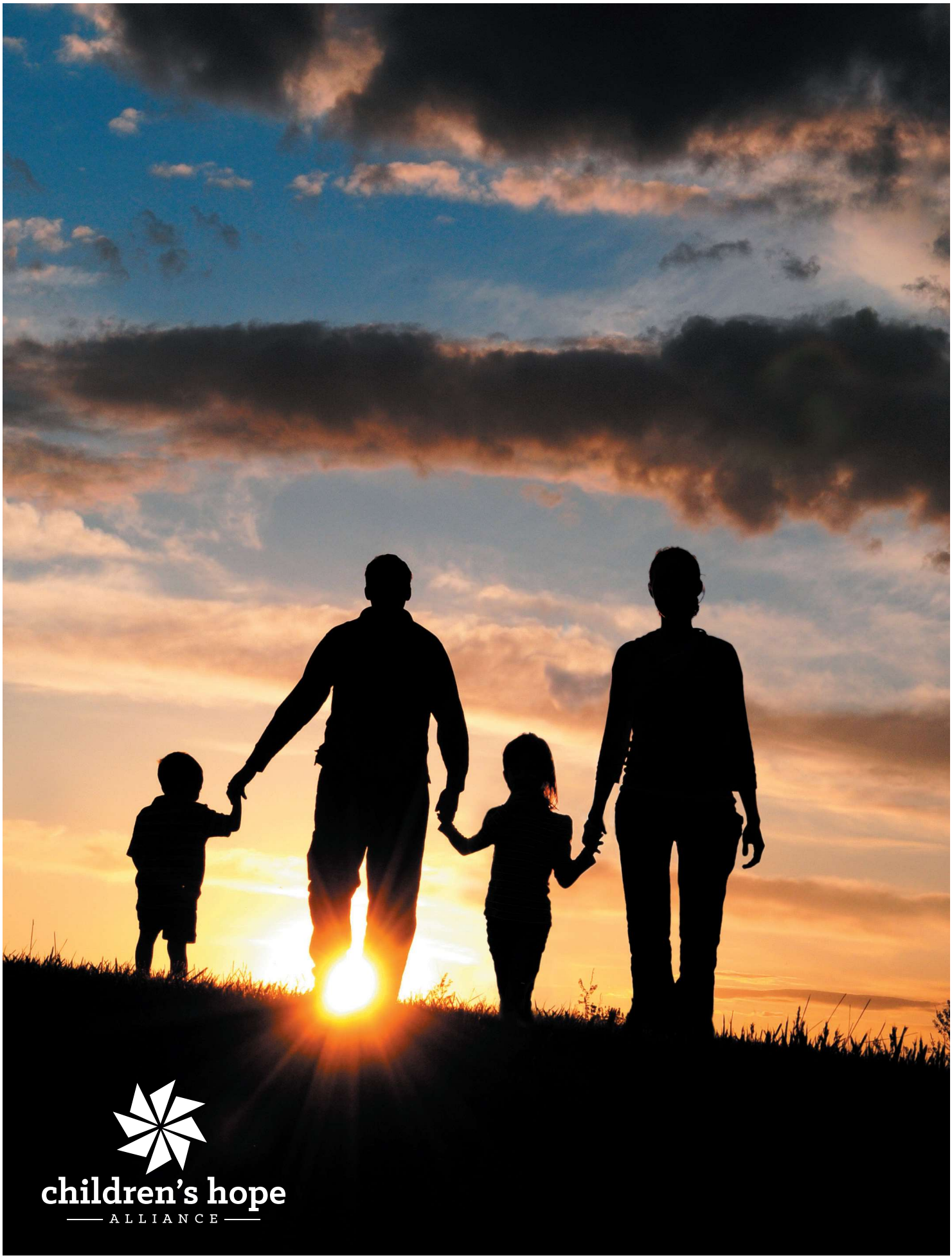
VOLUNTEER HANDBOOK

We ♡ our Volunteers

children's hope
ALLIANCE


children's hope
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welcome
to Children's Hope Alliance

Welcome to Volunteer Services at Children's Hope Alliance!

Volunteers are crucial to our mission, and you are an important member of our team. The continued support of volunteers and donors like you, make it possible for Children's Hope Alliance to help children and families in need in our communities.

The purpose of this volunteer handbook is to serve as a guide during your volunteer service, so please keep it handy.

If you ever have questions, please feel free to contact our volunteer coordinator, Julie Young, by email at JMYoung@childrenshopealliance.org or by phone at 704-437-4062.

Thank you for giving your time and talents at Children's Hope Alliance.
We hope your experience here is extremely rewarding!

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WHO we are

Children's Hope Alliance is a 501(c)(3) non-profit organization, that provided services to more than 1,860 children, families and individuals in 2020.

Barium Springs Home for Children was founded in 1883 in Statesville, NC. Grandfather Home for Children was founded in 1914 in Banner Elk, NC. In 2014, these two agencies merged in an effort to have a greater impact in helping children and families across the region.

The name chosen for the newly formed, merged organization was Children's Hope Alliance. This name allows everyone to understand our deeply rooted mission, to provide hope and healing for hurting children and families.

The future of Children's Hope Alliance is bright, our stability lies in our deeply-rooted mission and a willingness to attend to the special needs of each generation.

WHAT we do

Children's Hope Alliance provides an array of services for children, families and individuals throughout North Carolina. Our mission is to provide **Hope, Health, and Healing for Generations.**

HOPE: Ability to envision a positive future.

HEALTH: Skills to live a life of emotional, mental, physical, spiritual, and social wellness.

HEALING: Having sufficient emotional, mental, physical, spiritual, social and financial resources to tackle life's challenges from a position of strength and resiliency.

GENERATIONS: Creation of systemic change for the individual, extended family, and community by breaking the repetitive cycles of destructive behaviors, abuse, self-neglect, and system dependency.

Joint Commission Accredited

Children's Hope Alliance is Joint Commission Accredited. Joint Commission assists CHA to organize and strengthen client safety; strengthen community confidence in the quality and safety of care, treatment and services; improve overall risk management and risk reduction; enhance staff recruitment and development; and provide practical tools to strengthen and maintain performance excellence.

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MISSION: Hope, Health, and Healing for Generations

HOPE: Ability to envision a positive future

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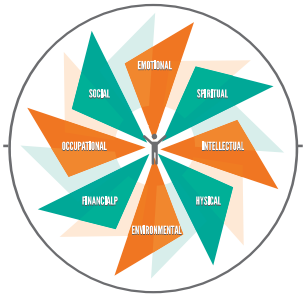
CORE VALUES:

- Commitment to Quality and Effectiveness
- Healthy Relationships
- Fully Integrated Technology Solutions
- Amplify Resource Impact
- Family-Centered
- Innovation
- Community Partnerships for Impact

Children and families from all walks of life seek help with mental, emotional, behavioral, and other problems. **Their journey starts here**.

