strike requires professional medical care.
●Check the person for burns and other injuries. If the person has stopped breathing, call 9-1-1 and begin CPR. If the person is breathing normally, look for other possible injuries and care for them as necessary. People who have been struck by lightning do not retain an electrical charge and can be handled safely.

Slide 10

Disaster Preparedness: Tornadoes
Tornadoes are violent by nature. They are capable of completely destroying well-made structures, uprooting trees and hurling objects through the air like deadly missiles. A tornado is a violently rotating column of air extending from the base of a thunderstorm down to the ground.

Tornado intensities are classified on the Fujita Scale with ratings between F0 (weakest) to F5 (strongest). Although severe tornadoes are more common in the Plains States, tornadoes have been reported in every state.

Slide 11



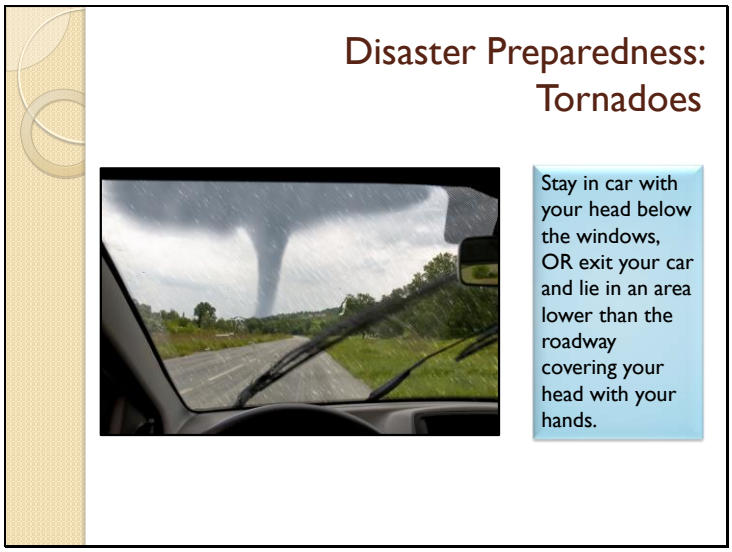
How to Prepare for a Tornado

In the case of a tornado watch, review and discuss your emergency plans, and check supplies and your safe room. Be ready to act quickly if a warning is issued or you suspect a tornado is approaching. Acting early helps to save lives! Move or secure lawn furniture, trash cans, hanging plants or anything else that can be picked up by the wind and become a projectile.

Tornado warnings indicate imminent danger to life and property. In the event of a tornado warning, go immediately under ground to a basement, storm cellar or an interior room (closet, hallway or bathroom) on the lowest floor with no windows.

Mobile homes are not safe during tornadoes or other severe winds.

Slide 12



If you are caught outdoors, seek shelter in a basement, shelter, or sturdy building. If you cannot quickly walk to a shelter:

●Immediately get into a vehicle, buckle your seat belt, and try to drive to the closest sturdy shelter.

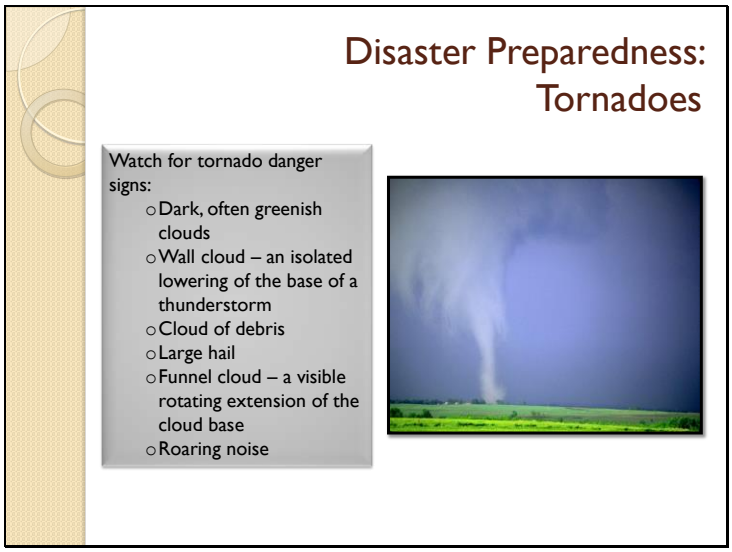
●If flying debris occurs while you are driving, pull over and park. Now you have the following options as a last resort:

●Stay in the car with the seat belt on. Put your head down below the windows, covering with your hands and a blanket if possible.

●If you can safely get noticeably lower than the level of the roadway, exit your car and lie in that area, covering your head with your hands.

Your choice should be driven by your specific circumstances.

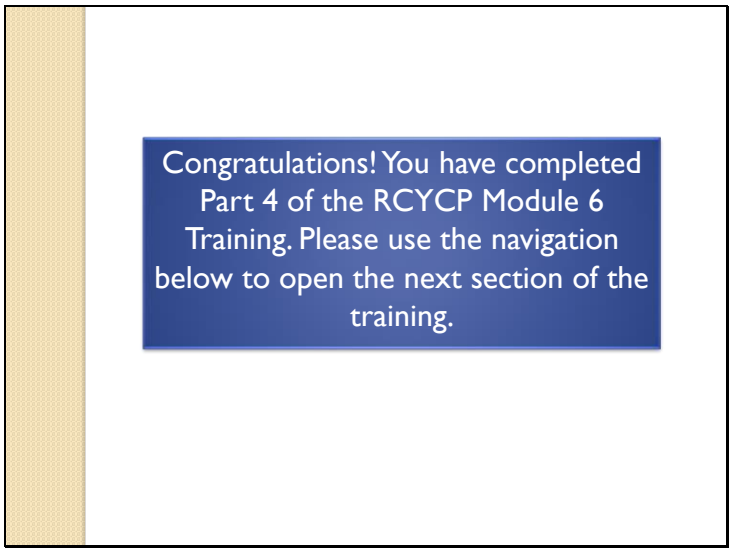
Slide 13



It can be helpful to know and watch for tornado danger signs:

- Dark, often greenish clouds – a phenomenon caused by hail
- Wall cloud – an isolated lowering of the base of a thunderstorm
- Cloud of debris
- Large hail
- Funnel cloud – a visible rotating extension of the cloud base
- Roaring noise

Slide 15



Congratulations! You have completed Part 4 of the RCYCP Module 6 Training. Please use the navigation below to open the next section of the training.

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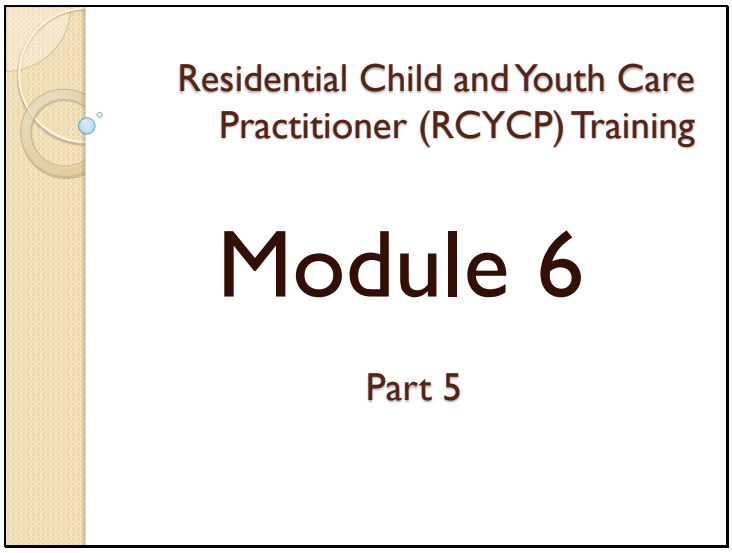


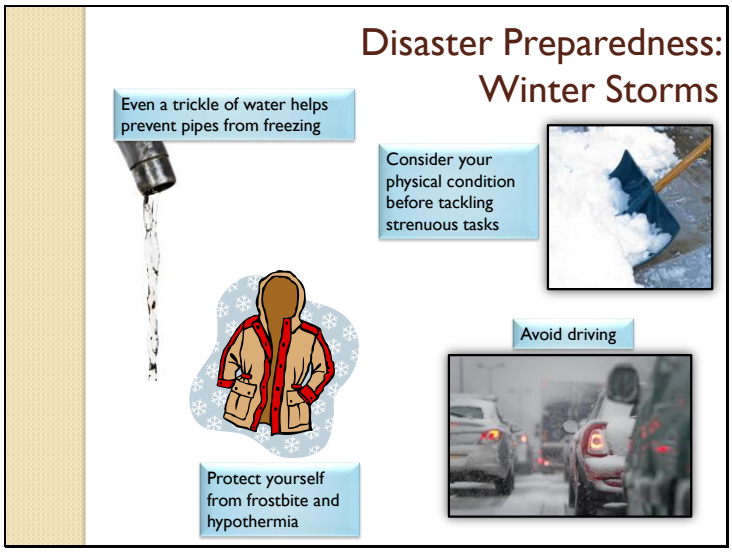
Residential Child and Youth Care Practitioner (RCYCP) Training
Welcome to Module 6, Part 5, of the Residential Child and Youth Care Practitioner Training.

Slide 2

Disaster Preparedness: Winter Storms
Let's talk about winter storms now. Winter storms can range from a moderate snow over a few hours to a blizzard with blinding, wind-driven snow that lasts for several days. Some winter storms are large enough to affect several states, while others affect only a single community. Many winter storms are accompanied by dangerously low temperatures and sometimes by strong winds, icing, sleet, and freezing rain.

Regardless of the severity of a winter storm, you should be prepared in order to remain safe during these events.

Slide 3



Disaster Preparedness: Winter Storms

Remaining safe during a winter storm is important:

●Running water, even at a trickle, helps prevent pipes from freezing.

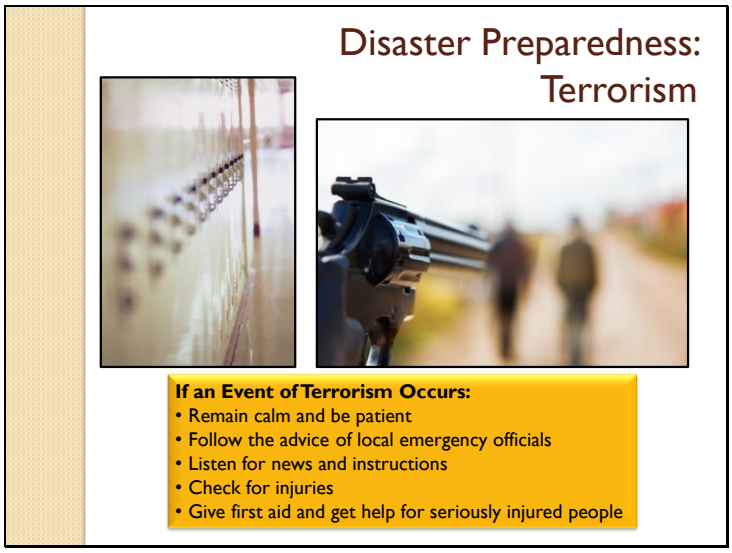
●All fuel-burning equipment should be vented to the outside and kept clear.

●Avoid driving when conditions include sleet, freezing rain or drizzle, snow or dense fog. If travel is necessary, keep a disaster supplies kit in your vehicle.

●Before tackling strenuous tasks in cold temperatures, consider your physical condition, the weather factors and the nature of the task.

●Protect yourself from frostbite and hypothermia by wearing warm, loose-fitting, lightweight clothing in several layers. Stay indoors, if possible.

Slide 4



Disaster Preparedness: Terrorism
Let's move away now from talking about weather disasters to other types of situations, that while unlikely, are important to be prepared to handle. We will begin with terrorism.

If an Event of Terrorism Occurs
●Remain calm and be patient.
●Follow the advice of local emergency officials.
●Listen to your radio or television for news and instructions.
●If the event occurs near you, check for injuries. Give first aid and get help for seriously injured people.

Slide 5

If an Event of Terrorism Occurs Near Your Home While you Are There

●Check for damage using a flashlight. Do not light matches or candles or turn on electrical switches.

●Check for fires, fire hazards and other household hazards. Sniff for gas leaks, starting at the water heater.

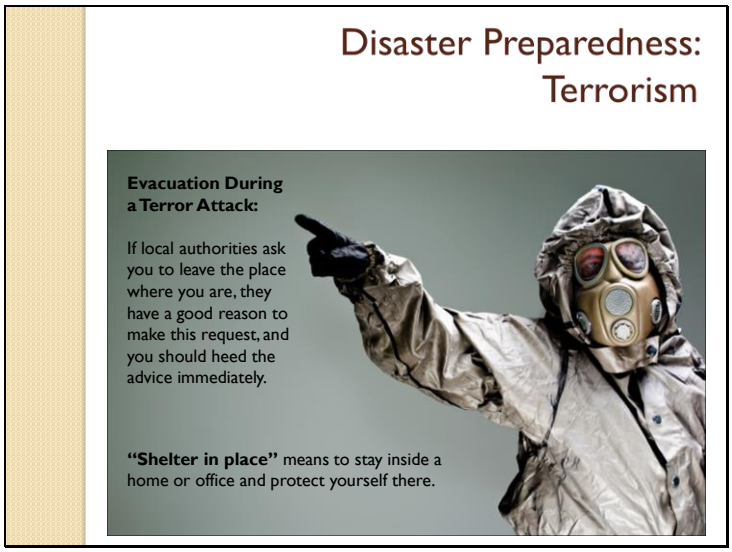
●If you smell gas or suspect a leak, turn off the main gas valve, open windows, and get everyone outside quickly.

●Shut off any other damaged utilities.

●Confine or secure your pets.

●Call your family contact—do not use the telephone again unless it is a life-threatening emergency.

Slide 6



If local authorities ask you to leave the place where you are, they have a good reason to make this request, and you should heed the advice immediately. Listen to your radio or television and follow the instructions of local emergency officials.
Your local authorities will provide you with the most accurate information specific to an event in your area. Staying tuned to local radio and television, and following their instructions is your safest choice.

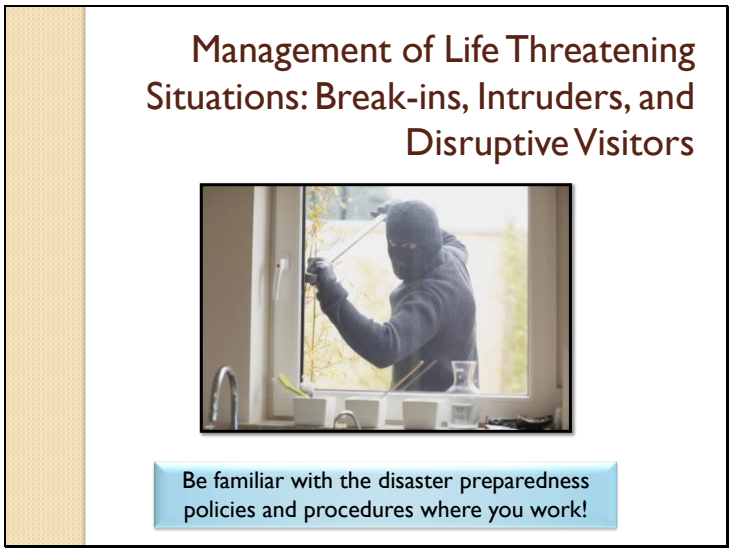
If you are advised by local officials to "shelter in place," what they mean is for you to remain inside your home or office and protect yourself there. Pay attention to news and radio reports for further information. Local officials may call for evacuation in specific areas at greatest risk in your community.

Slide 7

Exposure to a Terror Attack

It is important to be mindful of children's exposure to events. Raw, unedited footage of terrorism events and people's reaction to those events can be very upsetting, especially to children. The Red Cross does not recommend that children watch television news reports about such events, especially if the news reports show images over and over again about the same incident. Adults may also need to give themselves a break from watching disturbing footage. However, listening to local radio and television reports will provide you with the most accurate information from responsible governmental authorities on what's happening and what actions you will need to take.

Slide 8



Management of Life Threatening Situations: Break-ins, Intruders, and Disruptive Visitors
In addition to weather-related disaster policies and procedures, your agency will also have information about the management of life threatening situations such as break-ins, intruders, and disruptive visitors. Since policies and procedures for these types of situations vary by agency, it will not be covered in this module. Be sure to familiarize yourself with your agency's policies and procedures for these types of situations.

In the event of any type of disaster or life threatening situation, and in addition to any emergency responder you call, you will need to contact your program administrator, or the designated contact to inform them of the situation.

As always, be familiar with the specific disaster preparedness policies and procedures where you work.

Slide 10

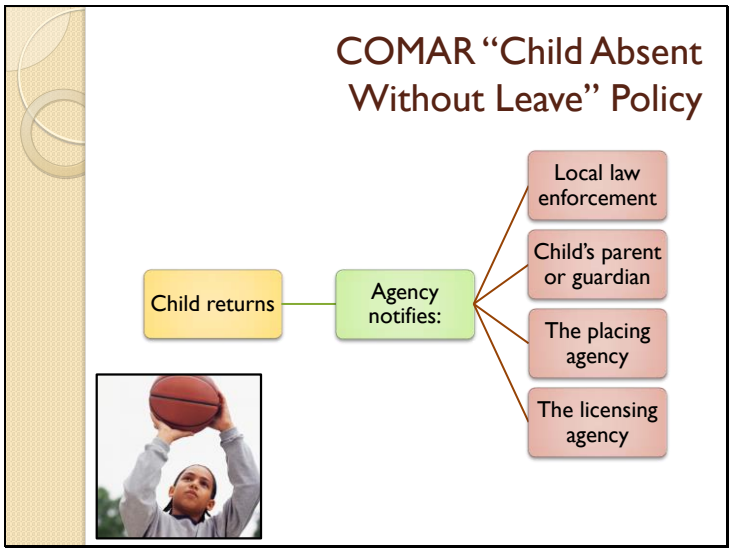
COMAR "Child Absent Without Leave" Policy
Finally, let's discuss the policies and procedures for when a child has been discovered missing from your residential child care facility. This is a situation that is referred to as "child absent without leave." Your agency will have a written policy in place for this type of situation. Once again, be familiar with this policy and its procedures. Let's look at COMAR's guidelines for absent without leave situations.

Slide 11

According to COMAR, unless otherwise specified in the child's individual plan of care, if the child has not returned to the program within 1 hour of the program discovering that the child is missing or unaccounted for, your agency will immediately notify:

- The local law enforcement authority
- The placing agency
- The licensing agency, and
- The child's parent or legal guardian, unless inconsistent with the child's plan of a care.

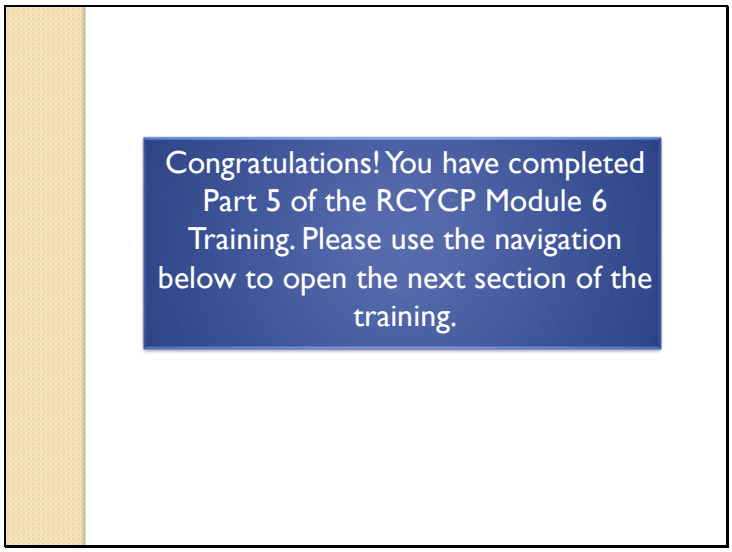
Slide 12



When a child who was missing or unaccounted for returns to the program, your agency will immediately notify:

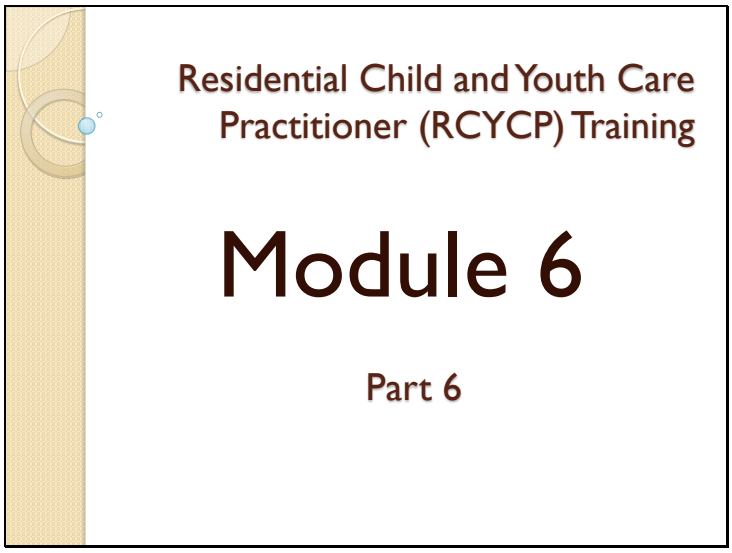
- The local law enforcement authority
- The child's parent or legal guardian
- The placing agency, and
- The licensing agency

Slide 14



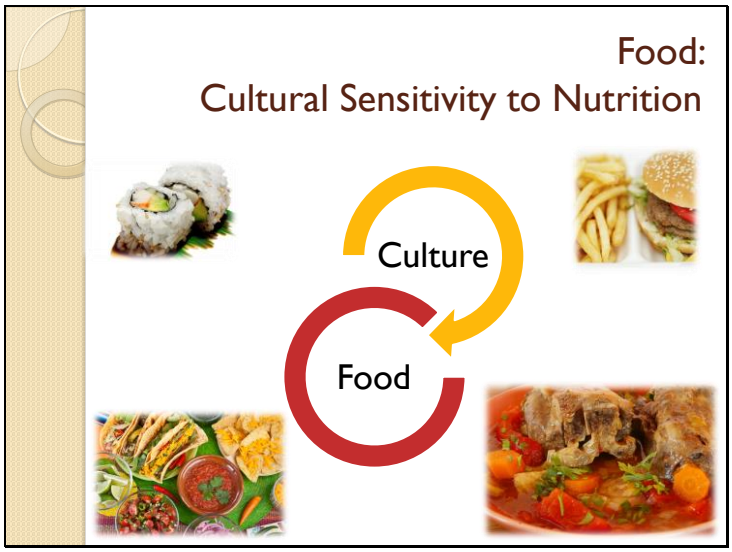
Congratulations! You have completed Part 5 of the RCYCP Module 6 Training. Please use the navigation below to open the next section of the training.

Slide 1



Residential Child and Youth Care Practitioner (RCYCP) Training
Welcome to Module 6, Part 6 of the Residential Child and Youth Care Practitioner Training.

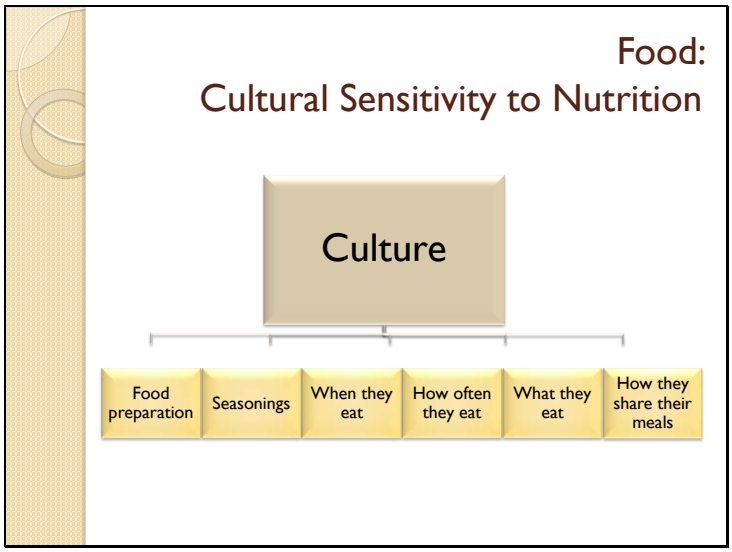
Slide 2



Food: Cultural Sensitivity to Nutrition

Let's talk now about cultural sensitivity to nutrition. We have talked about the way that culture affects individuals and the importance of being culturally competent. Another significant way that culture affects people is through nutrition. Food choices, which can be very personal, are influenced by culture. For many people, culture-specific foods are linked to their families. The youth you work with may feel a strong sense of identification with certain cultural foods, or may feel connected to their family through their choice of foods. They might also reject certain cultural foods as a way to distance themselves from their family.

Slide 3

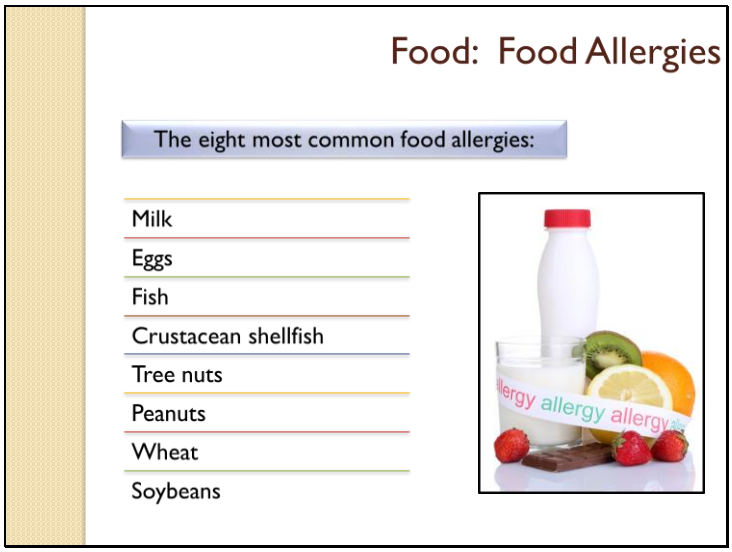


Let's look at the ways that foods vary among cultures. Culture influences how people prepare food, how they use seasonings, when they eat, how often they eat, and what they eat. It also affects how they share their meals with others. Are meals a social time, or for eating only? These practices can differ from region to region and from family to family.

Slide 4

So what can you do as an RCYCP to be sensitive to these cultural and family food practices? Be respectful of the variety of cultural traditions related to food and the wide variation in food practices within and among cultural groups. Observe, ask questions, and share food experiences to get a better understanding of these practices among the youth with whom you work. Demonstrate that you are open-minded, non-judgmental, and trustworthy. Holidays can be a great way to learn about people's food practices within their culture because holidays typically have an emphasis on food.

Slide 5



Food: Food Allergies

Let's take a moment now to talk about food allergies. Each year millions of people have allergic reactions to food. Although most food allergies cause relatively mild and minor symptoms, some food allergies can cause severe reactions, and may even be life threatening. Since there is no cure for food allergies, people must avoid food allergens. If they ingest something they are allergic to, they must take appropriate steps to prevent serious health consequences.

While there are more than 160 foods that can cause allergic reactions in people with food allergies, the eight most common foods (and the ones that, by law, must be identified on food packages) are:

- Milk
- Eggs
- Fish
- Crustacean shellfish
- Tree nuts
- Peanuts
- Wheat
- Soybeans

It is likely that some of the kids you work with will have food allergies. This information should be known to the individuals themselves, as well as to the staff at your facility. First and foremost, be aware of any policies and procedures that your facility has in place to deal with a food allergen issue among any residents.

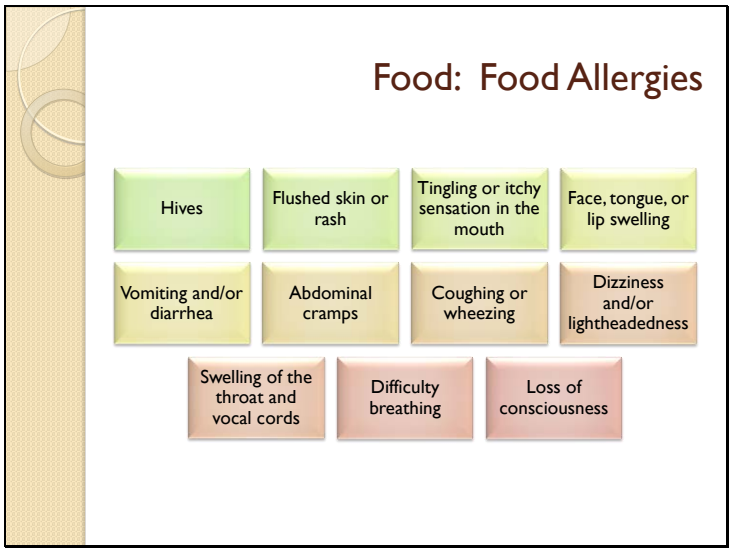
Slide 6

People with food allergies should be taught to read labels and avoid the offending foods.

The law requires that food labels identify the food source of all major food allergens. It may be identified in several different ways:
●It may be in the food name itself (for example: peanuts)
●It may be listed in the ingredient list on the package (for example: contains: sugar, peanuts…)
●It may be in parentheses following the name of the ingredient (for example: "lecithin (soy)," "flour (wheat)," and "whey (milk)"
●It may be immediately after or next to the list of ingredients in a "contains" statement (for example: "Contains Wheat, Milk, and Soy")
●It may be after the list of ingredients in a "made in" statement, (for example: "made in a plant that processes peanuts")

You can help the youth you work with become more responsible for their food allergies, if they aren't already, by having them read labels on foods to become familiar with identifying allergens.

Slide 7



Additionally, individuals with food allergies and the people who work with them need to be aware of potential reactions to allergens, be able to recognize reactions early, as well as know what to do in the event of a reaction.
Allergic reactions can include:

- Hives
- Flushed skin or rash
- Tingling in mouth or itchy sensation in the mouth
- Face, tongue, or lip swelling
- Vomiting and/or diarrhea
- Abdominal cramps
- Coughing or wheezing
- Dizziness and/or lightheadedness
- Swelling of the throat and vocal cords
- Difficulty breathing
- Loss of consciousness

Slide 8

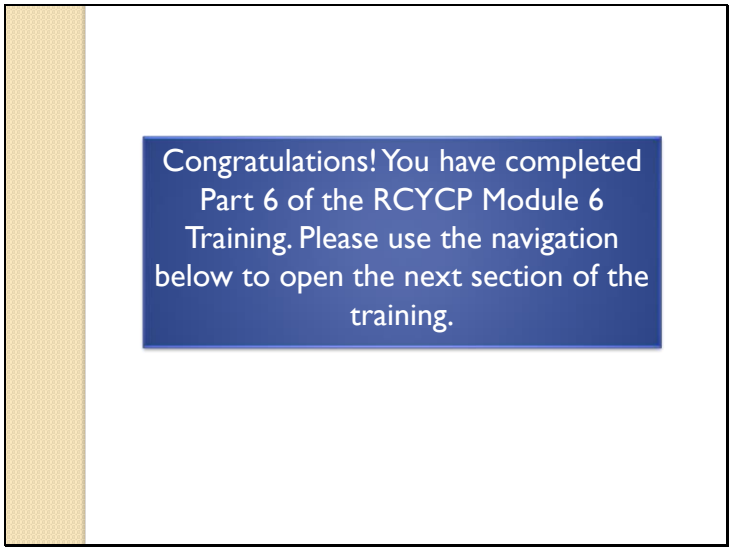
Initially, mild symptoms that occur after ingesting a food allergen can become severe and lead to a life-threatening allergic reaction called anaphylaxis. Anaphylaxis can lead to constricted airways in the lungs, severe lowering of blood pressure and shock, and suffocation by swelling of the throat.

Some kids may have epi-pens (injectable epinephrine) that they have on hand in case of an allergic reaction. Other kids might need allergy medication such as Benadryl to treat their allergic reactions. Some might even need emergency services. This information should be available to you and the other staff who work with a child with food allergies. Once again, be familiar with the policies and procedures to deal with an allergic reaction.

Being aware of food allergies and taking proper precautions is of extreme importance and can mean the difference between life and death. Click on the link to read an article about a tragic food allergy event.

Article about California Girl at Family Camp in Sacramento:
http://www.medicaldaily.com/peanut-allergy-death-natalie-giorgi-13-dies-camp-sacramento-after-accidentally-eating-peanut-butter

Slide 9



Congratulations! You have completed Part 6 of the RCYCP Module 6 Training. Please use the navigation below to open the next section of the training.

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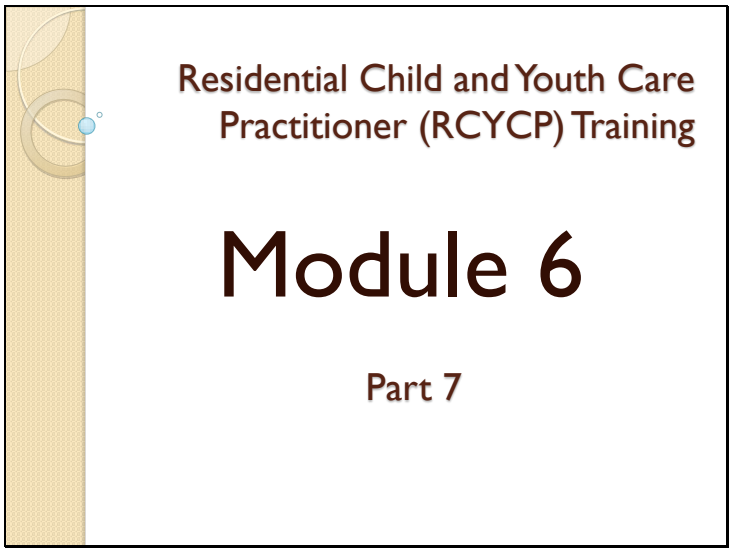
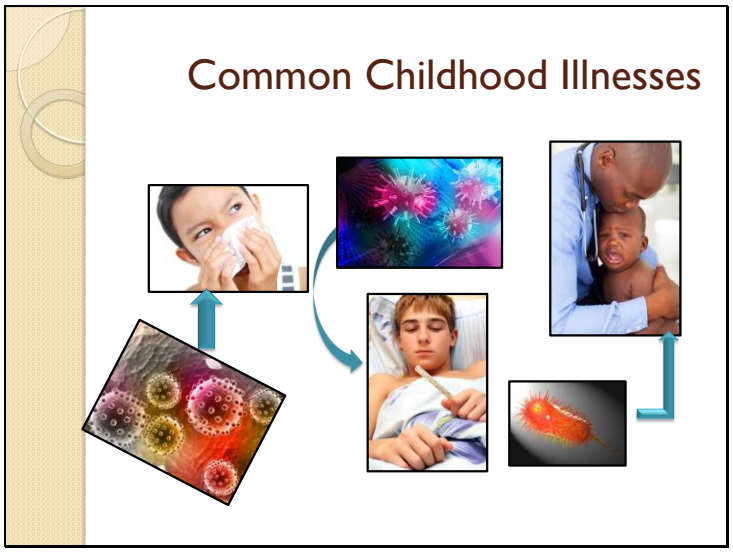


Residential Child and Youth Care Practitioner (RCYCP) Training
Welcome to Module 6, Part 7 of the Residential Child and Youth Care Practitioner Training.

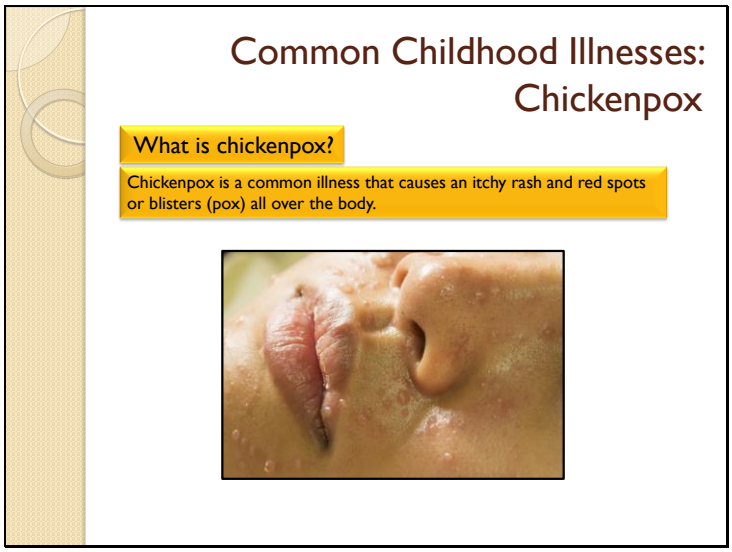
Slide 2



Common Childhood Illnesses
As an RCYCP you will be working with children in close quarters. You might remember from being in school that when one person gets sick, those germs are often spread quickly to others in the same class. The same is true in residential care. One person getting sick can start a chain reaction of other people getting sick.

The best way to prevent the spread of illness is to practice good hygiene, which includes proper hand washing. Another important way to prevent the spread of illness is to recognize the symptoms of an illness early, so that the illness can be treated before it spreads. Being familiar with the signs and symptoms of common childhood illnesses can help you, as an RCYCP, identify children who are sick and should receive treatment. Let's look at some of the most common childhood illnesses now.

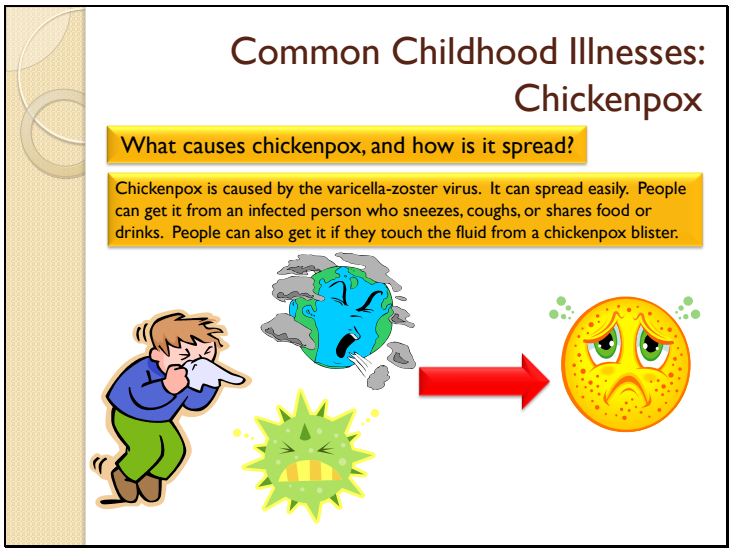
Slide 3



Common Childhood Illnesses: Chickenpox
What is chickenpox?

Chickenpox (also known as varicella) is a common illness that causes an itchy rash and red spots or blisters (pox) all over the body. It is most common in children. But most people will get chickenpox at some point in their lives if they haven't had the chickenpox vaccine. Chickenpox usually isn't a serious health problem in healthy children. But a child with chickenpox needs to stay home from school.

Slide 4

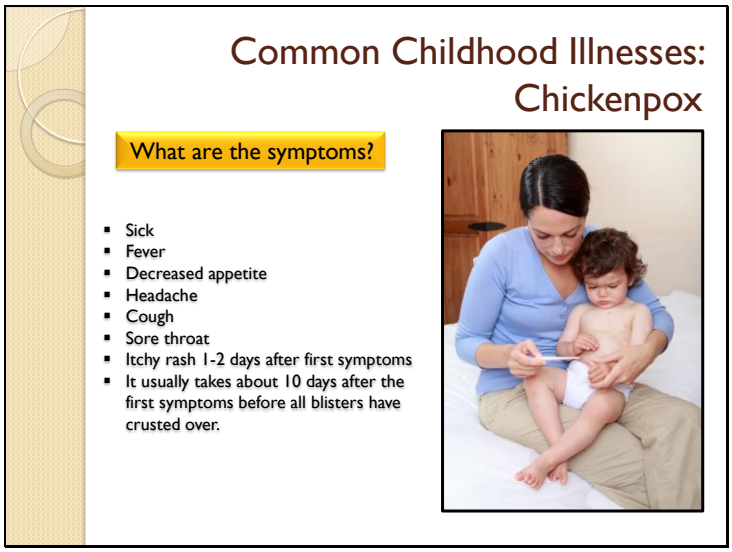


What causes chickenpox, and how is it spread?

Chickenpox is caused by the varicella-zoster virus. It can spread easily. People can get it from an infected person who sneezes, coughs, or shares food or drinks. People can also get it if they touch the fluid from a chickenpox blister.

A person who has chickenpox can spread the virus even before he or she has any symptoms. Chickenpox is most easily spread from 2 to 3 days before the rash appears until all the blisters have crusted over.
People are at risk for chickenpox if they have never had the illness and haven't had the chickenpox vaccine.

Slide 5

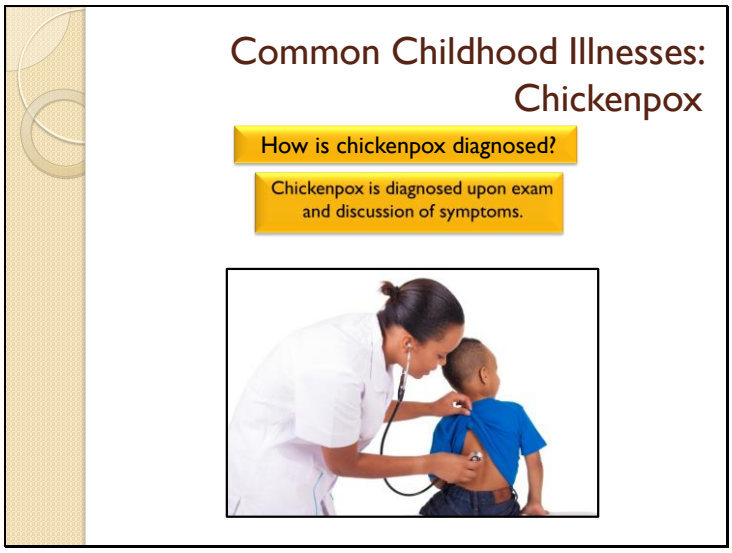


What are the symptoms?

The first symptoms of chickenpox usually develop about 14 to 16 days after contact with a person infected with the virus. Most people feel sick and have a fever, a decreased appetite, a headache, a cough, and a sore throat. The itchy chickenpox rash appears about 1 or 2 days after the first symptoms start.

After a chickenpox red spot appears, it usually takes about 1 or 2 days for the spot to go through all its stages. This includes blistering, bursting, drying, and crusting over. New red spots will appear every day for up to 5 to 7 days.
It usually takes about 10 days after the first symptoms before all blisters have crusted over. This is when the person with chickenpox can return to school or work.

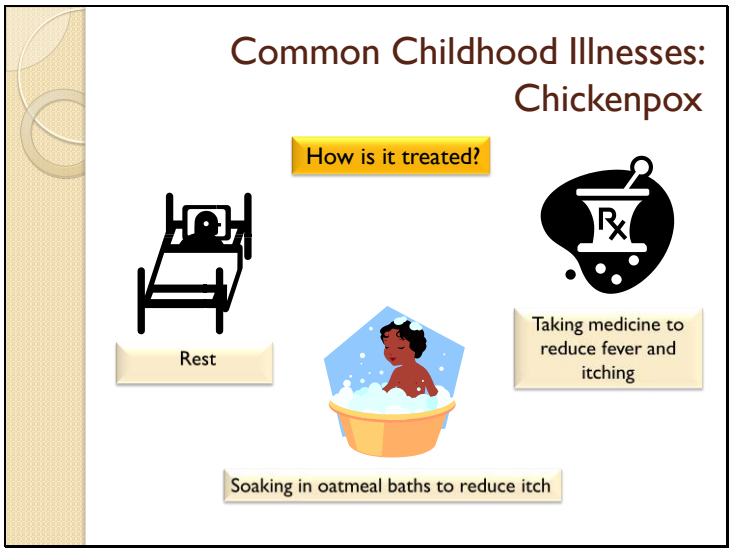
Slide 6



How is chickenpox diagnosed?

Chickenpox is diagnosed upon exam and discussion of symptoms. A healthy child with chickenpox symptoms may not need to visit a doctor. Sometimes a discussion of symptoms with a doctor by phone is enough.

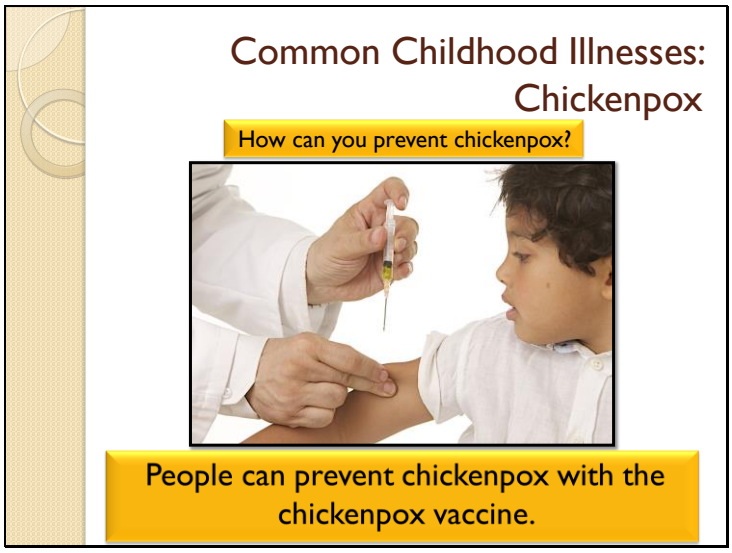
Slide 7



How is it treated?

Most healthy children and adults need only home treatment for chickenpox. Home treatment includes resting and taking medicines to reduce fever and itching. People can soak in oatmeal baths to help with itching.
People with long-term diseases or other health problems may need more treatment for chickenpox, including immunoglobulin treatment (IG) or antiviral medicine.

Slide 8



How can you prevent chickenpox?

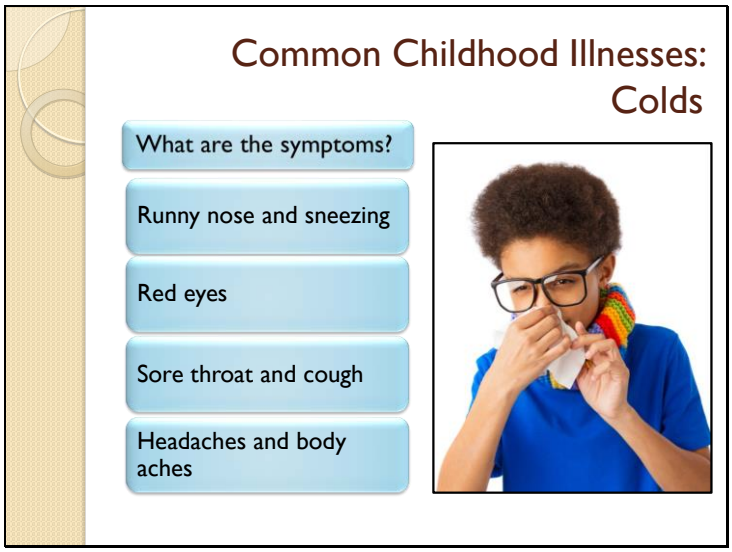
People can prevent chickenpox with the chickenpox vaccine. Children get the chickenpox vaccine as part of their routine immunizations.
If you have been around a person who has the virus and you have not had chickenpox or the vaccine, you still may be able to prevent the illness. Get a shot of chickenpox antibodies or the vaccine right away.

Slide 9

Common Childhood Illnesses: Colds
Everyone gets a cold from time to time. Children get more colds than adults. Colds usually last 1 to 2 weeks. People can catch a cold at any time of year, but they are more common in late winter and early spring.

There is no cure for a cold. Antibiotics will not cure a cold. When people catch colds, they can simply treat the symptoms.

Slide 10

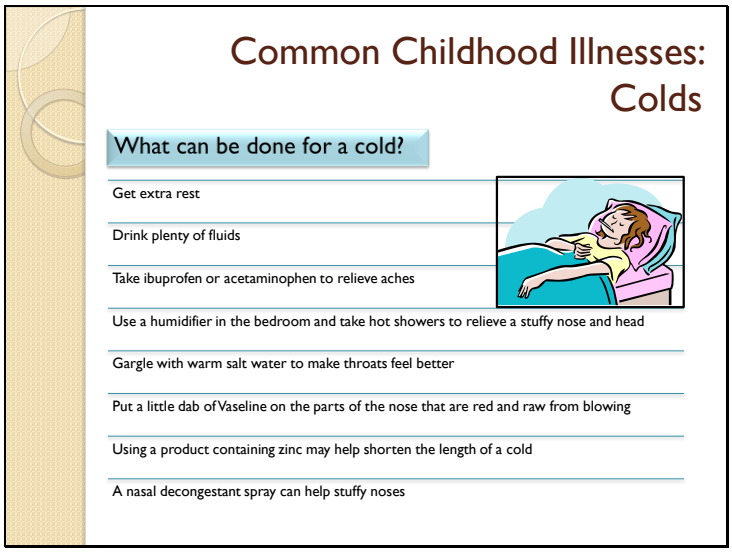


What are the symptoms?

Lots of different viruses cause colds, but the symptoms are usually the same:
●Runny nose and sneezing
●Red eyes
●Sore throat and cough
●Headaches and body aches
Typically, people feel a cold come on over the course of a couple of days. As the cold gets worse, a person's nose may get stuffy with thicker mucus.

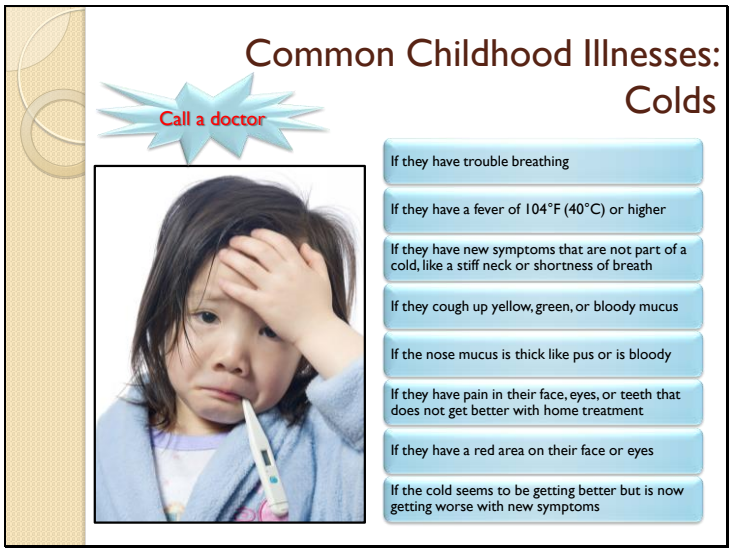
A cold is not the same as the flu (influenza). Flu symptoms are worse and come on faster. People who have the flu feel very tired. They may also have a fever and shaking chills, lots of aches and pains, a headache, and a cough.
When cold symptoms last more than 2 weeks, or when people feel sick with a cold all of the time, it may signal other problems such as allergies or sinusitis. Call a doctor if this occurs.

Slide 11



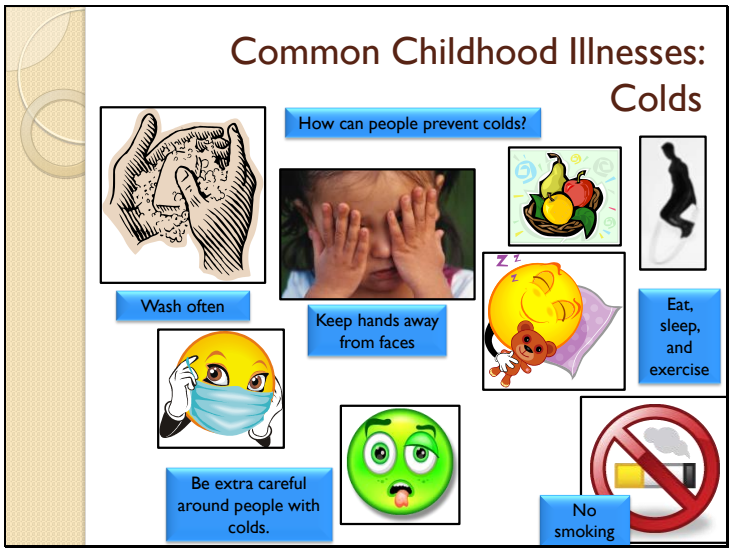
What can be done for a cold?
There are a number of things people can do to help themselves when they are sick with a cold.
Get extra rest. Slow down just a little from their usual routine. They don't need to stay home in bed, but they should try not to expose others to their cold.
Drink plenty of fluids. Hot water, herbal tea, or chicken soup will help relieve a stuffy nose and head.
Take ibuprofen (such as Advil or Motrin), or acetaminophen (such as Tylenol) to relieve aches. They should be sure to follow the package instructions carefully.
Use a humidifier in the bedroom and take hot showers to relieve a stuffy nose and head. Saline drops may also help thick or dried mucus to drain.
Gargle with warm salt water to make throats feel better.
Put a little dab of Vaseline on the parts of the nose that are red and raw from blowing.
Using a product containing zinc, for example Cold-Eeze, may help shorten the length of a cold by up to a day, but it has to be taken as soon as people have any cold symptoms.
A nasal decongestant spray can help stuffy noses, but should not be taken for more than 3 days in a row.
People who take medicine for colds should be careful to check the directions, dosages, and warnings on all the package labels.