However a child and family enters the doors to services – whether it's through mental health, social services, or a community provider – their situation is assessed to find the **best solution for them:** A solution that offers hope, health, and healing on their journey.



Through the lens of Whole Person Integrated Care (WPIC), **services are identified for their needs**. When a child or family has needs in addition to our services, we connect them with others who can help.

Our main objective is to ensure children have a safe home and their family is thriving within their community.

overview of CHA PROGRAMS

Outpatient Therapeutic Services has one focus: the well-being of the whole person. We work with children, teens, adults, and families to develop the skills and mindset needed to transcend challenges and live a life of emotional health. Children's Hope Alliance Outpatient Services offer both assessment and treatment for various needs in mental and behavioral health. Services are offered in diverse modalities through a comprehensive service array, using evidence-based and evidence-informed practice.

Psychiatric Residential Treatment Facility (PRTF, King Home) is the highest level of care a troubled child can receive, other than hospitalization. Youth at this level need around-the-clock care from our staff and are generally at risk of hurting themselves or others.

Treatment Alternatives for Sexualized Kids (TASK) is a treatment model designed to meet the complex needs of youth who have engaged in sexually harmful behavior. TASK is an intensive community-bases service that includes in-home and outpatient components.

Child-focused Assertive Community Treatment Team (Child ACTT) is a unique and highly individualized family-focused, complete multidisciplinary service with the mission of healing hurting children in their own homes and communities through a combination of face-to-face, virtual, and technology integrated services to meet the daily needs of clients. Treatment includes individual and family therapy, wellness coaching, medication management, respite, care coordination, and crisis supports.

Catawba Valley Healthy Families (CVHF) is a voluntary home visitation program designed to empower parents to support their child(ren)'s healthy development by establishing a nurturing and safe home environment and encouraging parents to set and achieve goals specific to the hopes and dreams they have for their families.

Intensive Family Preservation & Family Reunification Services (IFPS) teams work with families in their homes to resolve crises, establish stability, develop self-help and living skills, enhance parenting skills and strategies to help a child manage his/her behavior. These services are focused on helping parents keep a child in their home and may also provide support by making connections to needed community resources for food, utilities, housing, clothing, and more.

Intensive In-Home Services (IIH) works to make sure children in our care have a safe and protective family environment. One way we can help families is by providing services in cases where children are at risk of, or are currently experiencing, an out-of-home placement. The goal of treatment is to help the youth and family learn new, effective, and sustainable ways of dealing with trauma.

Foster Care Services is a statewide program that provides safe homes for children ages 0-18. Most often, our foster families care for children age 9 and over. Frequently, these children are siblings and we often see those with significant mental health or medical needs. Most of these children have also suffered from abuse and/or neglect.

Day Treatment (DTX) helps children struggling with behavioral or attachment issues, who are also struggling in the classroom setting. This program provides students with greater behavioral and therapeutic support by maintaining a balance between education and therapeutic issues.

The **Transitional Living Program (TLP)** establishes and maintains a safe, healthy, productive, and family home-like setting for young adults ages 18-21, transitioning to the world-at-large. A supportive, consistent, and purposeful life-changing structure allows these young people to acquire the requisite academic, social, emotional, vocational, and independent living skills to be self-sufficient and successful in college, career, and community-based living.

BARIUM SPRINGS
GIVING HOPE TO CHILDREN & FAMILIES
— EST. 1891 —

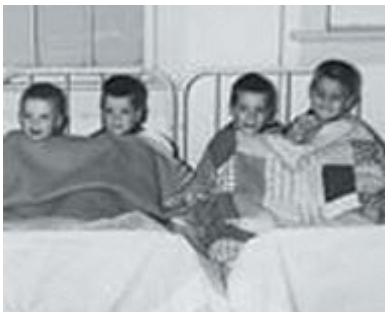
The History of Barium Springs Home for Children

In 1883, two Presbyterian women in Charlotte, North Carolina founded the Presbyterian Orphans Home, now called Barium Springs. As needs grew and space did not, the Presbyterian Synod purchased acreage for the Home in Barium Springs, NC. The land they purchased was the site of the legendary, healing "Barium Springs."

The Legendary Springs

In the mid-1700s, the first settlers to explore the area discovered nine springs. These waters contained healthful minerals, with the largest of the springs containing barium. A company called The Great Human Repair Shop was formed and shipped water from the springs throughout America, England, and Ireland. To accommodate patients who visited the springs, a 30-room hotel was built. This area and the business it created boomed until the end of World War I when the land was sold to Davidson College and then to the Presbyterian Synod.

The Orphanage Era



After purchase of the land, Presbyterian Children's Home moved to Barium Springs. Over the next ten years, the campus grew with cottages, an infirmary and a school. Until the 1950's, children coming to Barium Springs were mostly orphans who would stay for long periods of time. Many came as infants and stayed until graduation from high school or college. During the reign of the Home's legendary charismatic leader, Mr. Joseph Boudinot (J.B.) Johnston (1922 - 1949), the children produced 85% of the Home's food needs. The Home once operated a farm, orchard, dairy, laundry, print shop, and shoe repair shop, as well as a Baby Cottage, and had a successful athletic program in football, basketball, wrestling, and track. Christian education was a part of daily life at the Home.

Changing Times, Changing Needs

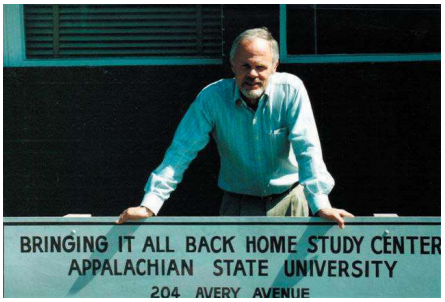
In the 1950's, needs for an orphanage decreased, partially due to peacetime and advances in medical technology. Instead, children needing care had one or both parents still living; but they suffered from abuse and neglect. Not only did these children need a place of refuge, but they also required treatment and therapy. Services expanded in 1969 to include high-quality, full-day childcare for working parents. Later, an alternative school was founded for early middle school to high school students who were not successful in traditional classroom settings.

To meet the needs of children today, Barium Springs has become a full service child welfare agency. Our stability lies in our deeply-rooted mission and a willingness to attend to the special needs of each generation.