Slide 12



When should people call a doctor? If:
•they have trouble breathing.
•they have a fever of 104°F (40°C) or higher.
•they have new symptoms that are not part of a cold, like a stiff neck or shortness of breath.
•they cough up yellow, green, or bloody mucus.
•mucus from their nose is thick like pus or is bloody.
•they have pain in their face, eyes, or teeth that does not get better with home treatment, or they have a red area on their face or around their eyes.
•their cold seemed to be getting better after a few days but is now getting worse with new symptoms.

Slide 13



How can people prevent colds?
There are several things people can do to help prevent colds:
●Wash their hands often.
●Be extra careful in winter and when they are around people with colds.
●Keep their hands away from their faces. Peoples' noses, eyes, and mouths are the most likely places for germs to enter bodies.
●Eat well, and get plenty of sleep and exercise. This keeps bodies strong so it can fight colds.
●Do not smoke. Smoking makes it easier to get a cold and harder to get rid of one.

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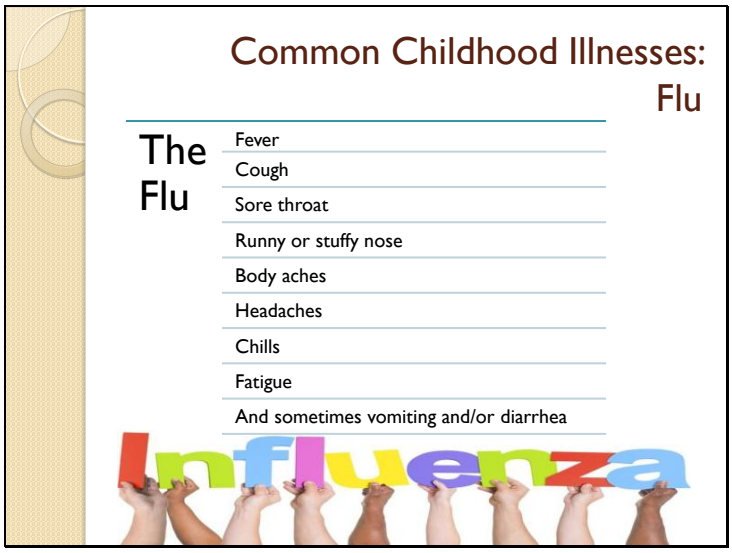


Common Childhood Illnesses: Flu

Influenza (commonly known as “the flu”) is an infection of the nose, throat, and lungs caused by influenza viruses. There are many different influenza viruses that are constantly changing. The most important way people can protect themselves from the flu is to get an annual flu vaccine.

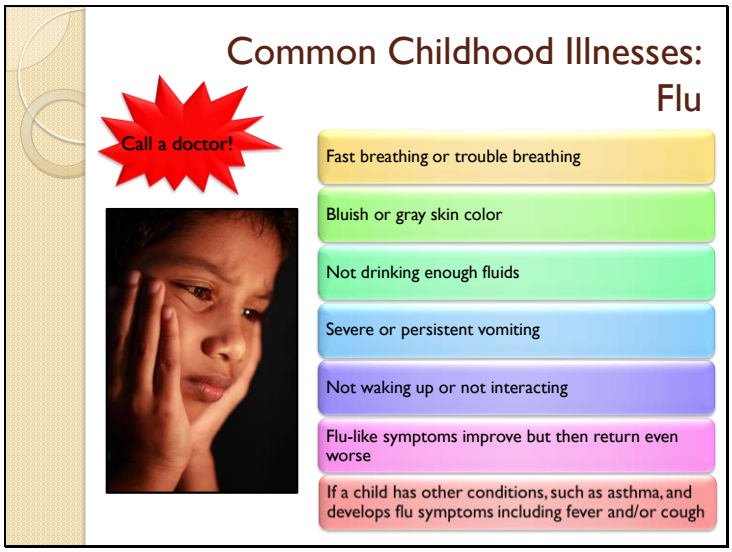
Symptoms of the flu can include:

- Fever
- Cough
- Sore throat
- Runny or stuffy nose
- Body aches
- Headache
- Chills
- Fatigue
- And sometimes vomiting and/or diarrhea

Some people with the flu will not have a fever.

Flu illness can vary from mild to severe. It can be especially dangerous for young children, and children of any age who have other health conditions, such as asthma, diabetes, neurological and neurodevelopmental conditions, and those who have weakened immune systems due to disease or medication.

Slide 15



When should people call a doctor?
Call for emergency care, or take a child to the doctor immediately if a child of any age has any of the following warning or emergency signs:

- Fast breathing or trouble breathing
- Bluish or gray skin color
- Not drinking enough fluids as seen by not going to the bathroom or making as much urine as they normally do
- Severe or persistent vomiting
- Not waking up or not interacting
- Flu-like symptoms improve but then return with fever and a worse cough
- If a child has other conditions, such as asthma, and develops flu symptoms including fever and/or cough

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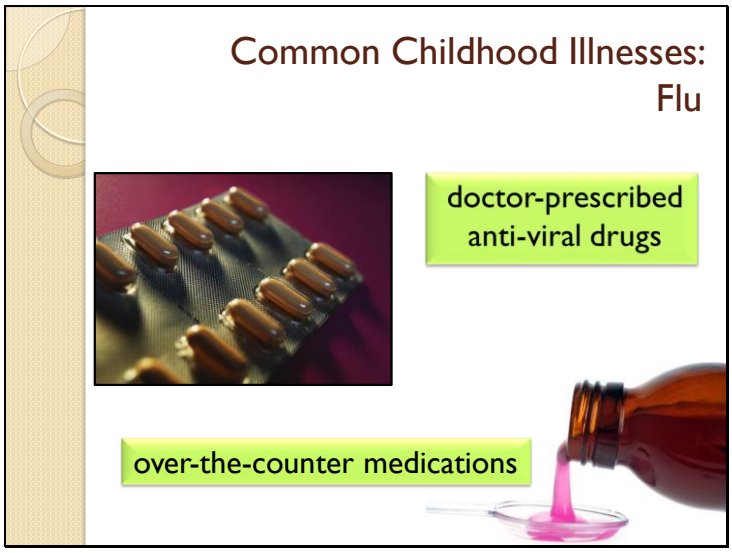

Treatment for the flu can include doctor-prescribed antiviral drugs that help to make people feel better and get better sooner, as well as help to prevent serious flu complications like pneumonia. They work best when they are started during the first two days of illness and can be critical to help those individuals who have other health conditions.

Other over-the-counter medications such as those used to treat colds can be helpful to ease flu symptoms. Some of these include Tylenol, ibuprofen, and decongestants.

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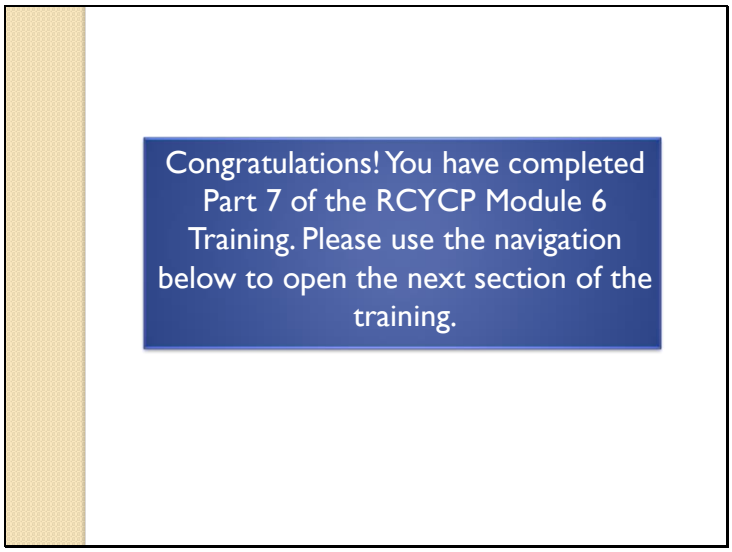
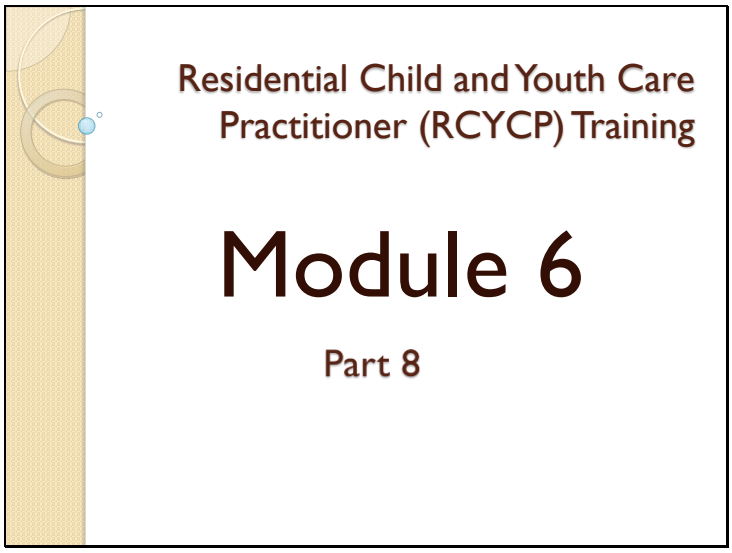


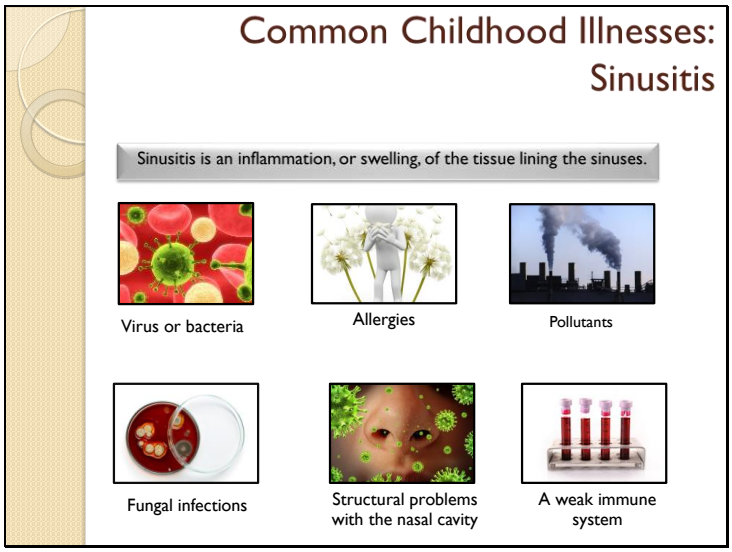
Congratulations! You have completed Part 7 of the RCYCP Module 6 Training. Please use the navigation below to open the next section of the training.

Slide 1



Residential Child and Youth Care Practitioner (RCYCP) Training
Welcome to Module 6, Part 8 of the Residential Child and Youth Care Practitioner Training.

Slide 2



Common Childhood Illnesses: Sinusitis

Sinusitis (more commonly known as a sinus infection) is an inflammation, or swelling, of the tissue lining the sinuses. Normally, sinuses are filled with air, but when sinuses become blocked and filled with fluid, germs (bacteria, viruses, and fungi) can grow and cause an infection.

Most sinus infections are caused by a virus, although some can be caused by bacteria.

Other causes of sinus infections include:

- Allergies
- Pollutants (such as airborne chemicals or irritants)
- Fungal infections
- Structural problems with the nasal cavity (such as blockage of nasal ducts)
- A weak immune system

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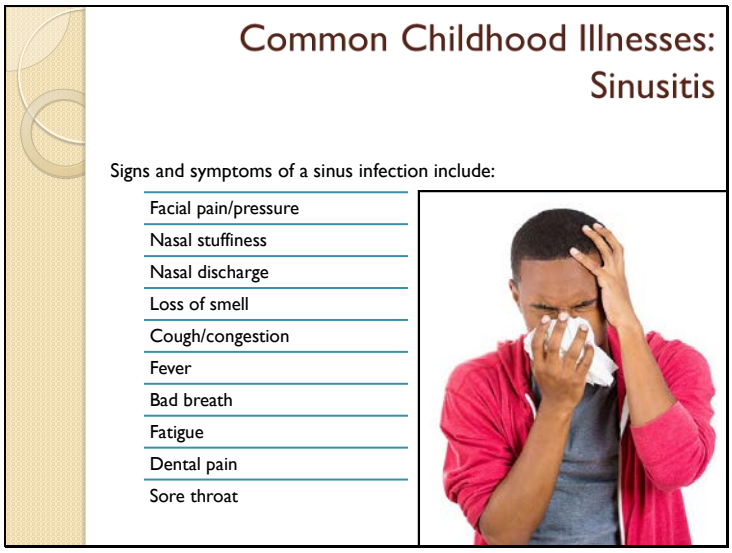

Signs and symptoms of a sinus infection include:

- Facial pain/pressure
- Nasal stuffiness
- Nasal discharge
- Loss of smell
- Cough/congestion
- Fever
- Bad breath
- Fatigue
- Dental pain
- Sore throat

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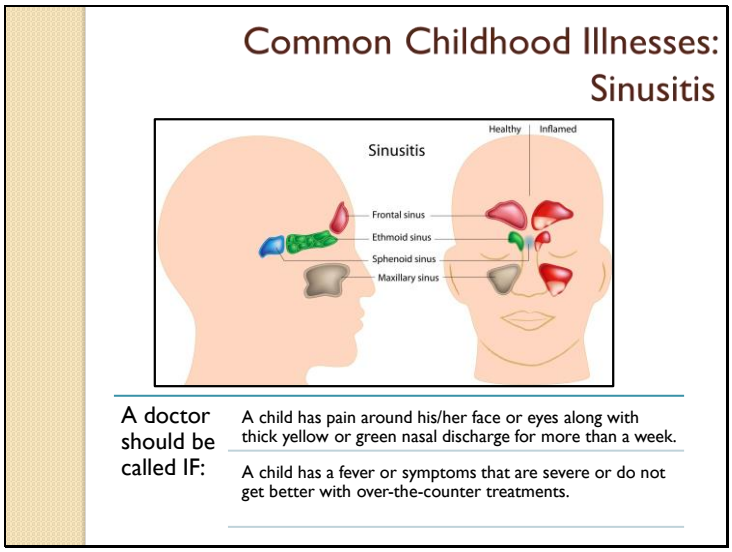

Sometimes it can be difficult to tell whether these symptoms are the result of a cold or a sinus infection. Most colds go away without medical treatment. Some viral sinus infections also clear up on their own.

A doctor should be called if a child has pain around his/her face or eyes along with thick yellow or green nasal discharge for more than a week.

Also, a doctor should be called if a child has a fever or symptoms that are severe or do not get better with over-the-counter treatments.

Sinusitis is first treated with medication. Antibiotics are usually used if symptoms persist for more than 10 days.

Decongestants and other drugs help decrease the swelling in the sinuses and nasal passages.

Steam, humidifiers, and hot showers may be recommended to loosen mucus.

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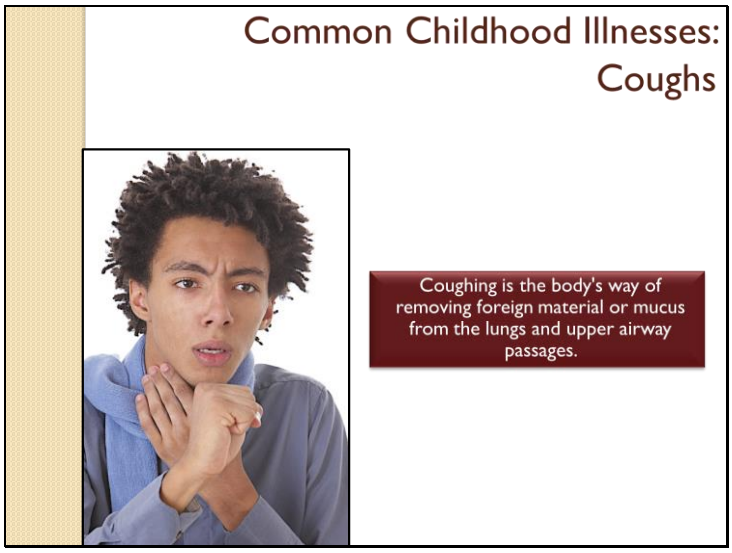
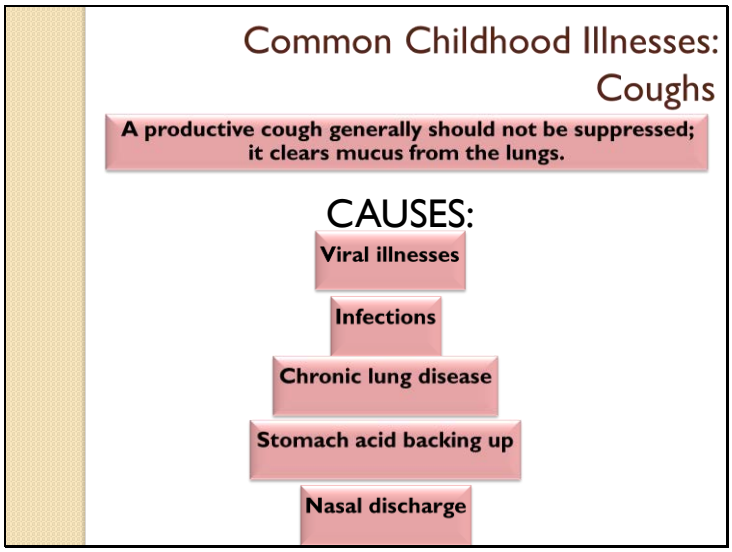


Common Childhood Illnesses: Coughs
Coughing is the body's way of removing foreign material or mucus from the lungs and upper airway passages.

A cough is only a symptom, not a disease, and often the importance of a cough can be determined only when other symptoms are evaluated.

Slide 6



Productive coughs

A productive cough produces phlegm or mucus (sputum). The mucus may have drained down the back of the throat from the nose or sinuses or may have come up from the lungs. A productive cough generally should not be suppressed; it clears mucus from the lungs. There are many causes of a productive cough, such as:

●Viral illnesses. It is normal for people to have a productive cough when they have a common cold. Coughing is often triggered by mucus that drains down the back of the throat.

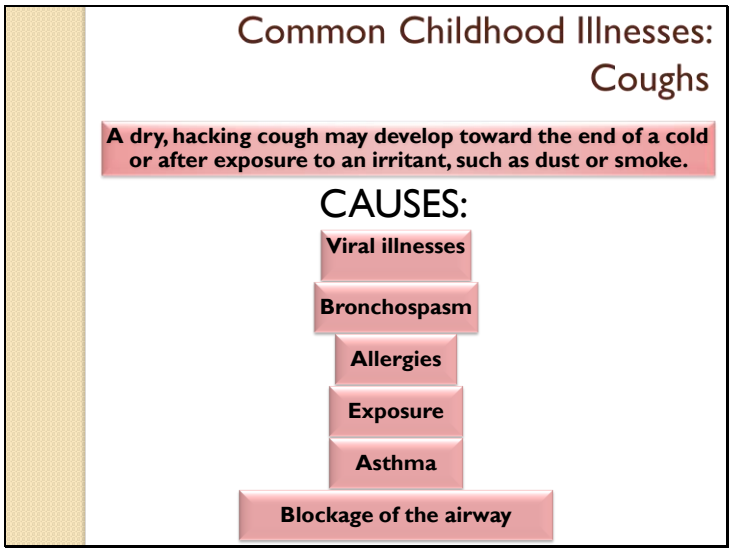
●Infections. An infection of the lungs or upper airway passages can cause a cough. A productive cough may be a symptom of pneumonia, bronchitis, sinusitis, or tuberculosis.

●Chronic lung disease. A productive cough could be a sign that a lung disease is getting worse or that someone has an infection.

●Stomach acid backing up into the esophagus. This type of coughing may be a symptom of gastroesophageal reflux disease (GERD) and may awaken kids from sleep.

●Nasal discharge (postnasal drip) draining down the back of the throat.

Slide 7



Nonproductive coughs

A nonproductive cough is dry and does not produce sputum. A dry, hacking cough may develop toward the end of a cold or after exposure to an irritant, such as dust or smoke. There are many causes of a nonproductive cough, such as:

●Viral illnesses. After a common cold, a dry cough may last several weeks longer than other symptoms and often gets worse at night.

●Bronchospasm. A nonproductive cough, particularly at night, may mean spasms in the bronchial tubes (bronchospasm) caused by irritation.

●Allergies. Frequent sneezing is also a common symptom of allergic rhinitis.

●Exposure to dust, fumes, and chemicals.

●Asthma. A chronic dry cough may be a sign of mild asthma. Other symptoms may include wheezing, shortness of breath, or a feeling of tightness in the chest.

●Blockage of the airway by an inhaled object, such as food or a pill.

Many coughs are caused by a viral illness. Antibiotics are not used to treat viral illnesses and do not change the course of viral infections. The significance of the cough is determined by a doctor upon examination of other symptoms.

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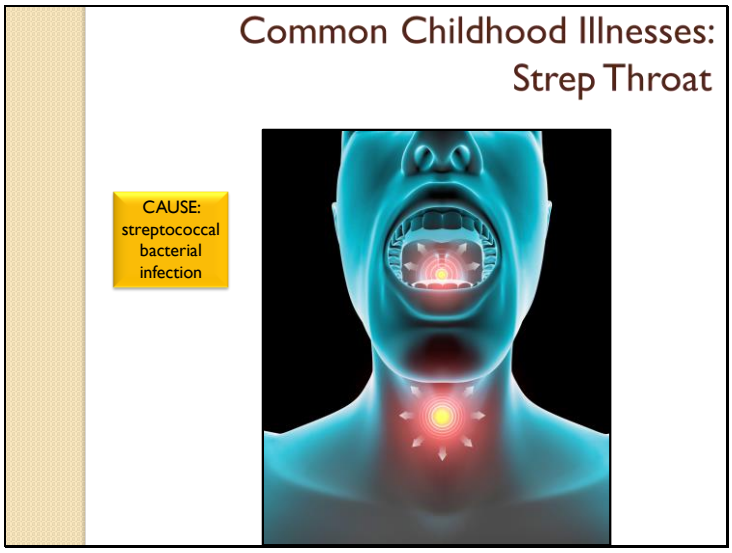

Common Childhood Illnesses: Strep Throat

Sore throats are common with a number of different viral infections, and often are not concerning. There is one type of sore throat, however, that, if left untreated, has the potential to cause serious complications such as kidney inflammation and rheumatic fever which can do damage to the heart. This type of sore throat is the result of a streptococcal bacterial infection, hence the term strep throat.

Strep throat is common between the ages of 5 and 15, but can affect people of all ages.

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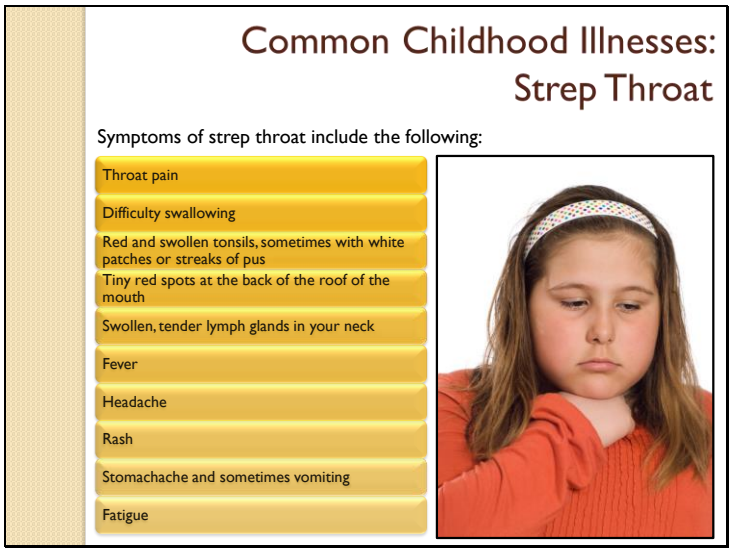

Symptoms of strep throat include the following:
- Throat pain
- Difficulty swallowing
- Red and swollen tonsils, sometimes with white patches or streaks of pus
- Tiny red spots on the soft or hard palate — the area at the back of the roof of the mouth
- Swollen, tender lymph glands (nodes) in your neck
- Fever
- Headache
- Rash
- Stomachache and sometimes vomiting, especially in younger children
- Fatigue

Call a doctor for an appointment if a child has any of the following symptoms:
- A sore throat accompanied by tender, swollen lymph glands (nodes)
- A sore throat that lasts longer than 48 hours
- A fever higher than 101 F (38.3 C) in older children, or any fever lasting longer than 48 hours
- A sore throat accompanied by a rash
- Problems breathing or difficulty swallowing anything, including saliva

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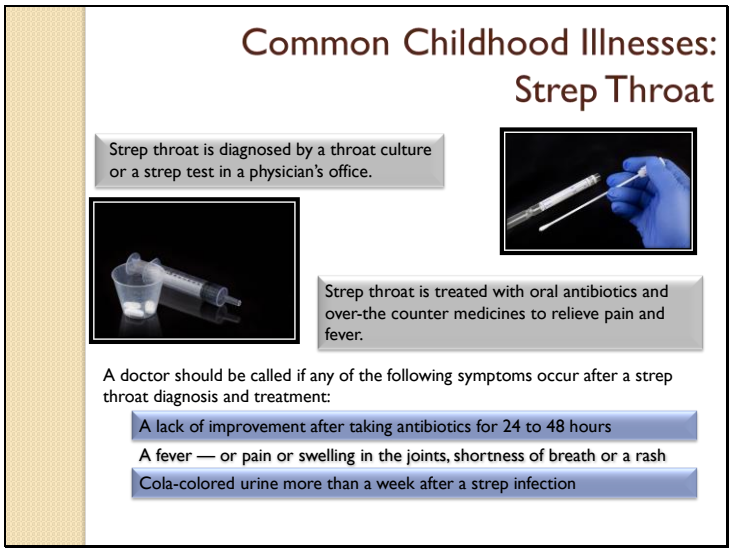

Strep throat is diagnosed by a throat culture or a quick strep test in a physician's office. Strep throat is treated with oral antibiotics. Additionally, over-the-counter medications such as acetaminophen or ibuprofen can be used to relieve throat pain and reduce fever. Typically, a child will feel better within the first 1 to 2 days of treatment, and can often return to school 24 hours after beginning treatment. A doctor should be called if any of the following symptoms occur after a strep throat diagnosis and treatment:

●A lack of improvement after taking antibiotics for 24 to 48 hours

●A fever — or pain or swelling in the joints, shortness of breath or a rash — after a strep infection, even as long as three weeks after infection; these can be indicators of rheumatic fever

●Cola-colored urine more than a week after a strep infection, as this may indicate kidney inflammation

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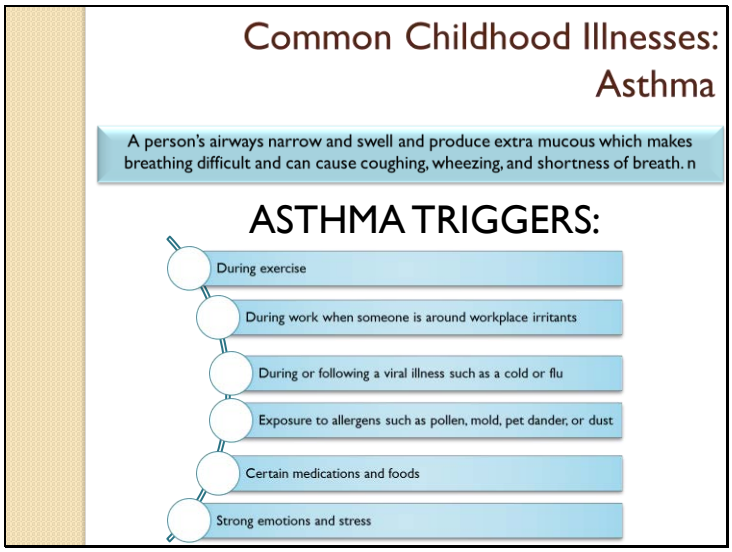
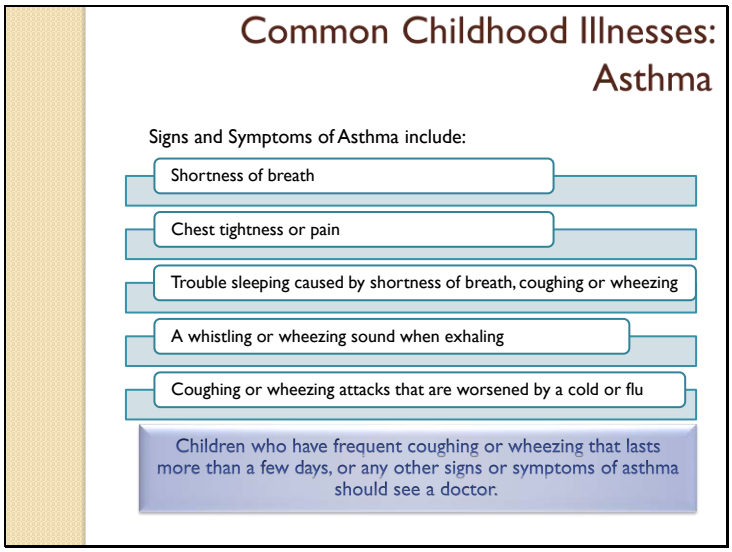


Common Childhood Illnesses: Asthma
Asthma is a condition in which a person's airways narrow and swell and produce extra mucous which makes breathing difficult and can cause coughing, wheezing, and shortness of breath. Some people never have asthma, while others do. There is no known reason for this discrepancy, although asthma is believed to be the result of a combination of genetics and environment.

For people who are prone to asthma, there can be a number of different triggers. They include:
●During exercise – especially when the air is cold and dry
●During work when someone is around air pollutants or workplace irritants such as gases, fumes, smoke, or dust
●During or following a viral illness such as a cold or flu,
●Or when someone is exposed to allergens such as pollen, mold, pet dander, or dust
●Certain medications and foods can trigger asthma as well – even strong emotions and stress can trigger asthma

Slide 13



Signs and Symptoms of Asthma include:

- Shortness of breath
- Chest tightness or pain
- Trouble sleeping caused by shortness of breath, coughing or wheezing
- A whistling or wheezing sound when exhaling (wheezing is a common sign of asthma in children)
- And, coughing or wheezing attacks that are worsened by a respiratory virus, such as a cold or the flu
- Children who have frequent coughing or wheezing that lasts more than a few days, or any other signs or symptoms of asthma should see a doctor.

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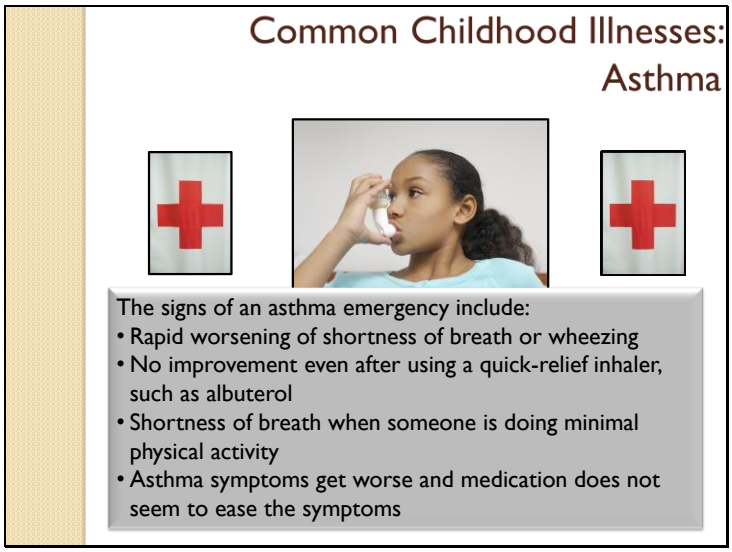
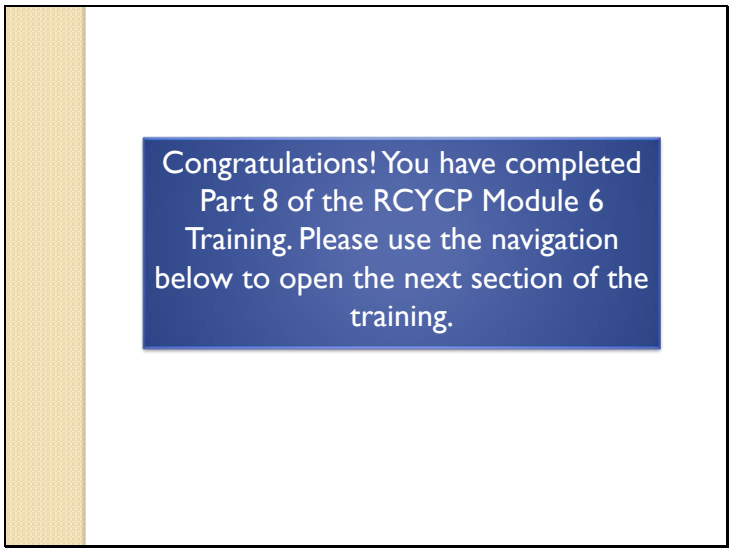


There is no cure for asthma. Treatment for asthma focuses on prevention and long-term control. People with asthma are typically treated with long-term asthma medications, such as inhaled corticosteroids, quick relief medications such as rescue inhalers during an asthma attack, and allergy medications such as oral or nasal sprays.

Since asthma can be life-threatening, it is important to recognize the signs of an asthma emergency and seek immediate treatment. The signs of an asthma emergency include:
●Rapid worsening of shortness of breath or wheezing
●No improvement even after using a quick-relief inhaler, such as albuterol
●Shortness of breath when someone is doing minimal physical activity
Additionally, children should see a doctor if asthma symptoms get worse and medication does not seem to ease the symptoms, or they are using their quick-relief inhaler more often than previously.

Slide 16



Congratulations! You have completed Part 8 of the RCYCP Module 6 Training. Please use the navigation below to open the next section of the training.

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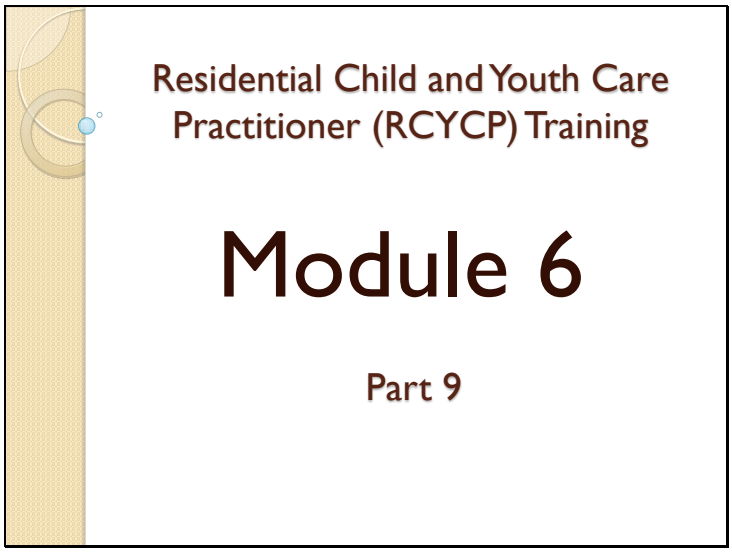

Residential Child and Youth Care Practitioner (RCYCP) Training
Welcome to Module 6, Part 9 of the Residential Child and Youth Care Practitioner Training.

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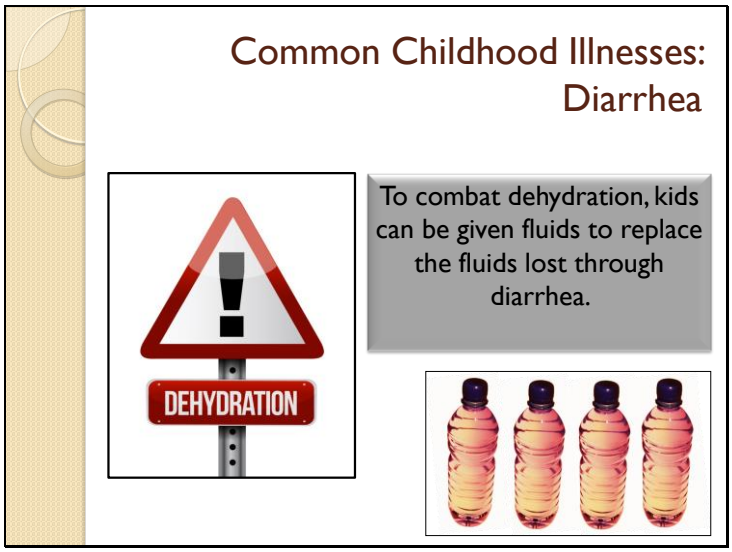


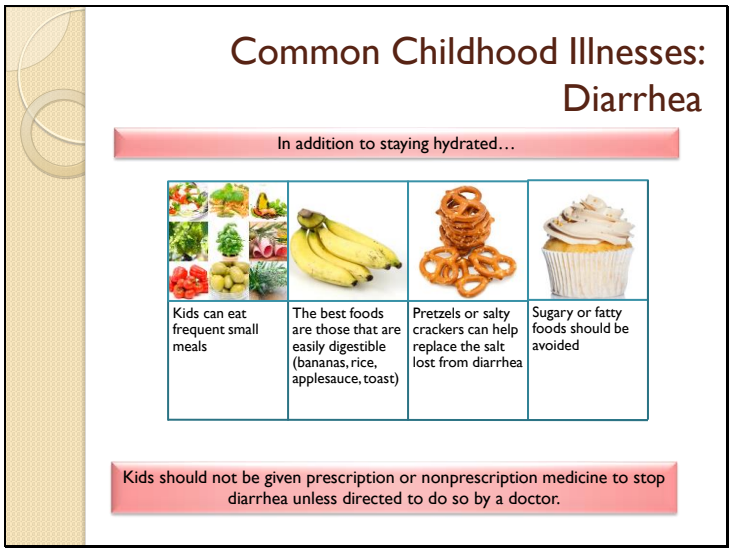
Common Childhood Illnesses: Diarrhea

Diarrhea is the body's way of ridding itself of germs, and most episodes last a few days to a week. Diarrhea often occurs with fever, nausea, vomiting, cramps, and dehydration. Some of the most common reasons kids get diarrhea include:

- Infection from viruses
- As a side effect from medications
- Food poisoning

Dehydration is one of the most worrisome complications of diarrhea in children. Mild diarrhea usually doesn't cause significant fluid loss, but moderate or severe diarrhea can. To combat dehydration, kids can be given fluids to replace the fluids lost through diarrhea. The best fluids are ORS (oral rehydration solutions) such as Pedialyte or Rehydralyte which provide essential electrolytes. If those are unavailable kids can drink water.

Slide 3



In addition to staying hydrated

- Kids can eat frequent small meals
- The best foods for kids that have diarrhea are those that are easily digestible (bananas, rice, applesauce, toast)
- Pretzels or salty crackers can help kids replace the salt lost from diarrhea
- Foods containing large amounts of sugar or fat should be avoided.
- Kids should not be given prescription or nonprescription medicine to stop diarrhea unless directed to do so by a doctor.
- Kids and those around them should practice good hand-washing
- Children with diarrhea from a viral illness should not attend school or be around others who can catch the illness.

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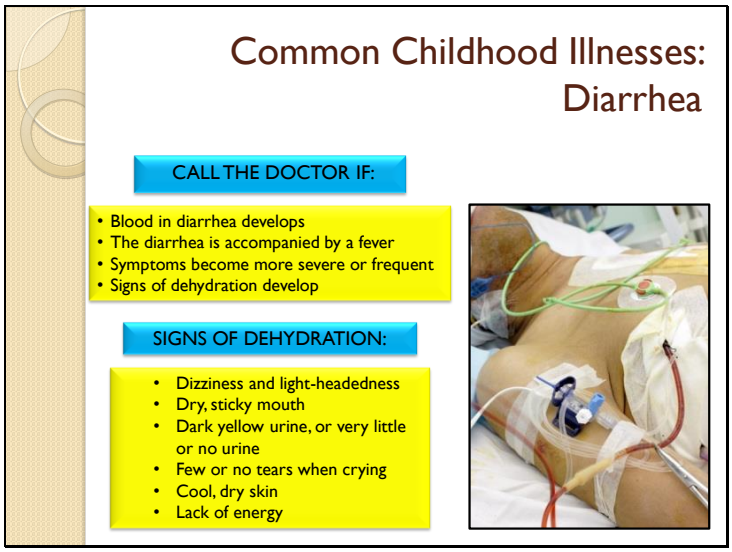

A call to the doctor will be important if any of the following occur:
●Blood in diarrhea develops.
●The diarrhea is accompanied by a fever.
●Symptoms become more severe or frequent.
●Signs of dehydration develop. Severe dehydration is dangerous; it can cause seizures, brain damage, even death. Signs of dehydration include:

●Dizziness and light-headedness
●Dry, sticky mouth
●Dark yellow urine, or very little or no urine
●Few or no tears when crying
●Cool, dry skin
●Lack of energy

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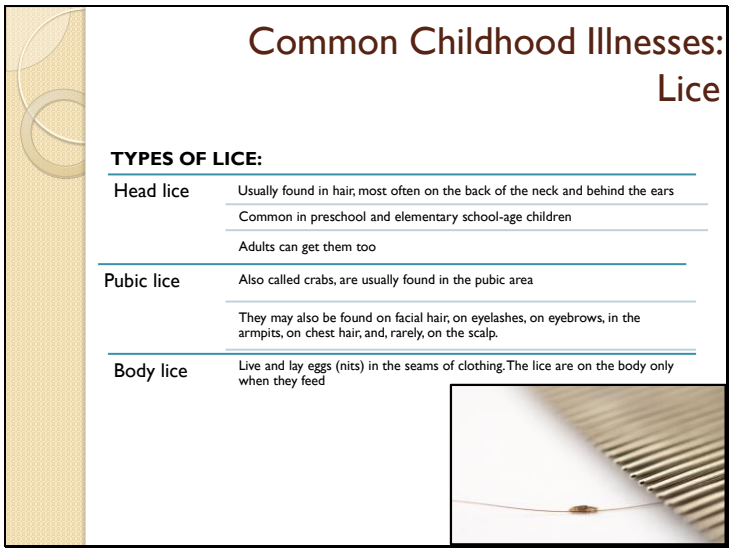

Common Childhood Illnesses: Lice
What are lice?

Lice are tiny insects that live on humans and feed on blood.

Three different kinds of lice live on humans:
●Head lice: They are usually found in hair, most often on the back of the neck and behind the ears. Head lice are common in preschool and elementary school-age children. Adults can get them too, especially adults who live with children.
●Pubic lice: also called crabs, these lice are usually found in the pubic area. But they may also be found on facial hair, on eyelashes, on eyebrows, in the armpits, on chest hair, and, rarely, on the scalp.
●Body lice: They live and lay eggs or nits in the seams of clothing. The lice are on the body only when they feed.

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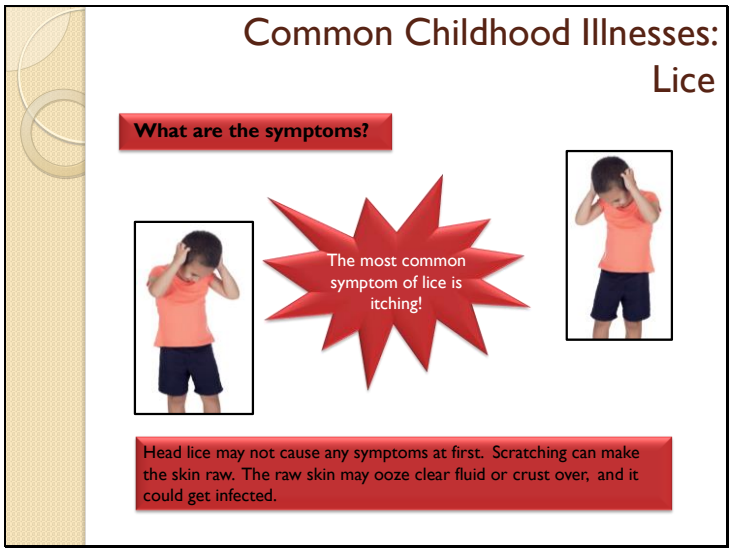


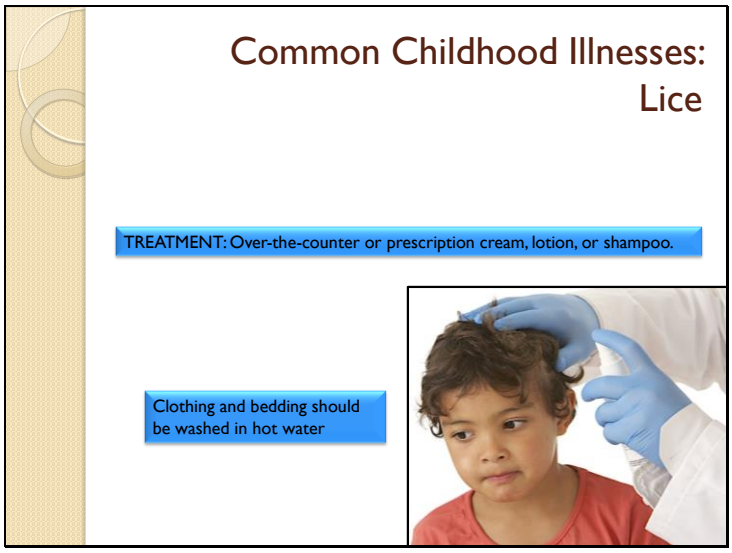
What causes lice infestation?

Lice spread easily from one person to another through close contact or through shared clothing or personal items (such as hats or hairbrushes). Lice cannot jump or fly.

What are the symptoms?
The most common symptom of lice is itching. There are different symptoms, depending on which type of lice a person has.
●Head lice may not cause any symptoms at first. Itching on the scalp may start weeks or even months after lice have started to spread. Scratching can make the skin raw. The raw skin may ooze clear fluid or crust over, and it may get infected.
●Pubic lice cause severe itching. Their bites may cause small marks that look like bruises on the torso, thighs, or upper arms. If pubic lice get on the eyelashes, the edges of the eyelids may be crusted. Lice and their eggs may be seen at the base of the eyelashes.
●Body lice cause very bad itching, especially at night. Itchy sores appear in the armpits and on the waist, torso, and other areas where the seams of clothes press against the skin. The lice and eggs may be found in the seams of the person's clothing but are typically not seen on the skin.

Frequent scratching can cause a skin infection. In the most severe cases of head lice, hair may fall out, and the skin may get darker in the areas infested with lice.

Slide 7



How is a lice infestation diagnosed?

A doctor can usually tell if a person has lice by looking closely for live lice or eggs in the hair. The doctor may also comb through the hair with a fine-toothed comb to help detect lice. He or she may look at the lice or eggs under a microscope.
A doctor can also find pubic lice and body lice by looking closely at someone's body or clothing.

How is it treated?

Lice won't go away on their own. Treatment is absolutely essential to ridding someone of lice and preventing the spread of lice to others.
The most common treatment for lice is an over-the-counter or prescription cream, lotion, or shampoo. It is put on the skin or scalp to kill the lice and eggs. In some cases, additional treatments may be needed to make sure that all the eggs are dead. If two or more treatments don't work, a doctor may prescribe a different medicine.
It's also important to wash clothing and bedding in hot water to help get rid of lice.

Some people continue to have itching for 7 to 10 days after the lice and eggs have been killed. Steroid creams or calamine lotion can relieve the itching, as can antihistamines.

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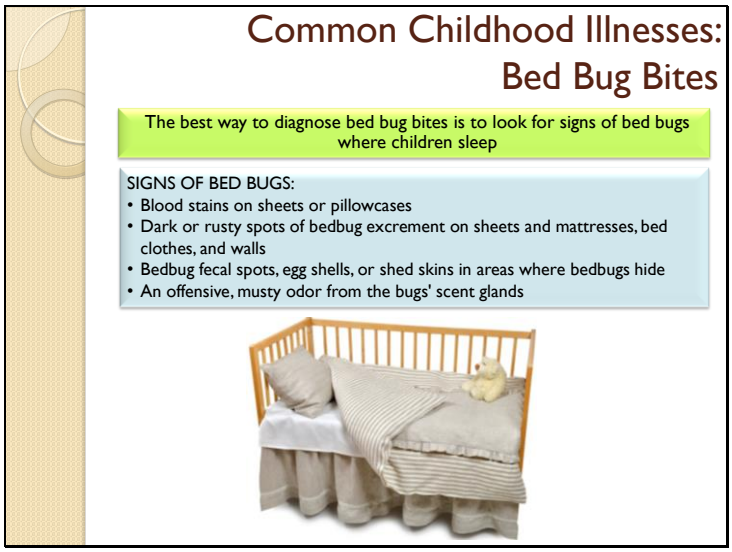

Common Childhood Illnesses: Bed Bug Bites
Bed bug bites cause itchy red welts that appear on the body, typically in a zigzag pattern. Because people don't usually know they have bed bugs, and because bed bugs are hard to see, people commonly mistake bed bug bites for other insect bites such as mosquito, flea, or spider, or for other common skin condition such as an itchy rash, hives, or chickenpox.

The best way to diagnose bed bug bites is to look for signs of bed bugs where children sleep.

Signs of bed bugs include:
●Blood stains on sheets or pillowcases
●Dark or rusty spots of bedbug excrement on sheets and mattresses, bed clothes, and walls
●Bedbug fecal spots, egg shells, or shed skins in areas where bedbugs hide
●An offensive, musty odor from the bugs' scent glands

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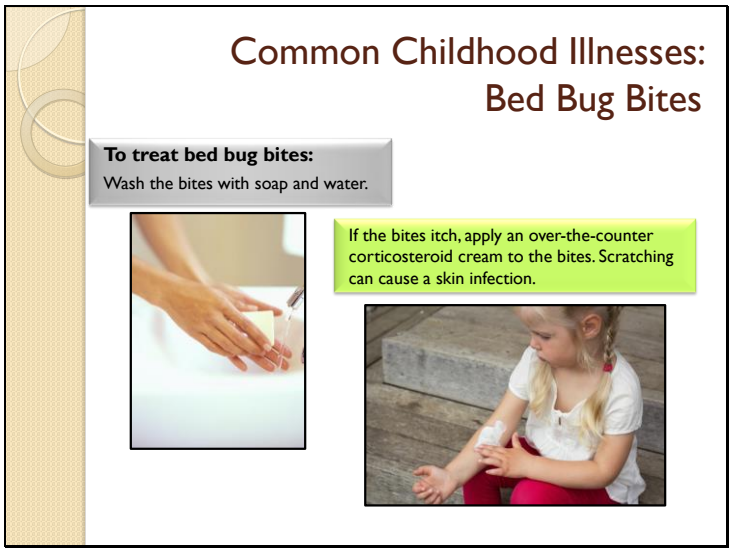

Unless there are signs of an infection or a serious reaction to bed bug bites, the condition can be treated without a trip to the doctor.

To treat bed bug bites:
Wash the bites with soap and water. This will help prevent a skin infection and help reduce itchiness.

If the bites itch, apply an over-the-counter corticosteroid cream to the bites. Scratching can cause a skin infection.
Bedbug bites usually heal and go away within a week or two.