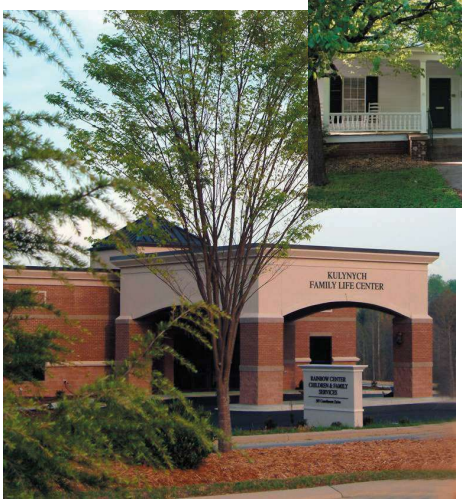
During fiscal year 2010-11, Barium Springs acquired four agencies in order to serve more children and families. During that time, quality providers like Rainbow Center in Wilkesboro, Our Father's Place in Statesville, Appalachian Family Innovations in Morganton, Winston-Salem and Asheville and finally, Mountain Youth Resources in Sylva, Bryson City and Franklin joined forces with Barium Springs. More children and families in need maintained services because of this growth.

If you would like to learn more about our rich history, visit the Barium Museum in Statesville, NC. There is a photo gallery and access to many books written about life at Barium Springs.

Our Father's Place, 2010



Appalachian Family Innovations, 2011



Rainbow Center, 2010

Mountain Youth Resources, 2011

The History of Grandfather Home for Children

Grandfather Home began in 1914 when Reverend Edgar Tufts, a Presbyterian minister, converted a farmhouse into an orphanage for homeless children. By August 1915 the home was filled with 16 children. Rev. Tufts saw the need to expand and called upon churches and donors for support. The first new building on campus, Grier Cottage, was opened to children in 1917. That tradition of responsive support continues to this day.

Over the decades, Grandfather Home refocused its ministry to provide help to a changing population of children in need. Starting in 1914 and for the next several decades, children were admitted due to the orphan or half-orphaned status. After World War II Grandfather Home started to serve children whose parents had some degree of dysfunction. Gradually, children from homes commonly referred to as broken families or troubled homes became residents.

Beginning in the 1970s and into the 1980s, children identified as abused and neglected were the primary referral source. As services continued to be refined for the provision of new services, children who came from significantly abusive situations were admitted. In the 1990s, the ministry's focus was on the child who had experienced significant abuse and multiple placements beyond his/her birth family – experiences that resulted in disruptive behavioral patterns.

In 2002, Grandfather Home began to develop its community services initiatives. This added dimension of work with children and families has blossomed. As the state children's services moved to a community focus and away from institutional treatment centers, Grandfather was prepared anew to meet the needs of children today who we have referenced for years as "the child now before us."

In the last decade, the landscape of treatment services for traumatized children has shifted significantly. The Grandfather Home ministry today often serves a child whose background includes sexual abuse. Unfortunately, a number of these children are so embedded in the cycle of abuse that they now exhibit sexually abusive behaviors. It is for this group of children that our mission provides a special focus of care.

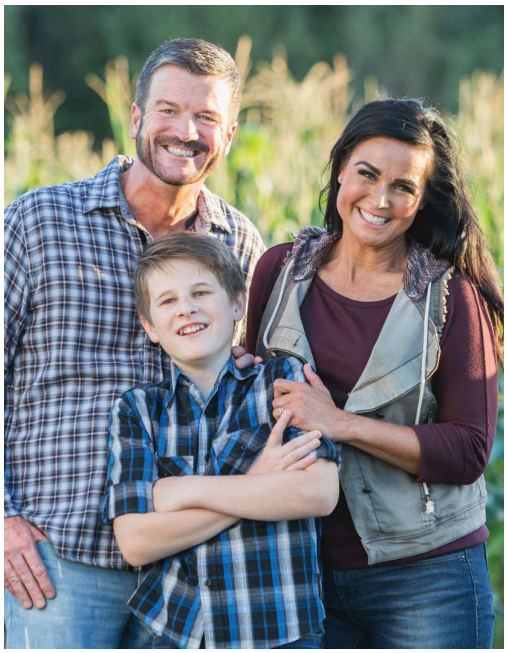
Two of North Carolina's most historic and prominent child welfare organizations have teamed up and now fall under a new umbrella name. In April 2014, Barium Springs and Grandfather Home for Children merged, making the combined agency one of the largest child service providers in North Carolina. Over the past year, Barium Springs and Grandfather Home operated together, but under two separate names. On March 30, 2014, the two agencies began operating as one cohesive organization under the name "Children's Hope Alliance."

The name adopted when these two agencies merged was, "Children's Hope Alliance." Under a new name, Barium Springs and Grandfather Home have continued to serve children in need, with a combined history of more than 220 years helping make a difference.

HOPE, HEALTH, and HEALING for GENERATIONS

children's hope ALLIANCE

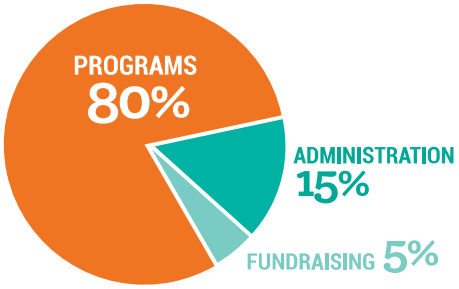
2019-2020 Impact Report on Mission



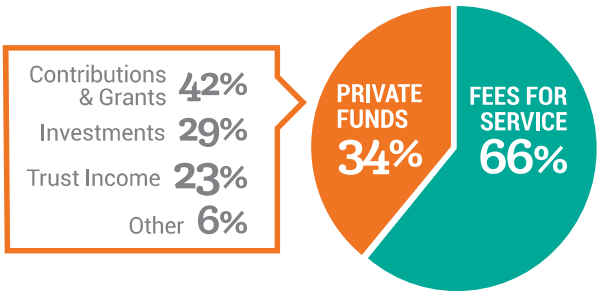
Your Gifts Matter

Each year, we are humbled by the continued generosity of the individuals, foundations, businesses and churches who contribute to the financial health and growth of our mission. You make such a positive impact in the lives of children and families who are struggling while we are working toward generational change. Without your help, many of them would be at risk of certain failure. But, you put a smile on their faces and hope in their hearts by providing the help and support they so desperately need. **Thank you!**

expenses



revenue



Percentages above are considered accurate but are unaudited.

Fees we receive for services (government and insurance reimbursements) only cover 66% of the cost of services.

We rely heavily on our endowment and private contributions in order to fully serve NC children and families in need. **We simply could not fund our mission without you.**

In 2019-2020, 80% of every dollar raised or paid went directly to programs that support children and families.