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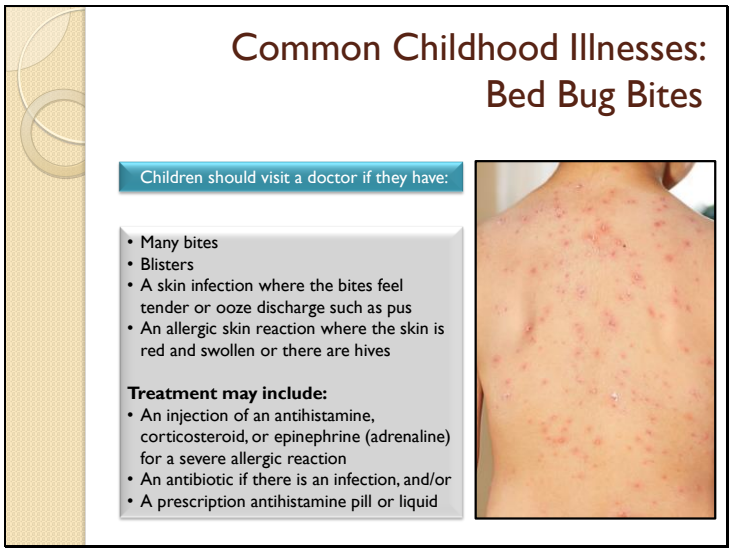

Children should visit a doctor if they have:
●Many bites
●Blisters
●A skin infection where the bites feel tender or ooze discharge such as pus, or
●An allergic skin reaction where the skin is red and swollen or there are hives

Treatment for serious bed bug bites or complications may include:
●An injection of an antihistamine, corticosteroid, or epinephrine (adrenaline) for a severe allergic reaction
●An antibiotic if there is an infection, and/or
●A prescription antihistamine pill or liquid

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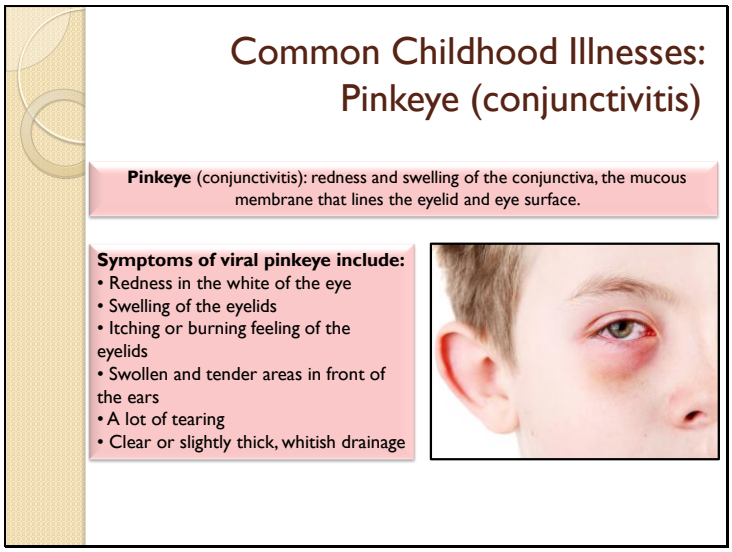
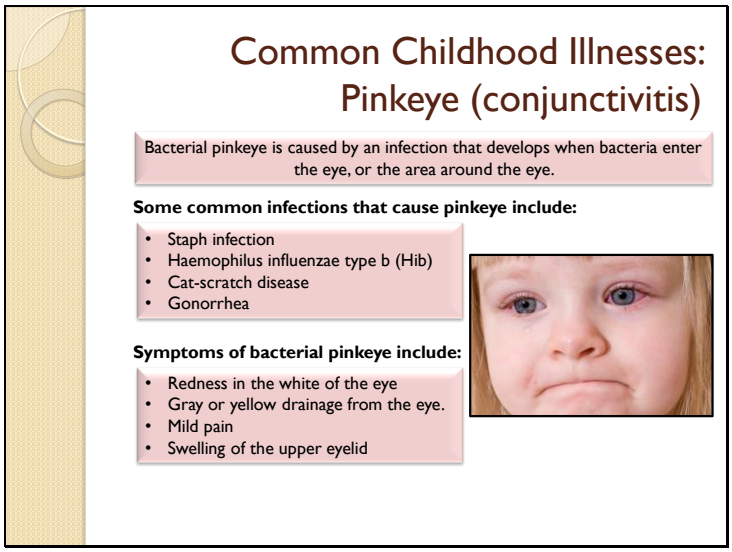


Common Childhood Illnesses: Pinkeye (conjunctivitis)
Pinkeye (conjunctivitis) is redness and swelling of the conjunctiva, the mucous membrane that lines the eyelid and eye surface. Pinkeye symptoms usually start in one eye and may then spread to the other eye. The most common type of pinkeye is caused by a virus and occurs most often in adults.

Viral pinkeye is often caused by an adenovirus, which is a common respiratory virus that can also cause a sore throat or upper respiratory infection. The herpes virus can also cause viral pinkeye.

Symptoms of viral pinkeye include:
●Redness in the white of the eye.
●Swelling of the eyelids.
●Itching or burning feeling of the eyelids.
●Swollen and tender areas in front of the ears.
●A lot of tearing.
●Clear or slightly thick, whitish drainage.
Viral pinkeye symptoms usually last 5 to 7 days but may last up to 3 weeks and can become ongoing or chronic.

Slide 13



Bacterial pinkeye is caused by an infection that develops when bacteria enter the eye, or the area around the eye. Some common infections that cause pinkeye include:

●Staph infection.
●Haemophilus influenzae type b (Hib).
●Cat-scratch disease.
●Gonorrhea.

Symptoms of bacterial pinkeye include:

●Redness in the white of the eye.
●Gray or yellow drainage from the eye. This drainage may cause the eyelashes to stick together.
●Mild pain.
●Swelling of the upper eyelid, which may make the lid appear to droop

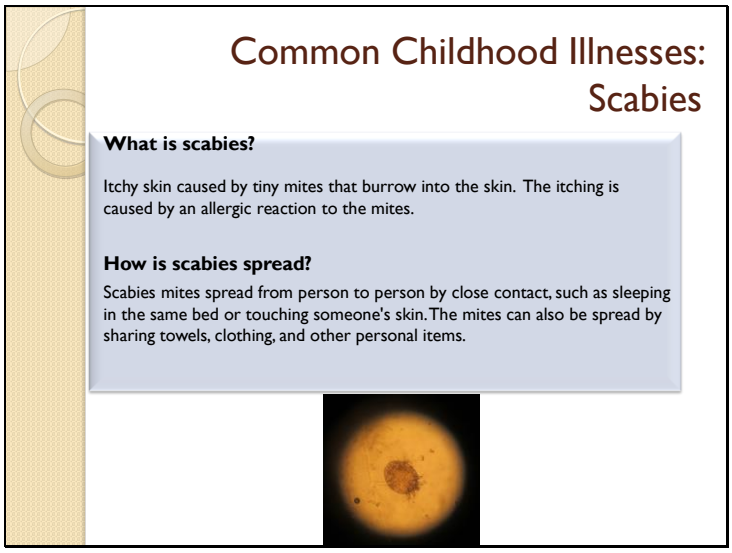
Bacterial pinkeye may cause more drainage than viral pinkeye. Bacterial infections usually last 7 to 10 days without antibiotic treatment and 2 to 4 days with antibiotic treatment.

Slide 14

Treatment for pinkeye includes:

- Washing hands frequently and thoroughly before and after touching eyes.
- Using warm or cool compresses, whichever feels better, to help relieve swelling and redness.
- Changing and washing towels and linens when they become soiled with drainage.
- Avoiding the use of contact lenses as long as symptoms are present.

Slide 15



Common Childhood Illnesses: Scabies
What is scabies?

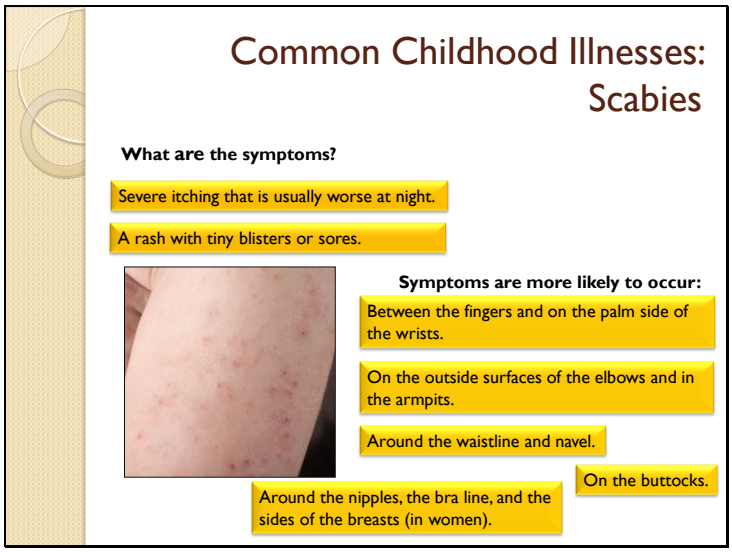
Scabies is a condition of very itchy skin caused by tiny mites that burrow into the skin. The itching is caused by an allergic reaction to the mites.

Scabies spreads very easily from person to person. It can affect people of all ages and from all incomes, social levels, and living situations.
With treatment, the scabies mites die and the itching goes away over a period of days to weeks. Without treatment, the mites continue to reproduce under the skin, causing more sores and itching.

How is scabies spread?

Scabies mites spread from person to person by close contact, such as sleeping in the same bed or touching someone's skin. The mites can also be spread by sharing towels, clothing, and other personal items.
Scabies often affects several household members at the same time. It can be spread to another person before the original person has symptoms.

Slide 16



What are the symptoms?

Scabies has two main symptoms:
●Severe itching that is usually worse at night. Small children and older adults tend to have the worst itching.
●A rash with tiny blisters or sores. Children tend to have worse skin reactions than adults.
Symptoms are more likely to occur:
●Between the fingers and on the palm side of the wrists.
●On the outside surfaces of the elbows and in the armpits.
●Around the waistline and navel.
●On the buttocks.
●Around the nipples, the bra line, and the sides of the breasts (in women).
●On the genitals (in men).

A rare form of scabies called crusted scabies or Norwegian scabies presents with many scaly and crusted sores.

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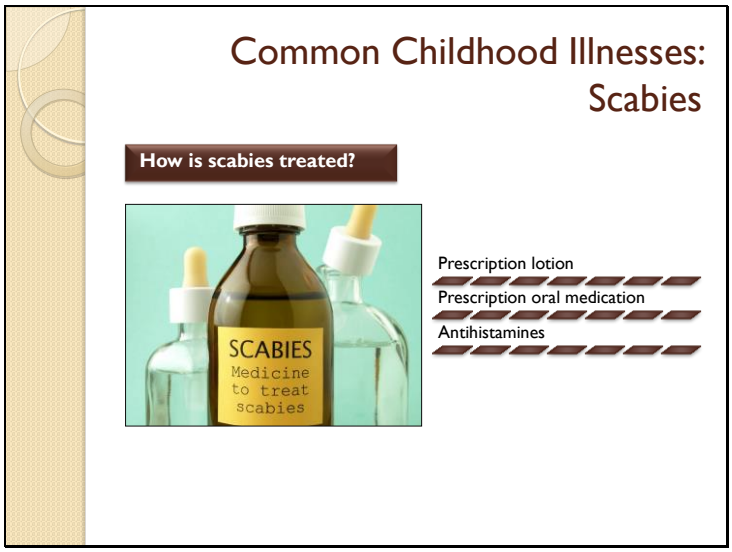

Common Childhood Illnesses: Scabies

How is scabies diagnosed?

Usually a doctor can diagnose scabies based on present symptoms. Scabies is especially likely if a person has had close contact with other people who have had the same symptoms.

A sample of the dry skin from an affected area can be examined under a microscope to confirm scabies as well.

How is it treated?

Scabies won't go away on its own. A doctor will prescribe lotion to treat and prevent the spread of scabies. In severe cases doctors may prescribe oral medication as well. When a person is treated, others who have been in close contact with that person are treated simultaneously. This keeps the mites from being passed back and forth from person to person. Additionally, until scabies has cleared up, people should avoid close contact and not share any personal items.

After treatment, the itching usually lasts another 2 to 4 weeks. Antihistamines (such as Benadryl), steroid creams, or, in severe cases, steroid pills can help relieve itching. A doctor should be consulted before using any of these medications.

Children can usually return to day care or school after treatment is completed.

If someone still has symptoms after 4 weeks, s/he may need another treatment.

To make sure that all the mites are killed:

●Immediately after treatment starts, all of the affected person's bedding, towels, and the clothing that was worn during the past 2 to 3 days (48 to 72 hours) should be cleaned. All items should be washed in hot water, and dried n a hot dryer. They can be also be dry-cleaned.

●Items that cannot be washed or dry-cleaned should be placed in a closed plastic bag for at least 7 days.

●The room or rooms used by the person who had scabies should be cleaned and vacuumed.

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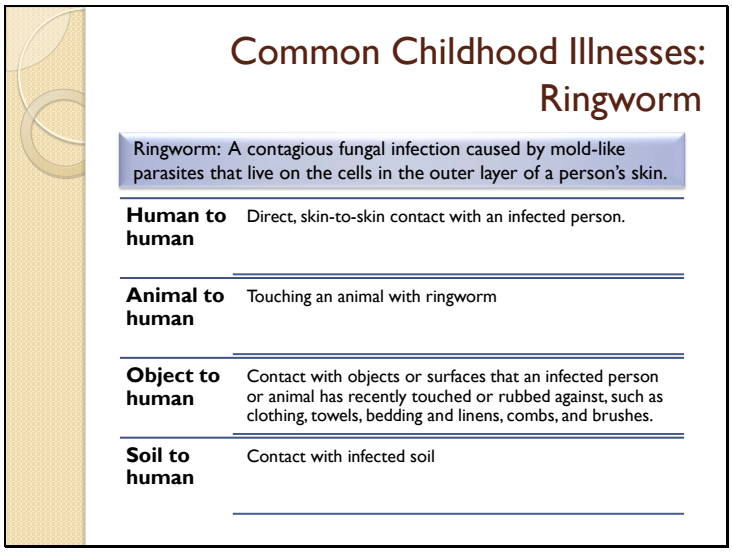

Ringworm is a contagious fungal infection caused by mold-like parasites that live on the cells in the outer layer of a person's skin. It can be spread in the following ways:

Human to human. Ringworm often spreads by direct, skin-to-skin contact with an infected person.

Animal to human. You can contract ringworm by touching an animal with ringworm. Ringworm can spread while petting or grooming dogs or cats. It's also fairly common in cows.

Object to human. Ringworm can spread by contact with objects or surfaces that an infected person or animal has recently touched or rubbed against, such as clothing, towels, bedding and linens, combs, and brushes.

Soil to human. In rare cases, ringworm can be spread to humans by contact with infected soil. Infection would most likely occur only from prolonged contact with highly infected soil.

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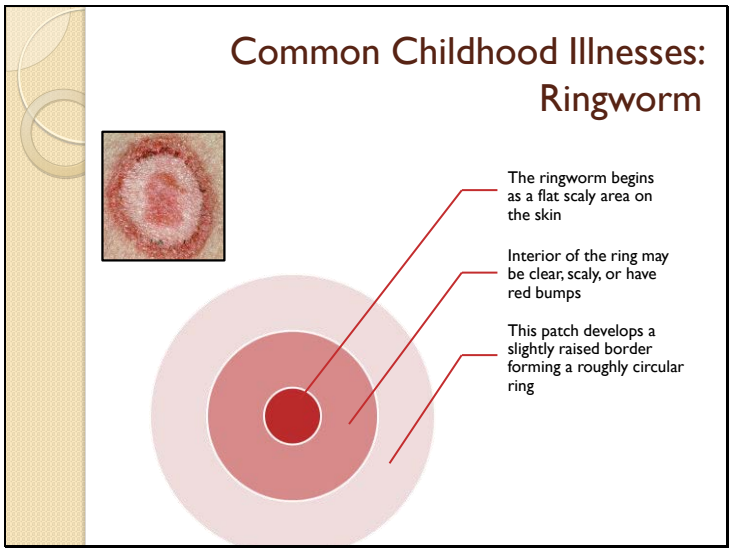
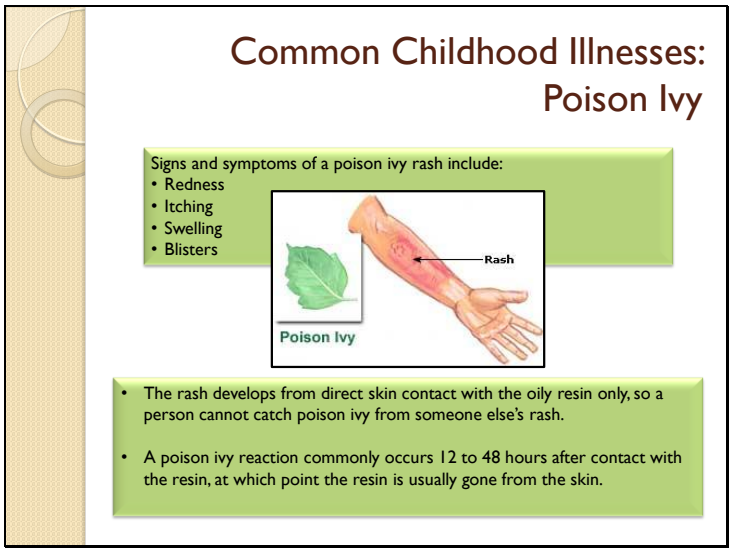


Ringworm typically begins as a flat scaly area on the skin, which may be red and itchy. This patch develops a slightly raised border that expands outward — forming a roughly circular ring. The interior of the ring may be clear, scaly or marked with a scattering of red bumps. In some people, several rings develop at the same time and may overlap.

If a rash develops and does not go away or begin to go way on its own for a week a trip to a family doctor or dermatologist is necessary. A doctor can diagnose ringworm by appearance; however, the doctor may need to do some skin scrapings from the affected area in order to diagnose it accurately.

Treatment for a mild case of ringworm involves over-the-counter anti-fungal cream, such as clotrimazole and terbinafine. More serious cases are treated by the doctor.

Slide 20



Common Childhood Illnesses: Poison Ivy

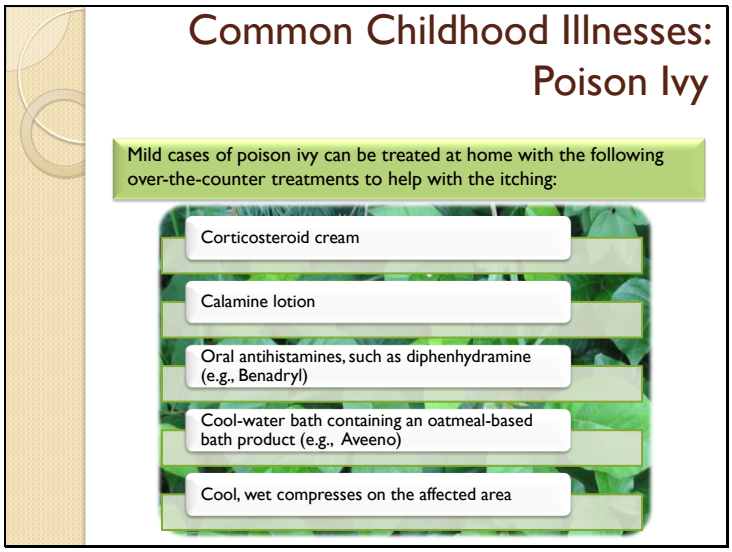
Poison ivy rash is caused by sensitivity to an oily resin found in the plant leaves, stems, and roots of the poison ivy plant. About half of all people who come into contact with the plant will develop the rash.

Signs and symptoms of a poison ivy rash include:

- Redness
- Itching
- Swelling
- Blisters

Typically the rash occurs in a straight line because of the way the plant brushes against the skin, but it may be more spread out if the contact with the oily resin has come from clothing or pet fur that has the resin on it. The rash develops from direct skin contact with the oily resin only, so a person cannot catch poison ivy from someone else's rash. A poison ivy reaction commonly occurs 12 to 48 hours after contact with the resin, at which point the resin is usually gone from the skin. Diagnosis of poison ivy is made by looking at the rash.

Slide 21



Mild cases of poison ivy can be treated at home with the following over-the-counter treatments to help with the itching:

- Apply an over-the-counter corticosteroid cream for the first few days
- Apply calamine lotion
- Take oral antihistamines, such as diphenhydramine (Benadryl, others),
- Soak in a cool-water bath containing an oatmeal-based bath product (Aveeno).
- Place cool, wet compresses on the affected area for 15 to 30 minutes several times a day.

More severe or widespread cases of poison ivy may require medical treatment such as corticosteroid pills, or antibiotics in the event of a bacterial infection at the site of the rash.

Children should be seen by a doctor if:

- The reaction is severe or widespread
- The rash affects their face or genitals
- Blisters are oozing pus
- They develop a fever greater than 100 F
- The rash doesn't get better within a few weeks

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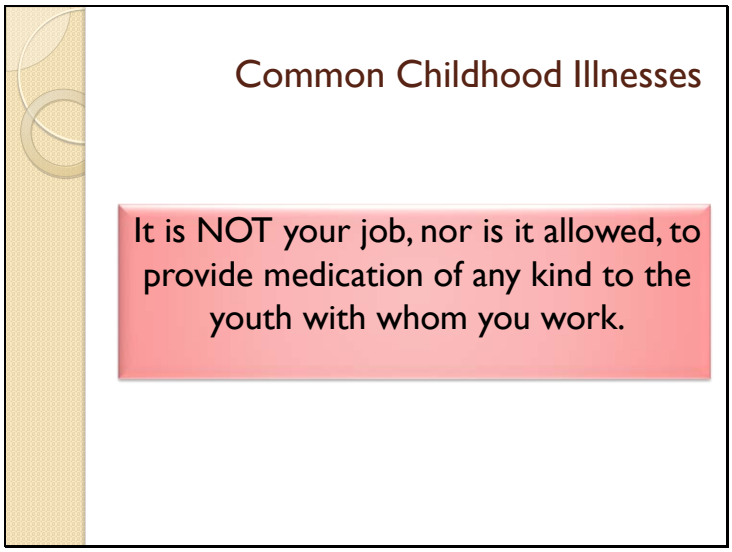
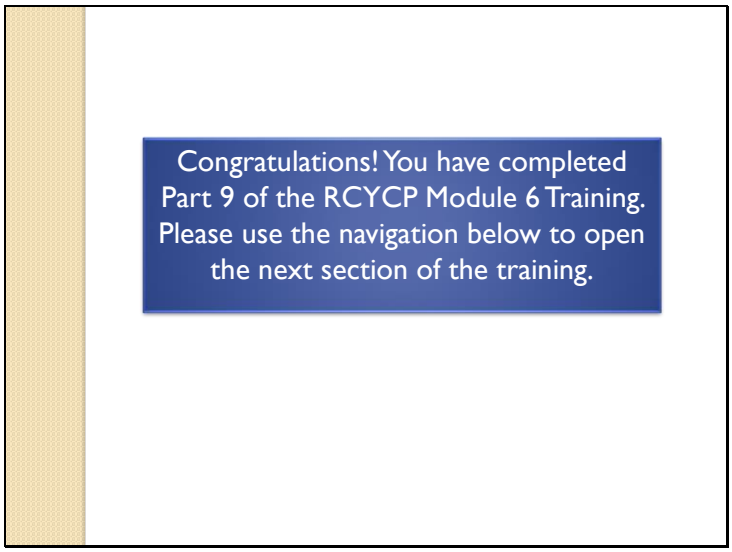


Common Childhood Illnesses

Now that you are familiar with common childhood illnesses, you may help identify youth who are in need of treatment. It is NOT your job, nor is it allowed, to provide medication of any kind to the youth with whom you work. Remember to follow all of your agency's policies and procedures regarding health issues and medical treatment.

Slide 25



Congratulations! You have completed Part 9 of the RCYCP Module 6 Training. Please use the navigation below to open the next section of the training.

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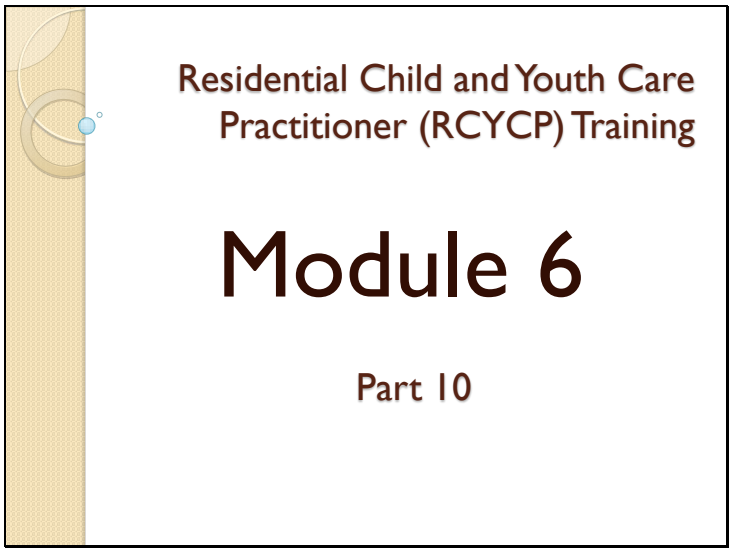
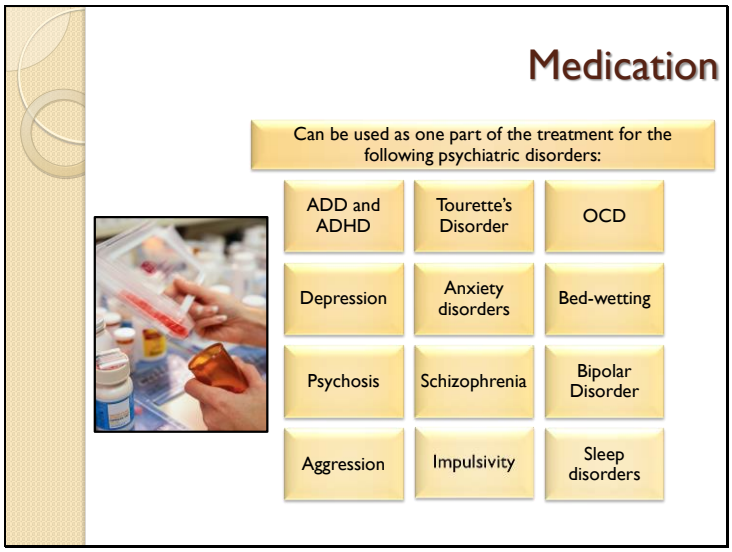


Residential Child and Youth Care Practitioner (RCYCP) Training
Welcome to Module 6, Part 10 of the Residential Child and Youth Care Practitioner Training.

Slide 2



Medication
Let's turn now to a discussion about medication.

Some of the youth that you work with will be on medication to treat various mental health disorders.
Medication does not cure the disorder. Rather, medication treats the symptoms. Without medication, individuals might suffer serious and disabling symptoms. Medication can be one part of an effective treatment for several psychiatric disorders including:

- ADD and ADHD
- Tourette's Disorder
- Obsessive-Compulsive Disorder
- Depression
- Anxiety disorders
- Bed-wetting
- Psychosis
- Schizophrenia
- Bipolar Disorder
- Aggression
- Impulsivity, and
- Sleep disorders

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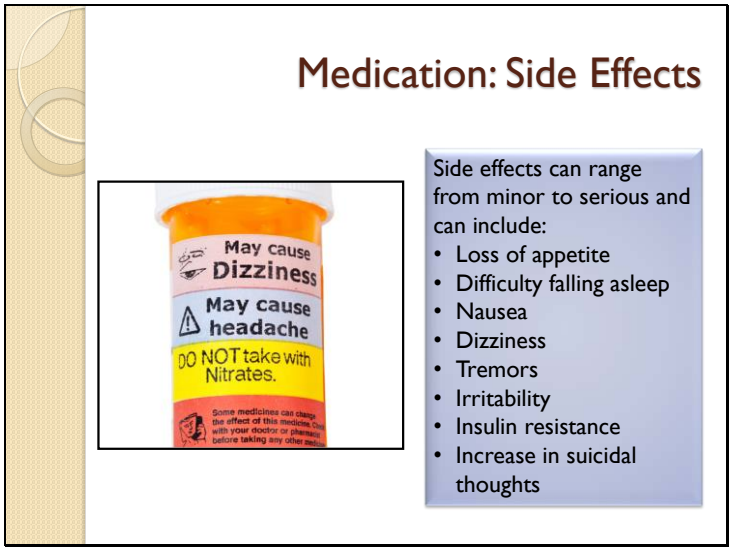
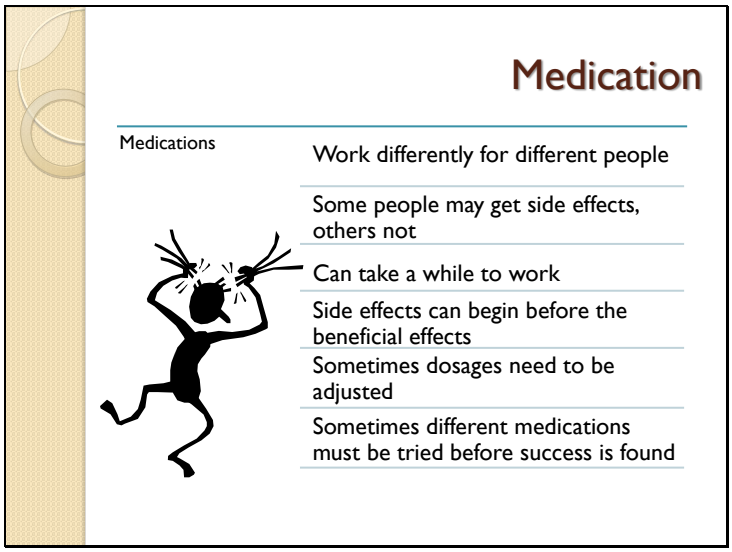


Medication: Side Effects

Medications which have beneficial effects might also have unintended side effects. These side effects can be relatively minor, such as loss of appetite or difficulty falling asleep, or more serious, such as nausea, dizziness, tremors, irritability, insulin resistance, or an increase in suicidal thoughts.

Slide 5

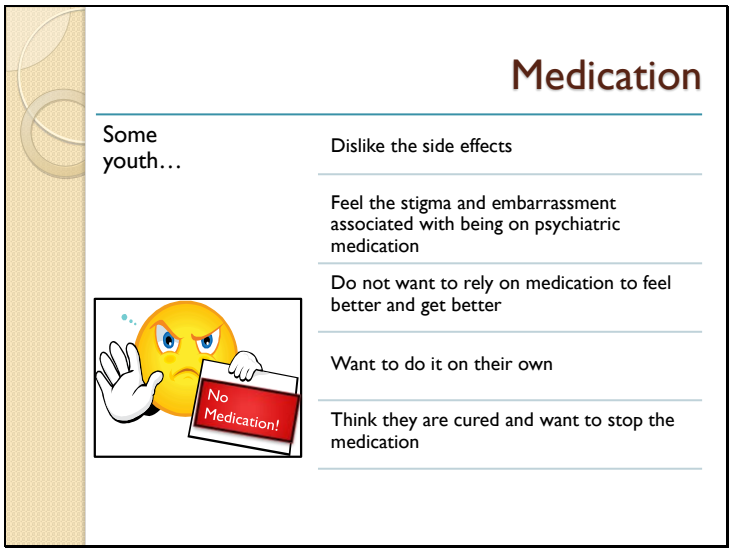


Medication

Medications work differently for different people. Some people might suffer from side effects, while some do not.

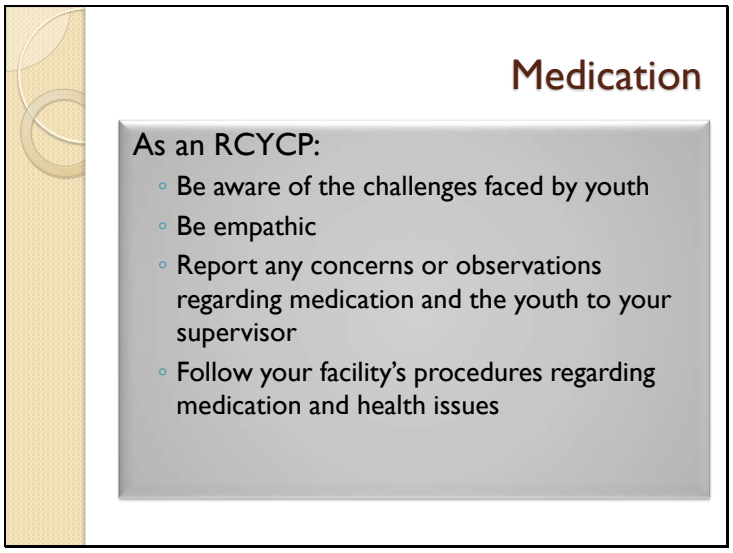
Medications can take a while to work. Some take weeks to work. Sometimes side effects begin before the beneficial effects kick in. Sometimes dosages need to be adjusted, or different medications tried before success is found. This can be a long and frustrating process for youth.

Slide 6



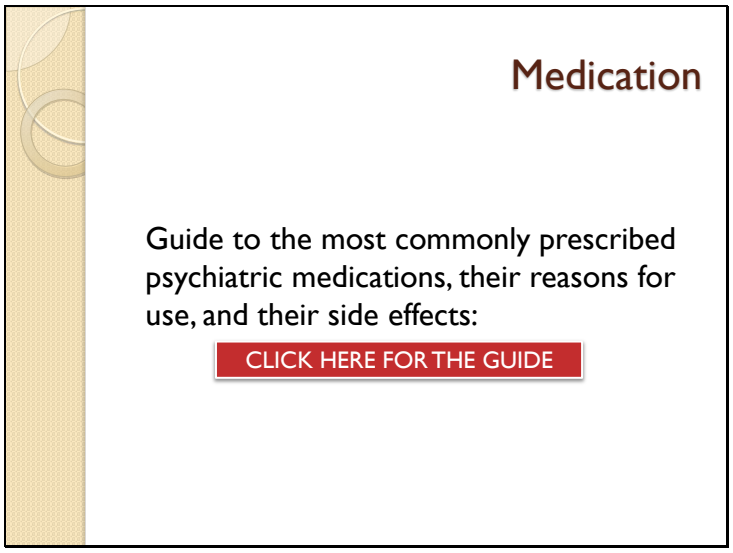
Additionally, you will work with youth who do not like taking their medication. Some youth simply dislike the side effects and for that reason do not want to take it. Some feel the stigma and embarrassment associated with being on psychiatric medication. Some youth do not want to rely on medication to feel better and get better. They want to "do it on their own." There are others who do so well on medication, they think they are "cured" and so want to stop using the medication.

Slide 7



Your job as an RCYCP is to be aware of, and empathic to, the challenges faced by the youth with whom you work. This includes all of the aforementioned struggles associated with mental health-related medication. Additionally, you need to report to your supervisor any concerns or observations you have regarding medication and your youth. For example, if a youth is not taking his/her medication, or if you notice that a youth appears pale and sweaty after taking his or her medication, follow your facility's procedures regarding health issues, and report your observations and concerns to your supervisor immediately.

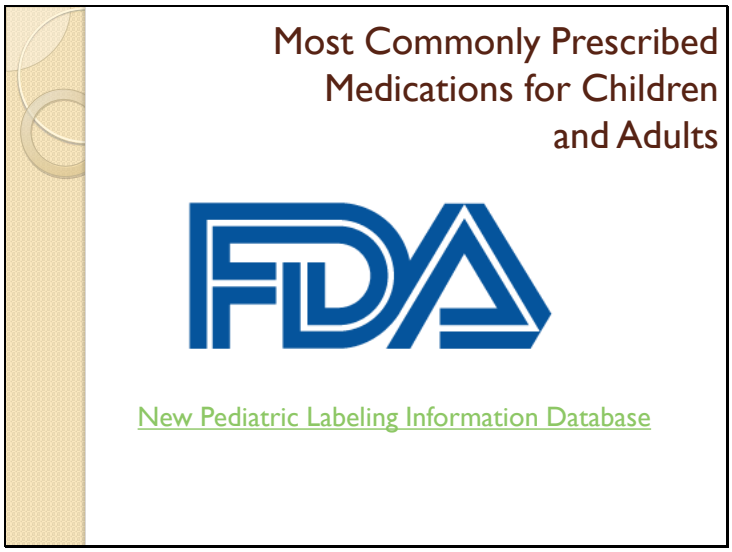
Slide 8



The following guide will give you an overview of some of the most commonly prescribed medications, their reason for use, and their side effects. The guide is broken down by class of drug.

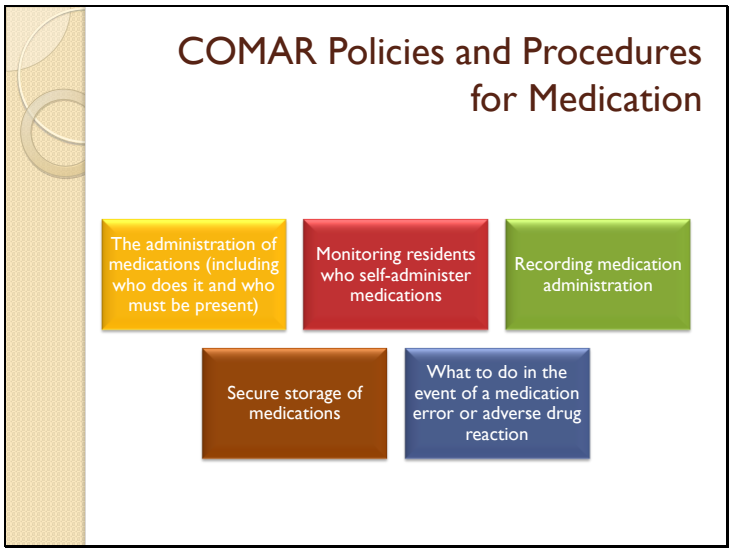
Click on the link below to look at the most commonly prescribed medications for children and adolescents, as well as their use and side effects.

Slide 9



Most Commonly Prescribed Medications for Children and Adults
There also is a useful Federal Food and Drug Administration website that lists an exhaustive number of pediatric medications, their uses, and research information including side effects. Please visit the website listed below to get more information.
http://www.accessdata.fda.gov/scripts/sda/sdNavigation.cfm?sd=labelingdatabase

Slide 10



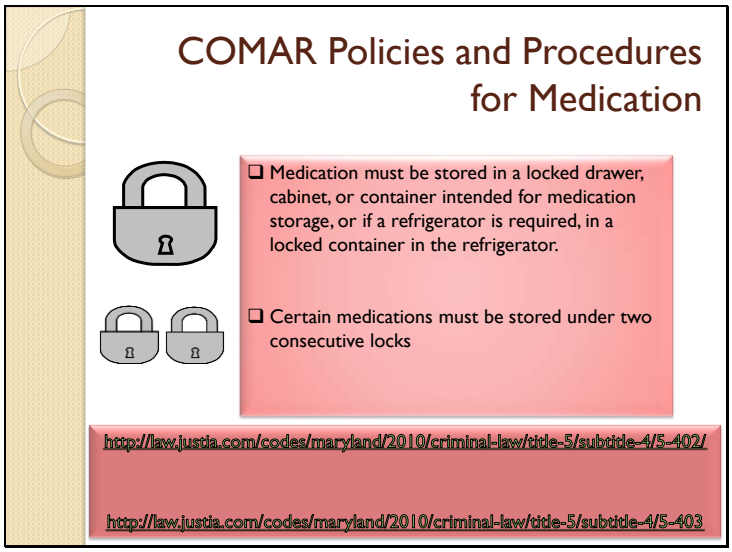
COMAR Policies and Procedures for Medication
Now let's turn to a discussion of COMAR regulations regarding medication management.

With regard to policies and procedures for medication, your facility will have instructions for RCYCPs and other staff concerning:

- the administration of medications (including who does it and who must be present)
- monitoring residents who self-administer medications
- recording medication administration
- secure storage of medications, and
- what to do in the event of a medication error or adverse drug reaction

You need to be familiar with these policies and procedures.

Slide 11

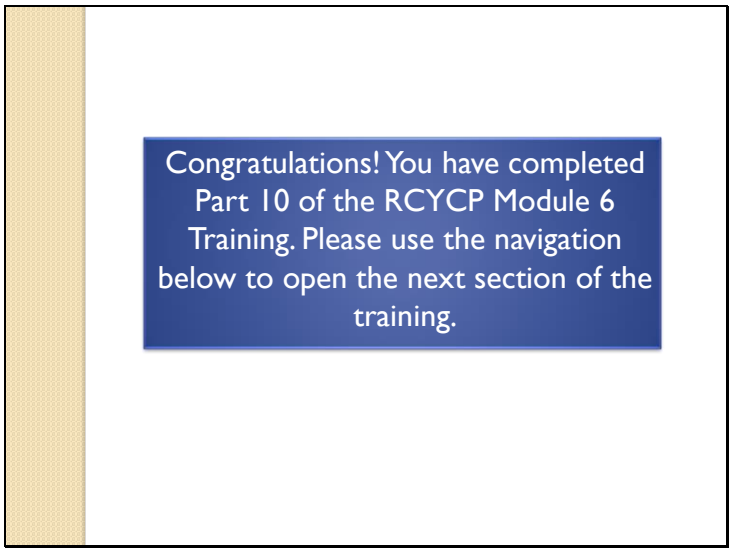


Additionally, it is important to be familiar with the regulations that COMAR has in place for residential child and youth care facilities with regard to medication. Let's look at those now:

Medication must be stored in a locked drawer, cabinet, or container intended for medication storage, or if a refrigerator is required, in a locked container in the refrigerator.

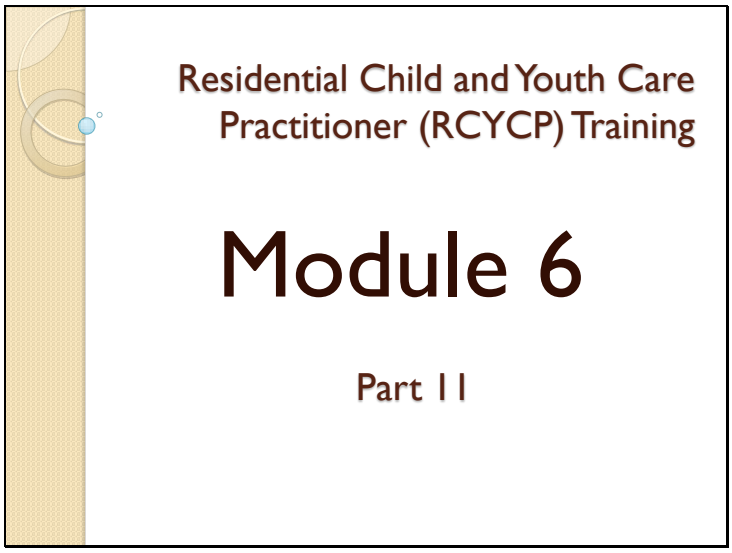
Certain medications must be stored under two consecutive locks. (These are medications as defined in Criminal Law Article, Title 5,
Annotated Code of Maryland. Click on the links below to see those medications.)
http://law.justia.com/codes/maryland/2010/criminal-law/title-5/subtitle-4/5-402/
http://law.justia.com/codes/maryland/2010/criminal-law/title-5/subtitle-4/5-403/

Slide 13



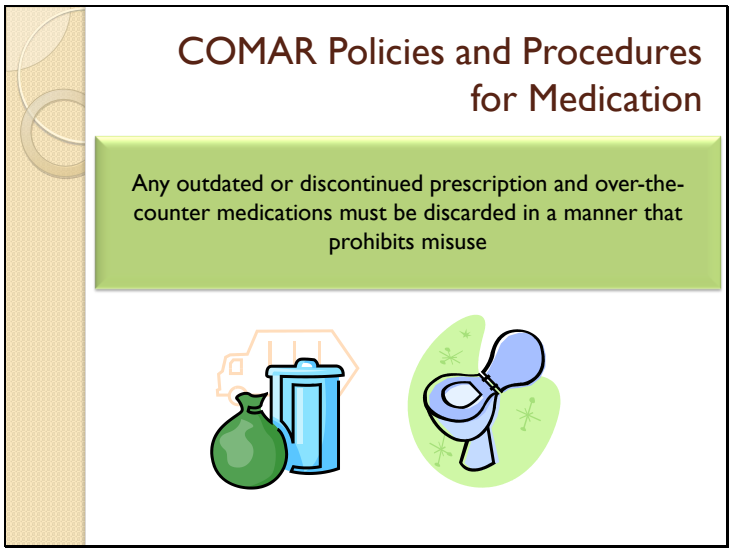
Congratulations! You have completed Part 10 of the RCYCP Module 6 Training. Please use the navigation below to open the next section of the training.

Slide 1



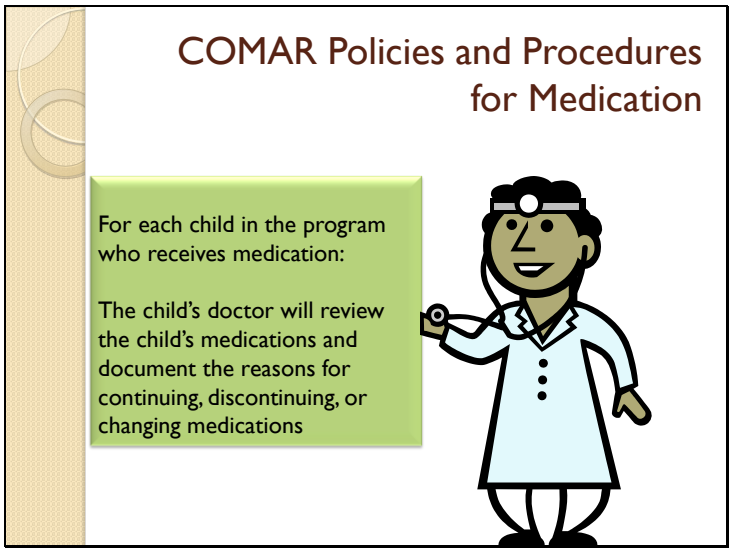
Residential Child and Youth Care Practitioner (RCYCP) Training
Welcome to Module 6, Part 11 of the Residential Child and Youth Care Practitioner Training.

Slide 2



COMAR Policies and Procedures for Medication
Any outdated or discontinued prescription and over-the-counter medications must be discarded in a manner that prohibits misuse

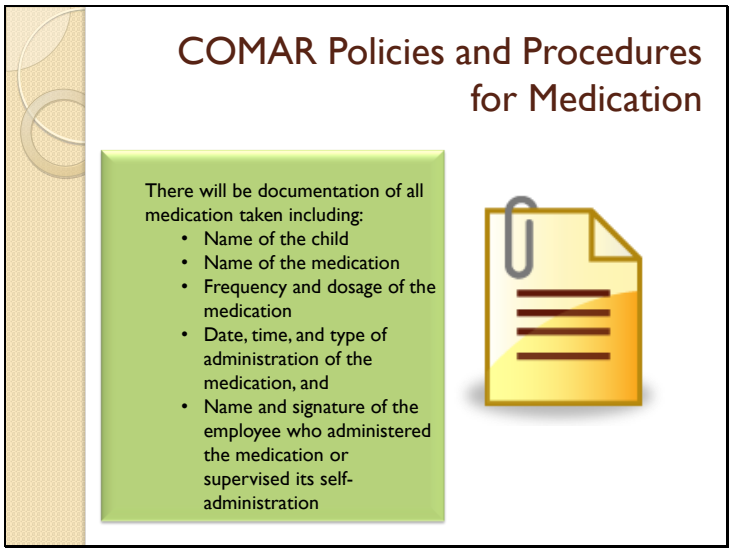
Slide 3



For each child in the program who receives medication:

The child's doctor will review the child's medications and document the reasons for continuing, discontinuing, or changing medications

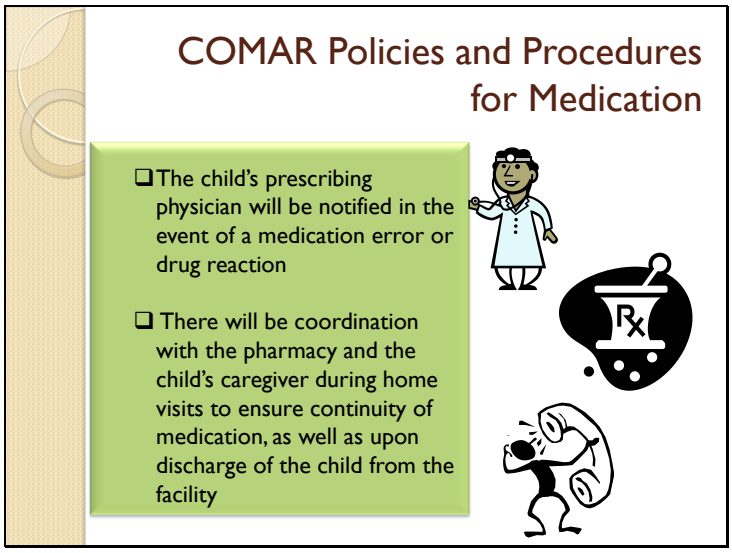
Slide 4



There will be documentation of all medication taken including:

- Name of the child
- Name of the medication
- Frequency and dosage of the medication
- Date, time, and type of administration of the medication, and
- Name and signature of the employee who administered the medication or supervised its self-administration

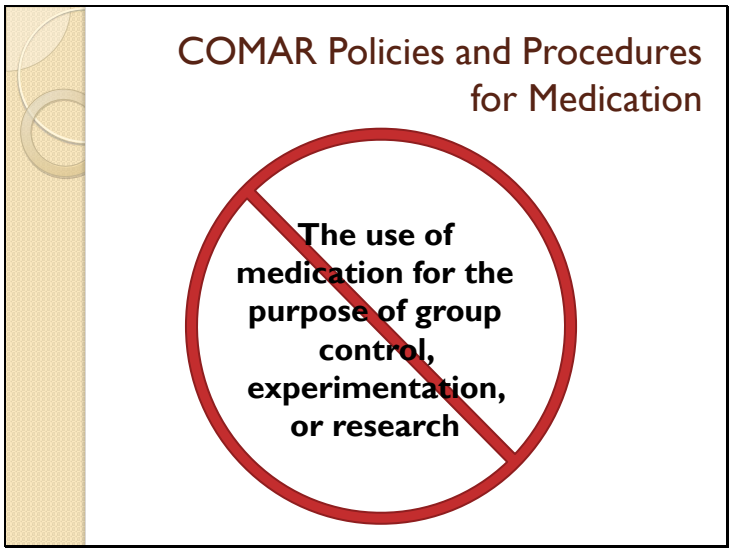
Slide 5



The child's prescribing physician will be notified in the event of a medication error or drug reaction, and

There will be coordination with the pharmacy and the child's caregiver during home visits to ensure continuity of medication, as well as upon discharge of the child from the facility

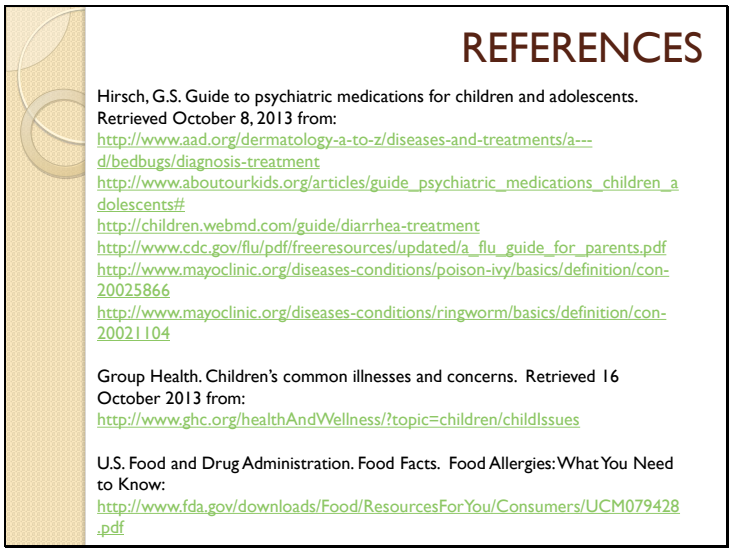
Slide 6



Finally, COMAR prohibits the use of medication for the purpose of group control, experimentation, or research.

You are now finished with Module 6.

Slide 7



Hirsch, G.S. Guide to psychiatric medications for children and adolescents. Retrieved October 8, 2013 from:
http://www.aad.org/dermatology-a-to-z/diseases-and-treatments/a---d/bedbugs/diagnosis-treatment
http://www.aboutourkids.org/articles/guide_psychiatric_medications_children_adolescents#
http://children.webmd.com/guide/diarrhea-treatment
http://www.cdc.gov/flu/pdf/freeresources/updated/a_flu_guide_for_parents.pdf
http://www.mayoclinic.org/diseases-conditions/poison-ivy/basics/definition/con-20025866
http://www.mayoclinic.org/diseases-conditions/ringworm/basics/definition/con-20021104

Group Health. Children's common illnesses and concerns. Retrieved 16 October 2013 from:
http://www.ghc.org/healthAndWellness/?topic=children/childIssues

U.S. Food and Drug Administration. Food Facts. Food Allergies: What You Need to Know:
http://www.fda.gov/downloads/Food/ResourcesForYou/Consumers/UCM079428.pdf

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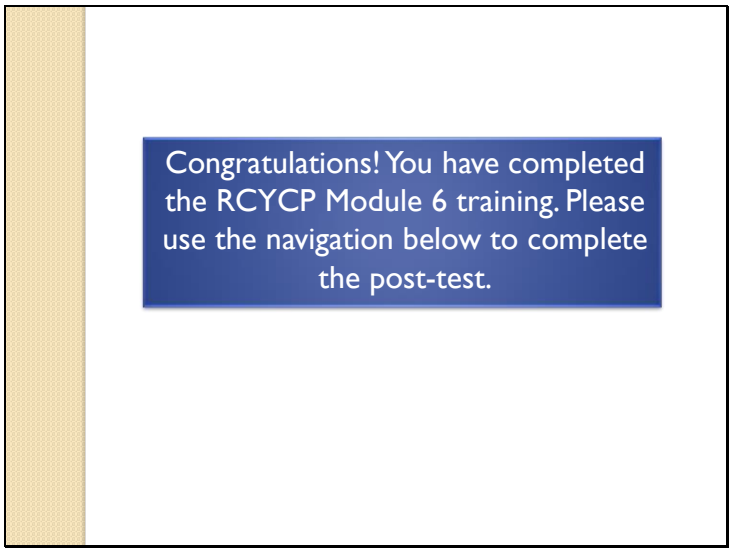
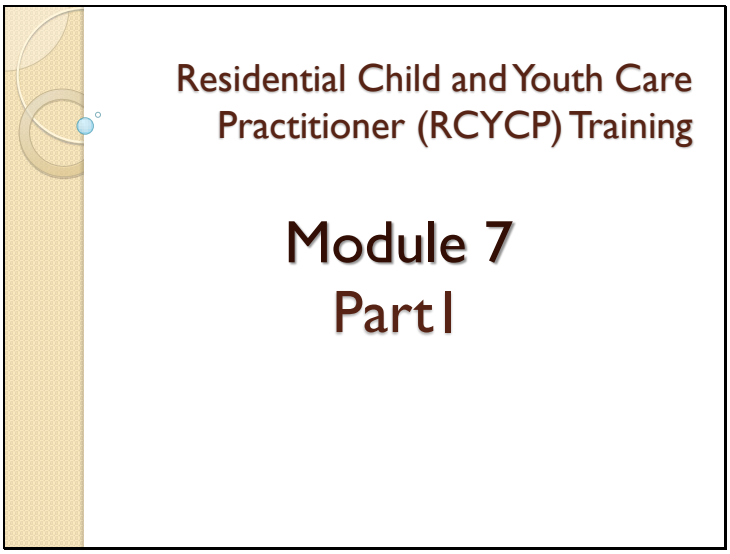


Congratulations! You have completed the RCYCP Module 6 training. Please use the navigation below to complete the post-test.

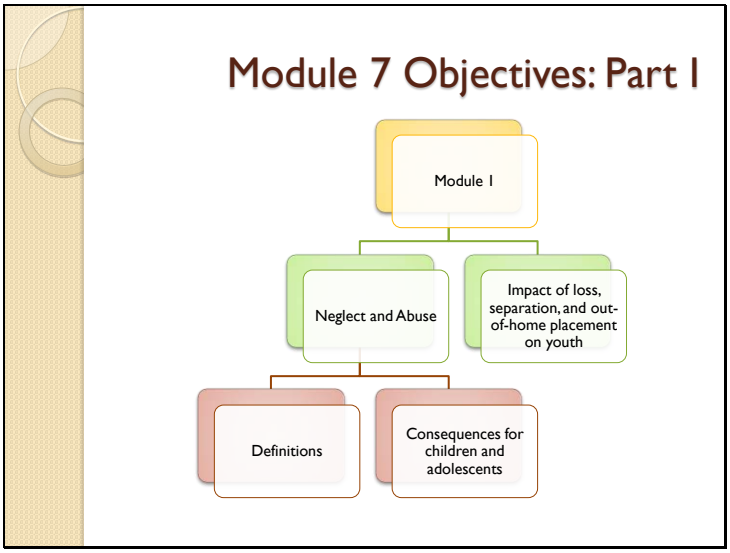
Slide 2



Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 7, Part 1 of the Residential Child and Youth Care Practitioner Training.

Slide 3



Module 7 Objectives: Part I

Welcome to Module 7: Trauma

The first part of this module is dedicated to an overview of specific types of neglect and abuse – how they are defined and the consequences of the abuse for children and adolescents. This section includes an overview on the impact of loss, separation, and out-of-home placement on youth.

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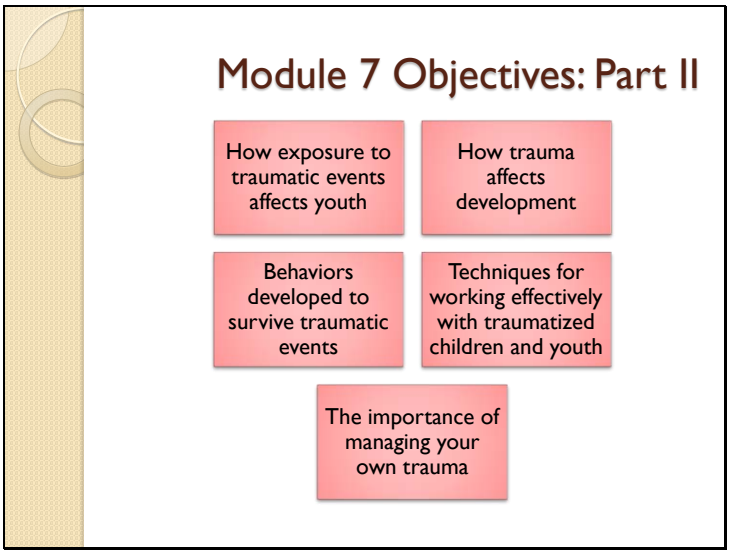


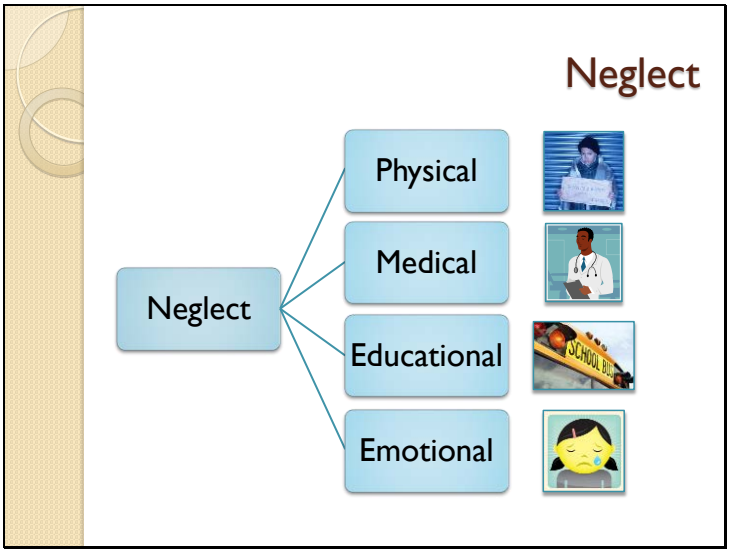
Module 7 Objectives: Part II

The second part of this module focuses on trauma in general and uses training materials from the National Child Traumatic Stress Network (NCTSN). Specifically, you will learn:

- How exposure to traumatic events has affected the thoughts, feelings, and behaviors of youth;
- How trauma may derail normal childhood and adolescent development and affect an individual's ability to adapt to and cope with challenging situations;
- The behaviors that young people develop to survive traumatic events, and what happens when these ways of coping are no longer appropriate;
- Techniques for working effectively with traumatized children and youth; and
- The importance of managing your own trauma to most effectively serve others.

Let's begin.

Slide 5

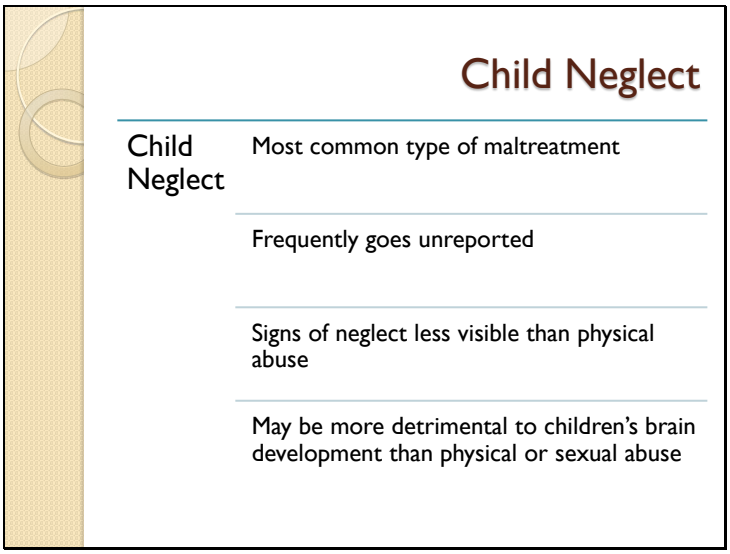


Neglect

Neglect is the failure of a parent, guardian, or other caregiver to provide for a child's basic needs. Neglect may be:

- Physical (e.g., failure to provide necessary food or shelter, or lack of appropriate supervision);
- Medical (e.g., failure to provide necessary medical or mental health treatment);
- Educational (e.g., failure to educate a child or attend to special education needs); or
- Emotional (e.g., inattention to a child's emotional needs, failure to provide psychological care, or permitting the child to use alcohol or other drugs).

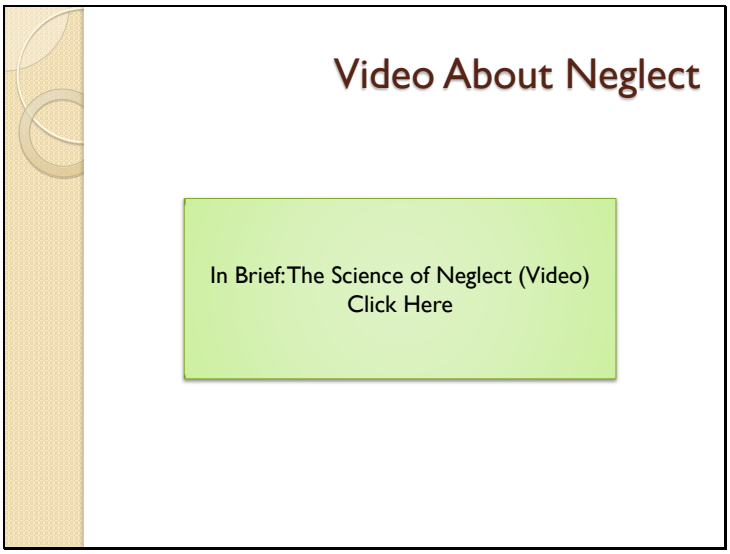
Slide 6



Child Neglect

Child neglect is the most common type of child maltreatment. Neglect frequently goes unreported, and historically has not received as much attention as child physical abuse. It is easier to see the negative repercussions of child physical abuse because it often leaves visible bruises and scars. The signs of neglect tend to be less visible than physical abuse; however, the effects can be just as detrimental. Some studies have even shown that neglect may be more detrimental to children's early brain development than physical or sexual abuse.

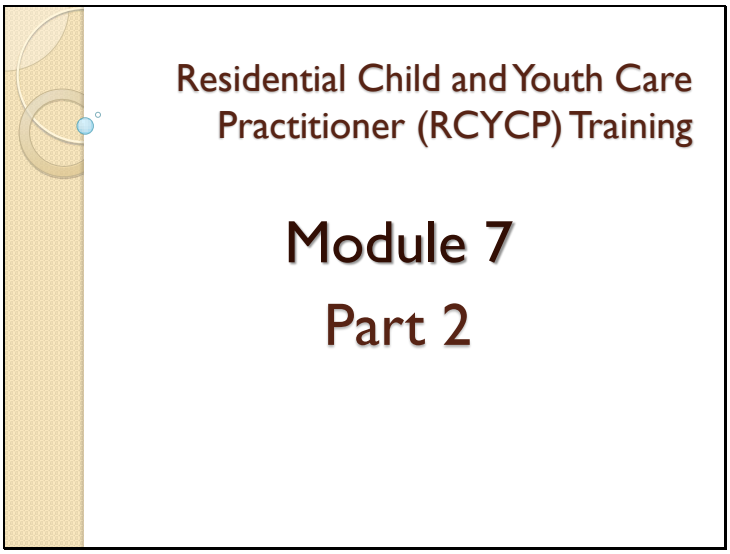
Slide 8



Video About Neglect

Click on the link to watch a short video about neglect:
http://www.youtube.com/watch?v=bF3j5UVCSCA&list=PLuKMerO1zya_3krFpcOKgaeB2_2zQgYua
(In Brief: The Science of Neglect 5:57)

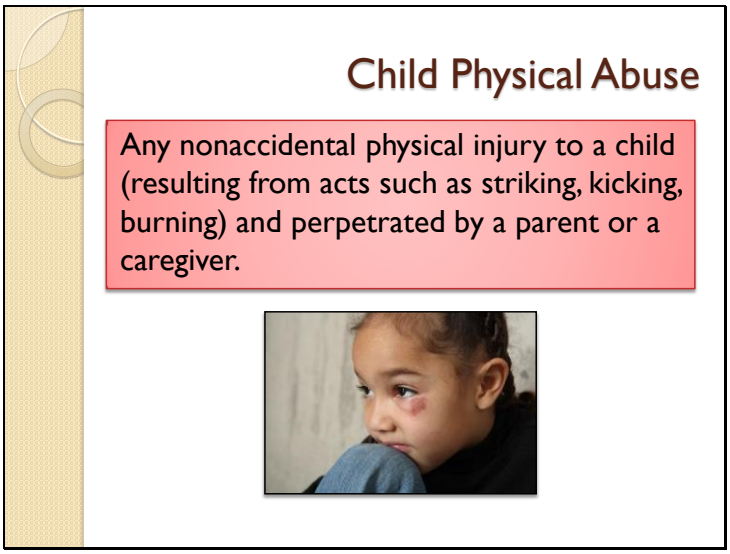
Slide 2



Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 7 of the Residential Child and Youth Care Practitioner Training.

Slide 3

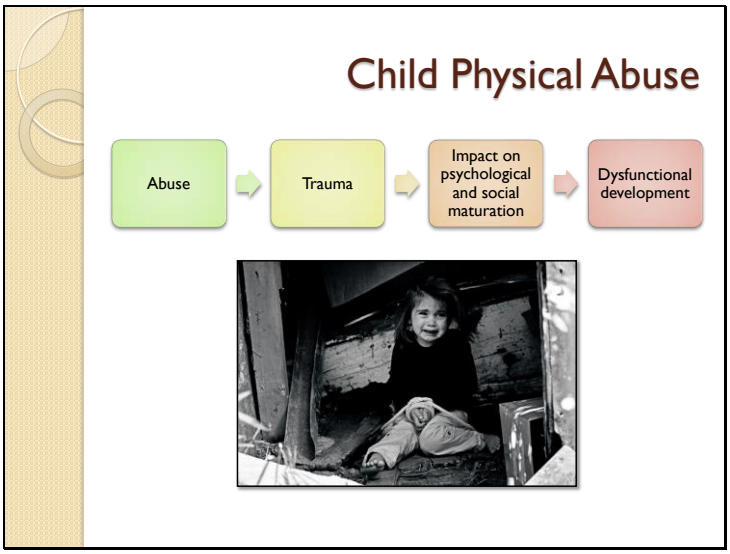


Child Physical Abuse

What is child physical abuse? This type of maltreatment is generally defined as any nonaccidental physical injury to a child (resulting from acts such as striking, kicking, burning) and perpetrated by a parent or caregiver.

Each year, hundreds of thousands of children are physically abused. Thousands actually die from that abuse. For those who don't, the consequences of the abuse are severe and last for years beyond the initial trauma.

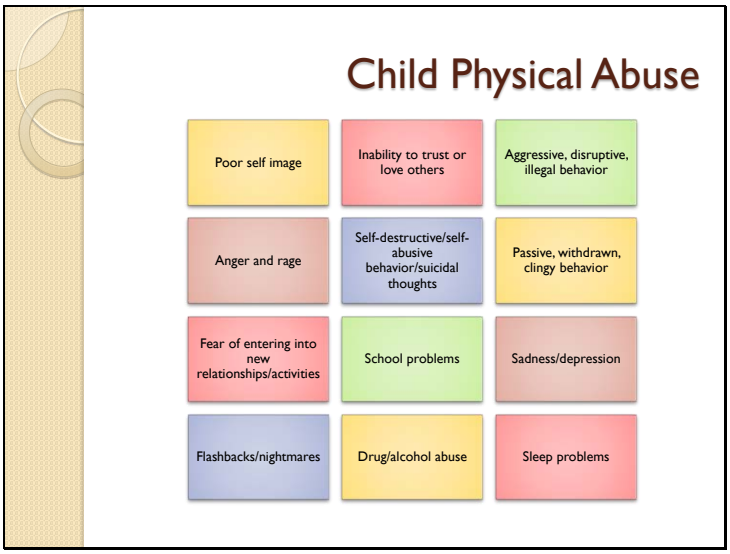
Slide 4



Child Physical Abuse

Children who are physically abused are traumatized during the most critical period of their lives – while they are developing their sense of self, forming their relationships, and learning coping skills. As a result, physical abuse impacts their psychological and social maturation, which, in turn, leads to dysfunctional development.

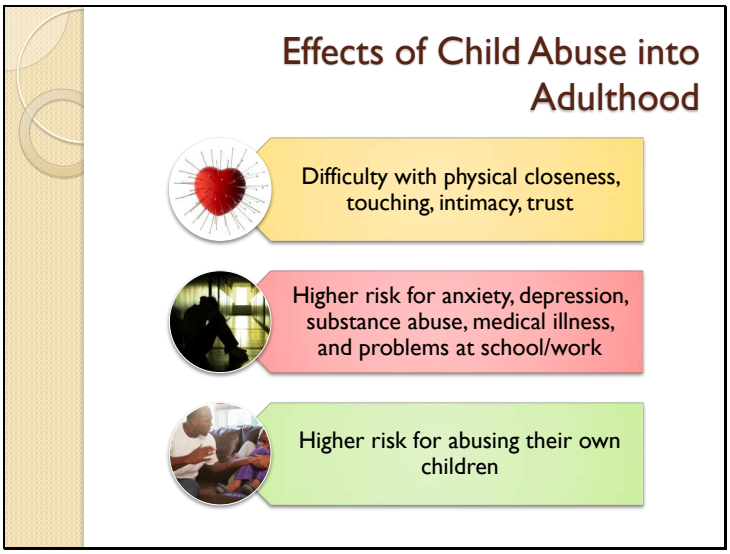
Slide 5



Not only does it affect their psychological well-being, but it affects behaviors and social relationships as well. Children who have been abused may display:

- A poor self-image;
- Inability to trust or love others;
- Aggressive, disruptive, and sometimes illegal behavior (abused and neglected children are more likely to be arrested for criminal behavior as a juvenile, more likely to be arrested for violent and criminal behavior as an adult, and more likely to be arrested for one of many forms of violent crime);
- Anger and rage;
- Self-destructive or self-abusive behavior; suicidal thoughts; Passive, withdrawn or clingy behavior;
- Fear of entering into new relationships or activities;
- Anxiety and fears;
- School problems or failure;
- Feelings of sadness or other symptoms of depression;
- Flashbacks and nightmares;
- Drug and alcohol abuse; and
- Sleep problems.

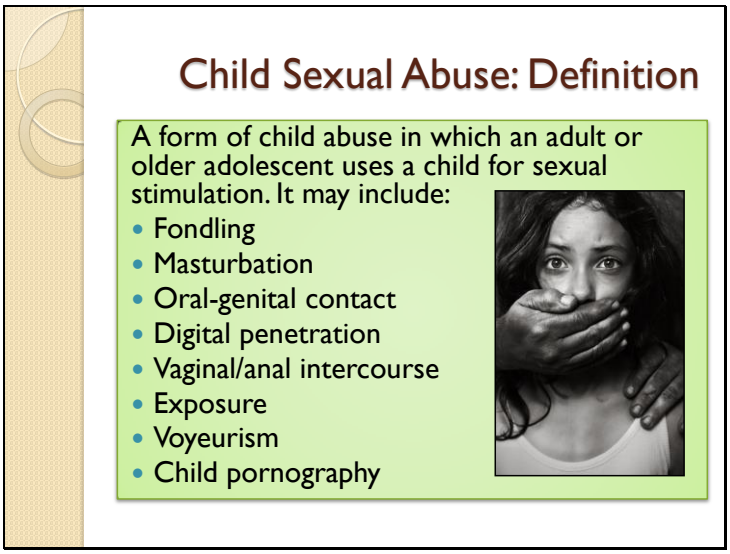
Slide 6



Effects of Child Abuse into Adulthood

For many, the effects of child abuse continue long into adulthood. Adults who were child victims of abuse may continue to have trouble establishing lasting and stable personal relationships. They may have difficulty with physical closeness, touching, intimacy, and trust. They are also at significantly higher risk for anxiety, depression, substance abuse, medical illness, and problems at school or work. Adults who were abused as children are also at a higher risk for abusing their own children.

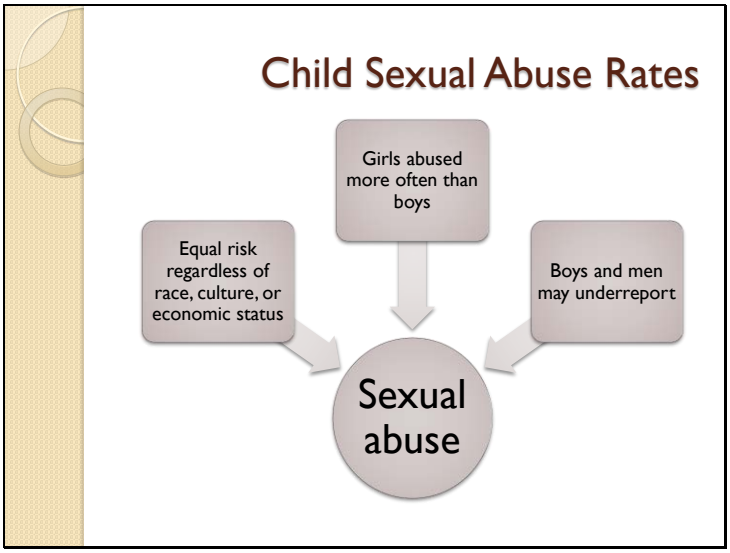
Slide 7



Child Sexual Abuse: Definition

So what is child sexual abuse? There is no universal definition; however, it is generally thought of as a form of child abuse in which an adult or older adolescent uses a child for sexual stimulation. Child sexual abuse may include fondling a child's genitals, masturbation, oral-genital contact, digital penetration, and vaginal and anal intercourse. It may also include noncontact types of abuse, such as exposure, voyeurism, and child pornography.

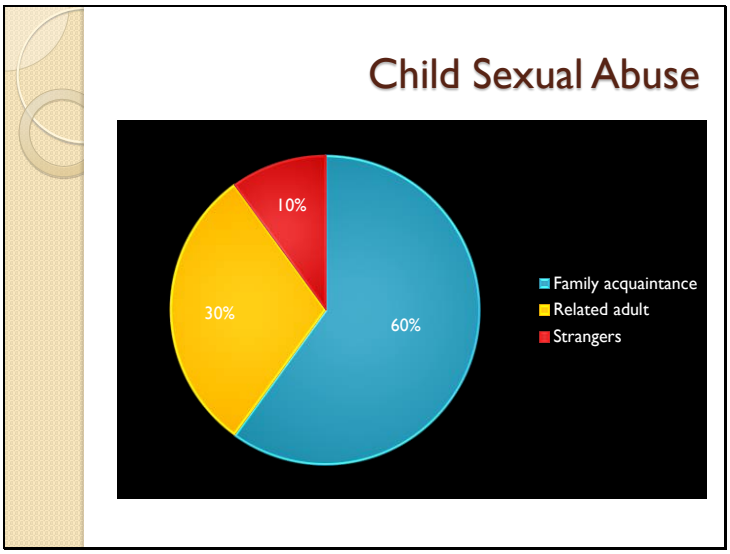
Slide 8



Child Sexual Abuse Rates

Children and adolescents, regardless of their race, culture, or economic status, are at approximately equal risk for sexual victimization. Statistically, girls are sexually abused more often than boys; however, it is believed that boys and men may underreport incidences of sexual abuse.

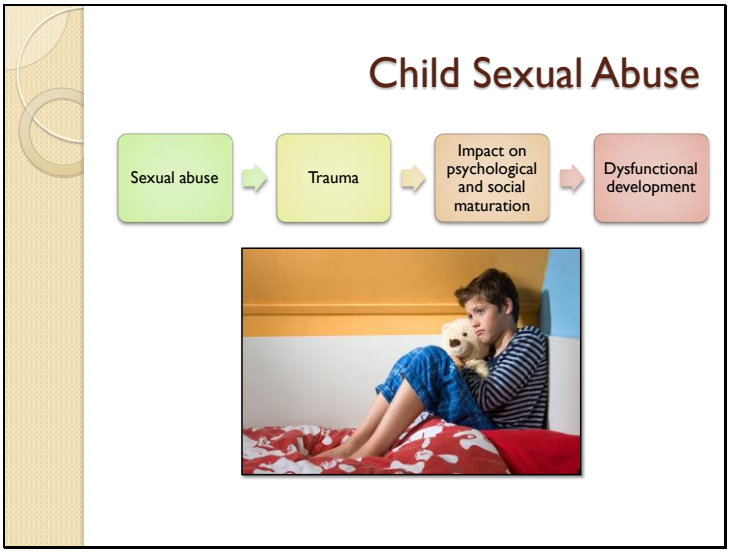
Slide 9



Child Sexual Abuse

Sexual victimization to a child or adolescent by a related adult (also termed incest) is common, with estimates suggesting that 30% of all sexual abuse cases fall into this category, while 60% of abusers are family acquaintances such as neighbors, friends, or babysitters. Less than 10% of sexual abuse perpetrators are strangers.

Slide 11



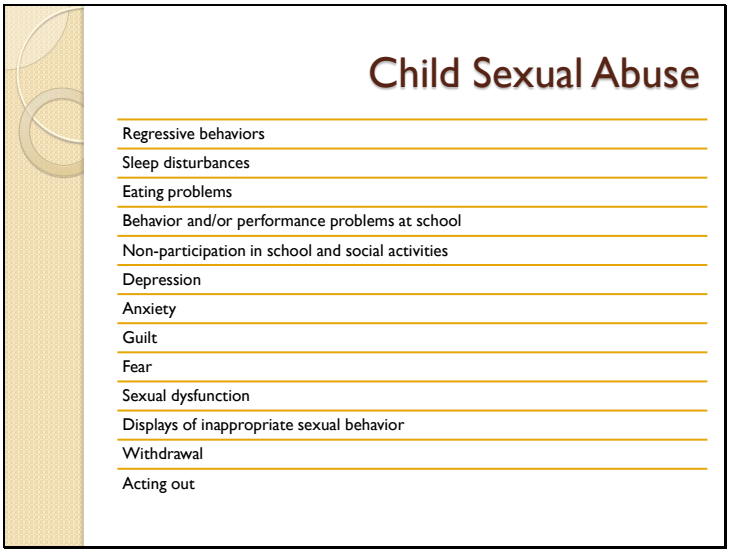
Child Sexual Abuse

Effects of Child Sexual Abuse

Just as with child physical abuse, children who have been sexually abused are traumatized during the most critical period of their lives – when they are developing their self, forming relationships, and learning coping skills.

Child sexual abuse impacts their subsequent psychological and social maturation and leads to dysfunctional development. Not only does it affect an individual's psychological well-being, but it affects behaviors and social relationships as well.

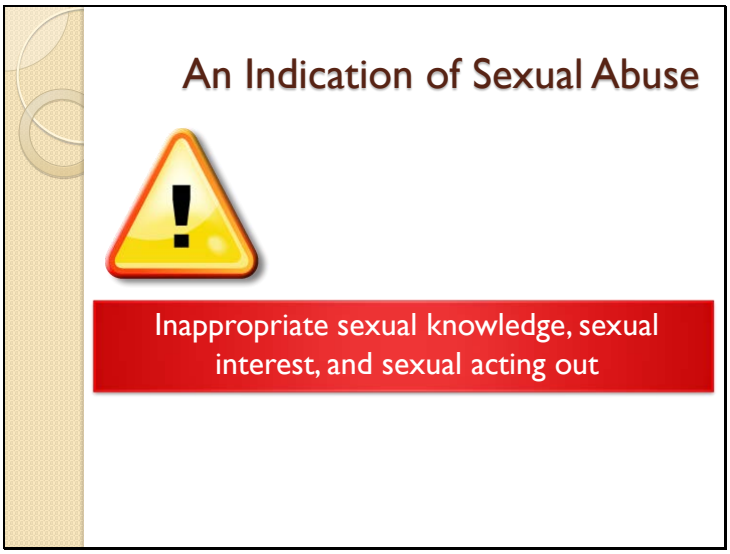
Slide 12



Children who have been sexually abused may display:

- Regressive behaviors (depending on the developmental stage during which the abuse took place; for example, thumb-sucking, bed-wetting)
- Sleep disturbances
- Eating problems
- Behavior and/or performance problems at school
- Non-participation in school and social activities
- Depression
- Anxiety
- Guilt
- Fear (generalized, as well as fear and anxiety regarding the opposite sex and sexual issues)
- Sexual dysfunction
- Displays of inappropriate sexual behavior
- Withdrawal
- Acting out

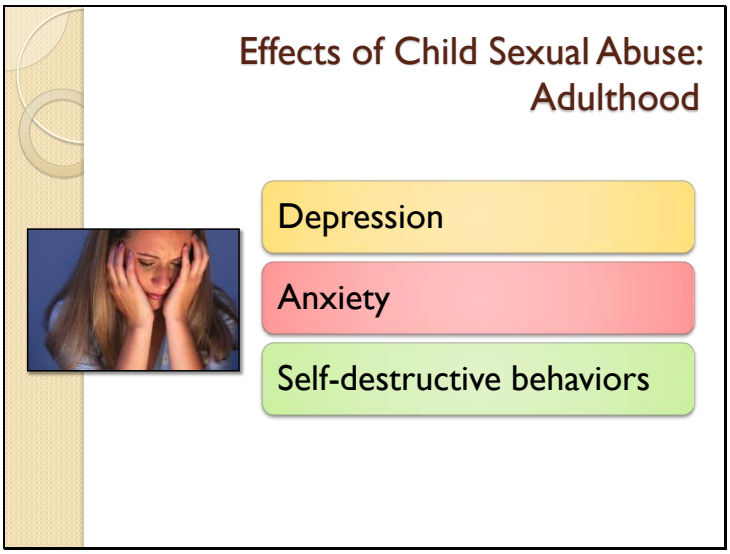
Slide 13



An Indication of Sexual Abuse

The strongest indication that a child has been sexually abused is inappropriate sexual knowledge, sexual interest, and sexual acting out by that child.

Slide 14



Effects of Child Sexual Abuse: Adulthood

For many, the effects of child sexual abuse continue long into adulthood. Adults who were child victims of sexual abuse commonly experience depression and high levels of anxiety, including anxiety attacks, situation-specific anxiety disorders, and insomnia. They may also engage in self-destructive behaviors such as alcoholism or drug abuse.

Slide 15

Additionally, adult personal relationships can be significantly impacted, as well as their adult sexual functioning. Adult survivors of sexual abuse are more likely than their non-abused counterparts to experience revictimization. They are more likely to be the victims of rape or to be involved in physically abusive relationships.

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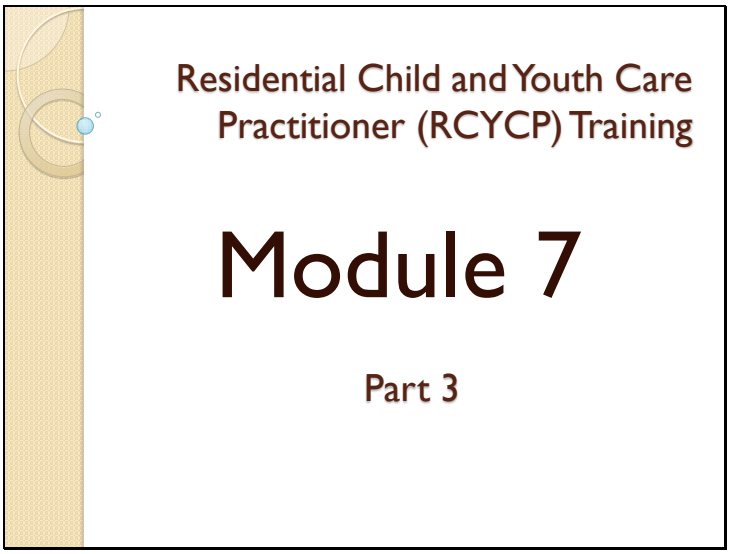

Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 7, Part 3 of the Residential Child and Youth Care Practitioner Training.

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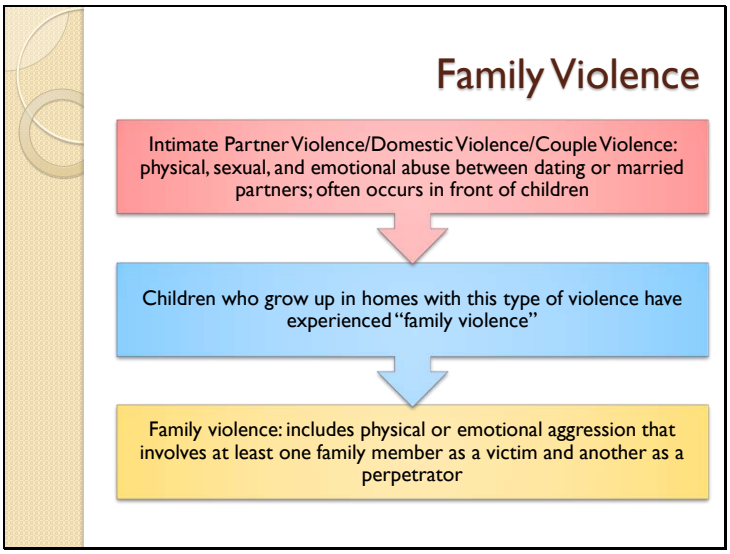

Family Violence

Intimate Partner Violence, or IPV, which is sometimes referred to as domestic violence or couple violence, encompasses physical, sexual, and emotional abuse between dating or married partners and often occurs in front of children. Children who grow up in homes where this type of violence occurs are said to have experienced "family violence." Family violence does not have to occur between intimate partners. Family violence includes physical or emotional aggression that involves at least one family member as a victim and another as a perpetrator (for example, siblings, grandparents, or cousins). This means that a child with a sibling who is the target of a family member's emotional or physical aggression can be said to be experiencing family violence, regardless of whether the child himself or herself is also on the receiving end of the aggression.

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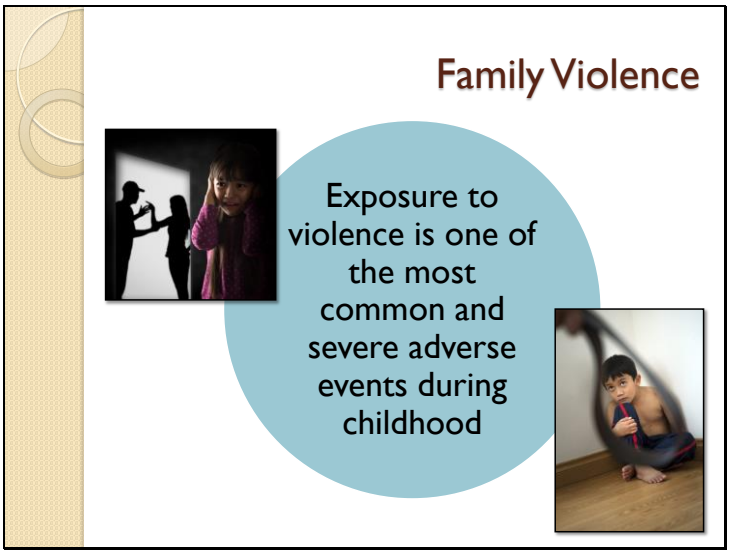

Family Violence

Youth's exposure to violence in the home occurs at high rates and is often noted as one of the most common and severe adverse events during childhood. Research indicates that each year, domestic violence occurs in the homes of approximately 30% of youth living with two parents. Since this statistic does not include other types of family violence, it can be said that the rate of youth who experience family violence is significantly higher.

Slide 5

The Experience of Family Violence: The Aftermath

The experience of family violence has an extremely profound and lasting effect on the children and adolescents who grow up in such environments and are witness to the violence, whether they are aware of the effect or not. These children also experience the aftermath of violence, such as moving to a shelter or witnessing police intervention. Because of their ages and developmental stages, however, the effects of family violence are different for children compared to adolescents.

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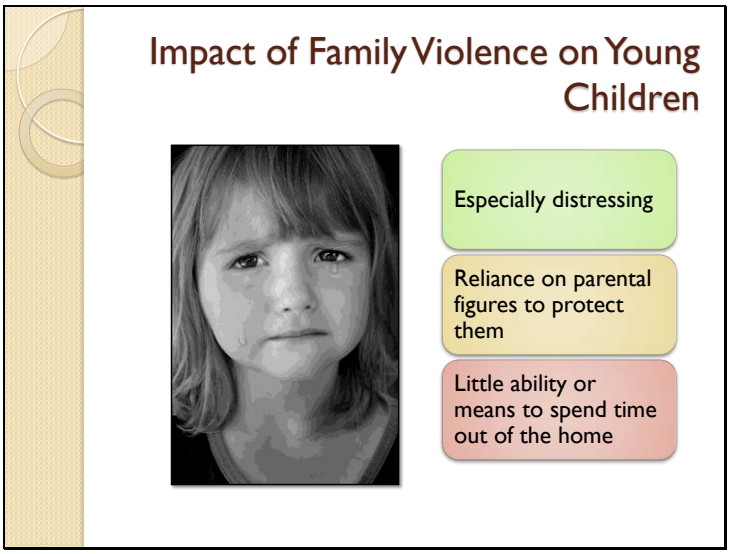

Impact of Family Violence on Young Children
Let's begin with the impact of family violence on young children. It is during this developmental time period that children are strongly bonded to their parents, are developing their concept of self-worth, learning prosocial behavior with others, and are developing emotional regulation.

For preschool children, witnessing interparental violence is especially distressing because they rely on parental figures to protect them from dangers and make their environment safe and predictable. And because they are at such a young age, they have little ability or means to spend significant time out of the home.

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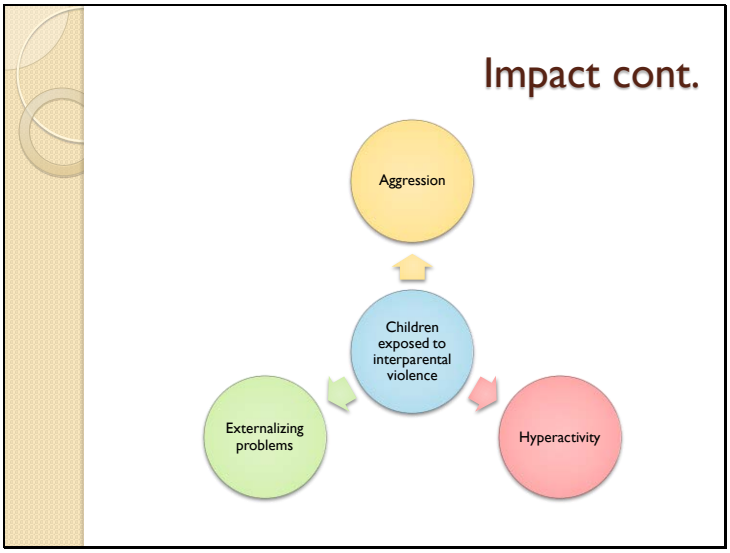

Research indicates that exposure to interparental violence takes a toll on children in a multitude of ways, both emotionally and physically:
Children exposed to interparental violence have an increase in aggression, hyperactivity, and externalizing problems (remember, externalizing problems means acting out);

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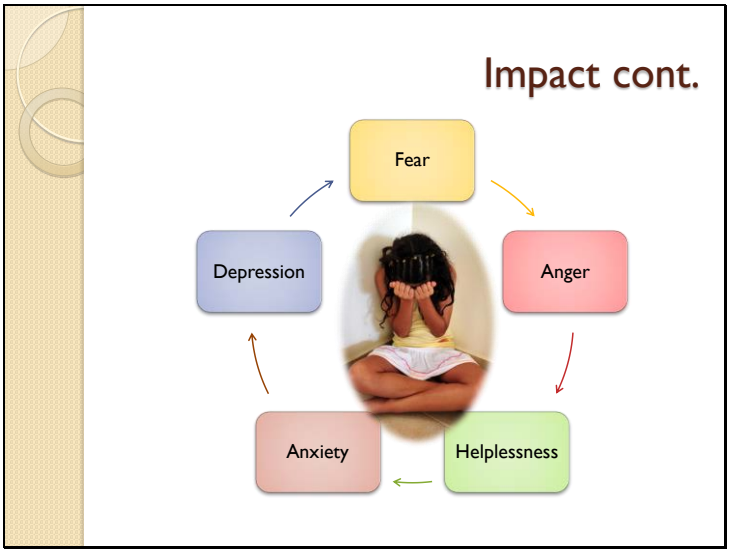

Children experience fear and anger, which lead to feelings of helplessness, anxiety, and depression:

- In one description of children's experience with serious forms of domestic violence, their living situation was defined as a type of war zone where sometimes they feel they can predict attacks, but sometimes the aggression is unexpected – leaving them with a sense of danger and uncertainty.

Slide 9

• Depending on who is involved in the violence, one or both parents may have compromised emotional availability

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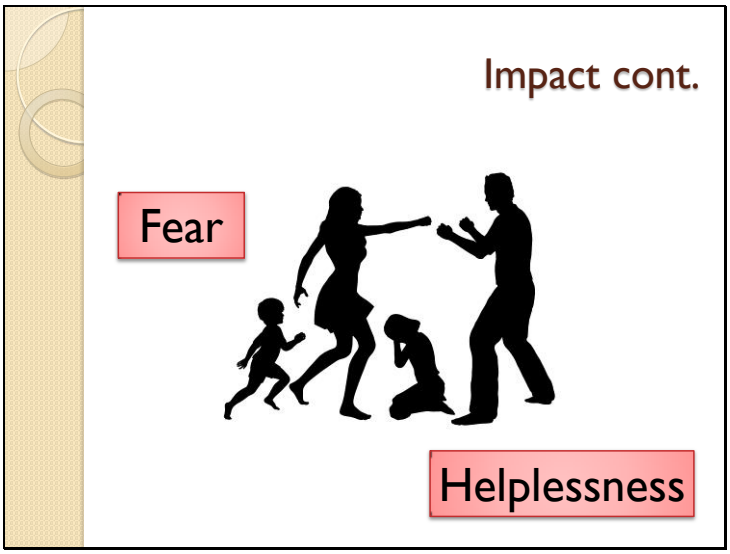

- Fear and helplessness can be particularly overwhelming when the threatened or actual injury is caused by one parent and is directed to the child, the other parent, or a sibling;

Slide 11

Children begin to view life as stressful and lonely, often believing they are not worth respect and comfort (a decline in self-worth);

- Being on the receiving end of parents' aggressive words and actions can damage children's perceptions of themselves as deserving, lovable individuals;
- It is not unusual for children to blame themselves for the abuse they receive, attributing it to their own perceived faults, behaviors, or negative traits;
- Even violence that occurs between parents (and not directly involving the child) can communicate a message of disregard for the child and lead the child to wonder: How can you care about me if you hurt my mom and destroy our family?

Slide 12

Children experience an increase in internalizing problems and social withdrawal (remember, internalizing problems means turning the stress inward and having problems internal to the child);

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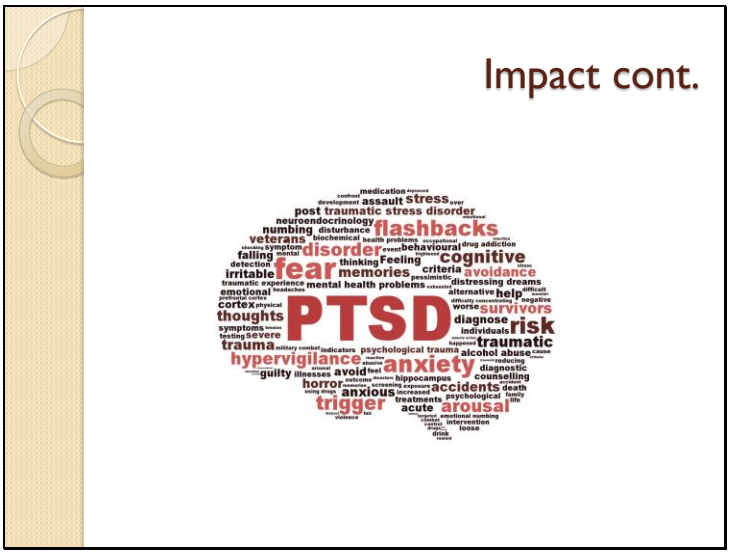

Children experience Post Traumatic Stress Disorder, or PTSD, symptoms, including talking about the violent event, an upset reaction response to memory triggers, hypervigilance, and separation anxiety:

Slide 14

• Children cannot rely on home as a safe base when threats of repeating violence are real, and there is no escape from the physical or emotional reminders of previous scary incidents

Slide 15

Children are more likely to have asthma, allergies, and gastrointestinal complications

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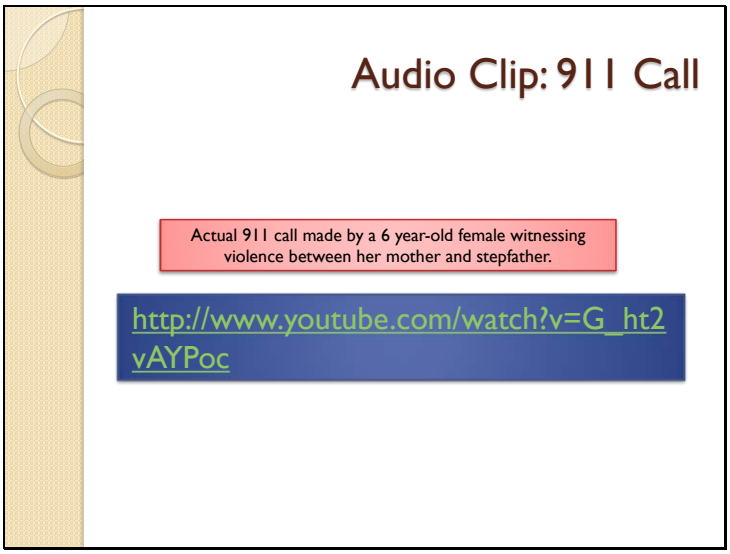


Audio Clip: 911 Call

Take a listen to this clip of an actual 911 call made by a 6 year old girl witnessing the violence between her mother and stepfather.

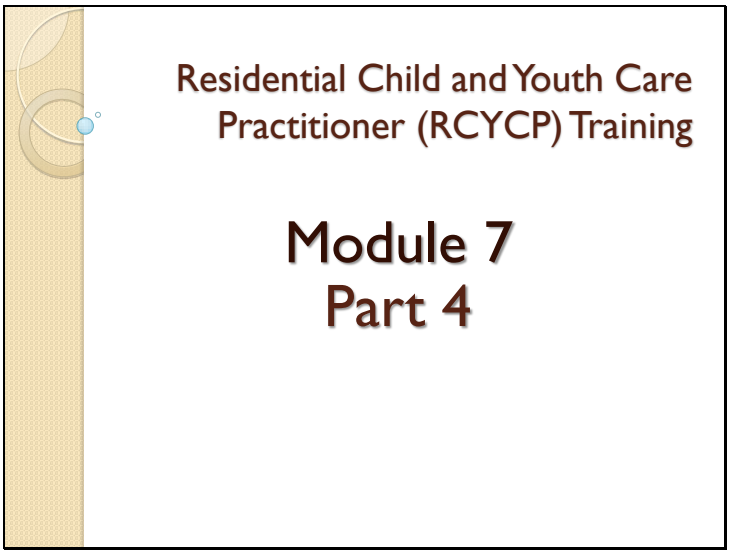
http://www.youtube.com/watch?v=G_ht2vAYPoc

Slide 17

Lisa's Story

Click on the link to read Lisa's story.
http://cdv.org/story/lisas-story/

Slide 2



Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 7, Part 4 of the Residential Child and Youth Care Practitioner Training.

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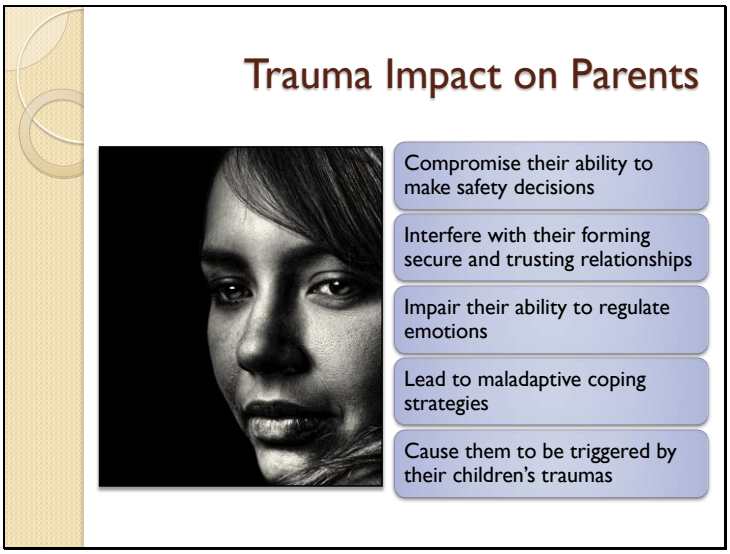

Trauma Impact on Parents

A personal history of trauma, for example in interparental violence, can affect parents too. That trauma can:

- Compromise parents' ability to make appropriate decisions about their own safety and their children's;
- Interfere with their ability to form and maintain secure and trusting relationships with their children, partners, and service providers;
- Impair parents' ability to regulate their emotions;
- Lead to maladaptive coping strategies, including substance abuse; and
- Cause parents to become triggered by their children's traumas and/or systems interventions.

(National Child Traumatic Stress Network, Child Welfare Committee, 2011)

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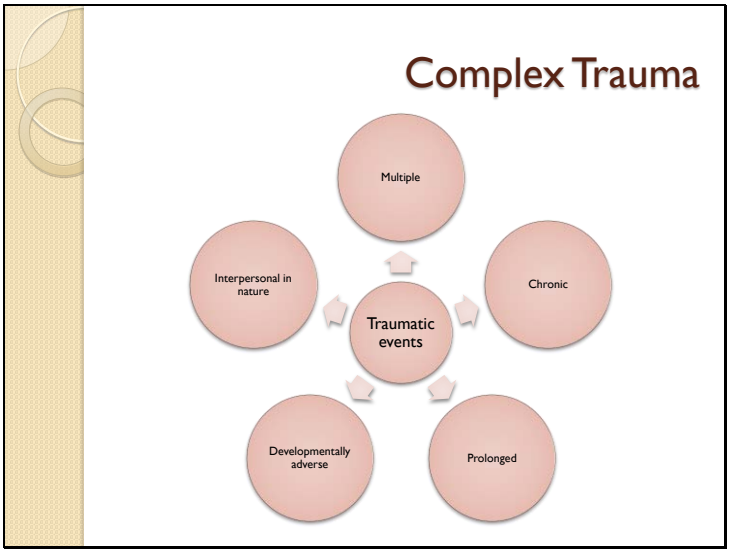

Complex Trauma

Complex Trauma: in some cases, children experience what is termed “complex trauma,” which refers to “the experience of multiple, chronic, and prolonged developmentally adverse traumatic events, most often of an interpersonal nature (e.g., sexual or physical abuse, war, community violence) and early life onset” (Margolin & Vickerman, 2007, p.4).

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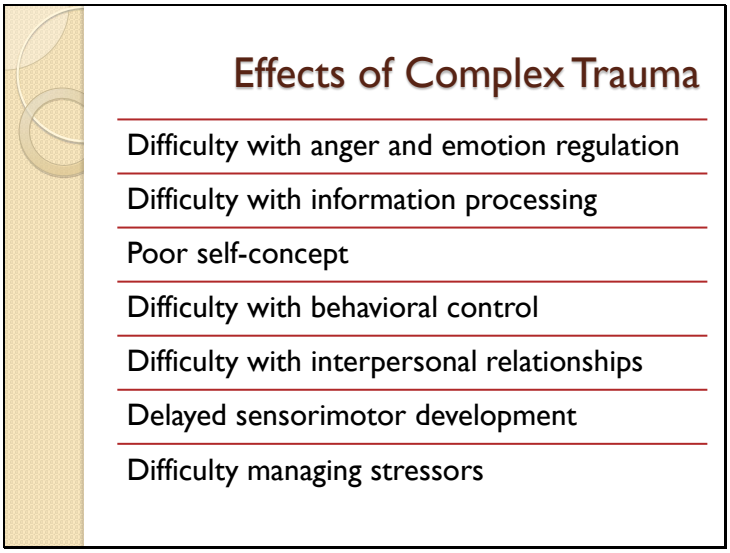

Effects of Complex Trauma

Complex trauma can result in:

- Difficulty with anger and emotion regulation;
- Difficulty with information processing, including attention, concentration, learning difficulties, and consciousness (for example, amnesia);
- Poor self-concept, including guilt and shame;
- Difficulty with behavioral control, including aggression and substance abuse;
- Difficulty with interpersonal relationships, including problems with trust and intimacy;
- Delayed sensorimotor development; and
- Difficulty managing stressors, such that even minor stressors can lead to serious distress.

Slide 6

Video: Early Adversity for Children

Click on the link to watch a short video on early adversity for children (affecting the brain) – The Impact of Early Adversity on Children's Development (3:53)
Http://www.youtube.com/watch?v=chhQc0HShCo

Slide 7

Adolescents and Family Violence

Adolescents are no less affected by family violence than young children, although it may manifest itself slightly differently. It is important to remember that adolescents who experience family violence have likely grown up with family violence, and thus were affected at an early age as well.