Our NC Locations

Asheville
Banner Elk
Charlotte
Greensboro
Lexington
Morganton
Statesville
Sylva
Wilkesboro
Winston-Salem

With 10 office locations, we served children and families from 64 NC counties.

1,860+

The lives of over 1,860 children and families were changed through Children's Hope Alliance last year.

PROGRAMS + SERVICES

Foster Care and Adoption Services

324 children are closer to their **forever home**

- Family & Therapeutic Foster Care
- Intensive Alternative Family Treatment
- Adoption & Post Adoption Services

Residential Services

184 children & young adults had a **safe home**

- Acute Care Services
- Transitional Living

Outpatient Therapeutic Services

812 children are on their **healing journey**

- Individual, Group and Family Therapy
- Dove House

Therapeutic Education

87 children improved in **school**

Family-based Services

455 at-risk children and families found **support**

- Intensive In-Home Services
- Intensive Family Preservation/Reunification Services
- Treatment Alternatives for Sexualized Kids (TASK)
- Catawba Valley Healthy Families
- Child-focused Assertive Community Treatment Teams (Child ACTT)

#BETHEHOPE

the facts

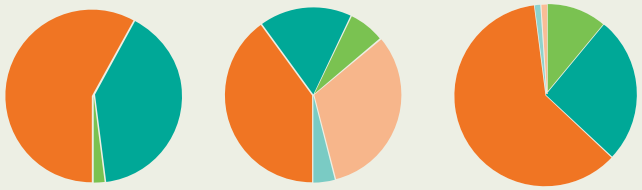
Nearly **1 in 2** NC children live in poor or low income, at-risk homes

1 in 5 NC children live in food insecure households

1 in 5 NC children has a mental, behavorial or developmental disorder.

72% of NC children who need mental health services do not receive them.

about the children & families you helped



Gender		Race		Age	
Male	58%	White	40%	0-5	11%
Female	40%	Black	17%	6-11	26%
Unreported	2%	Multiracial	7%	12-18	61%
		Hispanic	4%	19-24	1%
		Unrecorded	32%	25+ (young adults + parents)	1%

get involved

give
Join the Alliance to support children and families

advocate
Find us on social media – like, post, and share

volunteer
Help others find Hope, Health, and Healing

www.ChildrensHopeAlliance.org

CHA Volunteer Program

Mission for Volunteer Program

Volunteers are important roles at Children's Hope Alliance. Volunteers make it possible for us to provide safe and well-maintained environments, quality experiences and events, and financial support for the children, families, and communities that we serve. Without you, these opportunities to improve other's lives wouldn't be possible. Thank you for volunteering your time and talent with CHA.

Volunteer Opportunities at CHA

Check our website (www.childrenshopealliance.org/volunteer) for current opportunities.

Volunteer Expectations

As a volunteer, you have the right to:

- be treated as a co-worker and a valued team member.
- have a suitable assignment.
- know as much about the organization as possible-it's history, it's policies, and it's programs.
- train for the assignment and receive continued training and feedback to grow in your volunteer roles.
- a safe place to work.
- be heard, to feel free to make suggestions, and to have a part in planning.
- be recognized for your volunteer work through daily expressions of gratitude and at formal events.

Children's Hope Alliance has the right to expect you to:

- abide by the mutually agreed up on service commitment.
- honor your commitment and inform your department supervisor or volunteer coordinator ahead of time if you are unable to be present when scheduled.
- maintain a satisfactory standard of performance.
- adhere to policies and procedures for CHA volunteers.
- attend required training for the volunteer role.
- be punctual.
- behave in a professional manner, maintaining confidentiality at all times.
- communicate any problem related to the volunteer assignment.
- cooperate with staff and other volunteers.
- record volunteer hours worked.

▶ Interacting with clients and families

The Joint Commission on Accreditation of Healthcare Organizations requires that all employees and volunteers who work with or around patients understand how to deal with different age groups. This is what The Joint Commission refers to as "characteristic of populations served or age-competencies." This knowledge is essential for providing care to specific age groups. The following are the Environment of Care Competencies for the following age groups seen by CHA. Keep in mind that every client is to be treated at all times with courtesy and respect and full recognition of dignity and individuality.

For All Ages

Introduce yourself. Tell why you are there and wear your name tag.

Ask for names of clients and family members, then use them.

- Take emotions, feelings and ideas seriously.
- Maintain a positive attitude.
- Be honest.
- Be empathetic.
- Keep confidential information to yourself.
- Be creative — everyone loves to laugh and feel good.
- Respect and privacy are important.
- Recognized that all persons have equal value.

For Children

- Play is a child's work — encourage and support it.
- Each child is an individual — comparisons to others can hurt.
- Staring, pointing, or whispering about children who look or act different hurts their feelings.

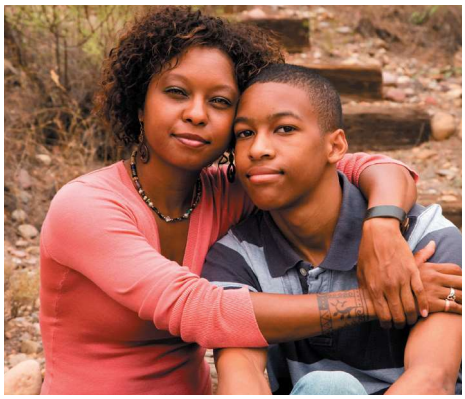
Age	Major Fears	Characteristics	Tips for Interaction
School age (6-11 years old)	Loss of control, pain, injury to the body, separation from parents, caregivers, or friends; disappointing their parents or caregivers; and death.	Sometimes they nod to show they understand when they really don't. Ask them to tell you what they understand. Reluctant to ask questions or reveal they don't know something. Curious about everything.	Offer choices, but only ones that can be granted. Help the child feel useful and valued by including them in discussions and giving them responsibilities wherever possible.
Adoles-cents (12-20 years old)	Loss of control, changed appearance, and separation from friends.	They have a strong need for privacy. Can be uncooperative, angry, shy, bored, or lonely at times.	Recognize their concerns about how they look to others. Encourage them to talk about their concerns. Encourage involvement when making decisions. Ask for the meanings of slang or other words you don't understand. Share information with the teen as well as their parents.

Tips for Working with Children

All of our interactions with children are guided by a respect for their feelings and concerns.