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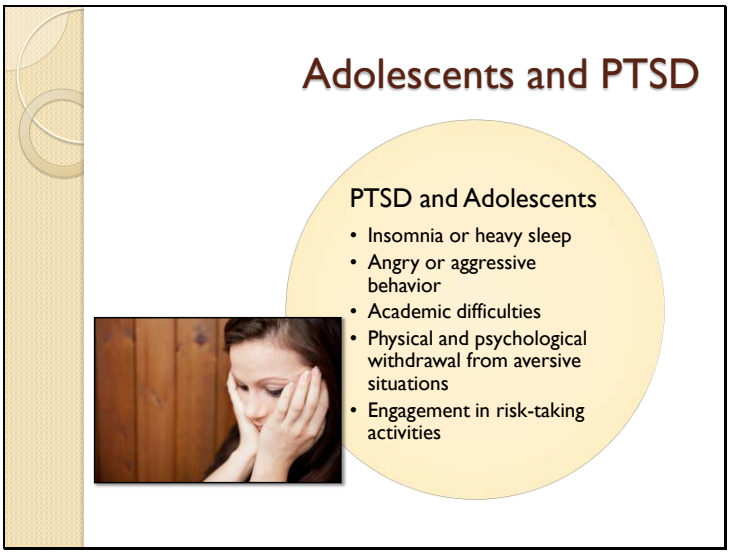

Adolescents and PTSD

Similar to young children, adolescents experience Post Traumatic Stress Disorder (PTSD) symptoms as well. In addition to those symptoms, adolescents might also experience:

- Insomnia or withdrawal into heavy sleep;
- Angry or aggressive behavior;
- Academic difficulties;
- Physical and psychological withdrawal from aversive situations; and
- Engagement in risk-taking activities, such as alcohol, drug abuse, suicide, eating disorders, delinquency, school truancy and suspension, and violence in dating relationships. Such behaviors then put them at further risk for aggression, violence, and social rejection, thus exacerbating the initial PTSD.

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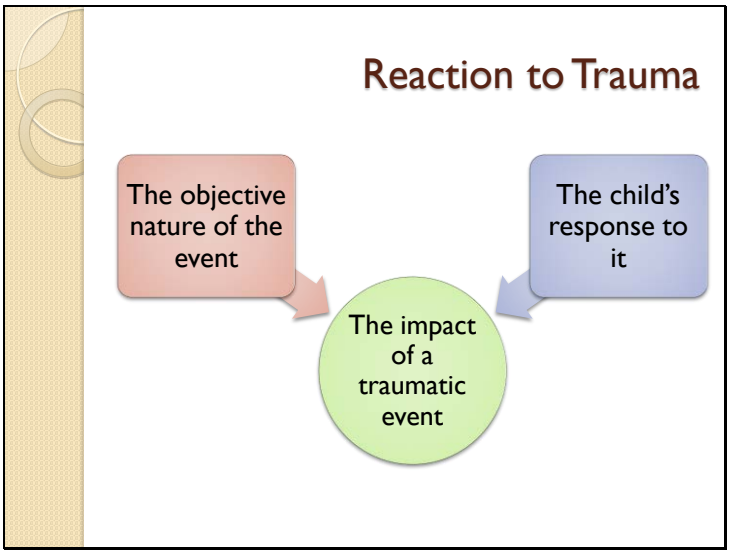

Reaction to Trauma

Not everyone reacts to trauma the same way. There is variability in the response to stressors and traumatic events that is based on the following:

The impact of a potentially traumatic event is determined by both:

- The objective nature of the event, and
- The child's subjective response to it.
- Something that is traumatic for one child may not be traumatic for another.

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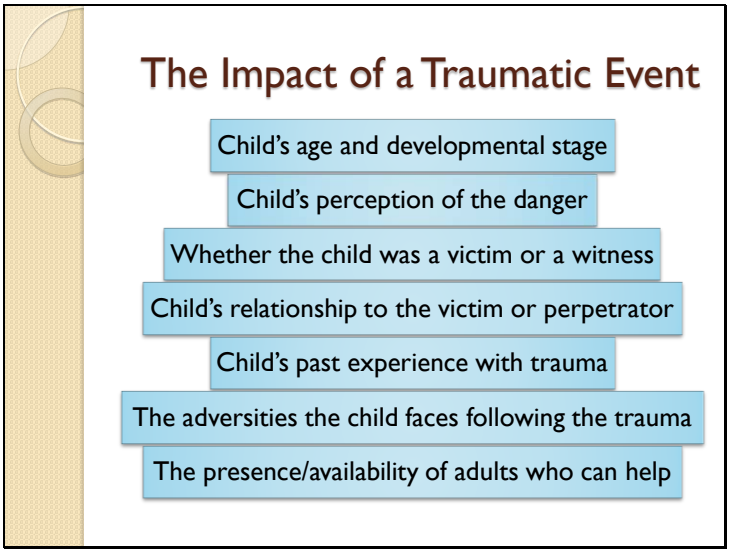

The Impact of a Traumatic Event

The impact of a potentially traumatic event depends on several factors, including:

- The child's age and developmental stage,
- The child's perception of the danger faced,
- Whether the child was the victim or a witness,
- The child's relationship to the victim or perpetrator,
- The child's past experience with trauma,
- The adversities the child faces following the trauma, and
- The presence/availability of adults who can offer help and protection.

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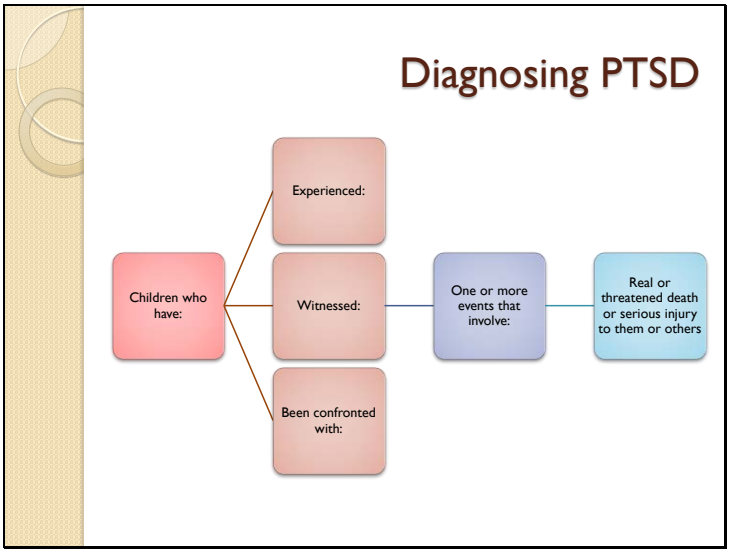

Diagnosing PTSD

In some cases, children who have experienced chronic or complex trauma may be diagnosed with post-traumatic stress disorder. According to the American Psychiatric Association's Diagnostic and Statistical Manual, PTSD may be diagnosed in children who have experienced, witnessed, or been confronted with one or more events that involved real or threatened death or serious injury to their physical integrity or that of others. In children under six, this may include learning that a traumatic event occurred to a parent or caregiver. (American Psychiatric Association, 2013)

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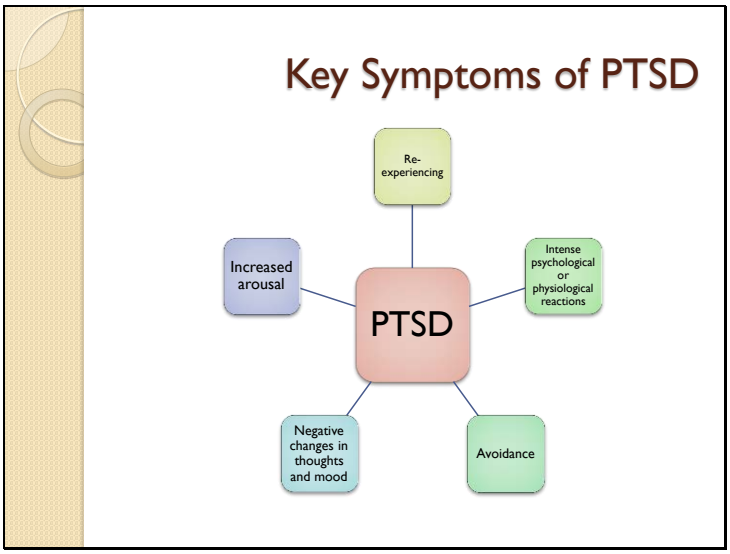

Key symptoms of PTSD include:

- Re-experiencing the traumatic event (for example, nightmares, intrusive memories);
- Intense psychological or physiological reactions to internal or external cues that symbolize or resemble some aspect of the original trauma;
- Avoidance of thoughts, feelings, places, and people associated with the trauma;
- Negative changes in thoughts and mood (such as the inability to recall aspects of the trauma, feelings of fear, guilt, sadness, shame or confusion, and loss of interest in activities); and
- Increased arousal (including heightened startle response, sleep disorders, and irritability).

Many children show signs of post-traumatic stress but do not meet the full diagnostic criteria for PTSD.

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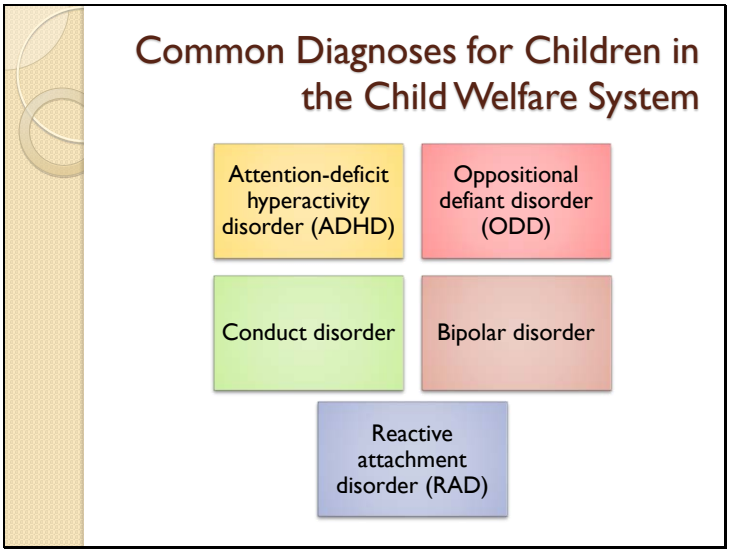

Common Diagnoses for Children in the Child Welfare System

Other common diagnoses for children in the child welfare system include:

- Attention-deficit hyperactivity disorder (ADHD)
- Oppositional defiant disorder (ODD)
- Conduct disorder
- Bipolar disorder
- Reactive attachment disorder (RAD)

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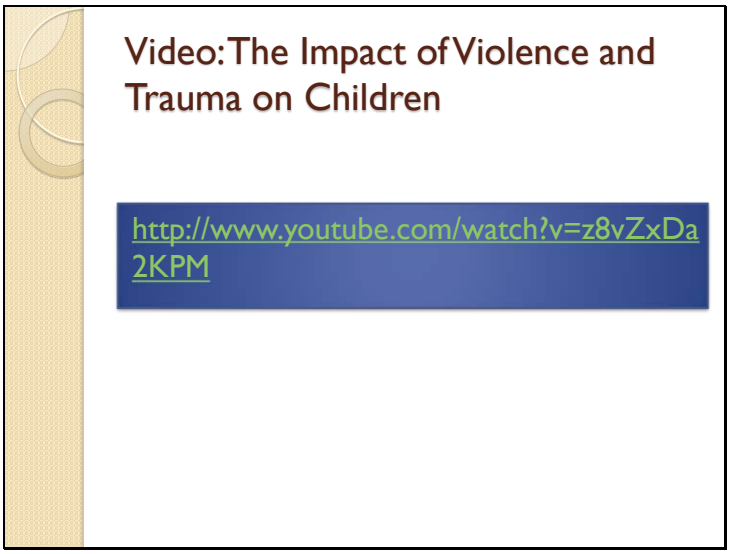

Video: The Impact of Violence and Trauma on Children

Click on the link to watch a short video about the impact of violence and trauma on children.
Through Our Eyes: Children, Violence, and Trauma—Introduction (7:53)
http://www.youtube.com/watch?v=z8vZxDa2KPM

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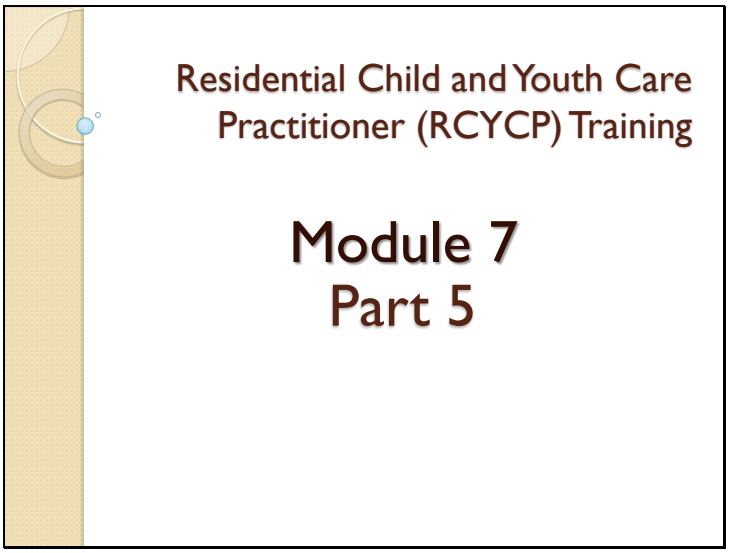

Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 7, Part 5 of the Residential Child and Youth Care Practitioner Training.

Slide 3

Impact of Loss, Separation, & Out-of-Home Placement

Let's talk now about the impact of loss, separation, and out-of-home placement on children and youth who are removed from their home due to the types of traumas just discussed.

Every year, 2 million children come into contact with the child welfare system due to investigations of family violence, parental abuse, or neglect. Many of these children end up being removed from the home and placed in temporary living situations, such as foster care or other residential placements like group homes. While it can be important and necessary to remove children from their home, it is equally important to recognize the traumatic impact that removal can have on such children and adolescents.

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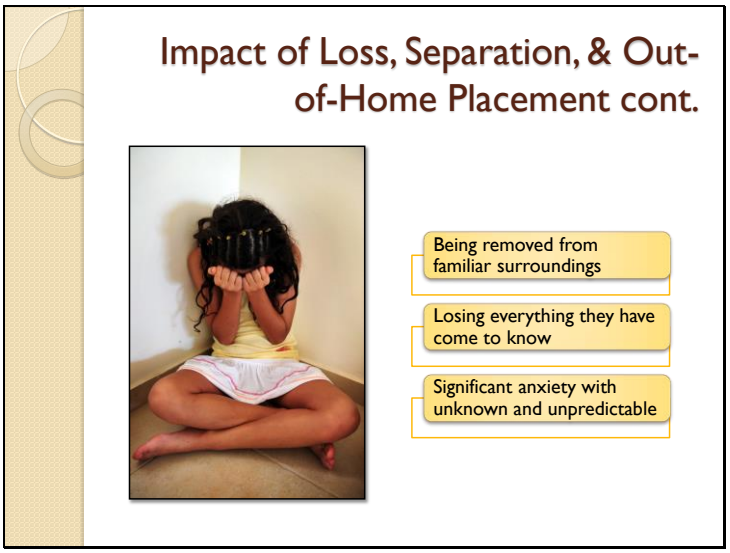

In addition to the trauma of the specific events surrounding removal from the home (like family violence and abuse), children and adolescents suffer the trauma of being removed from familiar surroundings and losing everything that they have come to know. Even if they are being removed from poor circumstances, there is significant anxiety associated with the unknown and unpredictable.

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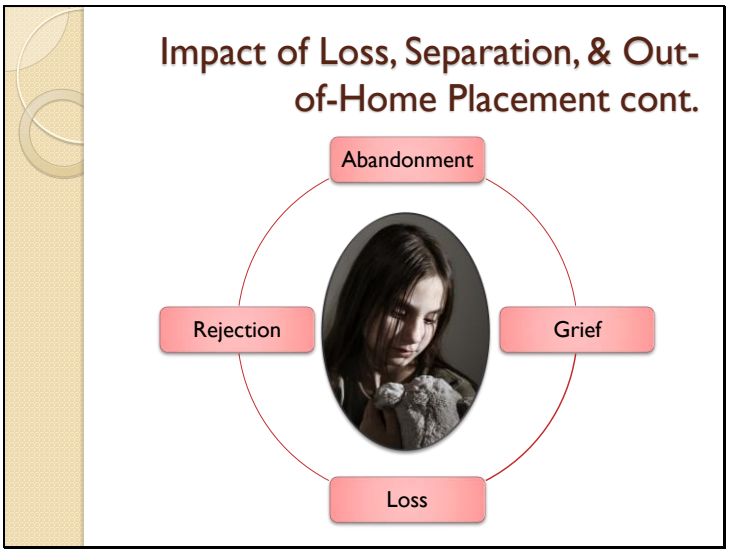

Separation from family can be devastating for kids, even when parents have been abusive. This separation disrupts the attachment process and can leave children with deep-rooted feelings of abandonment, grief, loss, and rejection. The attachment disruption is particularly harmful to infants and young children, and can result in significant negative developmental outcomes like those discussed previously in the section on attachment.

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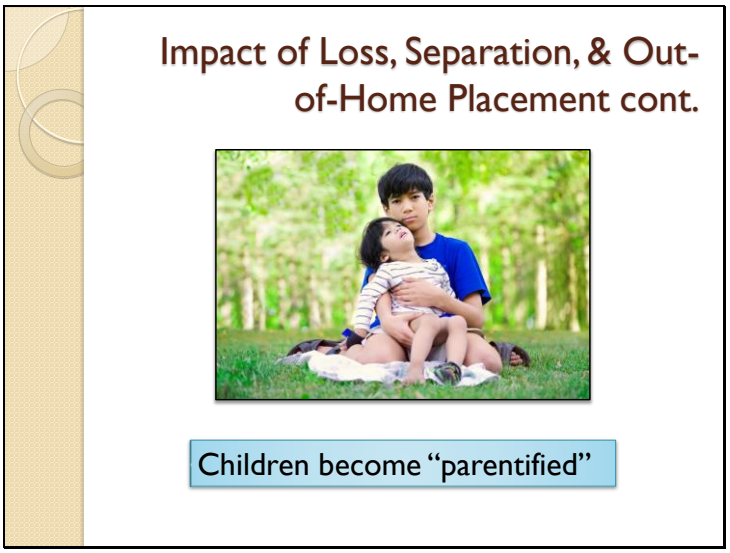

Youth may also be separated from siblings, again causing significant grief, loss, and anxiety. Often, children become "parentified" through this process – that is, taking on the worry for parents and siblings, something that should be reserved for adults.

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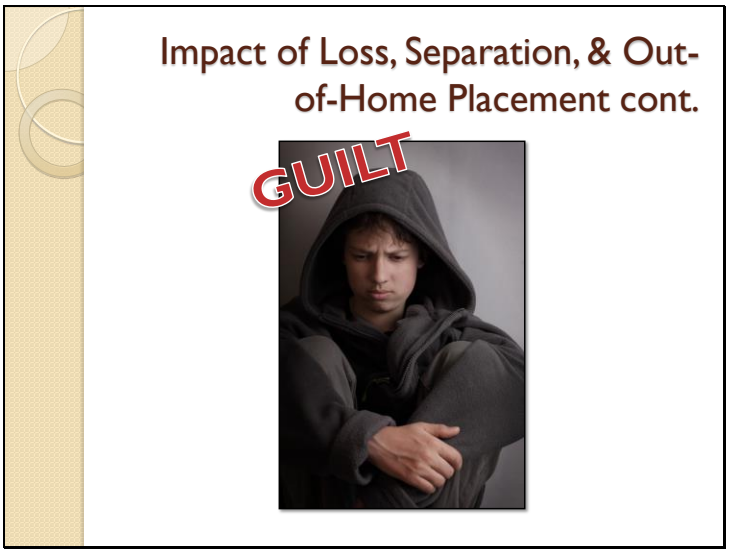

Frequently, youth experience some level of guilt with removal from the home, feeling as if they are the reason that their family has been broken up. For example, if a child is removed from the home due to sexual abuse or physical abuse, the child often feels responsible for the breakup of the family, and believes he or she is responsible for having to live in foster care.

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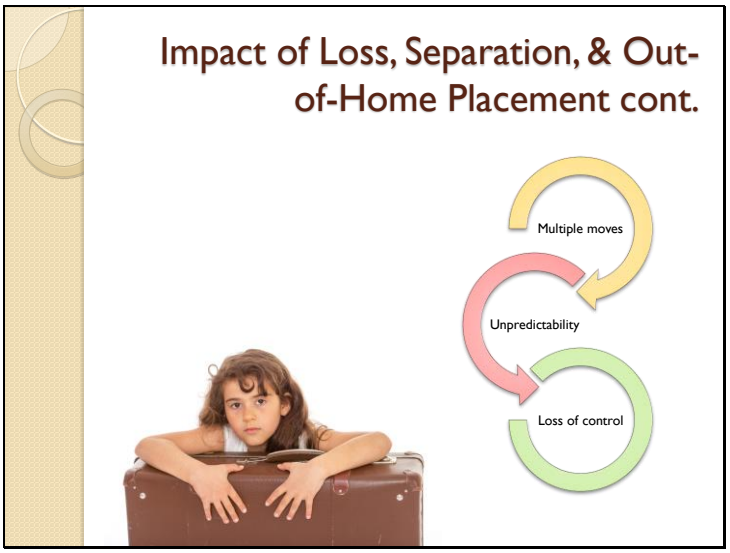

Often there is placement instability as well. For various reasons, many children move multiple times from home to home, furthering their feelings of unpredictability and loss of control. New friendships and relationships established are then disrupted, causing further distress to the youth. Children and adolescents may begin to expect and fear that they can be removed and replaced at any time. So while this process of separation, removal, and placement can be necessary for children and adolescents, it comes with significant negative consequences for them as well.

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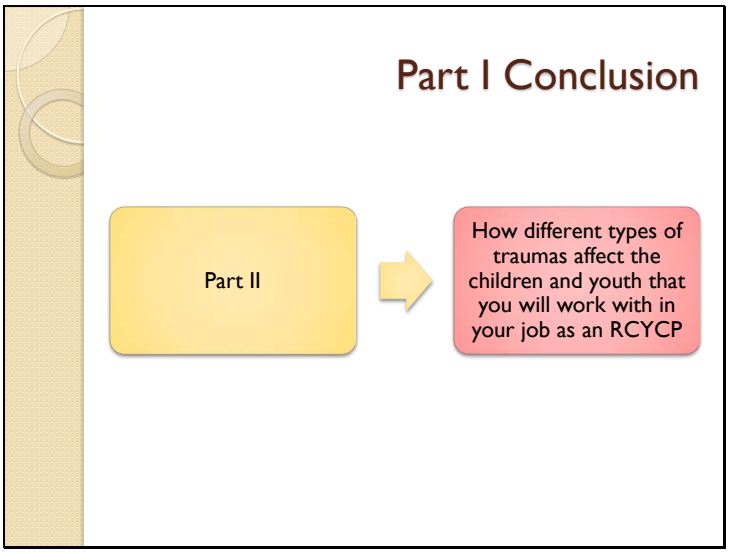

Part I Conclusion

This concludes part one of this module.

In part two of this module you will hear how these different types of traumas affect the children and youth that you will work with in your job as an RCYCP.

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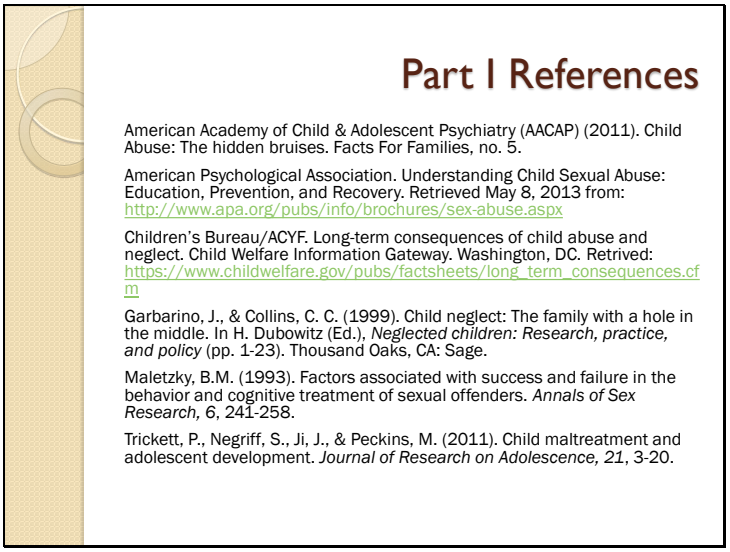

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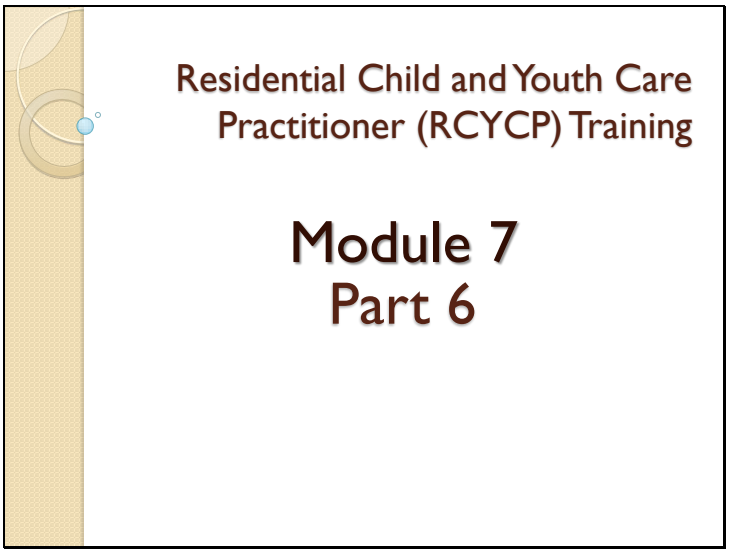
Trickett, P., Negriff, S., Ji, J., & Peckins, M. (2011). Child maltreatment and adolescent development. Journal of Research on Adolescence, 21, 3-20.

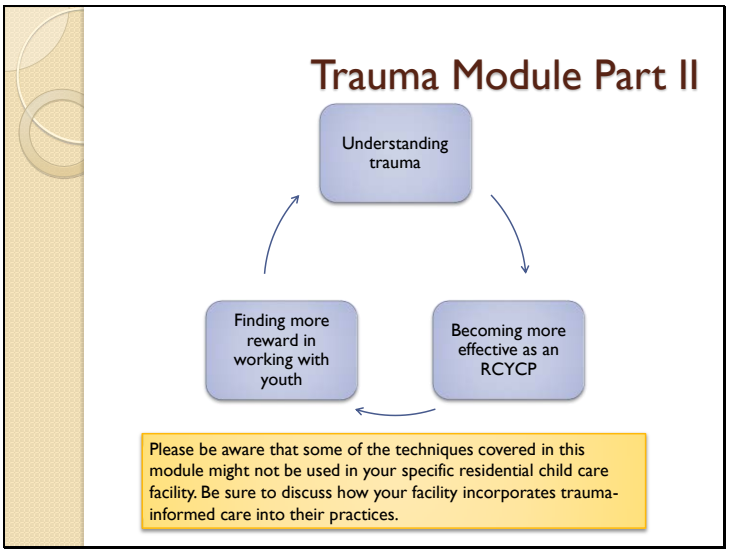
Slide 2



Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 7, Part 6 of the Residential Child and Youth Care Practitioner Training.

Slide 3



Trauma Module Part II

Welcome to part II of the Trauma module. This portion of the module uses training materials from the National Child Traumatic Stress Network (NCTSN). The slides from NCTSN, which are used with their full permission, are blue and are labeled as such.

In this module you will learn approaches and techniques to reduce the stress you face every day in interacting with traumatized youth. By understanding trauma, you'll become more effective at your job, and find more reward working with the youth in your care. Please be aware, however, that some of the techniques covered in this module might not be used in your specific residential child care facility. Be sure to discuss how your facility incorporates trauma-informed care into their practices.

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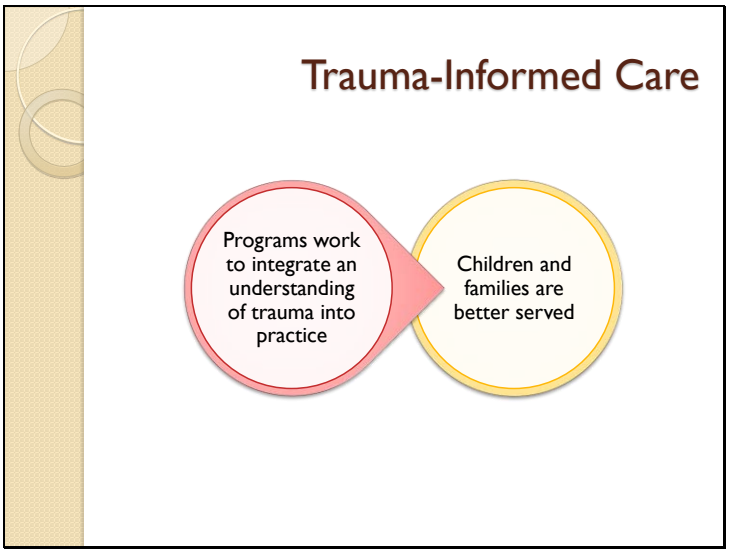

Trauma-Informed Care

Let's begin with a discussion of trauma-informed care. What does trauma-informed care mean? Essentially, trauma-informed care means that programs work to integrate an understanding of trauma into practice when working with children and families with a history of trauma. By doing so, the idea is that children and families are better served. The National Child Traumatic Stress Network considers the following seven components to be essential elements of a trauma-informed child welfare system.

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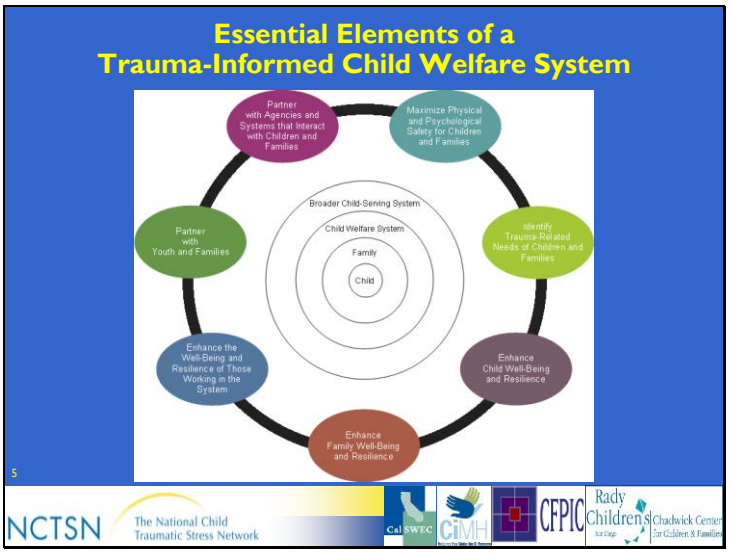

Essential Elements of a Trauma-Informed Child Welfare System

1. Maximize physical and psychological safety for children and families.

Although safety is one of the priorities of the child welfare system, individuals who have experienced trauma may still feel unsafe even when they are no longer in a dangerous situation. Given this, in addition to ensuring physical safety, it is important to help children and families feel psychologically safe. For example, this might mean explaining to children where they are going, with whom they will be staying, and ensuring that children have understood and been able to process information given to them.

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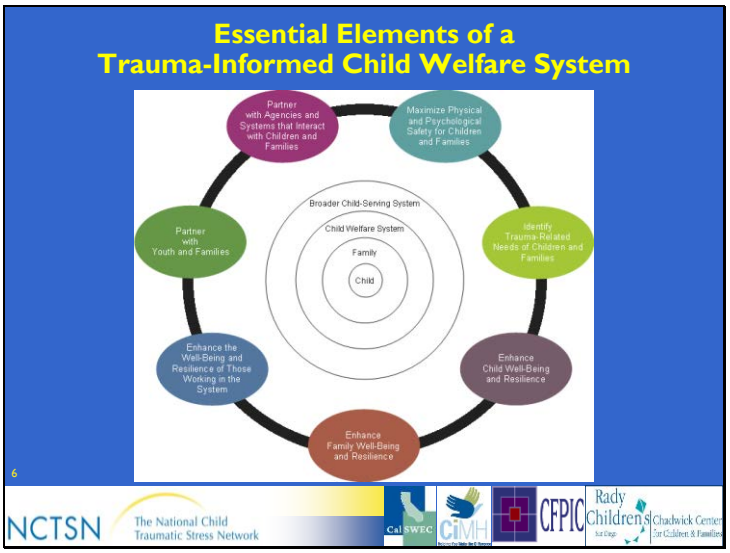
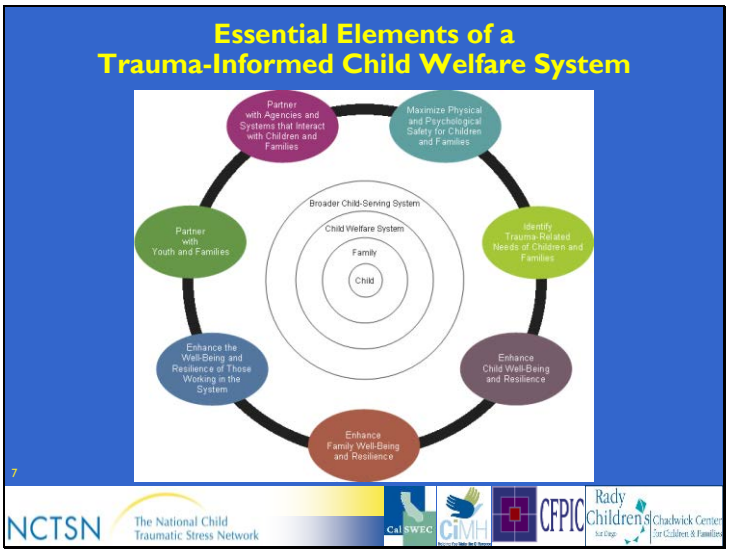


2. Identify trauma-related needs of children and families.

In order to help those who have been impacted by abuse, neglect, violence and other trauma, one must understand how trauma impacts children, families, and parents both generally and on an individual level. That means that child welfare staff, such as RCYCPs, should receive mandatory training on the effect of traumatic events on individuals at different ages and in different cultural contexts.

Slide 7



3. Enhance child well-being and resilience.

Some children who have experienced maltreatment and subsequent trauma are more resilient than others; most often these children have both internal and external resources (such as a strong relationship with an adult), success in school or other activities, and/or a temperament that helps them manage stress more readily. Child welfare systems should recognize and build on children's existing strengths, while linking them to trauma-informed services when needed. So for example, familiar and positive figures – including parents, teachers, neighbors, siblings, and other relatives -- remain involved in children's lives. Also, this concept means that children who have experienced traumatic events have access to trauma-based services and treatments when available and appropriate.

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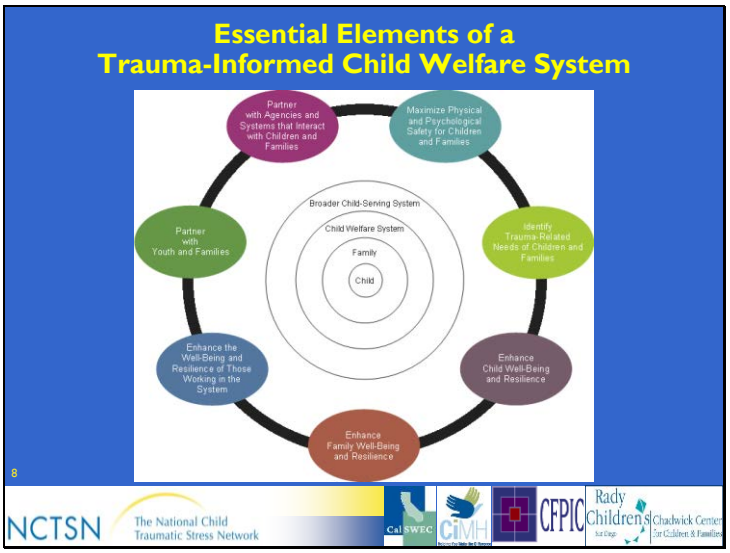

4. Enhance family well-being and resilience.

Families are a critical part of both protecting children from harm and enhancing their natural resilience. However, families and other caregivers may find it difficult to be protective if they have been affected by trauma and may need help and support in order to draw on their natural resources. Therefore, parents and caregivers who have experienced trauma should also be given services, treatment, and education to enhance their protective capacities, thereby increasing their children's resilience, safety, permanency, and well-being. Also, child welfare agencies should recognize that caregivers may also experience secondary traumatic stress related to their children's trauma and provide them with appropriate education and supports.

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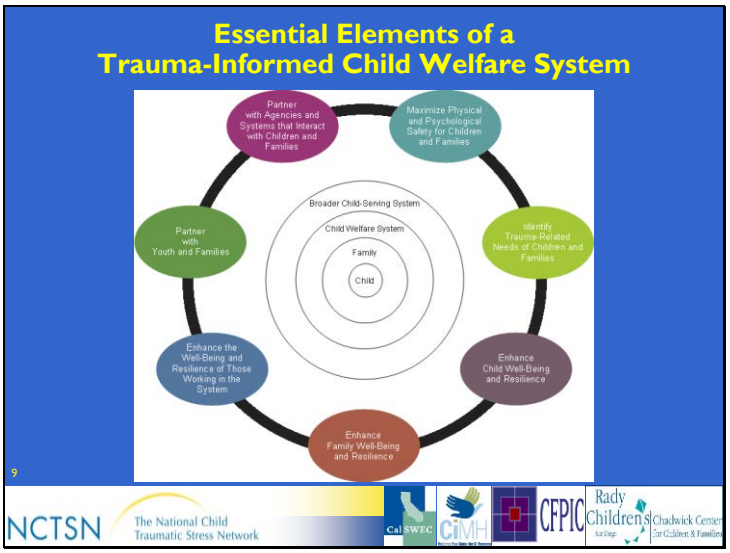

5. Enhance the well-being and resilience of those working in the system.

While child welfare staff play an important role in supporting children, their work with people who have experienced abuse, neglect, violence, and other trauma can result in secondary traumatic stress reactions. These physical and emotional responses can look similar to traumatic stress reactions and can make it difficult for staff to do their best work. Therefore child welfare workers, such as RCYCPs, need education about work-related trauma exposure, as well as support, supervision, and training to manage the effects of that secondary traumatic stress.

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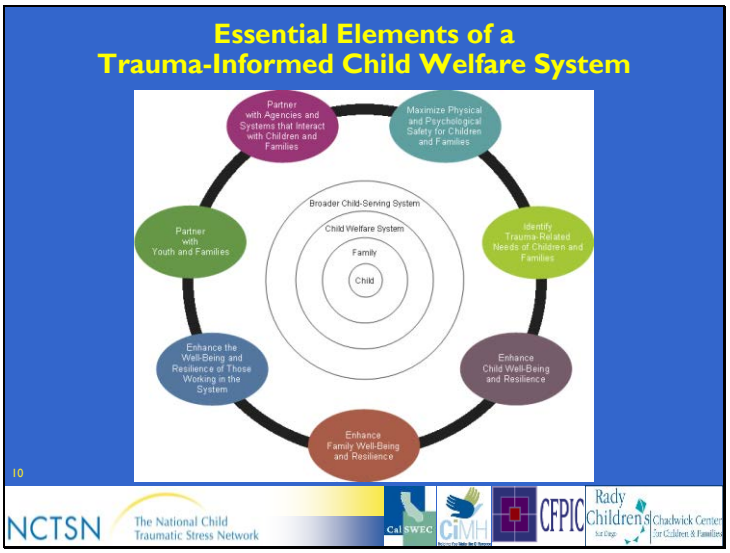

6. Partner with youth and families.

Youth and family members who have been involved in the child welfare system have a unique and valuable perspective. Youth and families must play an active role in service planning and can provide valuable feedback on how the system can better address trauma among children and families.

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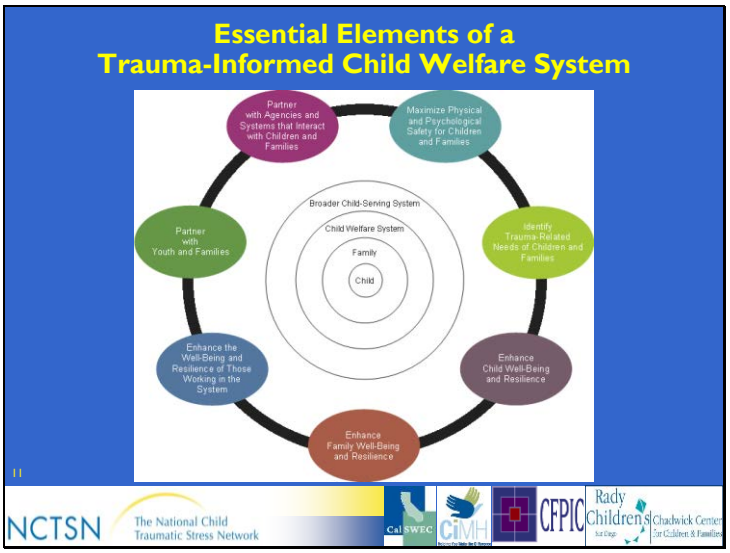
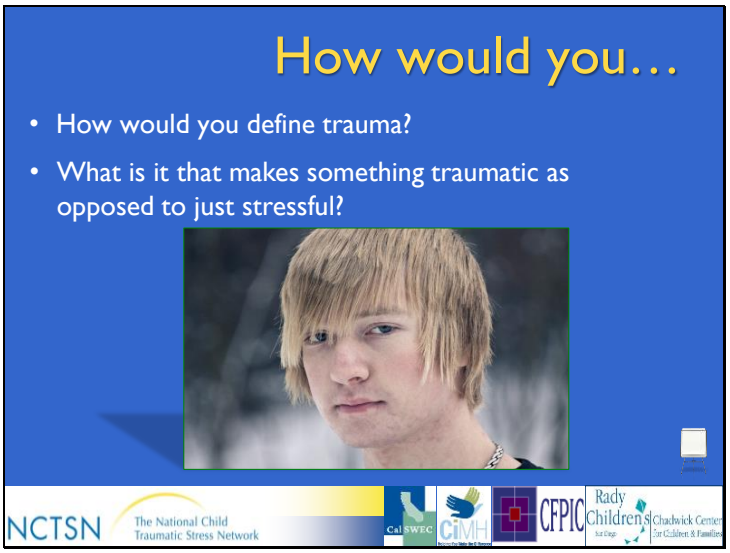


7. Partner with agencies and systems that interact with children and families.

Because trauma can affect many aspects of children's and families' lives, child welfare should partner with other service systems (for example, mental health, schools, the courts, law enforcement, domestic violence, and substance abuse programs) in identifying and addressing trauma.

Now that you know what trauma-informed care is, let's move on to helping you become a trauma-informed RCYCP. We will begin with a discussion of trauma.

Slide 12



How would you…

What is it that makes something traumatic as opposed to just stressful?

Slide 13

What is Trauma?

According to mental health experts, a traumatic event is different from an everyday upsetting event in a couple of important ways:

- A traumatic event threatens our lives or bodily integrity. It can also be traumatic to witness an event that threatens the life or bodily integrity of someone we love.
- Traumatic events cause us to experience an overwhelming sense of terror, horror, and fear. Our hearts pound in our chests, and we may vomit, lose control of our bladders or bowels, feel as if we're stuck in a nightmare, or even pass out.

A child's response to an event is based on the child's perception of the event. A child's body and mind might respond to an event as life-threatening even if it is not.

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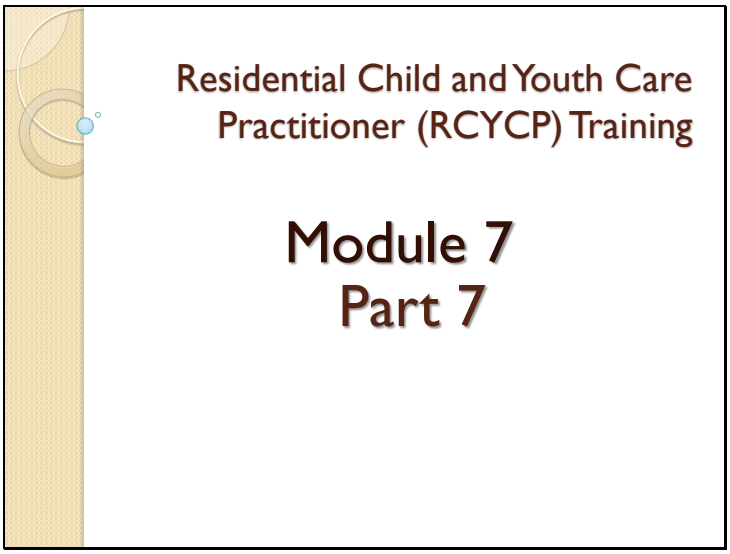

Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 7, Part 7 of the Residential Child and Youth Care Practitioner Training.

Slide 3

We Learn by Experience

Everything that we expect and believe about ourselves, about other people, and about the world that we live in, is learned through experience. Trauma is an experience that profoundly shapes how we see the world. For example, imagine that you're going for a hike and crossing a field near your home to get to the trail. You glance down, and in front of you is a huge snake. It begins to hiss and becomes defensive. How do you think you'd react?

Slide 4

We Learn by Experience

Now imagine that you need to cross another field a few days later. How do you think you'd feel about it? More than likely you're going to be watching the ground a lot more closely! If you happen to see an old rubber hose that someone dropped, you're likely to startle, even before the thought "Augh! Snake!" reaches your conscious awareness. Even if you'd been hiking many times before without seeing a snake, seeing a snake changes your expectations of hiking, and puts you on the lookout for danger.

That's because it's a lot safer to mistake a hose for a snake than to not recognize a snake.

Slide 5

The Fear Response in the Brain

Although most of us don't consider fear to be a pleasant experience, it is crucial for our survival. Living without fear would be as dangerous as living without the sensation of pain. Fear prepares us to react to danger.

Even from birth, the most primitive portions of the brain are activated when an infant senses danger. In young children, the reaction may involve crying, flailing, or if mobile, running toward a caregiver. The goal of these behaviors is for the children to protect themselves.

The basic fear response begins with input from a sensory organ (your eyes, nose, mouth, or skin) to the sensory thalamus, the teal area on the drawing of the brain. Input from the ears bypasses the sensory thalamus and goes directly to the amygdala, the red area on the drawing of the brain.

The sensory thalamus encodes the sensory input, and the amygdala adds the emotional response. Together the body becomes ready to fight, flee, or freeze.

While the sensory information is being encoded, the hippocampus – the yellow area on the drawing of the brain – provides context and facilitates short-term memory that later will contribute to long-term memory of the event. The hippocampus also starts to direct the cortex toward developing a quick action plan.

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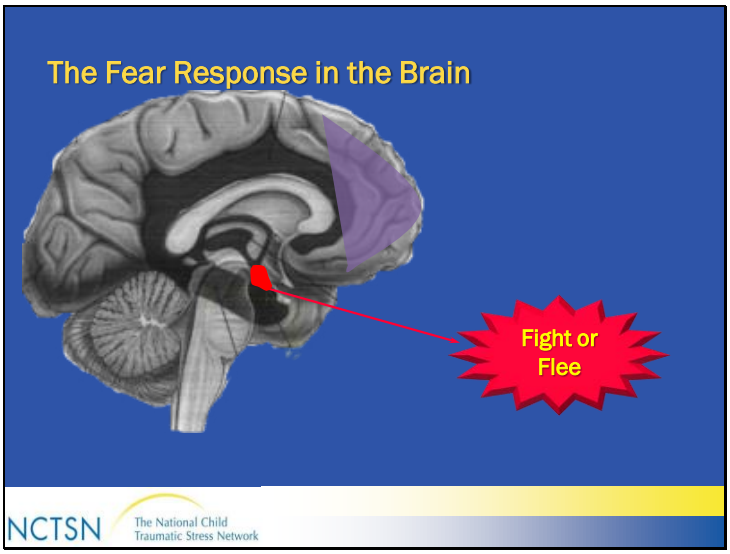

The Fear Response in the Brain

The prefrontal cortex, the purple area on the drawing of the brain, is the part of the brain designed to assist in cognition, judgment, and decision-making. The prefrontal cortex makes a calculation about the best protective action to take, which may be to flee, or fight. In some cases, the best protective action may be something else, like pushing a child out from in front of a car. This is a quick calculation that is not fully thought out.

Along with this process, the cortex is continually appraising threat and refining response. Like adults, older children and adolescents are increasingly more able to rely on their experience and learning to appraise in milliseconds the danger and potential protective response options. When the cortex determines that the threat has passed, it will send a signal to the amygdala to begin to calm the body.

What is important is that with practice and self-awareness, we can modify our fear responses, which seem totally automatic. For example, in a facility, we can tell ourselves the unit is really noisy, but noise does not equal threat.

There are many effective interventions that teach youth how to size up situations better, so that they can differentiate real danger from safe situations.

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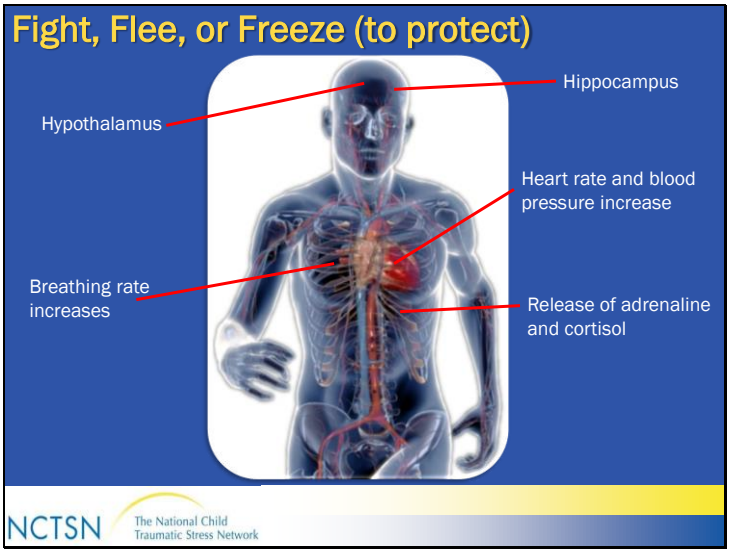


Fight, Flee, or Freeze (to protect)

Now let's review how the body prepares to respond.

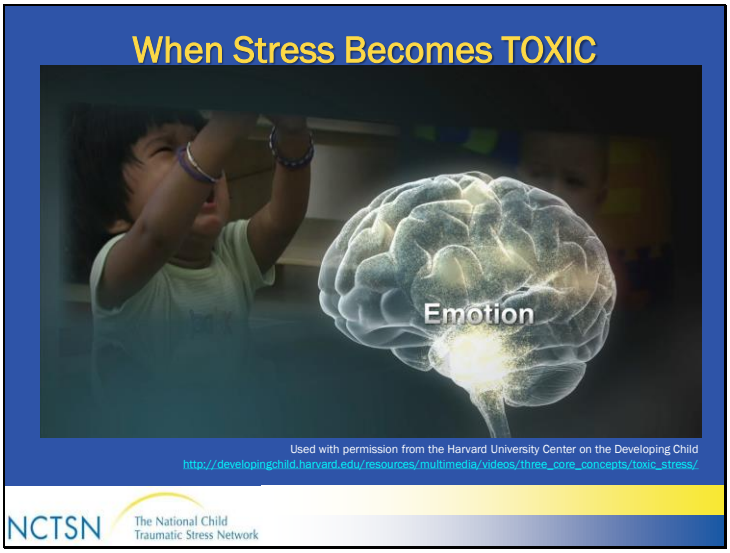
The hypothalamus, a small but important part of the brain, links the nervous system to the endocrine system. It tells the endocrine system to secrete stress hormones, such as adrenaline and cortisol, which can prepare the body to respond to threat or danger. In addition, the heart rate, blood pressure, and breathing rate all increase. Blood rushes to the muscles while digestion and the immune system are switched off. The hippocampus will store the memory of the danger.

It is important to note that the individual is in a highly alert state. The body and brain are working. Physical sensations are being encoded. These experiences and perceptions, as well as the outcome of the response, will all be used in future situations to prime the appraisal of danger.

Think about a youth who, for most of his life, observed his mother being assaulted. As a young child of 2 or 3, he have may run to the caregiver for protection (even if the caregiver was the one being assaulted). As a child of 8 or 9, he may run and hide as soon as he hears the yelling begin. His appraisal tells him that the caregiver has been unable to protect him in the past, and the offender is too big to subdue, and so it is safer to hide.

The adolescent has a more developed prefrontal cortex and more physical strength. He can use all the information gained from past experience and may decide to intervene and physically challenge the offender. The response to protect ourselves is ingrained, but our actions change with our changing appraisal of the situation.

Slide 8



When Stress Becomes TOXIC

Let's watch a brief clip to see what happens when fight, flight, or another response becomes a chronic state.

http://developingchild.harvard.edu/resources/multimedia/videos/three_core_concepts/toxic_stress/
(Toxic Stress Derails Healthy Development: 1:51)

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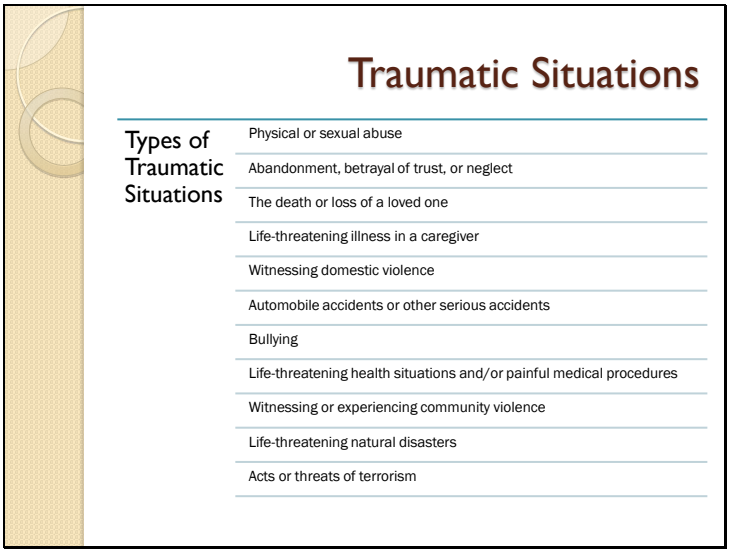

Traumatic Situations

So what types of situations can be traumatic?

- Physical or sexual abuse;
- Abandonment, betrayal of trust (such as abuse by a caregiver), or neglect
- The death or loss of a loved one;
- Life-threatening illness in a caregiver;
- Witnessing domestic violence;
- Automobile accidents or other serious accidents;
- Bullying;
- Life-threatening health situations and/or painful medical procedures;
- Witnessing or experiencing community violence (e.g., a drive-by shooting, a fight at school, or a robbery);
- Life-threatening natural disasters; and
- Acts or threats of terrorism.

Slide 10

Types of Trauma

Now let's look at different types of trauma:

- Acute trauma is a single traumatic event that is limited in time.
- Examples include:
  - Serious accidents,
  - Painful medical treatment,
  - Community violence,
  - Natural disasters (such as earthquakes, wildfires, and floods),
  - Sudden or violent loss of a loved one, and
  - Physical or sexual assault (for example, being shot or raped).
- During an acute event, children go through a variety of feelings, thoughts, and physical reactions that are frightening in and of themselves, and contribute to a sense of being overwhelmed.

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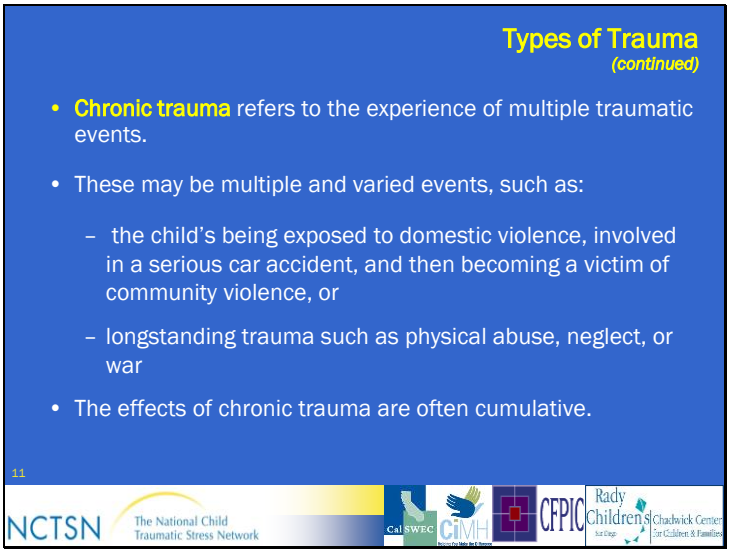

Types of Trauma (continued)

Chronic trauma refers to the experience of multiple traumatic events.

• These may be multiple and varied events — such as a child who is exposed to domestic violence, is involved in a serious car accident, and then becomes a victim of community violence — or long-standing trauma, such as physical abuse, sexual abuse, neglect, or war.
• The effects of chronic trauma are often cumulative, as each event serves to remind the child of prior trauma and reinforce its negative impact.

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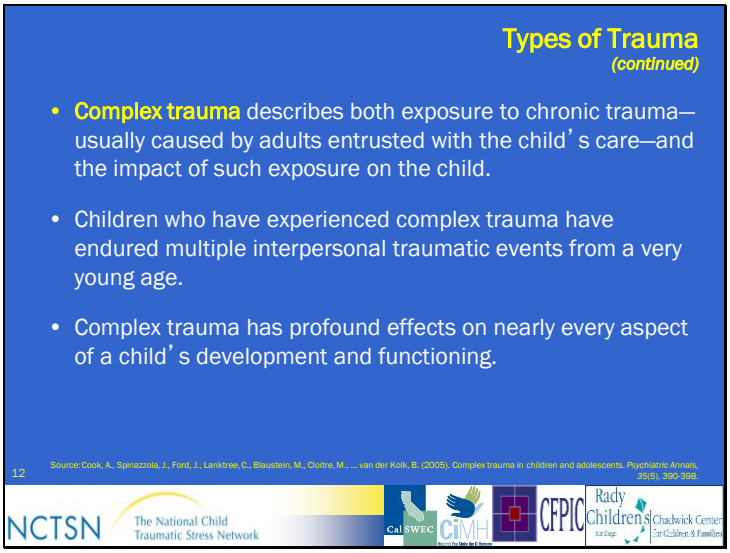
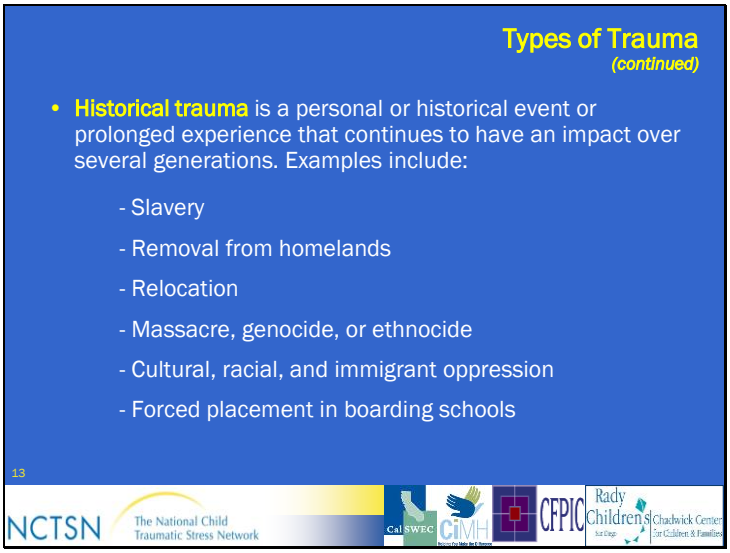


Types of Trauma (continued)

• Complex trauma describes both exposure to chronic trauma — usually caused by adults entrusted with the child's care—and the impact of such exposure on the child.
• Children who experience complex trauma have endured multiple interpersonal traumatic events from a very young age.
• Complex trauma has profound effects on nearly every aspect of a child's development and functioning.

Slide 13

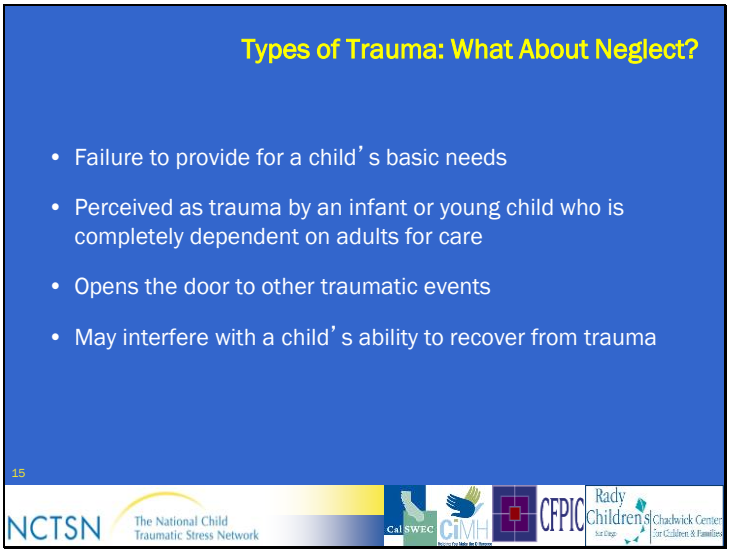


Types of Trauma (continued)

Historical trauma is a personal or historical event or prolonged experience that continues to have an impact over several generations.

- Examples include:
  - Slavery,
  - Removal from homelands,
  - Relocation,
  - Massacre, genocide, and ethnocide,
  - Cultural and racial immigrant oppression, and
  - Forced placement in boarding schools.

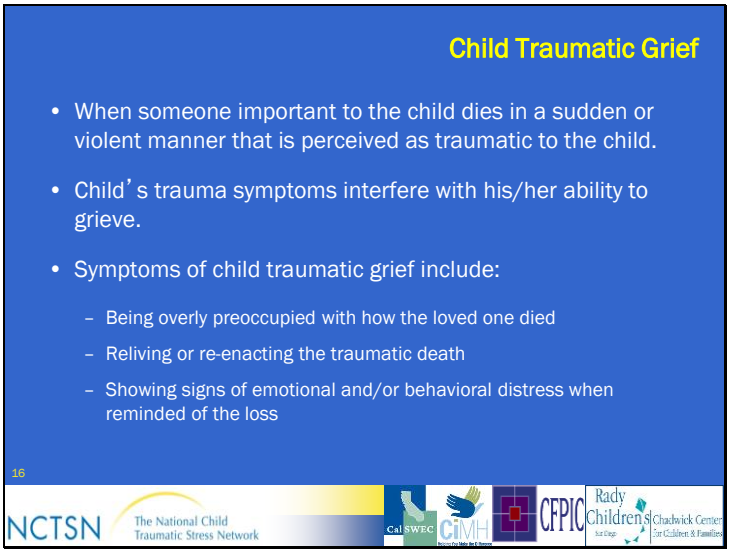
Slide 15



Types of Trauma: What About Neglect?

- Neglect can be thought of as trauma as well.
- It is a complex trauma that has profound effects on nearly every aspect of a child's development and functioning.
- It is a failure to provide for a child's basic needs.
- It is perceived as trauma by an infant or young child who is completely dependent on adults for care.
- It opens the door to other traumatic events, and it
- May interfere with a child's ability to recover from trauma.

Slide 16



Child Traumatic Grief, or CTG is:

- When someone important to the child dies in a sudden or violent manner, that is perceived as traumatic to the child.
- The child's trauma symptoms interfere with his or her ability to grieve.
- Symptoms of CTG include:
  - Being overly preoccupied with how the loved one died;
  - Reliving or re-enacting the traumatic death, which may include play that incorporates themes related to the death;
  - Showing signs of emotional and/or behavioral distress when reminded of the loss;
  - Attempting to avoid physical reminders of the traumatic death, such as activities, places, or people related to the death;
  - Withdrawing;
  - Showing signs of emotional constriction or numbing; and
  - Showing signs of a lack of purpose and meaning to one's life.

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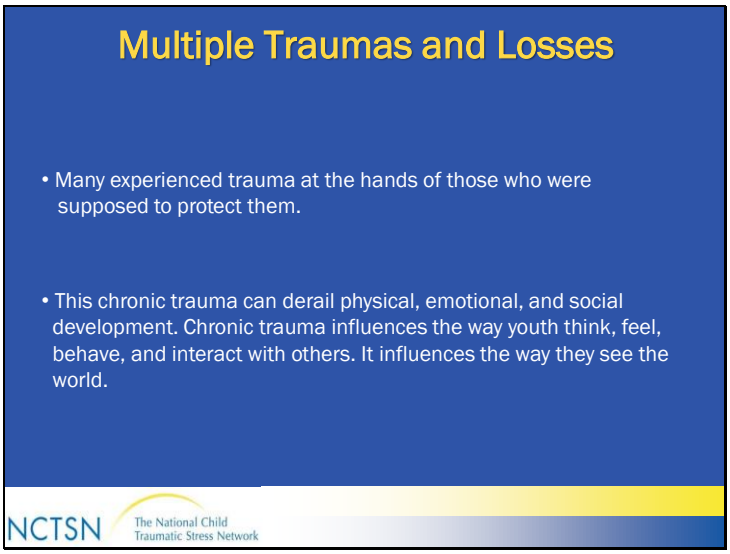

Multiple Traumas and Losses

- Many of the events that youth in residential care experience begin early in life and are at the hands of caretakers. These can be the most damaging.
- Chronic trauma can derail physical, emotional, and social development. It can influence the way youth think, feel, behave, and interact with others. It influences the way they see the world.

Slide 18

Factors which determine impact of trauma or loss

- Younger children have fewer coping skills and less ability to make sense out of their experience.
- The impact of trauma is cumulative. With each traumatic experience, a youth's coping resources are further depleted. For example, if a child was physically abused and witnessed domestic violence, but managed to function well enough, a violent assault at age 18 might bring the earlier experiences back and finally overwhelm the youth's ability to cope.

Trauma at the hand of a caregiver, especially when it begins early in life and goes on for a long time, is especially damaging. This kind of trauma interferes with the child's accomplishment of key developmental tasks, such as learning to trust.

What follows after trauma has a significant impact on a child's recovery. For example, the children in Hurricane Katrina suffered not only the immediate traumatic impact of the storm, but secondary adversities of being deprived of their homes, schools, and everything they had associated with safety. Another example: a child's mother dies, and, because there is no available kinship caregiver, she is placed in a foster home, where she's punished for acting sad.

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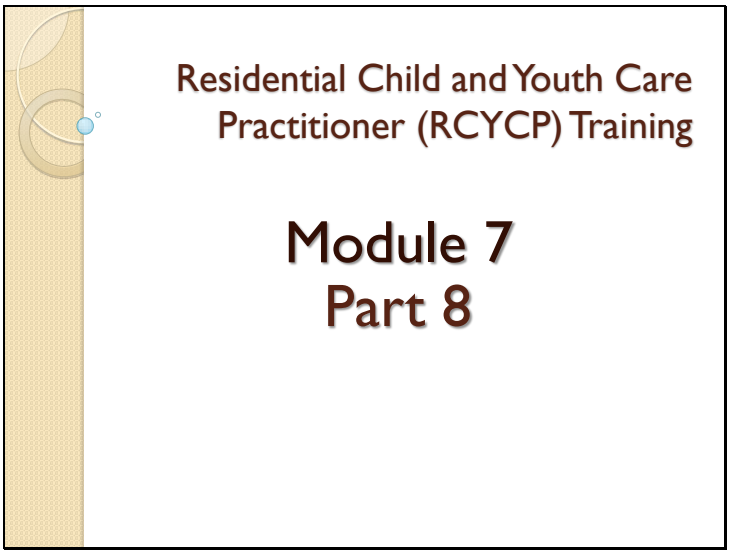
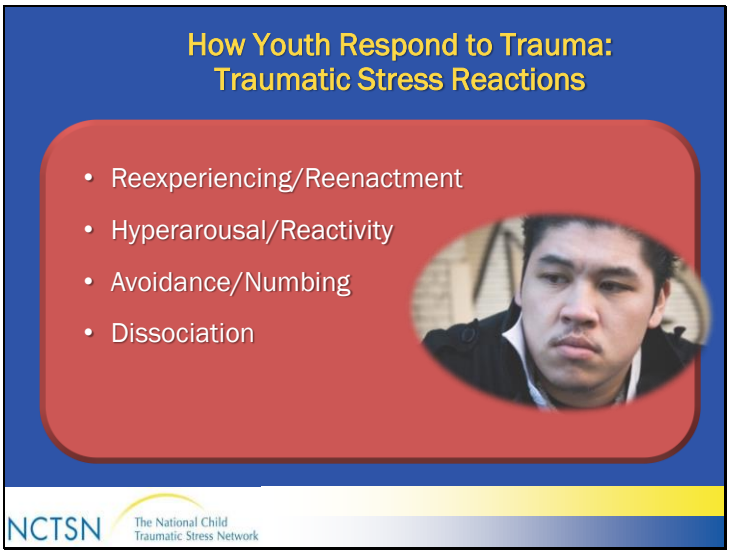


Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 7, Part 8 of the Residential Child and Youth Care Practitioner Training.

Slide 3



How Youth Respond to Trauma: Traumatic Stress Reactions

After a traumatic event, it is common to experience some of the following traumatic stress reactions. It is important to know that the effects of trauma are cumulative. The more traumatic events your youth have experienced, the harder it is for them to recover from any single event, and the more likely you are to see them exhibit traumatic stress reactions.

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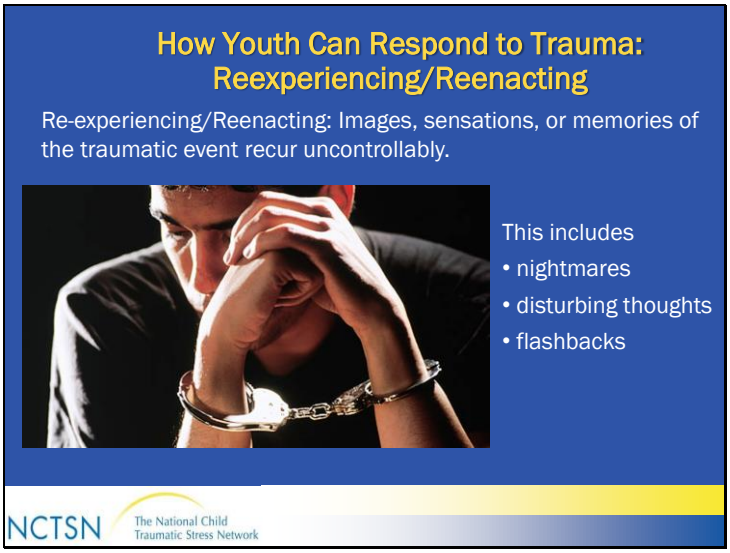
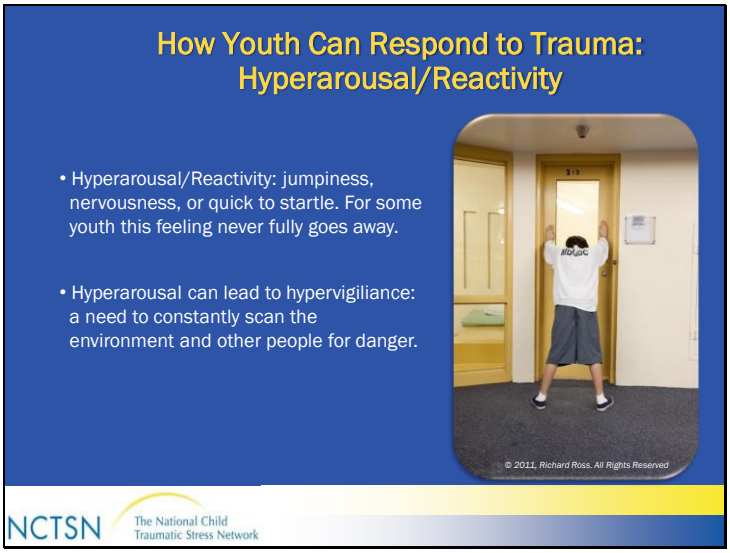


How Youth Can Respond to Trauma: Reexperiencing/Reenacting

Re-experiencing/Re-enactment is when thoughts, images, sounds, or feelings associated with the traumatic event come back into the mind uncontrollably. These thoughts, images, sounds, and feelings can also come back in dreams or nightmares. These images and sensations can be so intense, that we feel as if we are going through the trauma all over again. This is called a flashback. Young children may also re-experience or re-enact traumatic experiences through their play. They may try in their play to make whatever happened turn out differently. For example, have you ever been in a car accident and unable to get the images or sounds out of your head, no matter how hard you try?

Slide 5



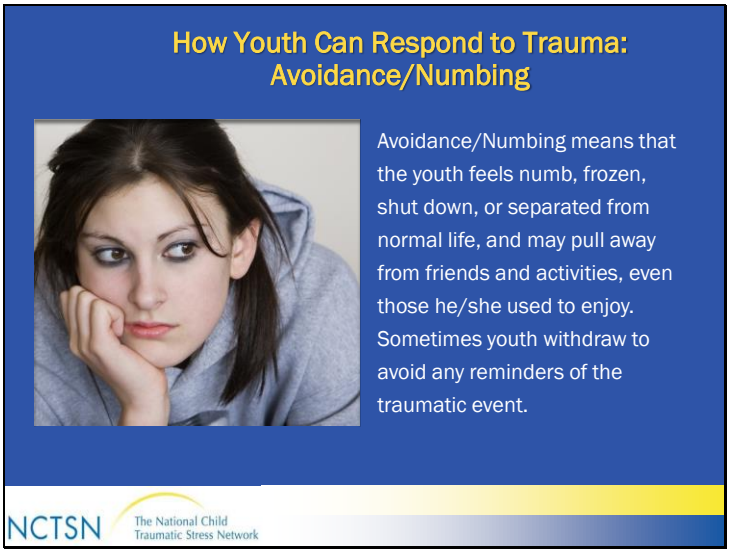
How Youth Can Respond to Trauma: Hyperarousal/Reactivity

Trauma expert Carl Bell said that youth who are hyperaroused "behave as if they are living on the balls of their feet." It's as if their bodies are primed to respond to any stressor with the "fight, flight, or freeze" reaction. Every time their bodies go into a fight, flight, or freeze reaction, they undergo all the physical changes designed to help the body react to danger, such as stress hormones flooding their systems. Many of these youth feel unsafe in situations where youth without trauma histories would not.

As a result, these youth may experience:

- Sleep problems,
- Anxiety,
- Rapid heart rate and breathing, and
- The appearance of Impulsiveness, inattentiveness, and restlessness.

Slide 6

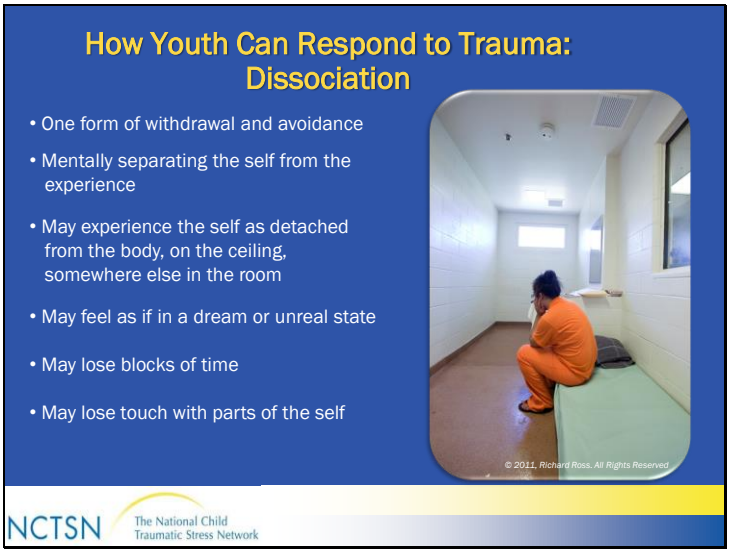


How Youth Can Respond to Trauma: Avoidance/Numbing

Avoidance/Numbing means that the youth feels numb, frozen, shut down, or separated from normal life, and may pull away from friends and activities, even those he/she used to enjoy. Sometimes youth withdraw to avoid any reminders of the traumatic event.

Sometimes during or after a traumatic event, we feel shut down, withdrawn, or numb, cut off from our feelings.

Slide 7



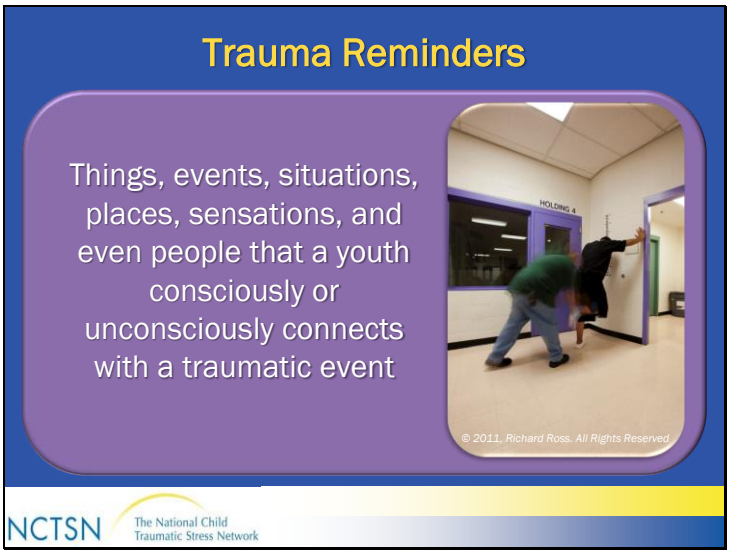
How Youth Can Respond to Trauma: Dissociation

Dissociation can occur when under stress, when strong emotions surface, or when the youth feels threatened, or it can become a youth's way of being in the world.

Dissociation is:

- One form of withdrawal and avoidance;
- Mentally separating the self from the experience;
- People may experience the self as detached from the body, on the ceiling, or somewhere else in the room;
- People may feel as if they are in a dream or unreal state;
- They may lose blocks of time;
- Or they may lose touch with parts of the self.

Slide 8



Trauma Reminders

Things, events, situations, places, sensations, and even people that a youth consciously or unconsciously connects with a traumatic event.

During the course of a traumatic event, everything associated with it may become linked in our brains with the trauma. This is not a conscious process; we may be unaware of the connections between a traumatic event and a reminder. All we know is that we suddenly feel bad or scared.

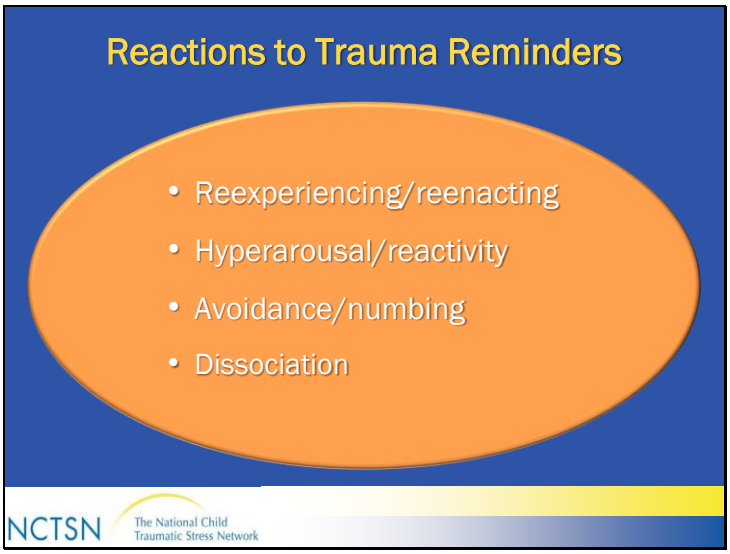
Slide 9

Reminders – All of us have them

A sound, places, people, smells, and images can bring up memories and feelings for all of us. These feelings can be positive or negative, depending on our individual associations.

Youth who experience trauma are also flooded by memories that include what they saw, how they felt, what they smelled, and their physical reactions during the traumatic events.

Slide 10



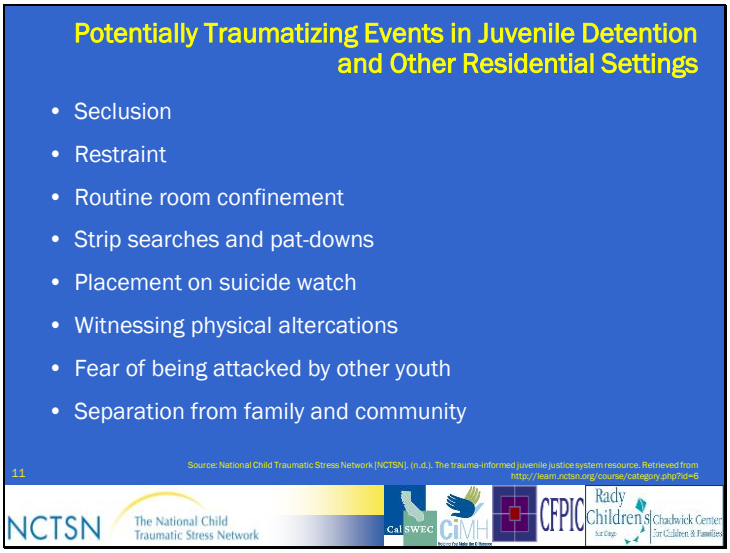
Reactions to Trauma Reminders

- Reexperiencing/reenacting
- Hyperarousal/reactivity
- Avoidance/numbing
- Dissociation

Reminders of trauma or loss can cause a youth to experience these traumatic stress reactions. The same reactions a youth has during or after a traumatic event can be experienced when the youth is exposed to a trauma reminder. Remember, the youth may not understand the connection between the reminder and his or her reaction.

Even years after a traumatic experience a trauma reminder can still have a powerful impact.

Slide 11



Potentially Traumatizing Events in Juvenile Detention and Other Residential Settings

Additionally, there are potentially traumatizing events in juvenile detention and other residential settings, for example:

- Seclusion,
- Restraint,
- Routine room confinement,
- Strip searches and pat-downs,
- Placement on suicide watch,
- Witnessing physical altercations,
- Fear of being attacked by other youth, and
- Separation from family and community.

Slide 12

Meet Elijah

- Elijah is 16 years old.
- He is currently serving a sentence for killing his mother's boyfriend.

Let's take a moment now and meet Elijah. He is 16 years old and is currently incarcerated for killing his mother's boyfriend. We will learn about Elijah and use his story periodically throughout this module as an example of the trauma-related issues we discuss.

Slide 13

THINKING ABOUT ELIJAH…

- Are there traumatic experiences and/or losses?
- Do you see any traumatic reactions?
- What could be potential trauma reminders?

Let's think about Elijah. What are his:
1. Traumatic experiences and losses.
2. Traumatic reactions and
3. Potential Trauma reminders.

Elijah's trauma experiences include:
- Physical abuse by mom and stepdad.
- Domestic violence.
- Death of his brother.
- Car accident.
- Neglect.
- The commission of his crime.
- Parental substance abuse.

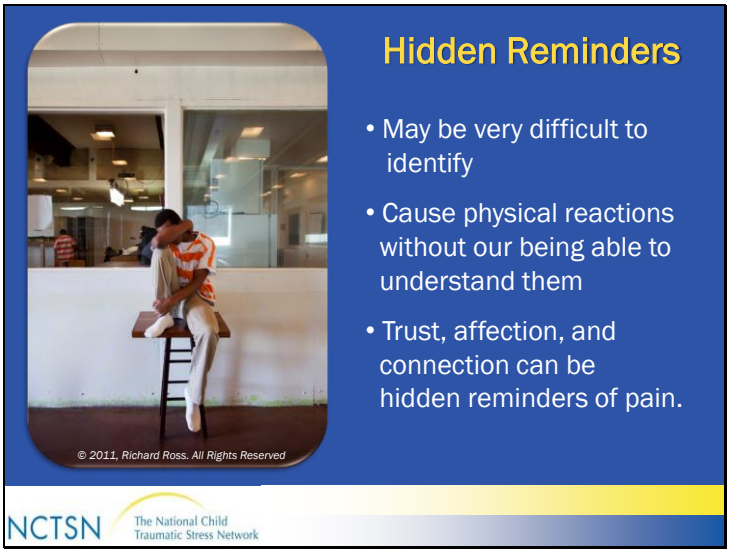
Elijah's traumatic stress reactions and survival coping strategies include:

- Dissociation.
- Avoidance – he would leave the house when things escalated with mom and men.
- Re-enactment – killing his mother's boyfriend.
- Re-experiencing – all of the bad dreams about his crime and the accident.

Elijah's possible trauma and loss reminders are:

- Hearing loud noises.
- Slamming doors.
- Observing physical violence.
- Riding in cars.
- Seeing bats (crime).
- Being too close to someone emotionally.

Slide 14



Hidden Reminders

Youth, especially those with multiple trauma histories, may respond to reminders that can never be identified. This is like when you wake up from a bad dream, your heart is racing, and you feel afraid, but you have no memory of the dream itself and what about it made you afraid. A trauma reminder for many youth with early interpersonal trauma is trust, affection, and connection. This is because when they had this type of feeling for a caregiver that person either victimized, abandoned, or neglected them. This is probably one of the key reasons that relationships can be so difficult for these youth.

When you see oppositional, defiant, aggressive behaviors, or bad attitude behaviors, consider that what you are seeing are reactions to trauma reminders.

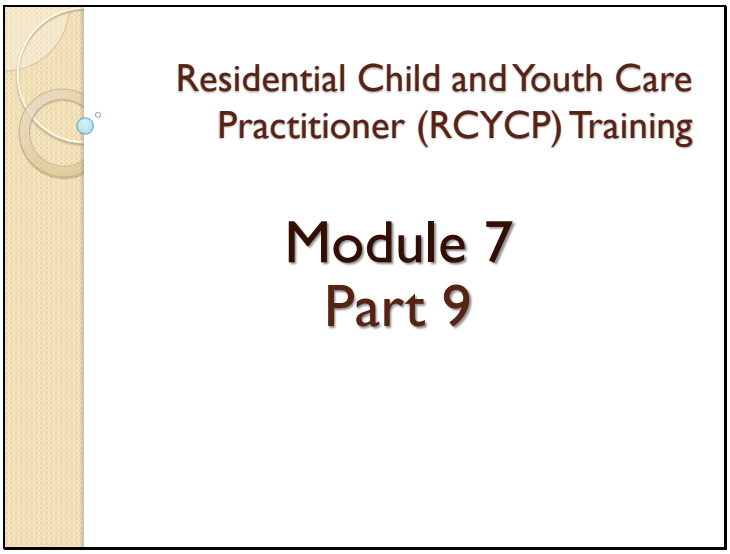
Slide 15

Loss Reminders

In addition to trauma reminders, youth who have experienced the loss of an individual important in their lives may also experience loss reminders. Loss reminders can include:

- Empty situations - Situations in which the person was supposed to be present but is not. For example, following a school shooting homeroom reminds a youth of her friend who used to sit next to her and was shot.
- Shared activities - Activities such as playing games, going for walks, making music, or making meals that the youth used to enjoy with someone who is now gone.
- Rituals - Activities such as graduations, birthdays, holidays, school activities, family reunions, award ceremonies, nightly prayers and wedding celebrations.

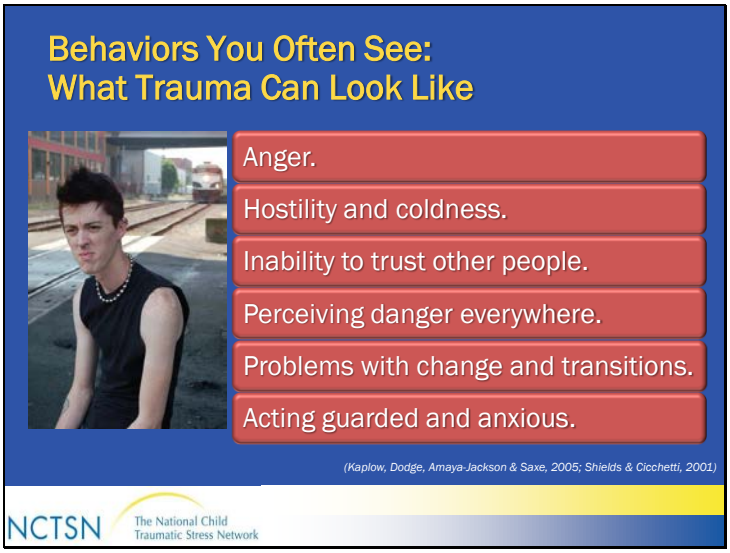
Slide 2



Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 7, Part 9 of the Residential Child and Youth Care Practitioner Training.

Slide 3



Behaviors You Often See: What Trauma Can Look Like

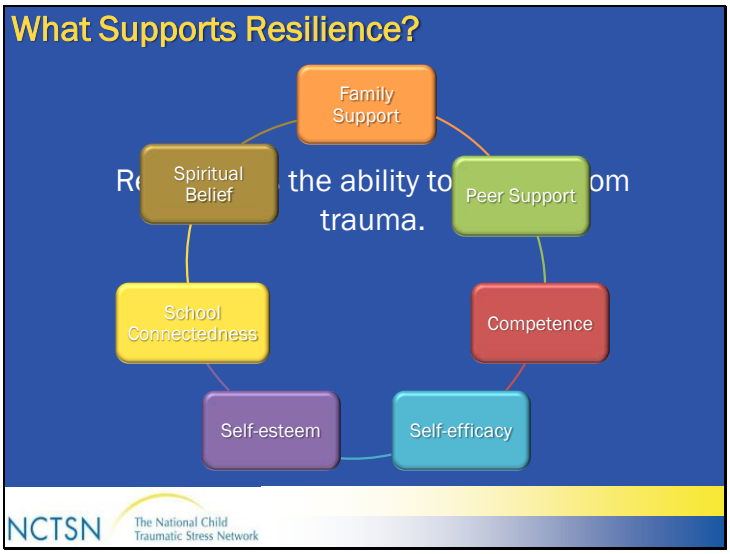
Now we are going to take a look at some behaviors that you may see that may be related to trauma.

- Anger.
- Hostility and coldness.
- Inability to trust other people.
- Perceiving danger everywhere.
- Problems with change and transitions.
- Acting guarded and anxious.

Slide 4

- Difficulty being redirected.
- Physical and emotional reactivity.
- Difficulty calming down after outbursts.
- Difficulty letting go, holding onto grievances.
- Regressive behavior (behaving much younger than his/her age).
- Rejecting support from peers and adults.

Slide 5



What Supports Resilience?

Let's talk about resiliency for a moment.

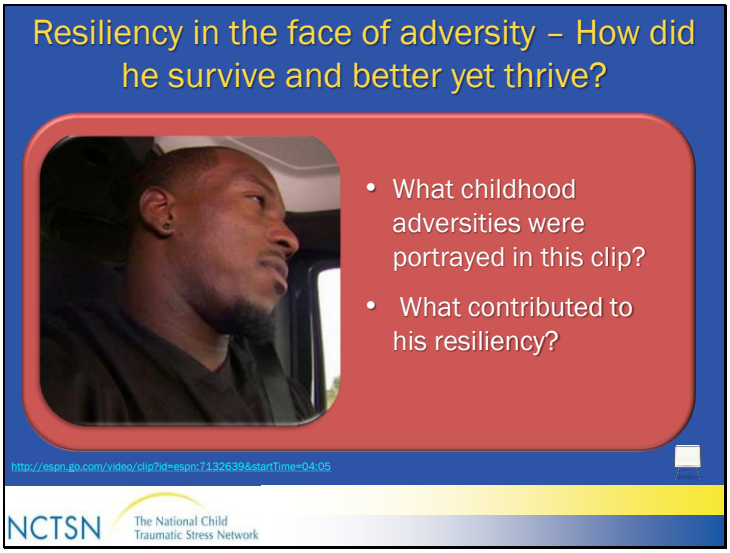
Resiliency is the ability to recover from trauma. Although nothing can entirely wipe out the effects of trauma, research has shown that there are certain factors in a youth's life that can promote resilience:

- Family and/or community support can help youth better cope with trauma and provide them ongoing support when they leave your facility. You can help youth to identify family, community members, or organizations that can support and nurture them while in care.
- Peer support for adolescents can be powerful. Assisting youth in identifying prosocial peers and helping them to determine how best to use friends as support is a good goal.
- Competence is having a suitable or sufficient skill, knowledge, or experience. You can ask youth if they have any activities or hobbies that make them feel like experts or competent. Being competent at something can help youth overcome a feeling of worthlessness or helplessness.
- Self-efficacy is the belief that you can do what you need to do, deal with challenges, and handle tough times. You can help a child feel more empowered to handle situations in the environment by helping them to build coping skills that they then use with a positive outcome.
- When youth have self-esteem they believe they are good people and worthy of love. Feelings of self-esteem are easily destroyed by name calling, put downs, and negative generalizations that a youth comes to believe are true. You can identify and point out to youth admirable

qualities, talents, good choices they make, or simply express belief in them to overcome the obstacles they face.

- School connectedness has been found to be another critical component of resiliency. Even youth who experience difficult life circumstances or home lives can be resilient when they feel a part of and are embraced by a school system that is looking out for them.
- Spirituality and the belief in a higher power can also decrease isolation and powerlessness for youth.

Slide 7



Resiliency in the face of adversity – How did he survive and better yet thrive?

We are going to watch a longer clip about the life of Patrick Willis, an NFL player who also faced many adversities. Throughout the clip, I want you to think about what may have contributed to his resiliency in the face of so much adversity.

http://www.youtube.com/watch?v=qCXa_DfrGZE
(ESPN E60 Presents Patrick Willis: 12:25)

Next slide
What childhood adversities were portrayed in this clip? We can see:
- Parental abandonment (mother).
- Physical abuse by father.
- Emotional and verbal abuse by father.
- Parental substance use.
- Removal from family home and potential separation from siblings.

Though not discussed in the clip, later in Patrick's life, his younger brother died in a drowning accident.

Next slide
What contributed to his resiliency? We could point to:

- His internal sense of family and desire to keep them together.
- His athletic abilities.
- Support of his school community.
- Support of his foster parents.
- His leadership skills.

Slide 8

Trauma Can Derail Development.

Now we are going to focus on trauma's impact on development.

Some important points are:
1. Childhood and adolescence are times of rapid development and continuous change.
2. Traumatic events at any age and stage of development can interfere with a child's developmental accomplishments.
3. The developmental tasks of adolescence must build on a foundation of gains from earlier years.

Slide 9

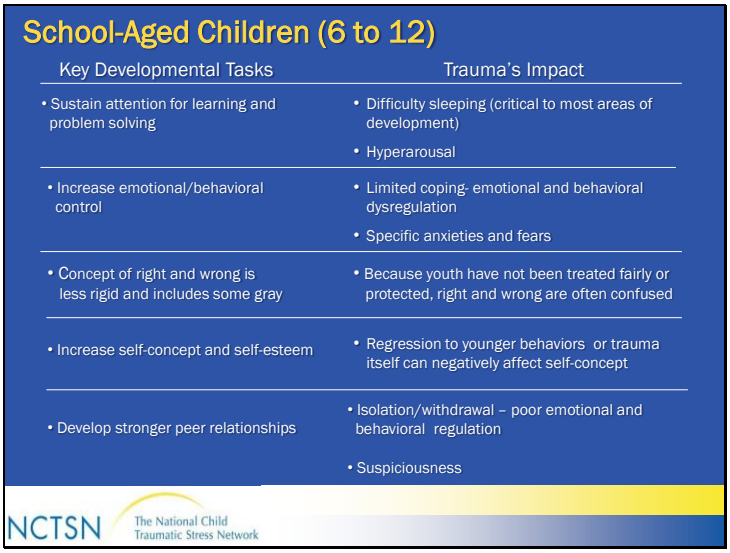
Young Children (0 to 5)

To recap from module 2, some developmental tasks for young children include:

- Developing a secure attachment with caregiver.
- Understanding their behavior's impact on the world (empowerment).
- Recognition of and response to emotional cues (empathy).
- Development of greater independence and capacity to assess danger.
- Beginning self-concept/self-esteem.
- Motor development.
- Language development.

While the developmental tasks of every age are important, development in infancy and early childhood forms the foundation for skills in later development. Attachment is a primary developmental task of early childhood that impacts many other areas of development and continues throughout a lifetime.

Slide 10



School-Aged Children (6 to 12)

As children enter a more structured school program they are gradually expected to sustain greater attention and engage in increased problem solving. Middle childhood is a stage of co-regulation, a period in which caregivers and children jointly control children's behavior. Within co-regulation, parents set broad standards and guidelines while children begin to be capable of initiating some basic cognitive and emotional coping skills to assist with behavioral control. Children in middle childhood loosen their rigid views on such topics as fairness and consequences. They develop higher-level thinking about "right" and "wrong" as moral development increases. They move from "I could get in trouble for this" to "I am behaving because it is the right thing to do."

Middle childhood is also the time when children begin to develop a greater self-concept. Their evaluation of themselves is what determines their self-esteem. They can evaluate their physical, emotional, academic, and social skills and make judgments about whether they are good or not at certain tasks. They may say "I am a good student but a bad athlete." They develop this self- awareness by comparing themselves to their peers and with input from parents, teachers, and other caregivers.

During middle childhood, children receive emotional support, learn different points of view, and share their thoughts and feelings with newfound friends. Children begin to test their communication and social interaction skills with their friends. Children learn how to manage

their emotions and get along with others through friendships. The development of friendships is highly dependent on a sense of mutual trust. Usually friendships at this age are between children of the same gender.

Slide 11

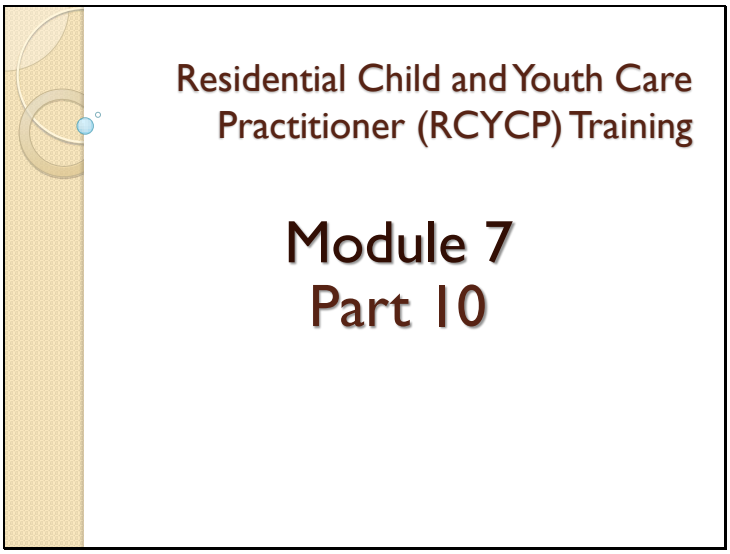
Development's Missing Stairs

When children endure multiple traumatic events over long periods of time, they are especially likely to have multiple gaps in their development.

Developmental gaps from earlier in childhood will challenge a youth's ability to complete the developmental tasks of adolescence. It is as if the youth is being asked to climb a stairway with missing steps.

During adolescence, traumatic events, secondary adversities associated with trauma, and frequent disruptions and changes in living situations can further impair the youth's chances of leaving adolescence prepared to be a productive high-functioning adult.

Slide 2



Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 7, Part 10 of the Residential Child and Youth Care Practitioner Training.

Slide 3

Experiences Build Brain Architecture

Now let's watch another clip to help us better understand how experiences shape the brain. Click on the link to watch the video.

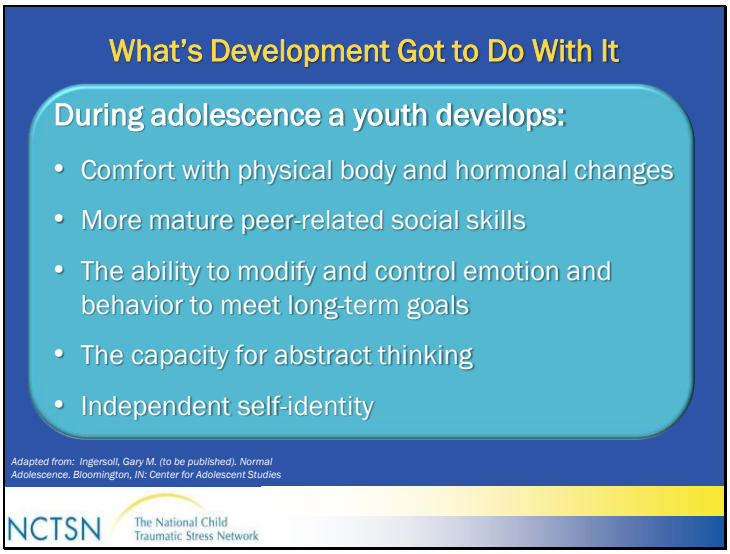
http://developingchild.harvard.edu/resources/multimedia/videos/three_core_concepts/serve_and_return
(Serve and Return Interaction Shapes Brain Circuitry: 1:42)

Slide 4

What's Development Got to Do With It

The major task facing adolescents (13 to 18) is to create a stable identity and to become a complete and productive adult.

Slide 5



During adolescence a youth develops:

- Comfort with physical body and hormonal changes
- More mater peer-related social skills
- The ability to modify and control emotion and behavior to meet long-term goals
- The capacity for abstract thinking
- Independent self-identity

Accomplishing this last task requires a youth to figure out who am I in the world – what do I stand for and believe in?

Slide 6

What's Development Got to do With It

Adolescent development relies upon what is learned in the course of relationships and through past experiences. Youth use these experiences and beliefs as a basis upon which to define themselves, make judgments about the world, and develop relationships with others.

Slide 7

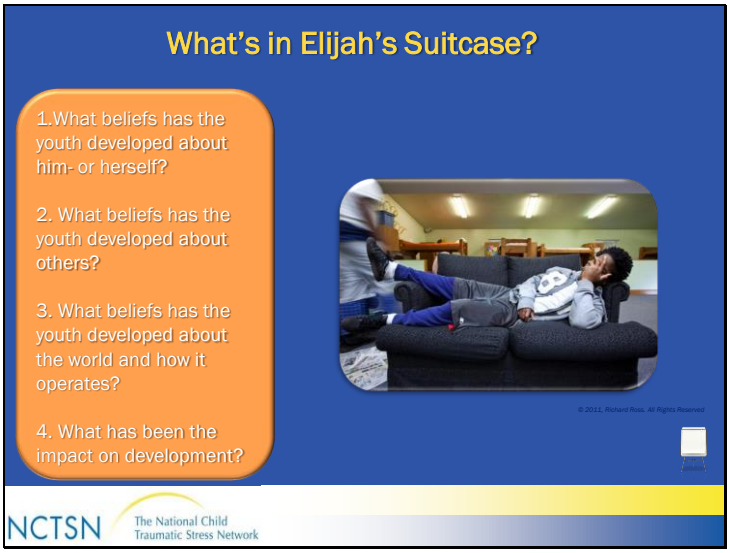
The Invisible Suitcase

Many youth who survived trauma have learned to expect and believe the worst about themselves and about the people responsible for caring for them and unfortunately about the way in which the world works as a whole.

These beliefs and expectations are like an "Invisible Suitcase" that they carry with them throughout their lives into new relationships and experiences with school, counseling sessions, placements, and the work world. The contents of the invisible suitcase can interfere with their development in adolescence.

But understanding the contents of the youth's Invisible Suitcase is critical to understanding the youth and helping him or her to overcome the effects of trauma.

Slide 8



What's in Elijah's Suitcase?

Let's think about Elijah again:

- What beliefs do you think he may have developed about himself? Maybe he thinks:
  - I ran my stepdad away.
  - I am responsible for my mom's safety.
  - I have to protect myself.
- What beliefs do you think he may have developed about others- like peers, caregivers, romantic partners? Perhaps he thinks:
  - My mom cares more about those guys than me.
  - No one loves me.
  - Adults will hurt you.
  - People are not there when you need them.
  - Parents can't protect kids.
- What beliefs do you think he may have developed about the world and how it operates? He might believe:
  - The world is unsafe.
  - Bad stuff happens all the time.
- What has been the impact on his development?
  - He took on the role of caregiver early in life.
  - He took on the caregiver/protector role for Kyle.

◦ It possibly impacted his cognitive functioning to the degree that he scores in the intellectually disabled range.
◦ He has difficulty with behavioral and emotional regulation.

Slide 9

How do traumatic events impact the tasks of adolescent development?

So how do traumatic events impact the tasks of adolescent development?

- Physically
- Socially
- Behaviorally and emotionally
- Cognitively
- Identity development and future orientation

Slide 10

Key Adolescent Developmental Tasks: Physical Development

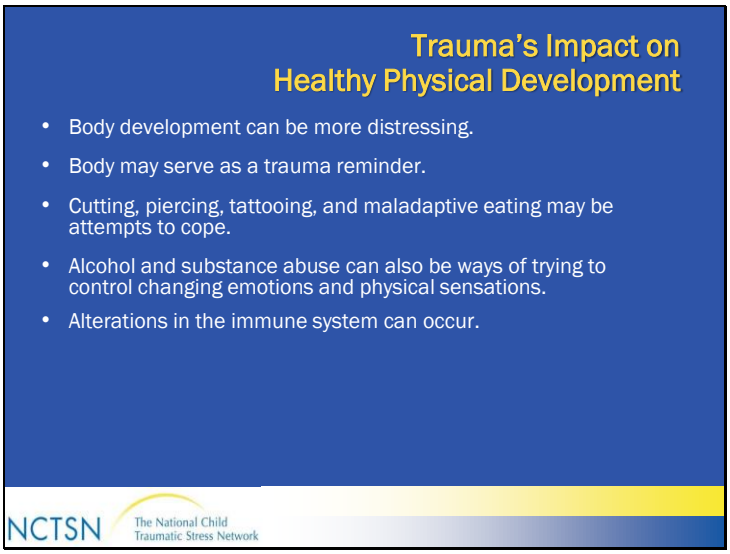
Now let's look more specifically at those adolescent developmental tasks and how trauma may alter their course.