- It is important to remember that children are very aware of what is being said and done around them; therefore, be certain when discussing a client or family that they are either included or that they cannot hear you. If parents or children ask you about another client, simply tell them politely that you do not know or that it is confidential information.
- Accept each child as an individual with his or her own strengths, weaknesses, and needs. Realize that presents challenges for the client and the entire family unit, and to not be judgmental.
- Encourage the children to be as independent as they are able to be, depending on their age.
- When helping children in an activity, do not do the activity for them. Your role is to supervise, guide, and provide encouragement. Never say anything negative about an activity in front of the children or their caregivers. Also, warn the child before it is time for the activity to end. Example: "In five minutes, we will need to begin cleaning up."
- Set limits firmly and consistently. Children will test you, but if you expect appropriate behavior, you are more likely to get it. Remember, a child needs a combination of love, warmth, and discipline.
- Praising a child is one of the best ways to help him feel good about himself and his accomplishments. A rule to keep in mind is to praise the child's act or accomplishment and not his personality or character. Instead of saying the child is "good" for something he has done, you might say, "You really helped me by cleaning up."
- Honesty is essential in dealing with children. Even very young children sense falsehoods and are aware if adults fail to keep their promises. Avoid making promises (for example, "I will be back later.") Our environment is dynamic, and it is difficult to always follow through on promises. We forget how seriously a child takes a promise, even a casual one like, "See you later." Consistency is one of the best ways to build trust and rapport with a child.
- It is sometimes embarrassing to assume a child's age or gender identity. Some clients do not look their age and often it is difficult to determine a child's gender.
- Please don't kiss a client. Ask before hugging.
- CHA does not discriminate against clients, their family, companions, or visitors based on sexual orientation, gender identity, identification as LGBTQ, or any sex stereotype.





Working with Parents/Guardians/Adults

Greet the families. Often the focus is only on the child, and parents welcome an opportunity to think about themselves for a few minutes.

- Introduce participants to one another if you think they have not met.
- Be especially attentive to families that are coming for the first time.
- Be available as a compassionate friend to listen when parents or caregivers need to talk. This is the greatest gift you can give them. Do not recite your own stories of similar experiences; instead, keep the focus on the parent and simpy acknowledge and validate his or her feelings.
- Avoid judging parents. They are under stress and are probably not at their best.
- Do realize that the topic of the child's treatment is an emotionally charged one for the parents. Remain willing to listen if the parents wish to discuss their child's treatment, but never ask intrusive questions. The parents and caregivers may not be comfortable revealing their feelings. Strict confidentiality of our clients and families should be maintained at all times.
- Avoid negative wording such as "What is wrong with your child?" Be sure to monitor your casual language.
- Be sensitive to the fact that others may have religious beliefs that are different from your own. Do not offer your own religious faith in order to encourage others.
- If you observe something that is disturbing to you, you are required to share it with an appropriate staff person. It may be that what you observe is information that can be valuable to improving client care. For example, if you observe parents having a heated argument or a parent being unusually rough with a child. We may be able to intervene to improve or alleviate stress.

▶ Limitations and Boundaries

Volunteers are not allowed to perform or participate in therapeutic capacities.

As a volunteer of CHA, it is important to ensure you establish healthy relationships that include firm boundaries. Firm boundaries will assist in preventing inappropriate conduct when interacting with clients, families and/or associated adults.

Inappropriate conduct/activities include but are not limited to:

- Accepting personal gifts from clients or families. There may be some exceptions such as a painting, hand drawing or craft. For these items, please consult with the program director. Any item purchased from a store or shop or that is of value should be refused, politely.
- Purchasing gifts for clients or family members is prohibited.
- Sharing personal contact information.
- Sharing personal problems.
- Loaning money or similar.
- Inviting clients and/or families to your personal residence or for other off-campus, non-CHA related and/or non-program related activities.
- Giving clients or families non-prescription medication.
- Sharing client information about one client with another client or family.

▶ Confidentiality and HIPAA

All information related to clients is strictly confidential. The very fact that a client is receiving services from CHA is confidential even when no other information regarding the client's condition or treatment is revealed. Federal and state law govern when and how we may release information about clients. If you receive any request (verbal, written, etc.) for any information related to a client, please alert the program director as soon as possible.

HIPAA, abbreviated from the Health Insurance Portability and Accountability Act of 1996, requires that everyone, including volunteers, safeguard and protect client information. This information, usually referenced as Protected Health Information (PHI) or Personal Identifiable Information (PII), can include medical records, conversations, faxes, emails, text messages, documents or any information that specifically identifies a client. Additionally, photographs and videos are considered PHI. All video, photography and/or auto recording of a client is strictly prohibited unless preapproved by Program Director and the CHA Privacy Officer.

As a volunteer at CHA, it is your responsibility to understand HIPAA and confidentiality.

If you have questions related to confidentiality and HIPAA, please reach out to the Program Director or contact the CHA Privacy Officer at 704-437-3366 or at compliance@childrenshopealliance.org.

▶ Information Management

Internet access is provided by Children's Hope Alliance in all CHA facilities and campus locations and are for business use only. Very limited incidental use for personal or non-business purposes is acceptable. Personal use must not involve any prohibited activity such as harassment, illegal conduct, offensive conduct, sexual material, obtaining unauthorized access, etc. Guest access to the internet is provided to clients, visitors, guardians and volunteers. Please check with the program manager for accessible areas and passwords. The inappropriate use outlined above is also applicable to guest network use.

▶ Social Media

CHA prohibits communicating with clients via social networking sites such as Facebook, Tik Tok, Instagram, LinkedIn, etc. This would include "friending", "networking", "instant messaging", etc. You are welcome to share any social media post by the office CHA social media pages, however, you may not acknowledge any connections with clients in any social media posts. Posting photographs, videos and/or audio recording of clients is strictly prohibited. If you choose to identify yourself as a CHA volunteer, all associated content must abide by CHA values and professional standards.

▶ Cell Phone Use

The use of cell phones while driving on campuses is prohibited. You may have your cell phone with you during your volunteer shift, however, you must not use it when you are working with children or their families.

▶ Dress Code

Volunteers should dress for their assignment, in other words the dress code is "dress for your day". Please keep in mind that you are setting an example for our youth and their families, many of which may have been neglected or abused.

Please do not wear:

- clothes that are distracting or revealing
- sleeveless shirts
- clothes with offensive sexual, racial, political, religious, age-related, ethnic, disability-related subject matter, or messaging or advertisements related to alcoholic beverages, tobacco, or drugs.
- uncovered tattoos that depict nudity or profanity, are inflammatory in nature, represent violence, drugs, sex, alcohol or tobacco products, or may otherwise be interpreted as offensive or scary.