During the course of adolescence, individuals:

- Adjust to outward changes in the body;
- Adjust to increased hormone levels.

At no other time since birth does an individual undergo such rapid and profound physical changes as during early adolescence. Puberty is marked by sudden rapid growth in height and weight. Also, the young person experiences the emergence and accentuation of gender-specific hormonal and physical development. The young person looks less like a child and more like a physically and sexually mature adult. The effect of this rapid change is that the adolescent often becomes focused on his or her body.

Slide 11



Trauma's Impact on Healthy Physical Development

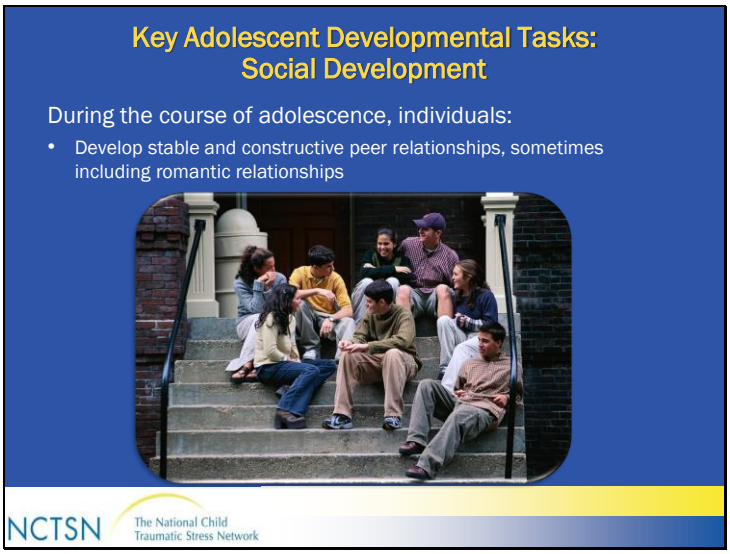
As the body develops, even youth without trauma histories describe the process as scary and awkward. For youth who have experienced traumas, particularly sexual or physical abuse, the new body, accompanying hormonal changes, and dating can serve as reminders of past trauma. Some youth who have experienced severe violence may also have physical scars that forever remind them of their history.

The rapid, unpredictable changes of puberty can increase the feeling of being out of control. Some youth engage in behaviors that are reckless to seek control, such as cutting, maladaptive eating, piercing, and tattooing. Substance use can also be an attempt to control physical sensations.

As we learned earlier in the module – chronic stress can have a significant impact on the immune system, which can cause the youth to experience multiple somatic complaints and may increase susceptibility to illnesses.

All these attempts to control physical symptoms and appearance may actually have an adverse effect and lead to a negative body image.

Slide 12



Key Adolescent Developmental Tasks: Social Development

During the course of adolescence, peer interaction hits the peak of importance in adolescence. It progresses in later adolescence and early adulthood as the depth and quality of these relationships mature based on common values and beliefs. If an adolescent is able to make friends and belong to a mutually supportive peer group he or she is likely to successfully adjust in other areas of development. Peers play the primary supportive role for emotional development. They help youth to begin to define who they are and how they fit into the broader community.

And of course, romantic interest becomes more prominent.

Slide 13

Trauma's Impact on Social Development

So how does trauma impact this piece of development related to relationships?

- Adolescent survivors of abuse experience many challenges in relationships.
- Adolescents who are re-experiencing their trauma or are troubled by trauma reminders may feel that they are weak, strange, childish or going crazy, because of their bouts of fear or exaggerated physical response. This may lead them to even further isolation, anxiety, and depression which can detract from social growth.
- For youth, intimate, trusting relationships with others can be difficult to establish or maintain because they have associated relationships with physical and emotional harm, and abandonment.
- The relationships they do form are often filled with disruptions from the effects of persistent distrust and suspiciousness. Their experiences may have modeled violence as a "normal" part of relationships. Thus many youth repeat the violence they endured or witnessed.
- The ability to understand another person and empathize with that individual is also a skill that may be difficult for multiply traumatized adolescents. Many youth who have witnessed or experienced severe violence may not experience empathy or fully understand their own emotions.
- Many survivors repeatedly reach out for connection. Because they are mistrustful and anxious they will shut down or reach out in unhelpful ways that make them vulnerable to more abuse. Examples include early sexual relationships with multiple partners, violent partners, or

age- inappropriate partners, or bonding together with antisocial peers who share their mistrust of others.

- Sometimes young people with significant trauma may be so desirous of close personal relationships they become overly dependent upon peers or romantic partners or they may isolate themselves, withdraw, or avoid intimate relationships altogether.
- Sometimes caregivers and providers erroneously expect trust and expect the youth to open up because we know or we care about them and want the best for them. But because this has not been consistent with the youth's experience, he or she responds first with distrust and avoidance, having learned not to trust or open themselves up in relationships as a way to avoid being hurt.

Slide 14

Key Adolescent Developmental Tasks: Behavioral and Emotional Development

During the course of adolescence, individuals develop increased impulse control and ability to defer gratification and think through consequences.

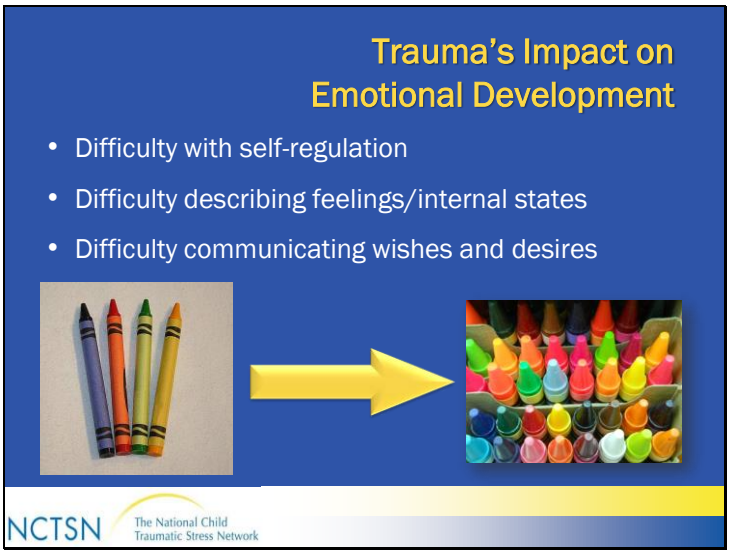
Slide 15

Trauma's Impact on Behavioral Development

Risk taking is particularly evident during early and middle adolescence. But gradually adolescents develop a set of behavioral self-controls and make choices about behaviors that are acceptable and safe for themselves and that will carry them into adulthood.

This transition to increased self-control and personal goal setting is a key developmental task that is often difficult for youth who have experienced significant trauma. As a result, these adolescents may engage in reckless behavior and fail to protect themselves or they may see everything as dangerous and become avoidant of any risk, which makes it difficult to grow and become independent.

Slide 16

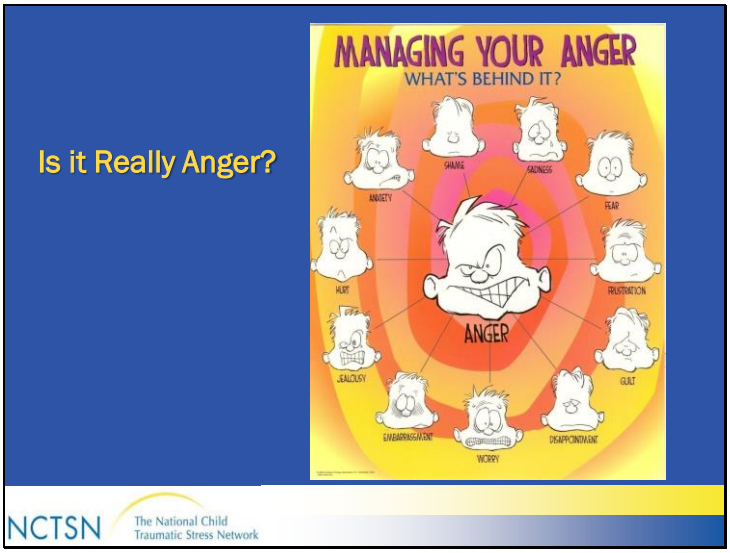


Trauma's Impact on Emotional Development

- Difficulty with self-regulation
- Difficulty describing feelings/internal states
- Difficulty communicating wishes and desires

One of the most prominent difficulties facing many youth who have experienced trauma is modulating their emotions, particularly when experiencing trauma reminders. These youth may also have a limited feelings vocabulary and a limited understanding of their emotional states. It is as if they have the trial-sized box of crayons version of emotion. They know happy, sad, and angry – and thus they respond based upon this limited scope of emotional understanding, instead of having a full-sized crayon box of emotions.

Slide 17



Is it Really Anger?

Anger is one of the primary emotions youth describe. The problem is that they often do not have a clear understanding of the true emotion that may underlie the anger. Learning to perceive gradations in emotions can help them modify their responses. For example, mom says she is coming to visit today but then she calls to say her car broke down and she can't come until next month. The youth's response may be one of anger followed by flipping tables or cursing at people, but the real feelings are:

- Disappointment
- Sadness
- Hurt

Next slide

Once youths are in touch with the complexity of their feelings they can see that they have choices about how to respond. It is important to understand that sometimes even when youth want to manage their emotions, their ingrained responses work against them. Within stable reasonably safe trusting relationships, these youth can build and practice the skills to override these automatic physical and emotional responses and calm down.

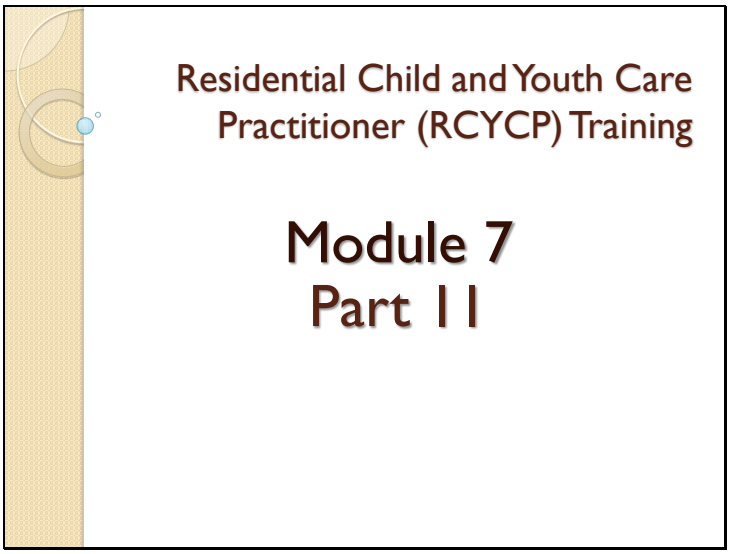
Slide 18

Physically Abused Children See Anger Where Others See Fear

Managing emotions is a two-part process. It involves not only understanding one's own emotions but also accurately interpreting the emotions of others.

Traumatized youth, and particularly those who have experienced significant interpersonal violence, often have difficulty discerning the emotions of others. A researcher compared abused and non-abused children's ability to detect when faces went from angry to fearful. Abused kids saw anger long after non-abused kids began to recognize fear. Defaulting to seeing anger in a face or tone of voice is far safer for youth who live in a violent environment than it would be to miss anger. Unfortunately, as they attempt to recover in a safer environment, they carry this survival response with them.

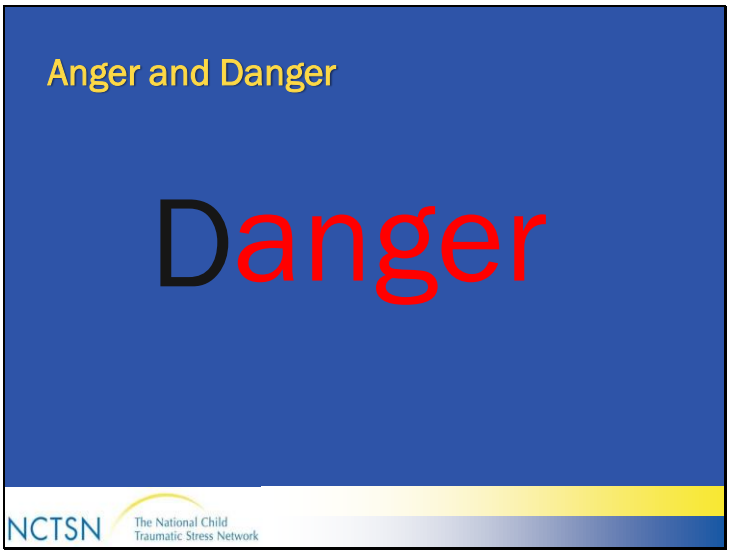
Slide 2



Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 7, Part 11 of the Residential Child and Youth Care Practitioner Training.

Slide 3



Anger and Danger

A child of violence often unconsciously engages all of his senses and much of his focus to detect even the smallest signs of anger in order to avoid the bigger threat or danger.

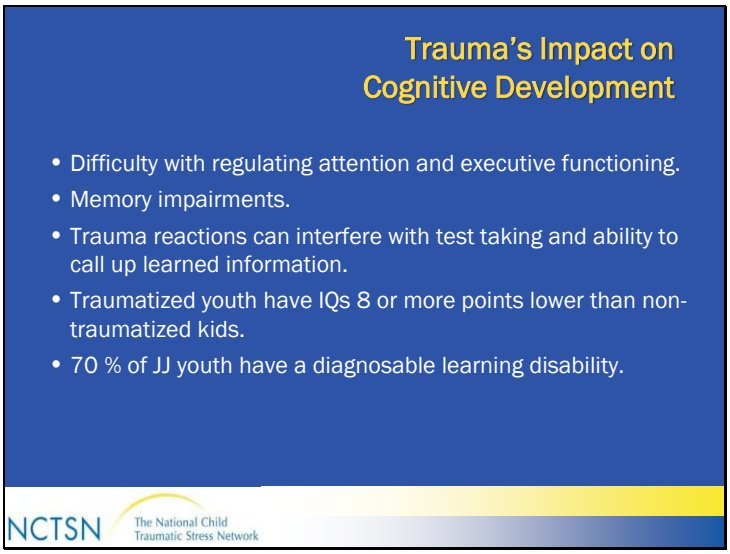
Slide 4

Key Adolescent Developmental Tasks: Cognitive Development

During the course of adolescence, individuals:
- Develop a greater capacity for abstract thought.
- Take in a great deal of new information, retain it, and apply it in order to achieve academically.

With regard to cognitive development:
- Before adolescence, children's thinking tends to be concrete. They need concrete examples of situations and problems before they can solve them.
- During adolescence, young people can understand abstraction; they can consider more hypothetical situations, and "what-ifs."

Slide 5



Trauma's Impact on Cognitive Development

- Difficulty with regulating attention and executive functioning.
- Memory impairments.
- Trauma reactions can interfere with test taking and ability to call up learned information.
- Traumatized youth have IQs 8 or more points lower than non-traumatized kids.
- 70 % of JJ youth have a diagnosable learning disability.

So how does trauma influence cognitive development?

Trauma and traumatic stress reactions interfere with basic attention and executive functioning necessary for higher level abstract thought. Intrusive traumatic memories which many youth experience during the day can get in the way of their ability to focus and think clearly. We know that many youth with chronic trauma have difficulty with memory. Hyperarousal can interfere not only with the intake of information but also with the demonstration of learning.

Studies have shown that youth who have experienced traumatic events tend to score on average eight points lower on IQ tests than youth without such backgrounds. Though they are not intrinsically less intelligent or capable, it is possible that the resources devoted to attention and learning have been diverted to survival.

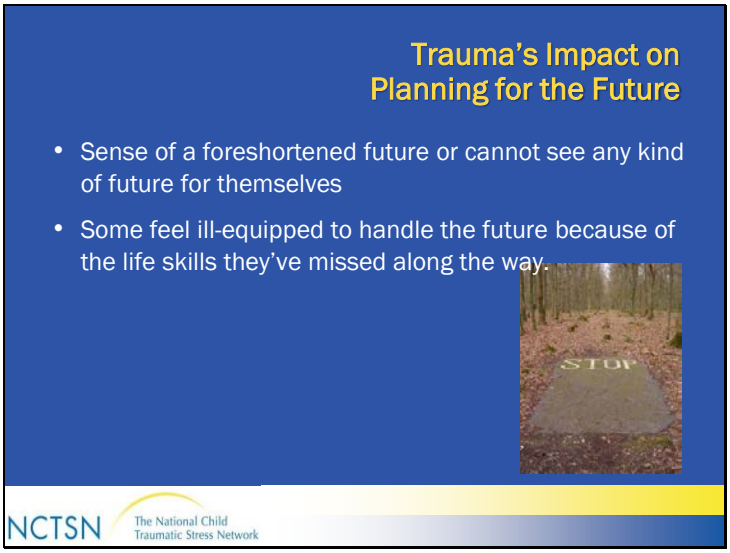
Slide 6

Key Adolescent Developmental Tasks Identity Development and Future Orientation

During the course of adolescence, individuals:
- Establish adult vocational goals
- Develop independent identities
- Begin to plan for and imagine their futures
- Forge new relationships with mentors and role models

A child's identity is largely an extension of one's parents and family. For many adolescents who've endured traumas at the hand of caregivers or within the family, this identity is at least partly negative. During adolescence, an individual recognizes his or her uniqueness and ability to define oneself as separate and different from one's background. An adolescent may have the opportunity to redefine his or her own identity. Mentors and role models can be very important to this process.

Slide 7

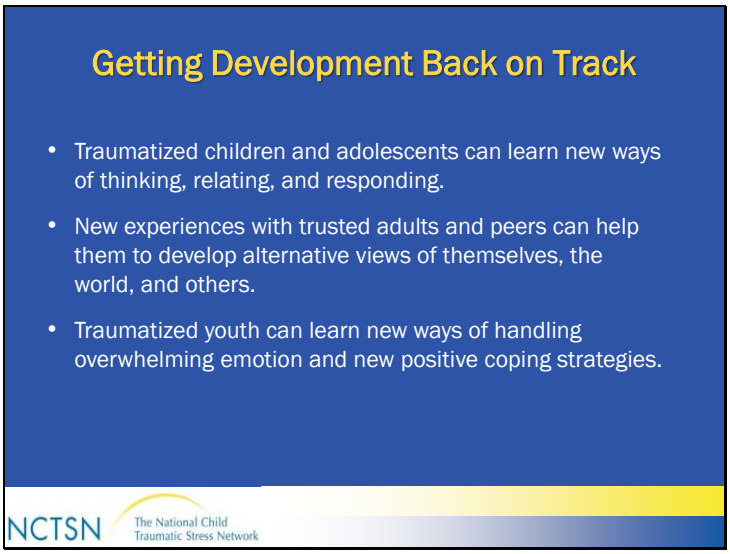


Trauma's Impact on Planning for the Future

- Sense of a foreshortened future or cannot see any kind of future for themselves
- Some feel ill-equipped to handle the future because of the life skills they've missed along the way.

Many youth who experience chronic trauma expend a lot of energy living in the moment focusing on safety and self-protection. This can severely interfere with future planning and can contribute to a sense of a foreshortened future. In addition, youth may feel incapable of transitioning into adulthood due to the missing of many of the development steps we have been talking about.

Slide 8



Getting Development Back on Track

- Traumatized children and adolescents can learn new ways of thinking, relating, and responding.
- New experiences with trusted adults and peers can help them to develop alternative views of themselves, the world, and others.
- Traumatized youth can learn new ways of handling overwhelming emotion and new positive coping strategies.

The good news is that youth whose development has been derailed by trauma can learn new ways of thinking, relating, and responding. In fact, the frontal cortex, the highest part of the brain, continues to develop throughout adolescence and even into adulthood.

In partnership with the youth, family, providers, and the community, we can help to “retrain” the brain through positive new experiences and examples. We can also help youth change the way they appraise their situations and “size them up differently.” So that when they approach a new threatening situation their options are greater. They can learn to more accurately assess risk so that they react appropriately to true danger and employ appropriate coping strategies when confronted by stressful situations. But it is important to recognize that unlearning and rebuilding take time and patience. A ten-week anger management course is not going to fix a way of thinking and behaving that for many youth has taken years to build. It can be a possible

start to the process as long as it occurs within the structure of an environment that supports skill development and provides good boundaries.

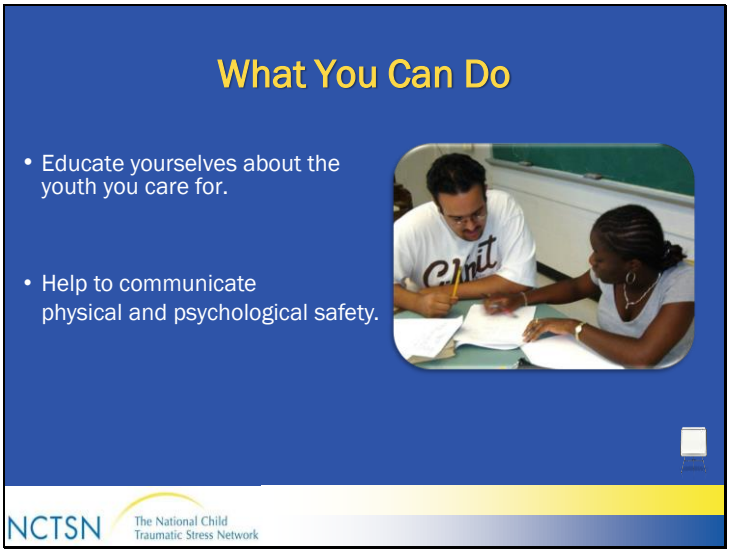
Slide 9

Helping Youth Get Back on Track

- Know you make a difference, even if you don't see the final result.

Many short-term care providers like foster parents, case workers, treatment providers, youth leaders, and RCYCPs can become frustrated when they do not see complete results from the interventions they try, the support they give, and the skills they model. It is important for us to take a more global and long-term approach. Recognize that the difficult behaviors and deregulated emotions you see in youth are the result of very bad seeds planted long ago. Building resilience and achieving recovery take time. A primary objective is to begin to help the child manage the emotions and behaviors born in trauma. While working on these through our relationships with them, we may begin to help them change their thinking about the world, themselves, and others.

Slide 10



What You Can Do

- Educate yourselves about the youth you care for.
- Help to communicate physical and psychological safety.

A first step in helping a youth is getting a good picture of how the youth's behavior fits into his or her history. You may need to integrate historical information from multiple sources, with what you learn from interacting with the youth.

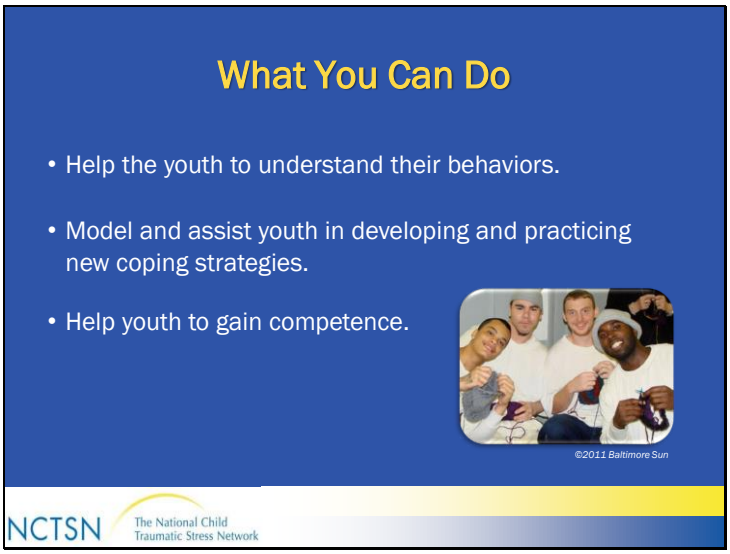
Each of you has valuable information that you may not know that you have unless you think about why a youth is demonstrating certain behaviors. Don't forget to ask the youth and the family how they understand these behaviors. You can be a model for youth by demonstrating a calm, rational approach to unlocking the mysteries of their own behavior.

A second crucial step for working with youth is to communicate physical and psychological safety. This will mean different things for different youth. But for many of our youth the world has been a harsh and unpredictable place. To recover they will need others to help them feel safe.

Take a piece of paper. Think of a specific time in your own life when you felt endangered, scared, or worried. Really try to remember what it felt like – both physically and emotionally.

Write the situation down on the piece of paper and then think about what it took to make you feel physically or psychologically safe.

Slide 11



- Help the youth to understand their behaviors.
- Model and assist youth in developing and practicing new coping strategies.
- Help youth to gain competence.

A third step is to help youth understand their behaviors and reactions. This alone can make them feel less childish, crazy, or overwhelmed.

Next you can model good coping strategies for the youth – and help them to develop and practice coping strategies –which we will talk more about in the next module.

Finally, one of the most significant ways to help a youth overcome trauma and loss and their sense of helplessness is to help them build competence. Being good at something will decrease feelings of incompetence and low self-concept.

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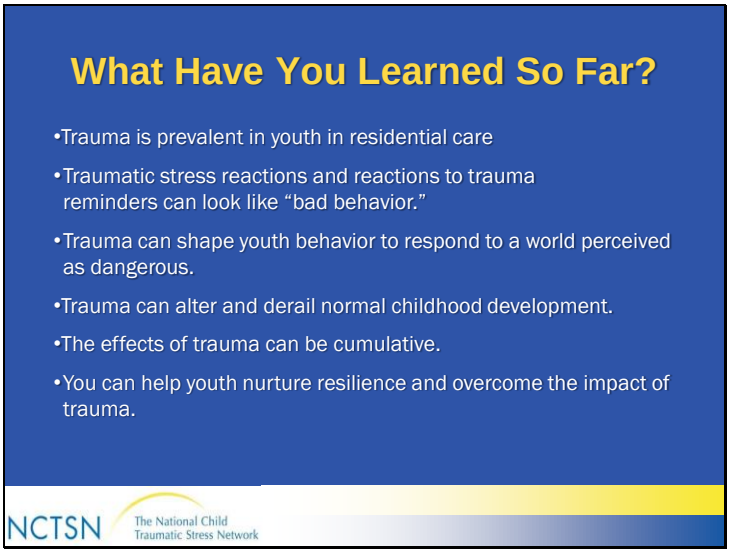

What Have You Learned So Far?

So what do we know so far?

- Trauma is prevalent in youth in residential care.
- Traumatic stress reactions and reactions to trauma reminders can look like "bad behavior".
- Trauma can shape youth behavior to respond to a world perceived as dangerous.
- Trauma can alter and derail normal childhood development.
- The effects of trauma can be cumulative.
- You can help youth nurture resilience and overcome the impact of trauma.

We've talked about the prevalence of trauma in residential care and how traumatic stress reactions can cause youth to behave "badly." This is because traumatic experiences can shape a child's brain and body to see danger everywhere. Trauma, especially when it occurs early in life and is repeated, can derail normal child development. Its effects are also cumulative. But, the good news is that you can help youth nurture resilience and overcome the impact of their traumatic past.

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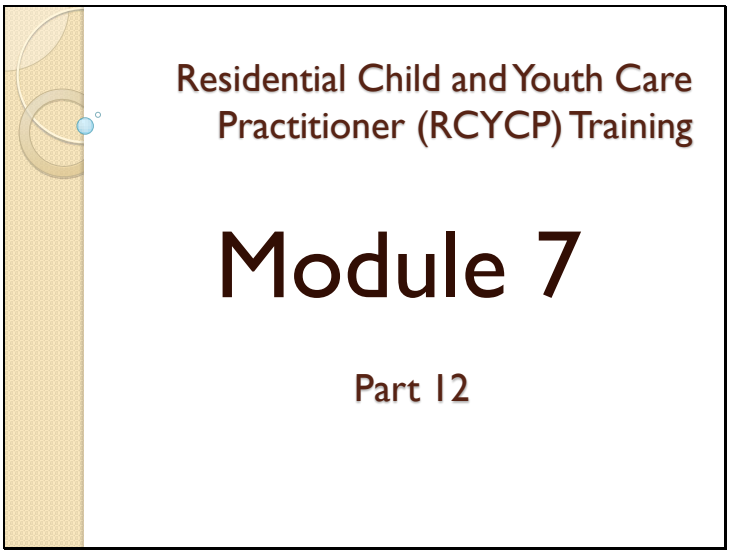


Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 7 Part 13 of the Residential Child and Youth Care Practitioner Training.

Slide 3

We Learn by Experience

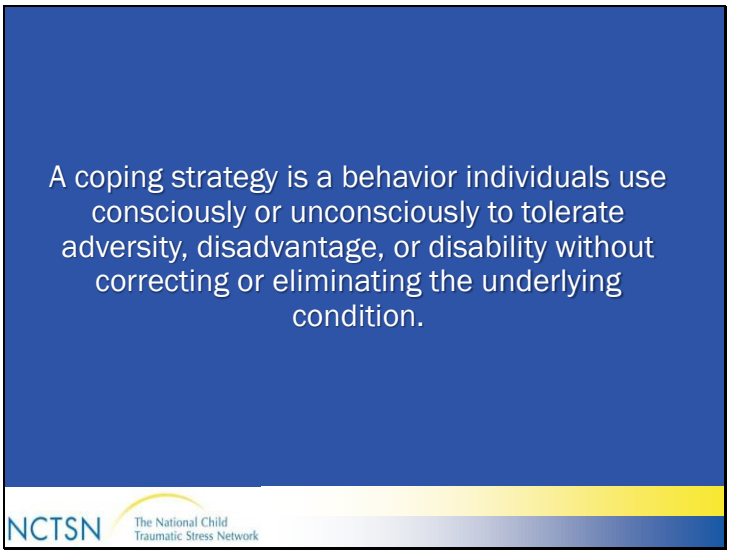
Trauma histories can lead to survival coping.

Now let's talk about coping strategies - what you can do to teach youth about their survival coping strategies, and help them develop alternatives ways to cope.

Remember earlier when we discussed that we learn by experience? After we've seen a snake in the road, we may react to a hose as if it were a snake.

Traumatized youth have learned to respond to rubber hoses as if they were snakes. Sometimes that is what has kept them alive – perceiving danger even when it does not exist. Their experiences have taught them this skill.

Slide 4



A coping strategy is a behavior individuals use consciously or unconsciously to tolerate adversity, disadvantage, or disability without correcting or eliminating the underlying condition.

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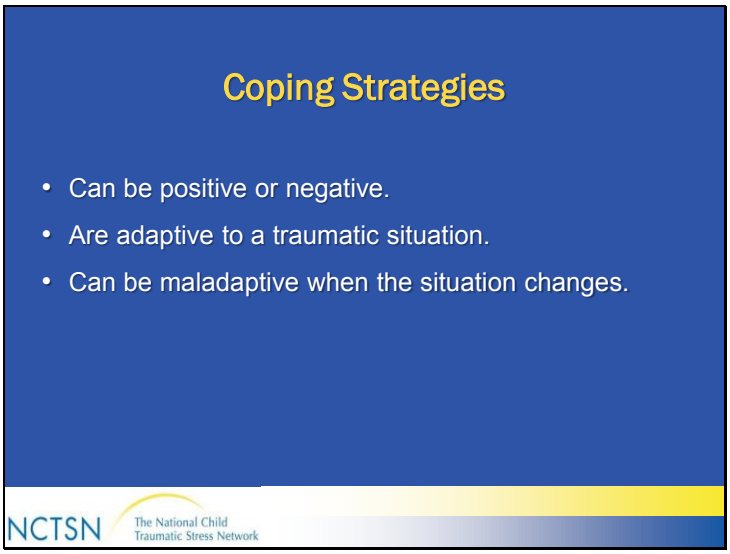


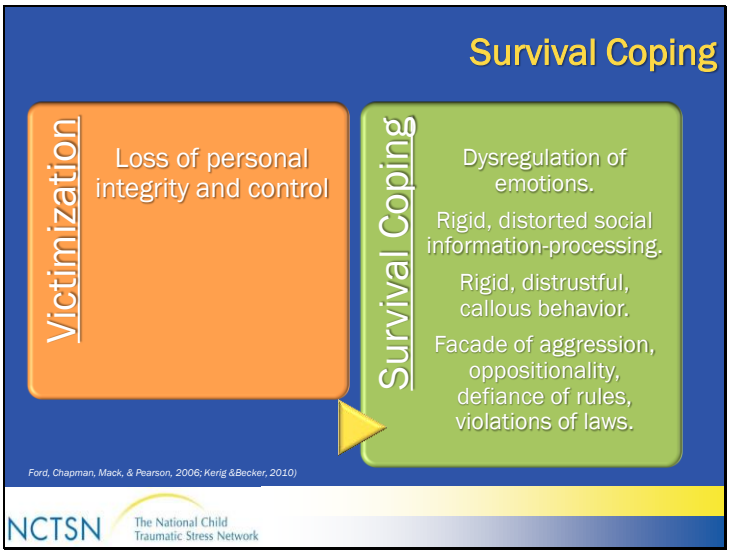
Coping Strategies

- Can be positive or negative.
- Are adaptive to a traumatic situation.
- Can be maladaptive when the situation changes.

People cope in different ways. Coping strategies can be positive or negative. For example, positive ways to cope would be to write in a journal, read a book, or exercise. Negative ways to cope could include self-destructive behaviors, violence, or extreme withdrawal. A coping strategy's appropriateness may also depend on other factors like age or context. So for example a coping strategy that is adaptive for a young child such as rocking back and forth in his or her room when Mom and Dad are fighting becomes maladaptive for an adolescent who is unable to tolerate any conflict without immediately engaging in that behavior.

Some youth engage in maladaptive or survival coping strategies, such as self-injury, substance abuse, fighting, eating disorders, high-risk sexual behavior, etc.

Slide 6



Survival Coping

Victimization: Loss of personal integrity and control.

Survival Coping:
- Dysregulation of emotions.
- Rigid, distorted social information-processing.
- Rigid, distrustful, callous behavior .
- Facade of aggression, oppositionality, defiance of rules, violations of laws.

One way to look at the contribution of traumatic experiences to behavior is to look at a model developed by Julian Ford and his colleagues:

Victimization causes a loss of confidence in one's personal integrity and control which can create a tremendous amount of anxiety or stress. When faced with other—even minor—stressors, subsequently, the youth may go into what Claude Chemtob and his colleagues first described as "survival mode," and which Ford terms "survival coping." This involves coping strategies designed to relieve the anxiety brought on by feeling "victimized" while attempting to protect oneself. There is a combination of anger and a "tough facade" - being rigid, distrustful, vengeful, and callous on the outside while feeling damaged, hopeless, and empty on the inside.

It’s kind of like an egg. Inside the youth, there are a lot of emotions and feelings but the youth builds a wall around these for protection. Anger and aggressive behavior are reactive responses, an attempt to survive.

Slide 7

How would you cope if these experiences were your reality? Take a moment and think about a youth that you have worked with or think about Elijah, the youth we introduced you to in this training that you know has experienced a traumatic event.

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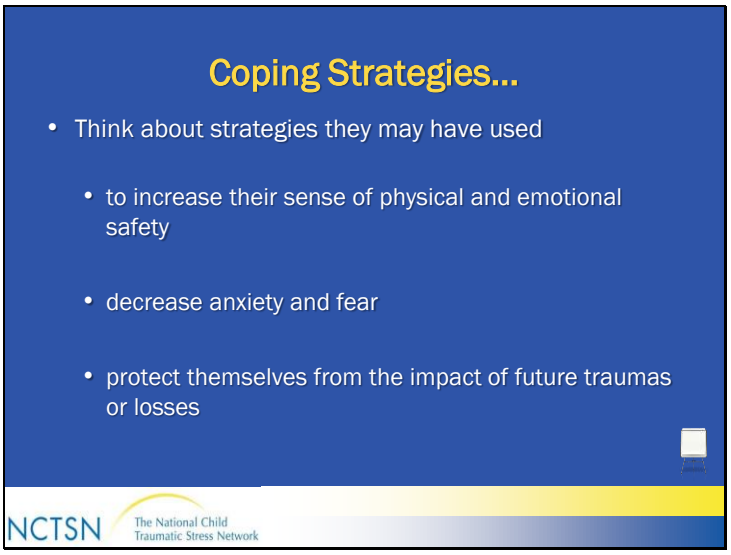


Coping Strategies…

Think about strategies they may have used to:

- increase their sense of physical and emotional safety
- decrease anxiety and fear
- protect themselves from the impact of future traumas or losses

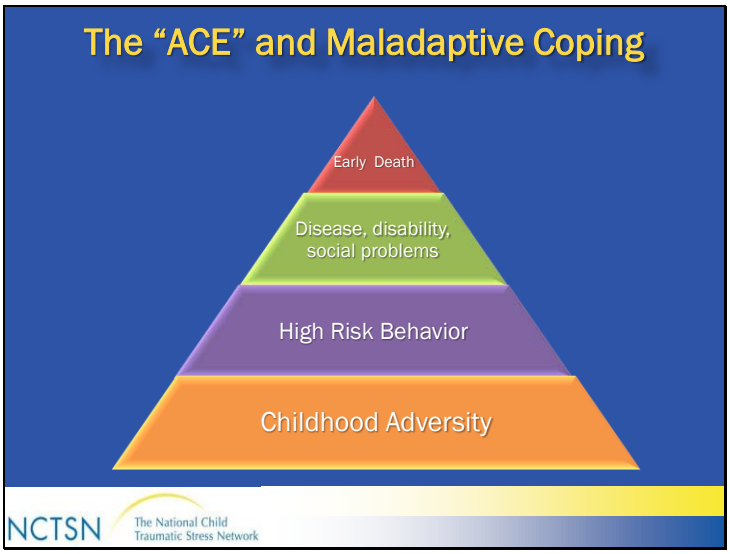
Slide 9

Survival Coping Strategies

The ones we often see in youth that are problematic are:

- Use of intravenous or misuse of prescription drugs
- Eating disorders
- Compulsive sex or high-risk sexual behavior
- Self-injury
- Drinking
- Smoking
- Hitting walls and fighting
- Suicidal behavior or ideation

Slide 10

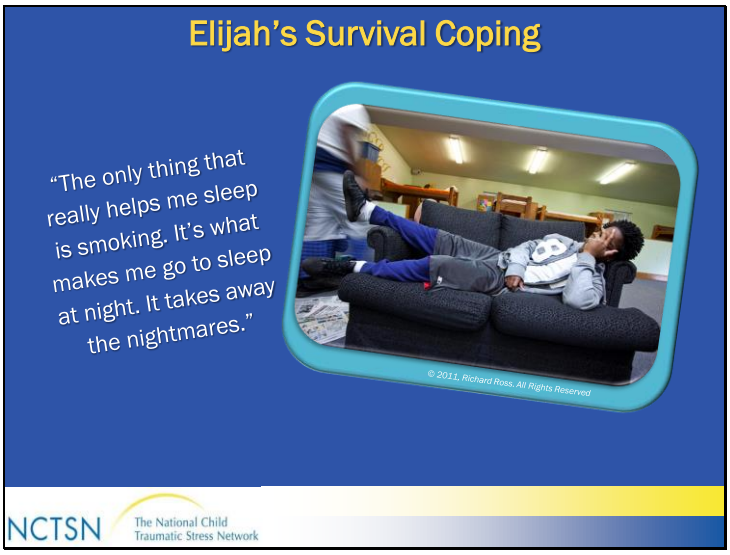


The "ACE" and Maladaptive Coping

Early Death
Disease, disability, social problems
High Risk Behavior
Childhood Adversity

People with trauma histories attempt to cope with maladaptive/survival coping strategies. As a result of these, people may attempt to cope using maladaptive/survival coping strategies to combat their feelings and anxieties. Unfortunately, these high-risk behaviors lead to many diseases, disabilities, and social problems like drug dependency, obesity, and involvement in violent relationships. These can lead to early death.

Slide 11



Elijah's Survival Coping

"The only thing that really helps me sleep is smoking. It's what makes me go to sleep at night. It takes away the nightmares."

Let's look at Elijah. He had consistent nightmares about the domestic violence he witnessed between his mother and her different boyfriends. The first time Elijah used weed he received it from a friend. They smoked up one night and when he came home he went upstairs and it knocked him out. After realizing he fell straight to sleep and didn't have nightmares he started smoking weed regularly in the evenings. It is hard for him to go to sleep without it. In the facility Elijah often becomes irritated and is involved in fights. Could this behavior be linked to lack of sleep?

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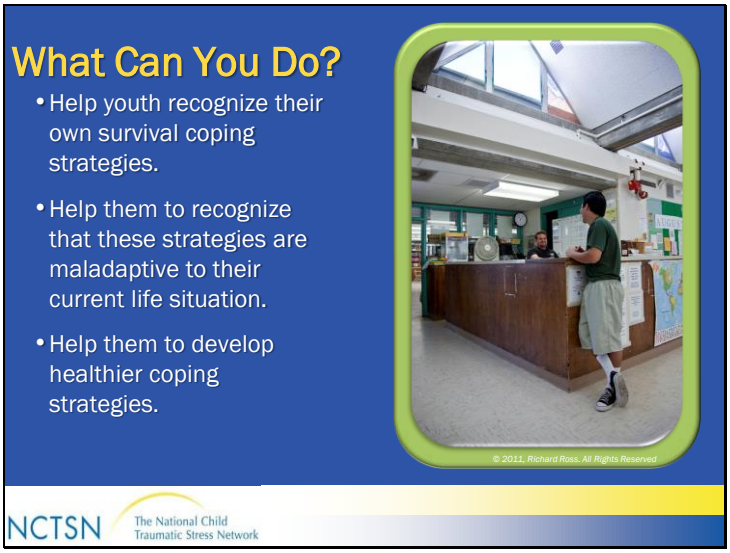


What Can You Do?

- Help youth recognize their own survival coping strategies.
- Help them to recognize that these strategies are maladaptive to their current life situation.
- Help them to develop healthier coping strategies.

Now that we've seen what survival coping strategies are and have seen their short- and long-term negative effects, let's move on to a few approaches you can take to help them learn and use alternative, positive coping behaviors.

Slide 13

An Alternate Way of Coping for Elijah

"I've learned that fighting is only going to get me into more trouble. Lifting weights helps me calm down."

Let's look at an example using Elijah. Elijah's unit manager knows he has anger control issues and fights on the unit when agitated. He notices him pacing around the milieu and asks him, "I notice you're pacing, what's going on?"

Elijah's response is, "I'm just pissed off."

The unit manager replies, "Right now you are just pacing and you have a choice. Instead of getting violent, what's another activity you can do that won't hurt yourself or someone else?" Elijah replies, "Okay, I guess I can go lift weights." The unit manager suggests, "Yeah that seemed to work last time you were upset."

Slide 14

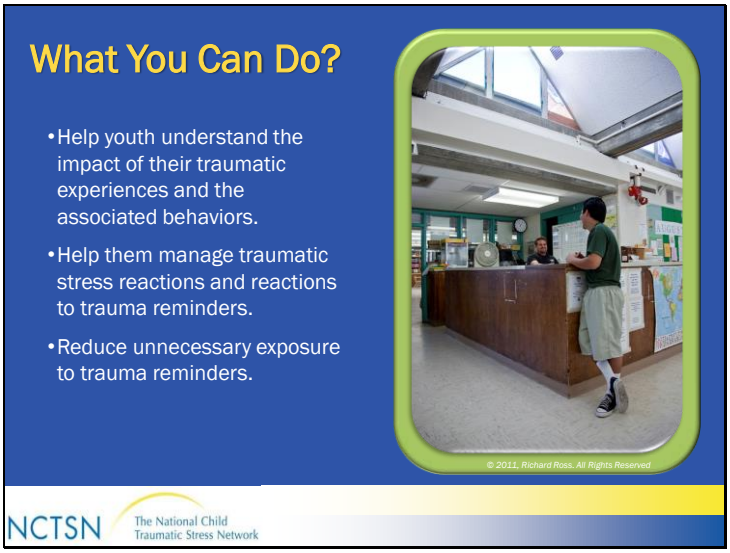
Why is it important?

When staff and youth understand that reactions to traumatic stress are at the root of many negative behaviors, they can work together to change those behaviors. This self-awareness can be used to help youth move away from survival coping to more positive coping strategies.

So how do you do this?

Please note that you, as an RCYCP, may not be doing this yourself. It will most likely be done by therapists or other clinicians who work with the youth; however, it is important for you to be aware of the process. Understanding the process is one step toward being a more effective RCYCP.

Slide 15



What You Can Do

- Help youth understand the impact of their traumatic experiences and the associated behaviors.
- Help them manage traumatic stress reactions and reactions to trauma reminders.
- Reduce unnecessary exposure to trauma reminders.

- The first step is psychoeducation so youth can understand the impact of traumatic experiences and how they have learned to behave because of them.
- The next step is helping them to manage their traumatic stress reactions and to recognize when they are reacting to a trauma reminder.
- We can help them reduce their exposure to trauma reminders, and so decrease the number of reactions they must go through in a day.

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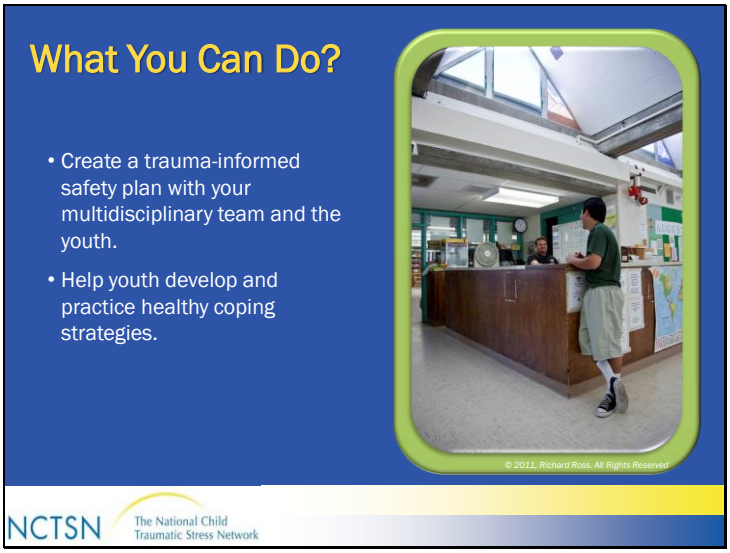

- Create a trauma-informed safety plan with your multidisciplinary team and the youth.
- Help youth develop and practice healthy coping strategies.

Earlier we focused on understanding maladaptive or survival coping youth engage in.

Now we are going to focus on what teams can do to help. Creating a trauma-informed safety plan is a wonderful, integrative way that youth and all staff can work together to understand the youth's traumatic reactions, warning signs, and coping strategies.

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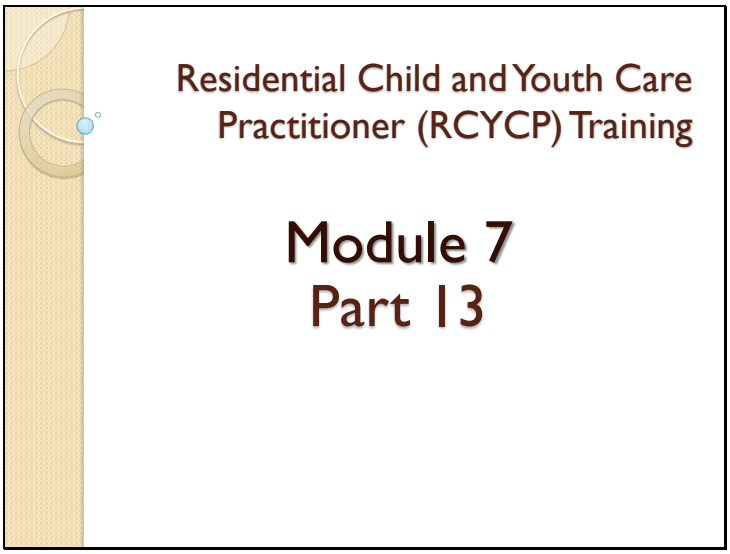
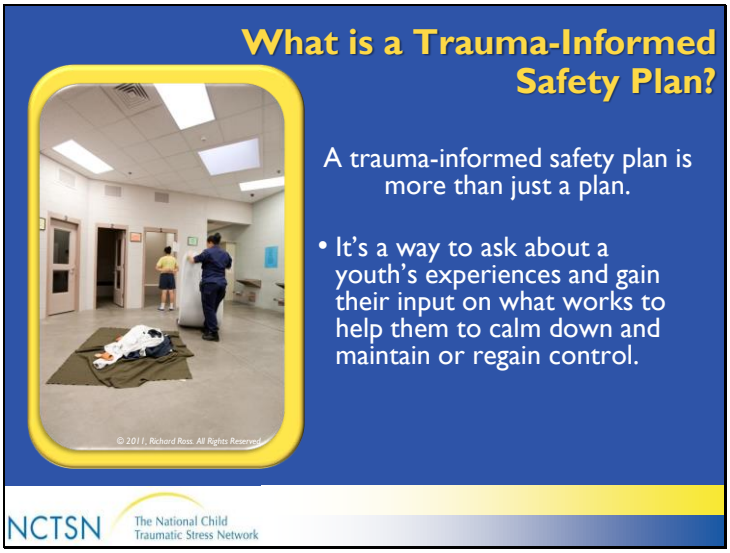


Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 7 Part 13 of the Residential Child and Youth Care Practitioner Training.

Slide 3



What is a Trauma-Informed Safety Plan?

- A trauma-informed safety plan is more than just a plan.
- It's a way to ask about a youth's experiences and gain their input on what works to help them to calm down and maintain or regain control.
- A trauma-informed safety plan is one tool that all staff may use to help a youth who experiences traumatic stress reactions.
- These plans are a way to ask youth about their previous traumatic experiences and gain their input on what works to help them to calm down and maintain or regain control. It provides staff with practical ways to support youth in their recovery.

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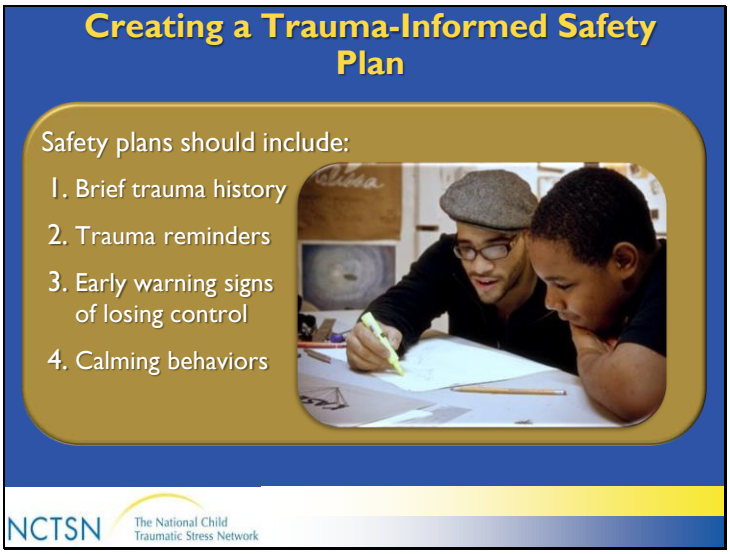
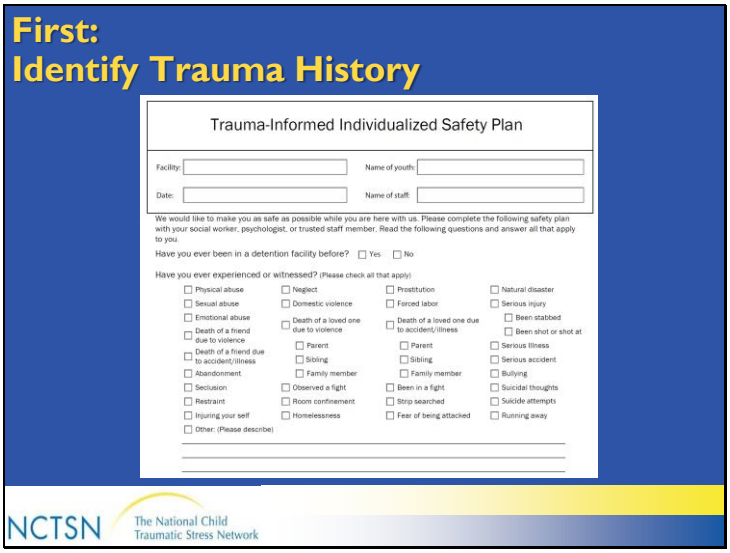


Creating a Trauma-Informed Safety Plan

A safety plan really only needs four basic components:
1. A brief history of a youth's previous trauma and loss experiences.
2. A list of trauma reminders. Know that discovering trauma reminders is a process and your list may change over time as the staff and youth work together to explore what may be making youth feel jumpy, unsafe, hyperaroused, angry, numb, etc.
3. A list of early warning signs that a youth is becoming upset or losing control. These are often linked to trauma reminders.
4. A list of calming behaviors that youth can do to help them regain control and calm their bodies and minds.

Slide 5

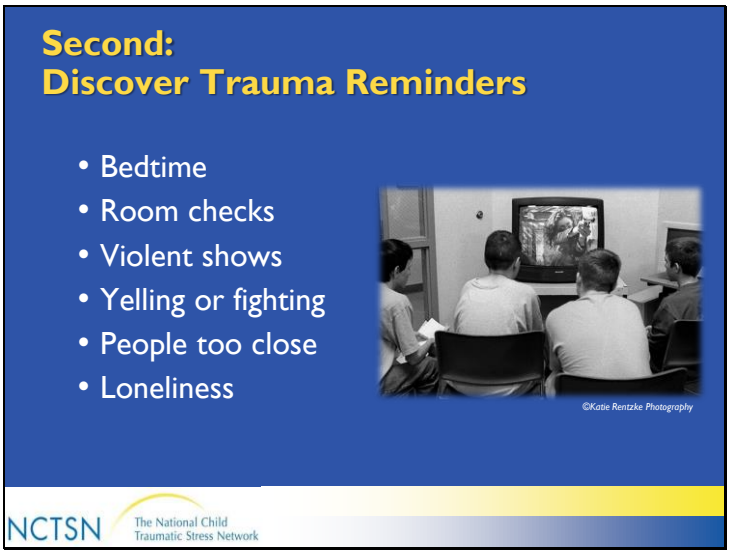


First: Identify Trauma History

Here is an example of a trauma-informed safety plan for use in a detention facility. Let's look at this and discuss the process.

First identify the trauma history:
In this first section of a safety plan you will see a list of traumatic events. These can be used to help youth begin to think about traumatic events they have experienced. There should also be blank spaces for them to add events.

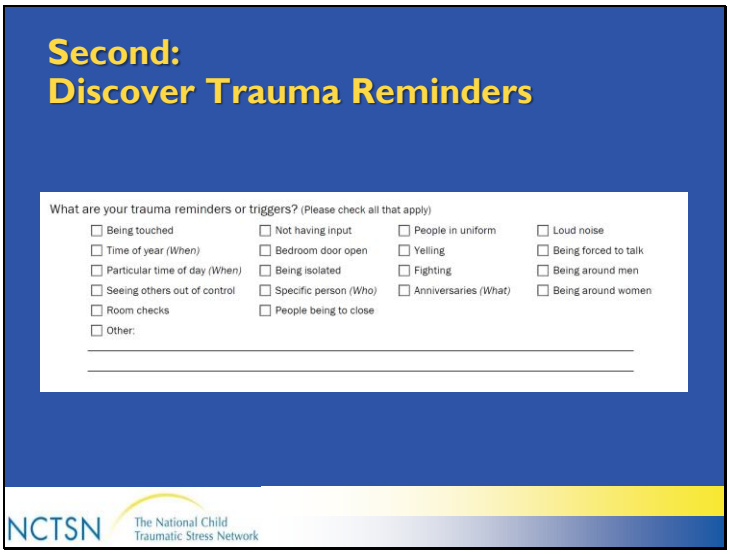
Slide 6



Second: Discover Trauma Reminders

- Remember, a trauma reminder is something that reminds a youth of a traumatic event and can lead to fear, panic, agitation, numbness, or other traumatic stress reactions. Some examples are noted on the slide and in the safety plan. Encourage the young people you work with to think of anything that bothers them, makes them feel uncomfortable, unsafe, or upset. Neither of you may immediately know whether this upsetting circumstance is related to a trauma and that is okay. Put down whatever they say.

Slide 7



Second: Discover Trauma Reminders

The next visual we have is the trauma reminders section of the trauma-informed safety plan.

Slide 8

Third: determine early warning signs:

• An early warning sign may be a feeling or behavior that lets the youth and maybe others know that he or she has experienced a trauma reminder or is feeling distressed. These early warning signs are personal and different for everyone. Here are just a few examples of some potential early warning signs, but you should rely on the individual to identify his/her own. You can also suggest those which you think you have observed and check the youth to see if these are accurate.

• By helping youth see the connection between warning signs and the events that led to them, the youth can begin gain self-awareness and the potential for greater self-control.

Slide 9

Third: Determine Early Warning Signs

The next section of the trauma-informed safety plan you are looking at is the early warning signs section.

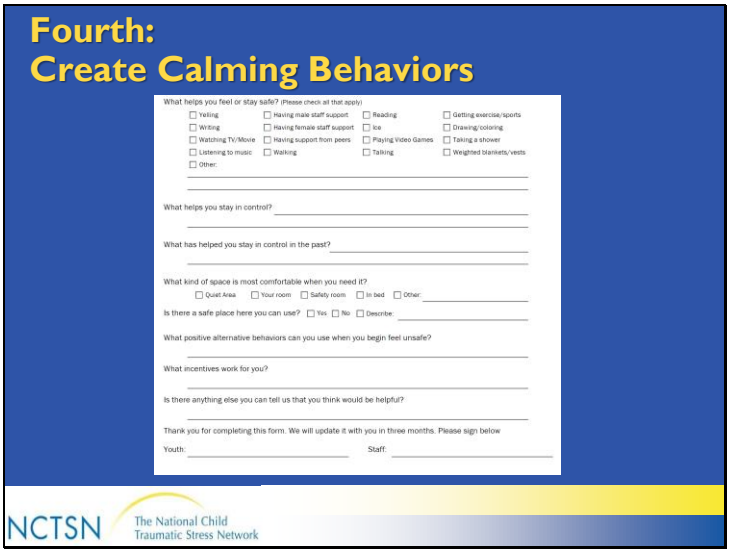
Slide 10

Fourth: create calming behaviors.

• Calming behaviors are something we all use when we get upset. You can help youth develop their own calming behaviors to prepare for a stressful event, or de-escalate when they recognize their early warning signs.

Some examples include:
- Taking time away from a stressful situation
- Going for a walk
- Talking to someone who will listen
- Working out
- Lying down
- Listening to music

Slide 11



Finally, you are looking at the calming behaviors section of the trauma-informed safety plan.

Slide 12

Calming Behaviors: Use the Senses

One way to help youth calm down is to show them how to use their senses. Since trauma reminders are experienced through the senses, you can also use the senses to calm. How we feel: calm, irritated, aroused, angry, tired, relaxed is directly affected by what we receive from our five senses. What thoughts come to you when you:

- See snow or the seashore?
- Take a shower using specialty bath products or smell leaves burning in the fall?
- Listen to soft music or music from your childhood?
- Get a haircut, manicure, or pedicure?
- Lower the lights in your office or bedroom?

They all engage our senses and for many of us can change our mood. We can help youth calm or manage stress by helping them to engage their senses by:

- Listening to music.
- Allowing them to use scented cleansers in the shower.
- Directing them to pictures of family in their rooms or possibly scenes they have drawn to hang on their walls.
- Providing stress balls.
- Using food items – fireballs are particularly good for youth who may seem numb, withdrawn, or at risk of cutting.

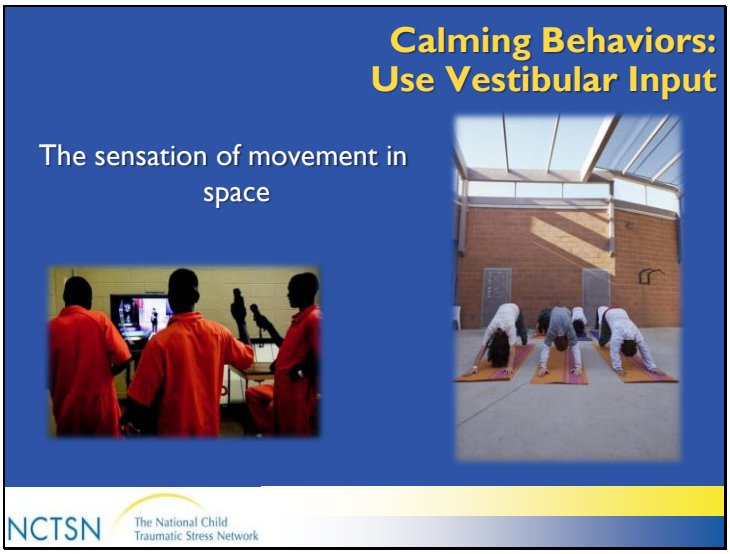
Slide 13

Calming Behaviors: Use Proprioception

- Pressure to the body's muscles or joints or activities that require us to use our muscles.
- Therapeutic use of weight such as a heavy quilt or weighted blanket.
- Pressure and weight can be grounding, calming, and organizing.

In addition to the five primary senses, we have hidden senses like proprioception. Proprioception is your perception of pressure to the muscles or joints. Think about what we do with infants when they are first born. As a way of calming them, we wrap them tightly in blankets, which place soothing pressure on their bodies. Many of us pile mounds of blankets on our beds, not only for warmth, but also for pressure against our bodies, which can be soothing. This can also include weightlifting, moving heavy objects, and even basic calisthenics like push-ups and sit-ups.

Slide 14

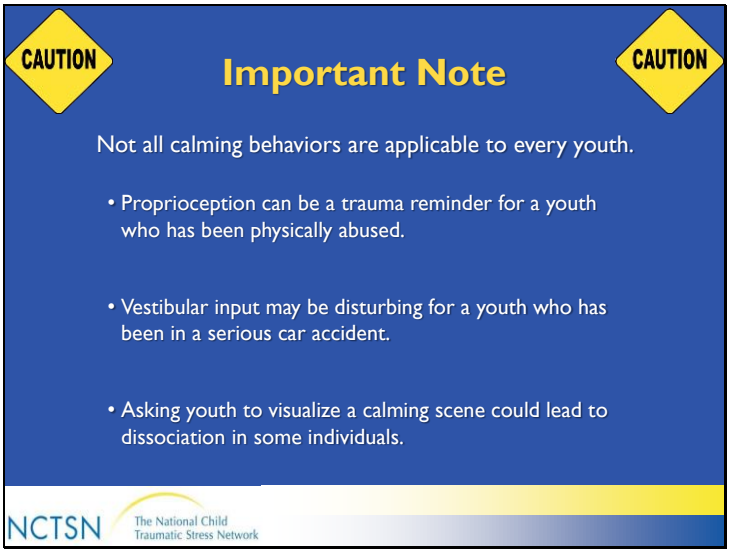


Calming Behaviors: Use Vestibular Input

The sensation of movement in space.

Another type of sensation is vestibular input (the sensation of movement in space). Vestibular input is why many of us enjoyed swinging as a young child or riding amusement park rides. It is the sensation of movement in space. This can be accomplished through aerobic exercise, dance, running, or playing sports.

Slide 15



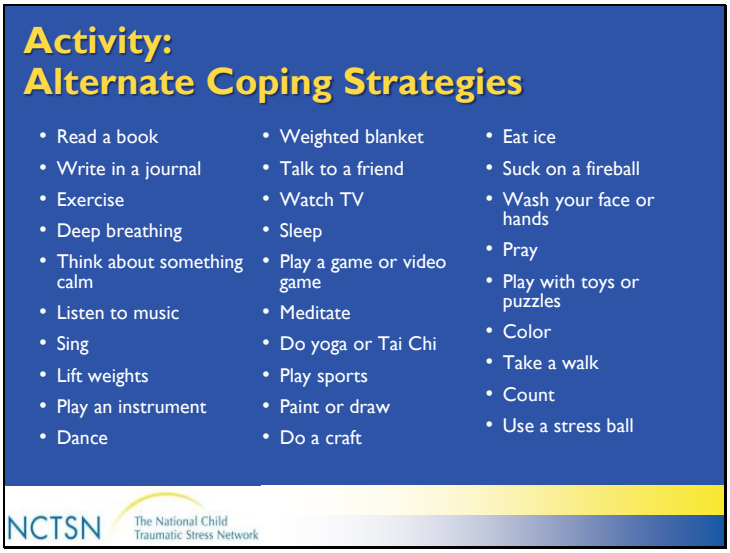
Important Note

Something important to note is that not all calming behaviors are applicable to every youth:

- Proprioception can be a trauma reminder for a youth who has been physically abused.
- Vestibular input may be disturbing for a youth who has been in a serious car accident.
- Asking youth to visualize a calming scene could lead to dissociation in some individuals.

Be aware of the young person's trauma history before suggesting these calming behaviors. If a youth tells you that a particular approach isn't working, listen and try something else.

Slide 17



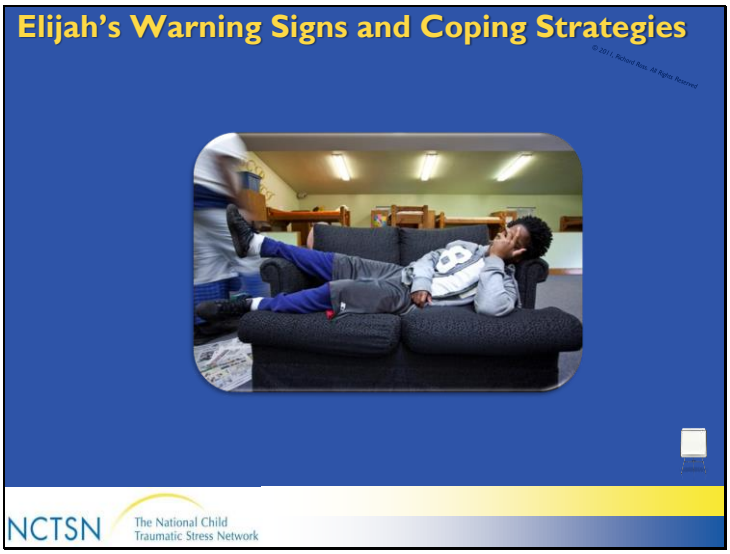
Activity: Alternate Coping Strategies

Some alternate coping strategies include:

- Reading a book
- Writing in a journal
- Exercising
- Deep breathing
- Thinking about something calm
- Listening to music
- Singing
- Lifting weights
- Playing an instrument
- Dancing
- Weighted blanket
- Talking to a friend
- Watching TV
- Sleeping
- Playing a game or video games
- Meditating
- Doing yoga or Tai Chi
- Playing sports
- Painting or drawing

- Doing a craft
- Eating ice
- Sucking on a fireball
- Washing your face or hands
- Playing
- Playing with toys or puzzles
- Coloring
- Taking a walk
- Counting
- Using a stress ball

Slide 18



Elijah's Warning Signs and Coping Strategies

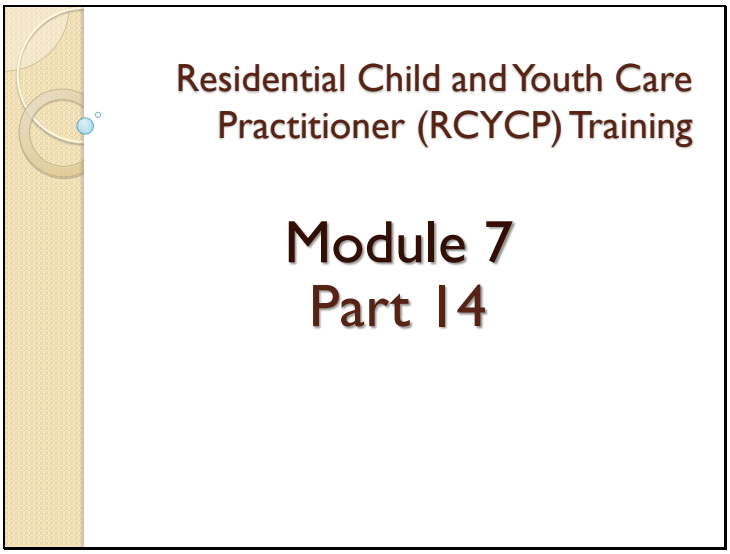
Let's go back to Elijah. His warning signs are:

- His body becomes hot.
- His jaws become clenched.
- His heart races.
- He has negative thoughts in his head.
- He has a startle response.

His potential coping strategies and resiliencies to build on are:

- Rocking.
- Listening to music.
- Decreasing noise – quiet space.
- Using a weighted or heavy blanket to produce pressure.
- Engaging in art or other tasks where he works with his hands.
- Spending time with staff he does trust.
- Preparing him before a visit with mom.
- Strategies to use after mom does not come for visitation.

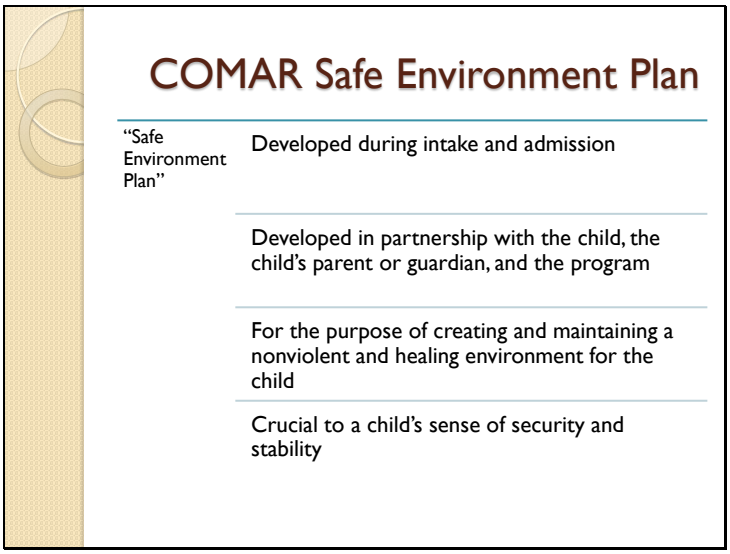
Slide 2



Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 7, Part 14 of the Residential Child and Youth Care Practitioner Training.

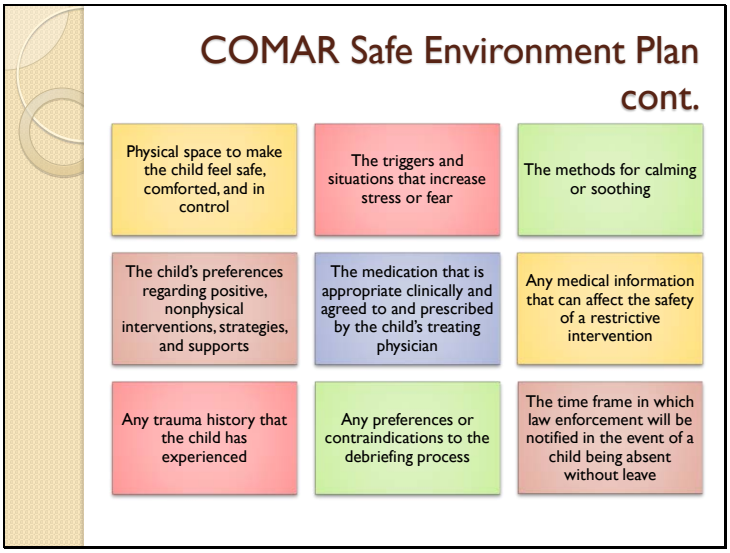
Slide 3



COMAR Safe Environment Plan

As mentioned, you as an RCYCP will not likely be making trauma-informed safety plans yourself, although the therapists or clinicians that work in your residential child care program may be doing so. What you may be doing, however, is implementing or helping to implement a "safe environment plan." COMAR regulations require that each program develops a safe environment plan for each child during intake and admission. The plan is developed in partnership with the child, the child's parent or legal guardian, and the residential child care program to develop a plan to create and maintain a nonviolent and healing environment for the child and to prevent the use of restraint. For children with trauma histories, a safe environment plan is crucial to a child's sense of security and stability. Let's take a moment and look at what a safe environment plan includes.

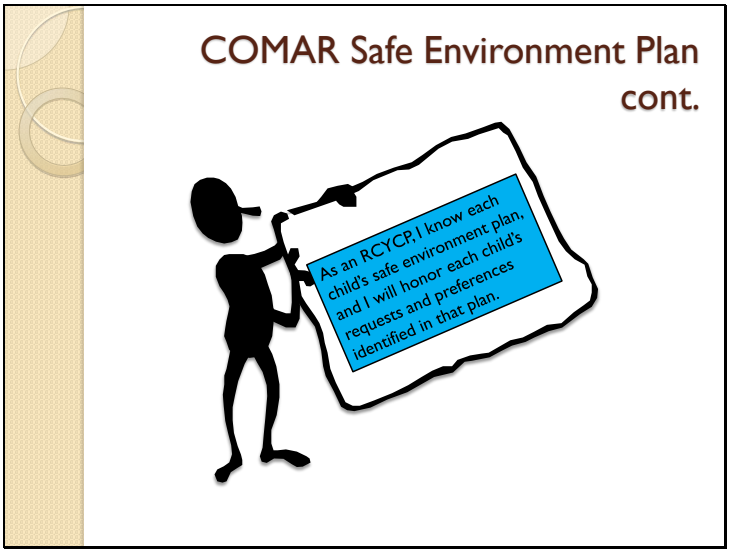
Slide 4



A safe plan should include:

1. Physical space that the program shall provide to make the child feel safe, comforted, and in control of the child's behavior;
2. The triggers and situations that increase stress or fear and may cause the child to lose control of his or her behavior, and how the child's loss of control of his or her behavior is manifested;
3. The methods for calming or soothing that the child prefers and has found to be successful;
4. The child's preferences regarding positive, nonphysical interventions, strategies, and supports if the child's level of agitation increases;
5. The medication that is appropriate clinically and agreed to and prescribed by the child's treating physician that the child may choose to take voluntarily, if the child's level of agitation increases despite the use of the alternative interventions identified in the safe environment plan ;
6. Any medical information that can affect the safety of a restrictive intervention
7. Any trauma history that the child has experienced;
8. Any preferences or contraindications to the debriefing process; and
9. The time frame in which law enforcement will be notified in the event of a child being absent without leave, not to exceed the legally specified time limits of COMAR.

Slide 5



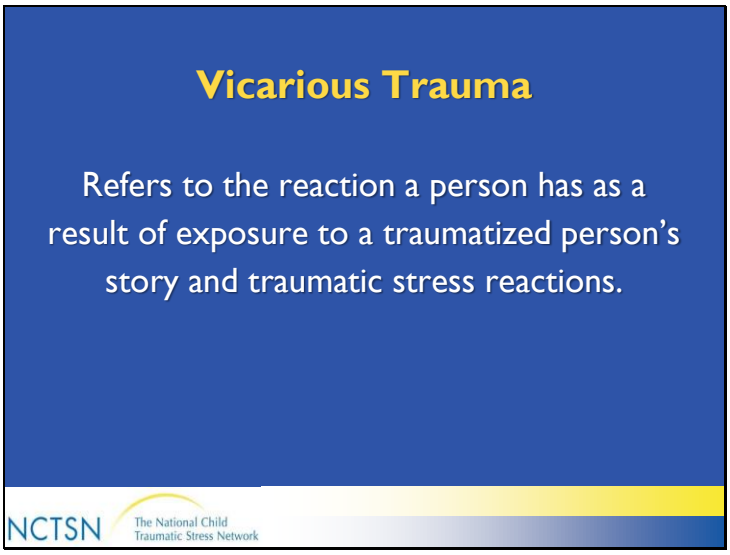
As an RCYCP you should be fully briefed on each child's safe environment plan, and honor each child's requests and preferences that are identified in that plan, unless it is clinically contraindicated in a particular situations (that is to say, that a clinical staff member has said that something else should be done).

Slide 6

Working with Traumatized Children, Youth & Families

We are going to shift gears here now and talk about the toll that working with traumatized children, youth, and families can cause for the RCYCP. Specifically, we are going to discuss vicarious trauma, organizational stress, and self-care. A lot of the material is based on Dr. Sandra Bloom's book entitled Destroying Sanctuary and is from NCTSN's materials.

Slide 7



Vicarious Trauma

Refers to the reaction a person has as a result of exposure to a traumatized person's story and traumatic stress reactions.

In addition to directly experiencing a traumatic event, many of us also absorb the traumas of the youth and families we work with. Each and every day we hear their stories, and watch the drama of those stories play out in front of us, often feeling ill-equipped or helpless to change their course. As a result, many of us experience another type of trauma called Vicarious Trauma. Hearing youths' stories and dealing with the aftermath of their traumas, including their behavior, thinking, and emotional responses, we can also develop traumatic stress reactions. Alternative names for vicarious trauma include:

- Compassion fatigue
- Secondary traumatic stress, and
- Vicarious traumatization

Slide 8

Effects of Vicarious Trauma

After hearing the trauma histories of youth or daily dealing with youths' traumatic stress reactions, it is not uncommon for staff to report:

- Dreaming, re-experiencing, or continually thinking about those traumatic events
- Trouble sleeping
- Being frequently reminded of the trauma, or trying to solve the problem
- Purposely avoiding areas of the facility or the people involved in a traumatic event or not coming to work so you don't have to deal with the issue.
- Feeling anxious or fearful
- Feeling depressed, overwhelmed, and hopeless

Slide 9

Vicarious Trauma Warning Signs

Vicarious trauma can lead to:

• Chronic exhaustion –you feel as if you don't have the time or energy to do all that needs to be done. You lay awake often in cyclical unproductive thought. You feel bone tired, soul tired, heart tired, and spirit tired. You may wonder whether what you are doing constitutes worthwhile work.

• Disconnection/Empathic Numbing – you feel so overwhelmed that you shut down. When you hear the stories of new youth you feel as if you have heard them so many times that you become numb. You may feel you have lost your empathy. This can also carry over to your home and community.

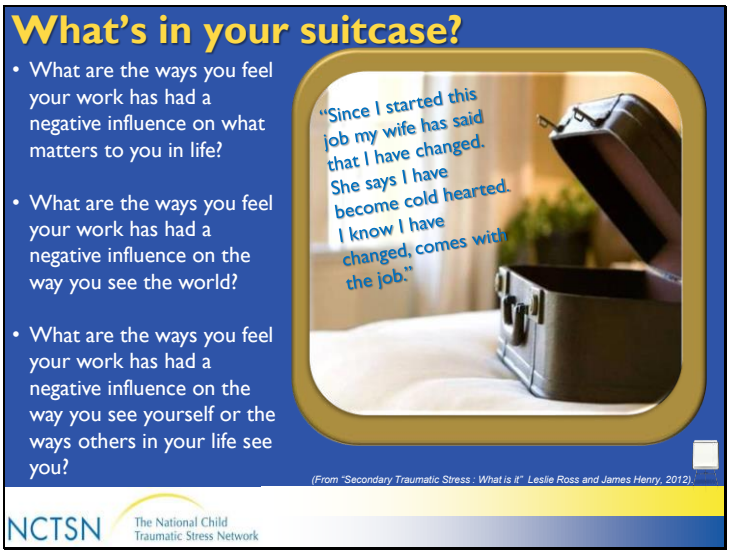
• Social withdrawal – you turn down social engagements, withdraw from intimacy with your spouse, and overlook commitments you have made to do with your children.

• Insensitivity to violence or injustice- you've become immune to the day to day experiences in the facility or in the community. You may see a youth obviously in distress while being restrained and just keep walking. You may hear horrific things that happen to children in your community without being affected

• Avoidance -the phone rings or your pager goes off and you think "I'm not answering it." You see your message light beeping and you ignore it. Your alarm clock goes off and you think of all the reasons you can't go in that day. You may have a sense of dread that you will be faced with more bad news or horrible experiences. You fear that you will be met at the door with big problems and no solutions.

• Boundaries – you compensate by switching into what you believe is high gear. You spend more time at work, take more work home, give up outside work activities to get to work earlier and then leave later. You make executive decisions that may intrude on the desires of others because you believe that's more efficient than asking someone's opinion. You take it personally when a youth fails.
• Anger/Cynicism – you begin to think none of what you're doing is going to work. You may think there is no hope, his mother is a crack head, the youth is manipulating, these kids are all psychopaths. You are suspicious of everyone's motives. Remember cynicism is quite contagious.
• Diminished Self-Care - you or your friends and family begin to notice that you are not doing what you used to do to take care of yourself. You may be less concerned about your appearance or exercising.
• Illness – you may begin to experience pain or illnesses. Your body is telling you that it is overwhelmed. Remember that an excess of stress hormones over time can affect your immune system.
• Survival Coping- instead of going to that happy hour once a week it becomes a daily ritual on the way home.
• When our coping mechanisms are significantly challenged and overwhelmed we also experience symptoms similar to those of the traumatized youth we serve.

Slide 11



What's in your suitcase?

Being immersed in the traumas of our youth can affect our worldview. It can have an impact on what we believe about the world, ourselves, youth, and others. Like our youth, we too develop an "invisible suitcase" of thoughts and beliefs as a result of our experience.

- What are the ways you feel your work has had a negative influence on what matters to you in life?
- What are the ways you feel your work has had a negative influence on the way you see the world?
- What are the ways you feel your work has had a negative influence on the way you see yourself or the ways others in your life see you?

Slide 12

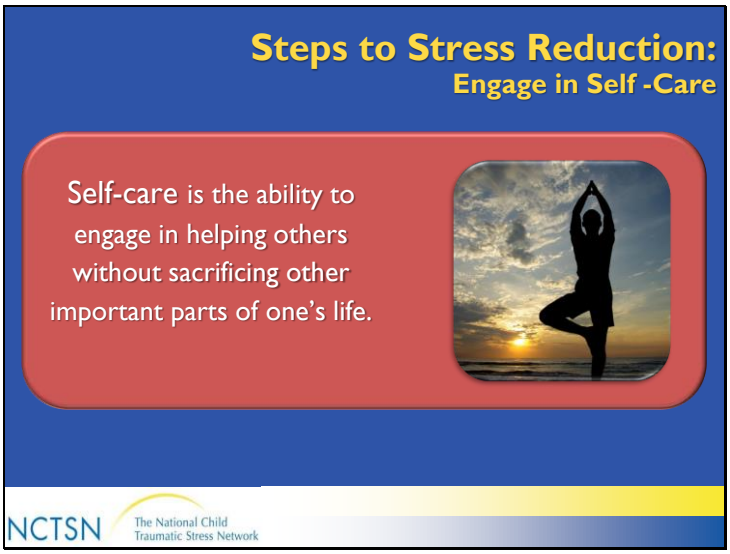
Vicarious Trauma: Risk and Resiliency Factors

We've seen that a number of factors can affect how any individual will respond to a traumatic event. In the same way, not everyone immersed in work with traumatized people develops signs of vicarious trauma. There are some factors that may make you more susceptible or more resilient.

- Personality and Coping Style- if you tend to avoid problems or withdraw from conflict; if you are the kind of person who sticks your head in the sand that can make vicarious trauma more likely. Taking an active problem solving role as issues come up, and asking for support can serve as a buffer. Asking for support can take the form of talking with a supervisor or co-worker to strategize potential solutions or help you to recognize that you are doing the best you can at the time.
- Past trauma history – trauma experiences are often very common among people in the helping professions. Your own trauma history can help you relate and have empathy for the youth's circumstances. However, it may be a risk factor because hearing about the youth's trauma may produce reminders of your own trauma history. If you have not found effective ways of dealing with your past trauma this may re-traumatize you and cause you to experience traumatic stress related symptoms.
- Current life circumstances – the more stress you are experiencing in your own life the more difficult you may find it to hear and manage the stressful life events of others. This may contribute to your feeling overwhelmed.

- Social Support - staying connected is a key piece of resiliency. If you give ample time to your social relationships, you won't have time to take so much of your work home. People who do not have this often feel alone in what is very hard work.
- Spiritual Resources - having some sort of connection to meaning and hope helps to transcend some of the adversities of the workplace.
- Work Style – if you are able to exercise good boundaries, hold reasonable expectations of yourself and others, including co-workers and youth, you will be less likely to feel hopeless or unsuccessful.

Slide 13



Steps to Stress Reduction: Engage in Self –Care

Self-care is the ability to engage in helping others without sacrificing other important parts of one's life.

One very important way to reduce stress is through self-care.

Self-care is:
Only taking responsibility for job functions you have control over
The ability to maintain a positive attitude towards the work despite challenges
The staff person's right to be well, safe, and fulfilled

Slide 14

Who is responsible for your self-care?

Some of you may say, “Yep– self-care. That is a wonderful goal, but how do I get there while working here with these youth?”

Your vicarious trauma and organizational stress can affect other staff, the youth, and the organization. The same goes for good self-care. It can have a positive impact on you, the youth, staff you work with, and the organization as a whole. But who is responsible for your self-care? Self-care is really the responsibility of many including:

- You
- Your coworkers
- Your supervisors, and
- The organization

There is a role for all in achieving self-care.

Slide 15

The A-B-C's of Self—Care

Awareness, Balance, Connection

We are going to begin by focusing on what you as an individual can do for yourself. Self-care is not an emergency response plan to be activated when stress becomes overwhelming. Self-care is NOT about acting selfishly ("It's all about me!"). Self-care is NOT about doing more or adding more tasks to an already overwhelming "to-do" list.

Healthy self-care can renew our spirits and help us become more resilient. Self-care is most effective when approached proactively, not reactively. Think of self-care as having three basic aspects:

- Awareness
- Balance and
- Connection

These are the "ABC's" of self-care.

Slide 16

Awareness

Body, Personal life, Professional life

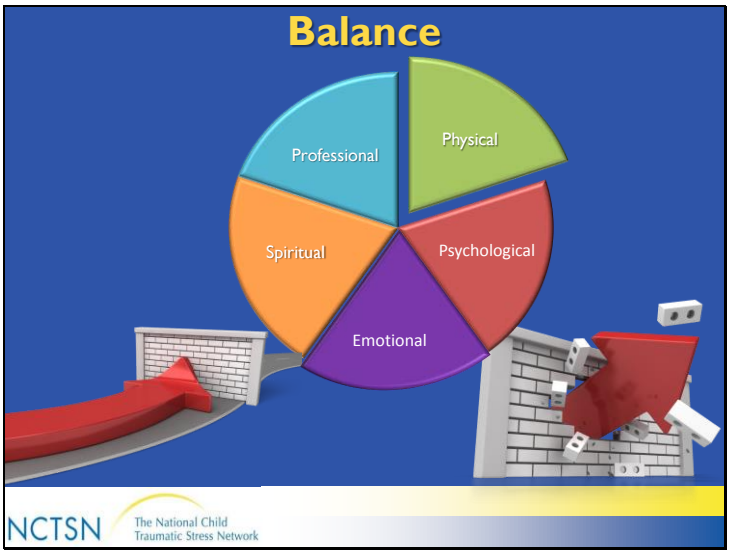
The first step in self-care is much like the first step a clinician, physician, or mechanic takes in diagnosing a problem. It involves a check-up of your body and mind. You are the only person who can take this first step because everyone's evaluation of stress and personal functioning is different. This step requires you to slow down enough and focus inwardly enough to determine how you are feeling, what your stress level is, what types of thoughts are going through your head, and whether your behaviors and actions are consistent with the who you want to be.

Slide 17

Balance

The second step is to seek balance among a number of different types of activities. These include work, personal and family life, rest, and leisure. You will be more productive when you've had opportunities to rest and relax. What helps you relax may be very different from what relaxes your family members and colleagues. It's important that the ways you relax aren't damaging to your health and well-being (i.e., survival coping strategies) or to the relationships that are important to you. Becoming aware of when you are losing balance in your life gives you an opportunity to change.

Slide 18



Taking care of yourself involves far more than relaxing. It requires that you focus on:

- Physical self-care
- Psychological self-care
- Emotional self-care
- Spiritual self-care
- Professional or workplace self-care

Next slide

As many of you know, we make great plans. But often something gets in the way of success For example, we might want to work out at least three times a week, but when the alarm clock goes off any small thing that gets in the way is sufficient to stop us like – I can't find my workout clothes.

Effective self-care does require good planning. A good solution to this workout dilemma that some people use is going to sleep in their workout clothes with their tennis shoes and socks right at the bedside. This is an example of how important it is to prepare to succeed at what you choose to adopt as a self-care strategy.

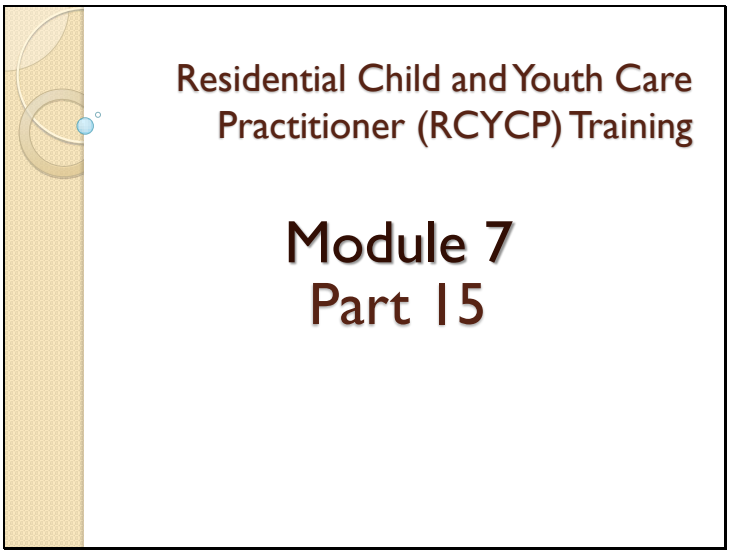
You have to practice self-care and good coping so you can work effectively with the youth and model the skills you are teaching them.

Slide 19

Connection…

The final letter is C for connection. It involves building connections and supportive relationships with your co-workers, friends, family and community. One of the most powerful stress reducers is social connection. Unfortunately, as we become more stressed we tend to avoid social connection especially when our minds tell us “everyone wants something from me.” We have to hear that thought, learn to set good boundaries, and reach out in new ways for connection. Remember to think about ways you can reconnect with family members.

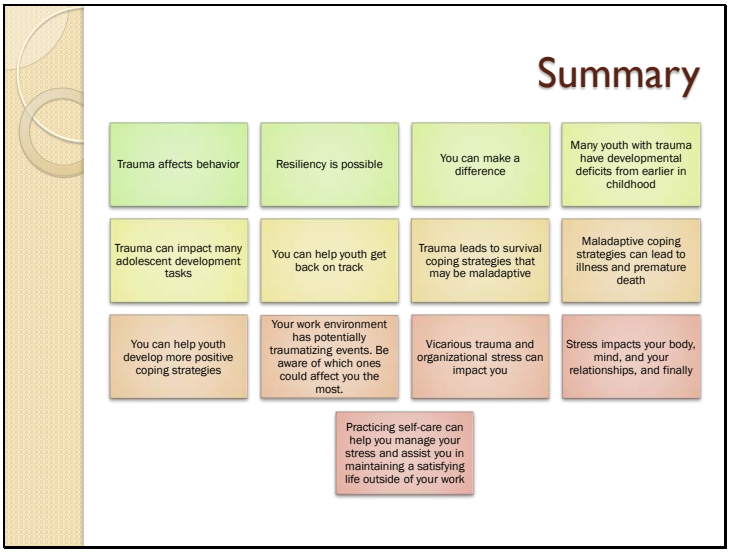
Slide 2



Residential Child and Youth Care Practitioner (RCYCP) Training

Welcome to Module 7, Part 15 of the Residential Child and Youth Care Practitioner Training.

Slide 3

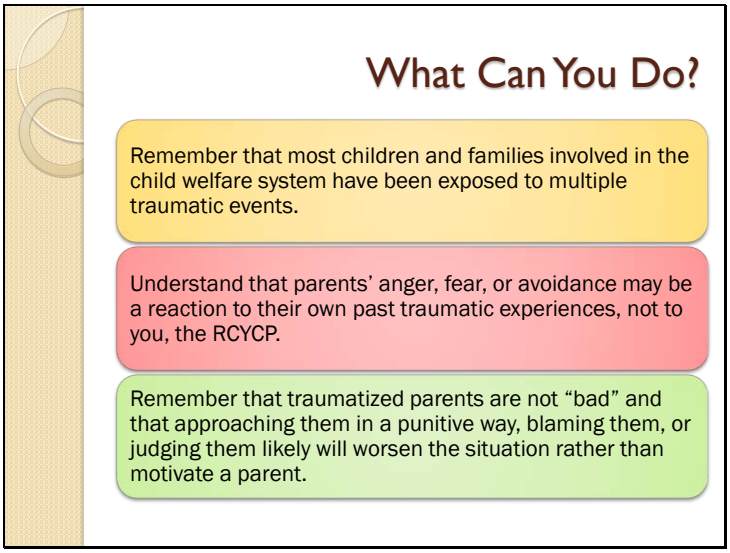


Summary

To summarize:

- Trauma affects behavior.
- Resiliency is possible.
- You can make a difference.
- Many youth with trauma have developmental deficits from earlier in childhood.
- Trauma can impact many adolescent development tasks.
- You can help youth get back on track.
- Trauma leads to survival coping strategies that may be maladaptive.
- Maladaptive coping strategies can lead to illness and premature death.
- You can help youth develop more positive coping strategies.
- Your work environment has potentially traumatizing events. Be aware of which ones could affect you the most.
- Vicarious trauma and organizational stress can impact you.
- Stress impacts your body, mind, and your relationships, and finally
- Practicing self-care can help you manage your stress and assist you in maintaining a satisfying life outside of your work.

Slide 4

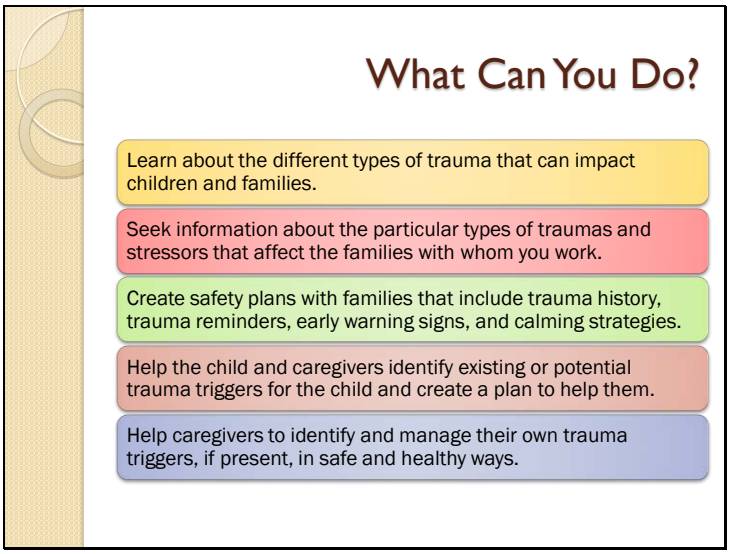


What Can You Do?

So what can you as an RCYCP do?

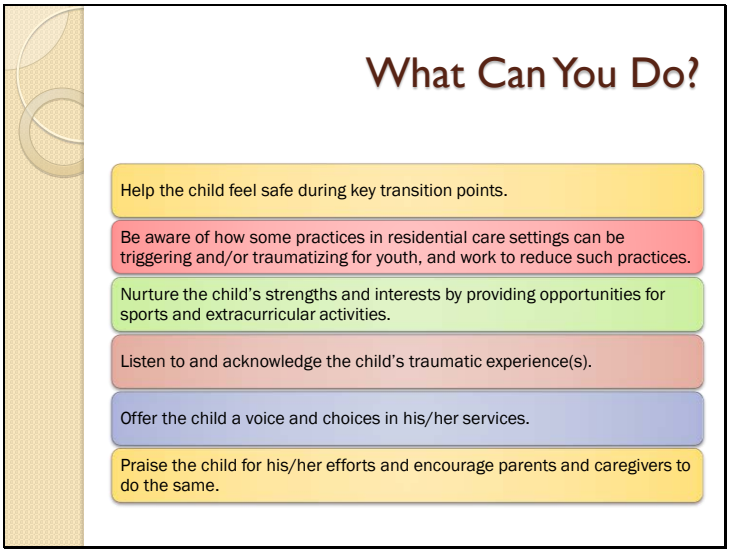
- Remember that most children and families involved in the child welfare system have been exposed to multiple traumatic events.
- Understand that parents' anger, fear, or avoidance may be a reaction to their own past traumatic experiences, not to you, the RCYCP.
- Remember that traumatized parents are not "bad" and that approaching them in a punitive way, blaming them, or judging them likely will worsen the situation rather than motivate a parent.

Slide 5



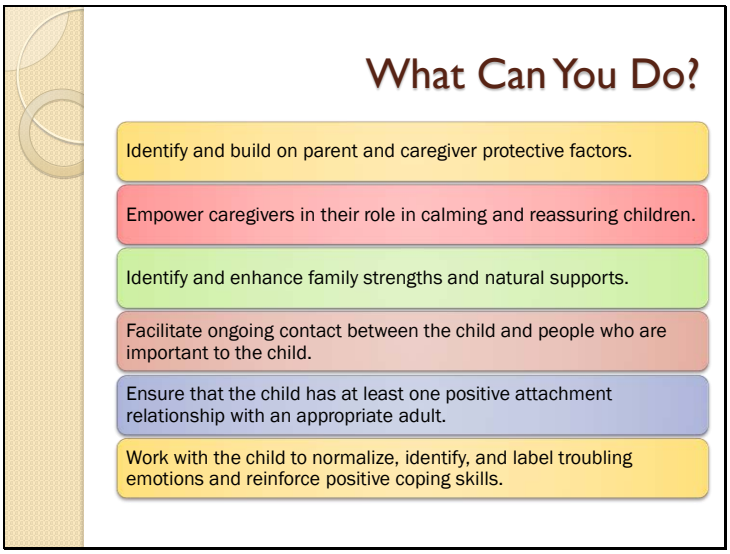
- Learn about the different types of trauma that can impact children and families.
- Seek information about the particular types of traumas and stressors that affect the families with whom you work.
- Create safety plans with families that include trauma history, trauma reminders, early warning signs, and calming strategies.
- Help the child and caregivers identify existing or potential trauma triggers for the child and create a plan to help them.
- Help caregivers to identify and manage their own trauma triggers, if present, in safe and healthy ways.

Slide 6



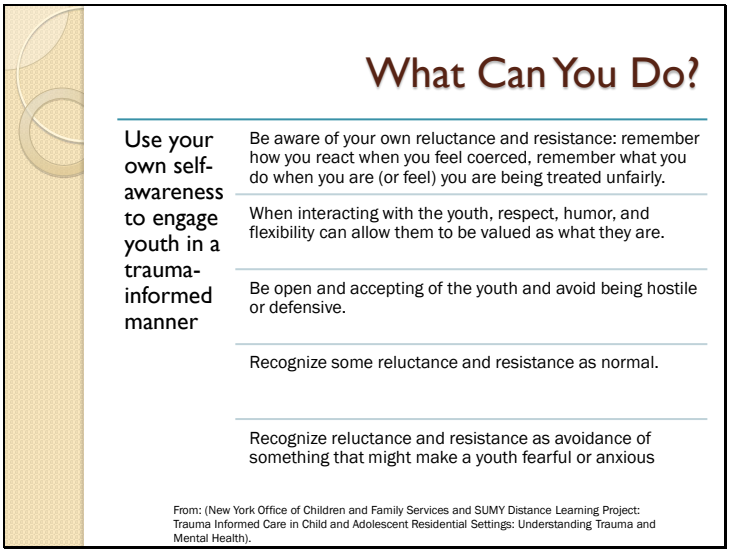
- Help the child feel safe during key transition points.
- Be aware of how some practices in residential care settings can be triggering and/or traumatizing for youth, and work to reduce such practices (for example, seclusion and restraint).
- Nurture the child's strengths and interests by providing opportunities for sports and extracurricular activities.
- Listen to and acknowledge the child's traumatic experience(s).
- Offer the child a voice and choices in his/her services.
- Praise the child for his/her efforts and encourage parents and caregivers to do the same.

Slide 7



- Identify and build on parent and caregiver protective factors.
- Empower caregivers in their role in calming and reassuring children.
- Identify and enhance family strengths and natural supports.
- Facilitate ongoing contact between the child and people who are important to the child (e.g., family, friends, teachers, etc.).
- Ensure that the child has at least one positive attachment relationship with an appropriate adult.
- Work with the child to normalize, identify, and label troubling emotions and reinforce positive coping skills.

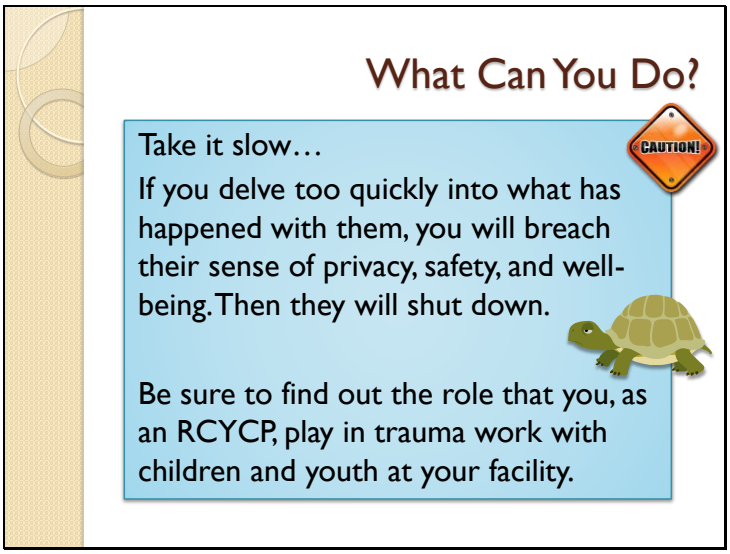
Slide 8



- Use your own self-awareness to engage youth in a trauma-informed manner:
  - Be aware of your own reluctance and resistance: remember how you react when you feel coerced, remember what you do when you are (or feel) you are being treated unfairly.
  - When interacting with the youth, respect, humor, and flexibility can allow them to be valued as what they are.
  - Be open and accepting of the youth and avoid being hostile or defensive.
  - Recognize some reluctance and resistance as normal.
  - Recognize reluctance and resistance as avoidance of something that might make a youth fearful or anxious.

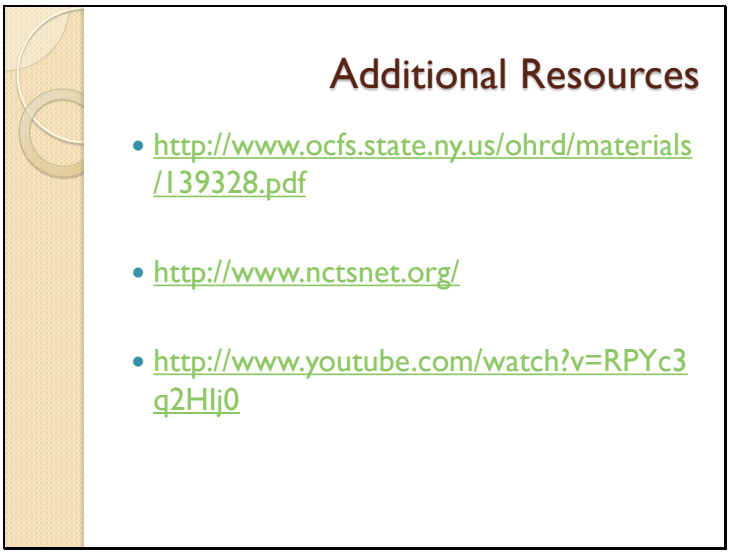
From: (New York Office of Children and Family Services and SUMY Distance Learning Project: Trauma Informed Care in Child and Adolescent Residential Settings: Understanding Trauma and Mental Health).

Slide 9



- Finally, and most importantly, as an RCYCP, one of your most important jobs is to develop a healthy and positive relationship with the youth. While it is important to be aware of the trauma that youth have experienced in their lives, you do NOT want to delve too quickly into what has happened with them, or else you will breach their sense of privacy, safety, and well-being. The result will be that they will shut down and not be willing to open up to you or feel comfortable. Once again, be sure to find out the role that you, as an RCYCP, play in trauma work with children and youth at your facility. When in doubt, use your supervisors to help guide you.

Slide 11

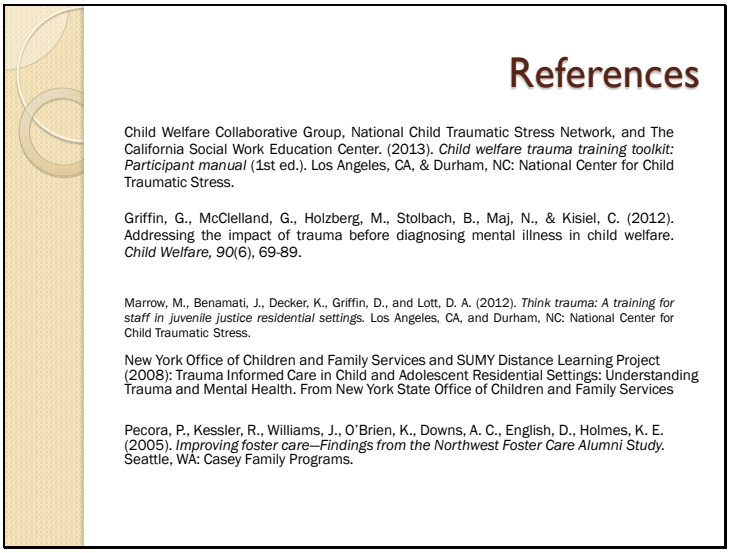


Additional Resources

For some other great resources and practical tips on working with children and adolescents in residential settings check out the following websites:

- http://www.ocfs.state.ny.us/ohrd/materials/139328.pdf
- http://www.nctsnet.org/
- http://www.youtube.com/watch?v=RPYc3q2Hlj0

Slide 12



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