▶ Public Relations

All media requests must be pre-coordinated by a member of the Children's Hope Alliance Communication Department. Before speaking to the media regarding Children's Hope Alliance or your volunteer service, please be sure to contact the Communications Department or volunteer coordinator. If you are contacted directly by a publication, broadcast, internet media, radio or other type of media representative, please inform the representative that the Children's Hope Alliance Communications Department must handle all media requests and approve any information given to the media.

▶ The Children's Hope Alliance Logo

The Children's Hope Alliance logo is trademarked and may not be used for any purposes without prior approval. You may not use it in any way outside of regular volunteer activities. The use of the logo is prohibited on personal social media or blog sites. All fundraising for CHA must be pre-approved and arranged with the permission of CHA's Development Department.

▶ Visitors

Your friends and relatives may not accompany you on Children's Hope Alliance campuses or functions unless they have completed the volunteer application and all applicable onboarding requirements.

▶ Smoking Policy

Smoking or the use of tobacco and electronic cigarettes is prohibited by volunteers in or on all Children's Hope Alliance buildings, grounds, parking lots, vehicles (including personal vehicles) and nearby entrances/exits to the CHA properties. We appreciate you abiding by this policy.

▶ Substance Abuse

Children's Hope Alliance is committed to maintaining a workplace that is free from the influence of alcohol and drugs. CHA prohibits the use, possession, manufacture, distribution or sale of drugs and alcohol on CHA property. If you are required by your physician to take a prescription medication during your volunteer shift, please secure it in a locked area (locker, personal car, etc.).

▶ Weapons-free Workplace

To help ensure a safe environment for children, families, volunteers, and staff, Children's Hope Alliance prohibits weapons on campus. A weapon is any object or instrument with the potential to cause physical injury.

All persons on CHA property are barred from carrying or otherwise transporting a handgun, firearm, or prohibited weapon of any kind on the premises regardless of their permit status. Contact the volunteer coordinator with any questions regarding this policy.

All weapons observed should be reported to Facilities as soon as possible at **704-818-1704** (Barium Springs campus) or 704-832-2245 (Grandfather Home campus) or 828-260-2633 (Director of Properties).

▶ Harassment

Children's Hope Alliance has a "zero-tolerance" policy towards harassment. This means we have zero tolerance for workplace harassment or violence (spoken, written, texted, etc.) Harassment is verbal or physical conduct that denigrates or shows hostility or aversion towards an individual because of their sex, race, color, religion, gender, national origin, age or disability. Any violation of this policy will result in disciplinary action up to and including immediate termination. Incidents must be reported to the HR Director, your supervisor, or by calling this confidential hotline — 215-884-6150. All complaints will be investigated. This includes harassment by an individual: staff, client, client's family, or another volunteer. There will not be any retaliation for reporting a complaint of harassment by an employee or volunteer.

▶ Client Abuse & Neglect Involving Volunteers

Policy

1. Children's Hope Alliance will not tolerate the mistreatment, neglect or abuse of client's or their family members. Each client should be treated with courtesy and respect and the full recognition of their dignity and individuality.
2. Every client has the right to be free of verbal, sexual, physical or emotional abuse, corporal punishment and involuntary seclusion. Clients must not be subjected to abuse by anyone, including, but not limited to: staff, other clients, volunteers, family members or legal guardians, or other individuals.
3. It is a crime to physically or emotionally neglect, abuse or threaten to neglect or abuse any client under the care or custody of Children's Hope Alliance. Any conviction for this offense carries the consequences identified by the Laws of North Carolina.
4. Everyone is a mandatory reporter under North Carolina Law. Failure to report actual, suspected or threatened abuse of any kind may result in disciplinary action up to and including termination.
5. Any volunteer convicted of failing to report client neglect or abuse is also subject to the consequences identified by the Laws of North Carolina.

How to report

- Contact your supervisor to report suspected abuse and/or neglect.
- Call the applicable county DSS. All county DSS numbers are posted on that county's website, or can be found online at: https://www.ncdhhs.gov/divisions/social-services/local-dss-directory
- You will need to cooperate fully with any ongoing investigation of abuse.

▶ Inclement Weather

In the event of dangerous weather conditions near the Children's Hope Alliance campus or event location, your safety is our priority. As a general rule, if the local schools are closed due to weather conditions, we do not expect you to report for your regularly scheduled volunteer shift. We ask that you call your program manager or the volunteer coordinator to confirm if you are not coming in for your shift.

▶ Children's Hope Alliance Volunteer Holidays

Volunteers for ongoing programs are not expected to report for volunteer shifts should it fall on a holiday. Please note these holidays listed below:

- New Year's Eve and New Year's Day
- Martin Luther King Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day and the day after
- Christmas Eve and Christmas Day

▶ Volunteer Termination

All volunteers deemed unsuitable for continued volunteer services at Children's Hope Alliance will be terminated and prohibited from further volunteer activity with the agency and its' programs. Volunteers may be terminated from volunteer services for:

- Breach of confidentiality
- Disregard/violation of the CHA policies
- Inability to work well with others
- Any concern the agency may have for the safety and comfort of our clients and their families.

▶ Volunteer Safety

Volunteers are expected to become familiar with the agency's policies regarding general safety, fire safety, emergency procedures and more. Please take time to become knowledgeable regarding these policies. Always report anything suspicious to the program director on duty immediately.

▶ Volunteer Access and Security

Volunteers will receive training for a specific shift and role while volunteering on a CHA campus. During this training and during your volunteer shift, you are not to enter areas on campus that are not relevant to your volunteer role.

While you are on shift, we encourage you to lock your belongings in a locker or your personal vehicle truck. Children's Hope Alliance is not responsible for the loss or damage to personal property or valuables. Please notify security of any missing items, suspicious people or packages on campus.

▶ Chemical Safety

When information is needed on certain cleaning or art chemical supplies, Safety Data Sheets (SDS) can provide the information. These sheets contain information on how to handle different substances. They are located in each building.

▶ Infection Control

Sickness

Volunteers should not report when ill because of the risk of transmitting the infection to clients, families, staff and other volunteers. Notify your volunteer coordinator or supervisor if you are unable to work as scheduled. Do not report to work if you have a temperature of 100.4 degrees F or greater, have had diarrhea or vomited in the last 24 hours, or have an active infection with measles, mumps, chicken pox, shingles, strep throat, conjunctivitis, Covid, cold or flu-like systems.

Hand Washing

Hand washing is the most effective method of preventing the spread of infection. The palms, back of the hands, in between fingers, and under the fingernails should be washed with antimicrobial soap for at least 20 seconds while vigorously rubbing them under water. Clean your hands often.

Spills

If there has been a spill or a child vomits, do not touch it. Notify the program director.

Art and Music Class Cleaning

As part of infection control, volunteer instructors should clean after each class. You will be trained on this process as part of your role. All supplies and surfaces will need to be disinfected, and it is important to follow product instructions when using disinfectant for cleaning, as well as following policies for hand washing, rinsing, etc.

▶ Fire Plan

Always familiarize yourself with your surroundings and know where the nearest fire alarm box, fire extinguisher and exits are located.

Use the RACE and PASS procedures described below for fire emergencies.

If you discover fire or smoke or you are responding to the scene of the fire, follow the RACE acronym (Rescue, Alarm, Contain, Extinguish or Evacuate):

1. R-**Rescue** any clients, staff or volunteers who may be in danger. Do not rescue anyone if it puts you at risk.
2. A-**Sound the alarm!** Pull the nearest fire alarm pull station to activate the alarm and call 911. Describe the nature of the situation to the operator.
3. C-**Contain the fire or smoke** by closing all doors and windows in your area.
4. E-**Extinguish the fire or evacuate.** If the fire is small, select the correct type of fire extinguisher and follow the PASS acronym (described below) when using the extinguisher. Once the fire is extinguished, stay at the site until the fire department arrives in an event that the fire re-lights itself. If the fire is too large or uncontrolled, evacuate yourself and others immediately.

How to use a fire extinguisher:

1. P-**Pull** the pin
2. A-**Aim** the nozzle at the base of the fire
3. S-**Squeeze** the handle releasing the extinguishing agent
4. S-**Sweep** the stream from side to side

Understanding Child Trauma

NCTSI
National Child Traumatic Stress Initiative

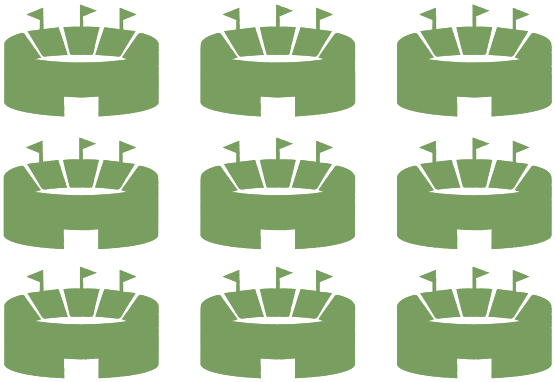
Child trauma occurs more than you think.

More than **TWO THIRDS OF CHILDREN** reported at least 1 traumatic event by age 16.[1] Potentially traumatic events include:

- PSYCHOLOGICAL, PHYSICAL, OR SEXUAL ABUSE
- COMMUNITY OR SCHOOL VIOLENCE
- WITNESSING OR EXPERIENCING DOMESTIC VIOLENCE
- NATURAL DISASTERS OR TERRORISM
- COMMERCIAL SEXUAL EXPLOITATION
- SUDDEN OR VIOLENT LOSS OF A LOVED ONE
- REFUGEE OR WAR EXPERIENCES
- MILITARY FAMILY-RELATED STRESSORS (E.G., DEPLOYMENT, PARENTAL LOSS OR INJURY)
- PHYSICAL OR SEXUAL ASSAULT
- NEGLECT
- SERIOUS ACCIDENTS OR LIFE-THREATENING ILLNESS

The national average of child abuse and neglect victims in 2013 was **679,000, or 9.1 victims** per **1,000 children.**[2]

Each year, the number of youth requiring hospital treatment for physical assault-related injuries would fill **EVERY SEAT IN 9 STADIUMS.**[3]



1 IN 4 HIGH SCHOOL STUDENTS was in at least **1 PHYSICAL FIGHT.**[4]

1 in 5 high school students was bullied at school; **1 IN 6 EXPERIENCED CYBERBULLYING.**[5]

19% of injured and 12% of physically ill youth have post-traumatic stress disorder.[6]

More than half of U.S. families have been affected by some type of disaster (**54%**).[7]

1 Copeland, W.E., Keeler G., Angold, A., & Costello, E.J. (2007). Traumatic Events and Posttraumatic Stress in Childhood. *Archives of General Psychiatry.* 64(5), 577-584.

2 U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2015). Child maltreatment 2013. http://www.acf.hhs.gov/sites/default/files/cb/cm2013.pdf

3,4,5 National Center for Injury Prevention and Control: Division of Violence Protection (2014). Taking Action to Prevent Youth Violence: A Companion Guide to Preventing Youth Violence: Opportunities for Action. http://www.cdc.gov/violenceprevention/youthviolence/pdf/opportunities-for-action-companion-guide.pdf

6 Kahana, S., Feeny, N. C., Youngstrom, E. R., & Drotar, D. (2006). Posttraumatic stress in youth experiencing illnesses and injuries: An exploratory meta-analysis. Traumatology, 12, 148-161. doi: 10.1177/1534765606294562

7 Save The Children (2014). 2014 National Report Card on Protecting Children in Disasters. http://www.savethechildren.org/atf/cf/%7B9def2ebe-10ae-432c-9bd0-df91d2eba74a%7D/SC-2014_DISASTERREPORT.PDF

NCTSN The National Child Traumatic Stress Network

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov

Understanding Child Trauma

NCTSI
National Child Traumatic Stress Initiative

It's important to recognize the signs of traumatic stress and its short- and long-term impact.

The signs of traumatic stress may be different in each child. Young children may react differently than older children.

PRESCHOOL CHILDREN

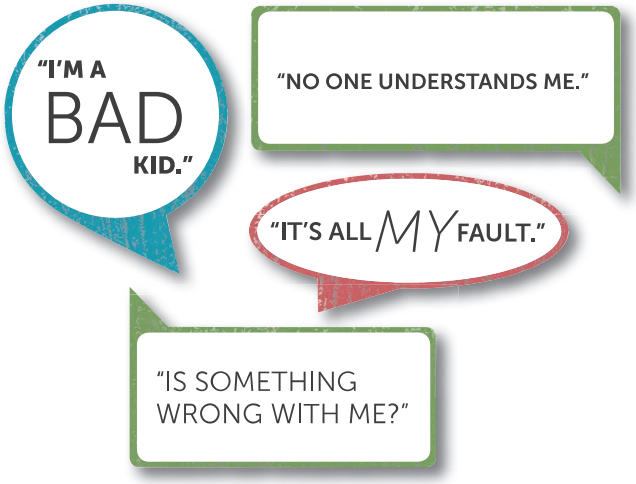
- Fear being separated from their parent/caregiver
- Cry or scream a lot
- Eat poorly or lose weight
- Have nightmares

ELEMENTARY SCHOOL CHILDREN

- Become anxious or fearful
- Feel guilt or shame
- Have a hard time concentrating
- Have difficulty sleeping

MIDDLE AND HIGH SCHOOL CHILDREN

- Feel depressed or alone
- Develop eating disorders or self-harming behaviors
- Begin abusing alcohol or drugs
- Become involved in risky sexual behavior



THE BODY'S ALARM SYSTEM

Everyone has an alarm system in their body that is designed to keep them safe from harm. When activated, this tool prepares the body to fight or run away. The alarm can be activated at any perceived sign of trouble and leave kids feeling scared, angry, irritable, or even withdrawn.

HEALTHY STEPS KIDS CAN TAKE TO RESPOND TO THE ALARM:

- Recognize what activates the alarm and how their body reacts
- Decide whether there is real trouble and seek help from a trusted adult
- Practice deep breathing and other relaxation methods

IMPACT OF TRAUMA

The impact of child traumatic stress can last well beyond childhood. In fact, research has shown that child trauma survivors may experience:

- Learning problems, including lower grades and more suspensions and expulsions
- Increased use of health and mental health services
- Increased involvement with the child welfare and juvenile justice systems
- Long-term health problems (e.g., diabetes and heart disease)

TRAUMA is a risk factor for nearly all behavioral health and substance use disorders.

NCTSN The National Child Traumatic Stress Network

Substance Abuse and Mental Health Services Administration
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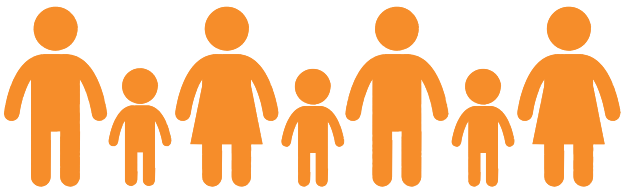
Understanding Child Trauma

NCTSI
National Child Traumatic Stress Initiative

There is hope. Children can and do recover from traumatic events, and you play an important role in their recovery.



A CRITICAL PART OF CHILDREN'S RECOVERY IS HAVING A SUPPORTIVE CAREGIVING SYSTEM, access to effective treatments, and service systems that are trauma informed.

GET HELP NOW
https://findtreatment.samhsa.gov
http://nctsn.org/resources/get-help-now
http://www.healthcaretoolbox.org

Not all children experience child traumatic stress after experiencing a traumatic event. With support, many children are able to recover and thrive.

As a caring adult and/or family member, you play an important role.

REMEMBER TO:

- ☐ Assure the child that he or she is safe.
- ☐ Explain that he or she is not responsible. Children often blame themselves for events that are completely out of their control.
- ☐ Be patient. Some children will recover quickly while others recover more slowly. Reassure them that they do not need to feel guilty or bad about any feelings or thoughts.
- ☐ Seek the help of a trained professional. When needed, a mental health professional trained in evidence-based trauma treatment can help children and families cope and move toward recovery. Ask your pediatrician, family physician, school counselor, or clergy member for a referral.
- ☐ Visit the following websites for more information:
  - http://www.samhsa.gov/child-trauma
  - http://www.samhsa.gov/trauma-violence
  - http://www.nctsn.org

NCTSN The National Child Traumatic Stress Network

Substance Abuse and Mental Health Services Administration SAMHSA www.samhsa.gov

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. SMA-15-4923 Printed 2015

Government of Western Australia
Department of Communities

Child development and trauma guide
5 - 7 years

Developmental trends

The following information needs to be understood in the context of the overview statement on child development:

Physical skills

- active, involved in physical activity, vigorous play
- may tire easily
- variation in levels of coordination and skill
- many become increasingly proficient in skills, games, sports
- some may be able to ride bicycle
- may use hands with dexterity and skill to make things, do craft and build things

Social-emotional development

- has strong relationships within the family and integral place in family dynamics
- needs caregiver assistance and structure to regulate extremes of emotion
- generally anxious to please and to gain adult approval, praise and reassurance
- conscience is starting to be influenced by internal control or doing the right thing "I would take it, but if my parents found out, they would be disapproving"
- not fully capable of estimating own abilities, may become frustrated by failure
- reassured by predictable routines
- friendships are very important, although they may change regularly
- may need help moving into and becoming part of a group
- some children will maintain strong friendships over the period
- may have mood swings
- able to share, although not all the time
- perception of, and level of regard for self, fairly well developed

Cognitive and creative characteristics

- emerging literacy and numeracy abilities, gaining skills in reading and writing
- variable attention and ability to stay on task; attends better if interested
- good communication skills, remembers, tells and enjoys jokes
- may require verbal, written or behavioural cues and reminders to follow directions and obey rules
- skills in listening and understanding may be more advanced than expression
- perspective broadens as experiences at school and in the community expand
- most valuable learning occurs through play
- rules more likely to be followed if he/she has contributed to them
- may have strong creative urges to make things

Possible indicators of trauma

- behavioural change
- increased tension, irritability, reactivity and inability to relax
- sleep disturbances, nightmares, night terrors, difficulty falling or staying asleep
- regression to behaviour of younger child
- lack of eye contact
- 'spacey', distractible, or hyperactive behaviour
- toileting accidents/enuresis, encopresis or smearing of faeces
- eating disturbances
- bodily aches and pains – no apparent reason
- accident proneness
- absconding/truanting from school
- firelighting, hurting animals

- obvious anxiety, fearfulness and loss of self esteem
- frightened by own intensity of feelings
- specific fears
- efforts to distance from feelings of shame, guilt, humiliation and reduced capacity to feel emotions
- reduced capacity to feel emotions - may appear 'numb', or apathetic
- 'frozen watchfulness'
- vulnerable to anniversary reactions caused by seasonal events, holidays, etc
- repeated retelling of traumatic event
- withdrawal, depressed affect
- 'blanking out' or loss of concentration when under stress at school with lowering of performance
- explicit, aggressive, exploitative, sexualised relating/engagement with other children, older children or adults
- verbally describes experiences of sexual abuse pointing to body parts and telling about the 'game' they played
- sexualised drawing
- excessive concern or preoccupation with private parts and adult sexual behaviour
- hinting about sexual experience and sexualised drawing
- verbal or behavioural indications of age-inappropriate knowledge of adult sexual behaviour
- running away from home

Child development and trauma guide
5 - 7 years

Trauma impact

- changes in behaviour
- hyperarousal, hypervigilance, hyperactivity
- regression in recently acquired developmental gains
- sleep disturbances due to intrusive imagery
- enuresis and encopresis
- trauma driven, acting out, risk taking behaviour
- eating disturbances
- loss of concentration and memory
- flight into driven activity or retreat from others to manage inner turmoil
- post-traumatic re-enactments of traumatic event that may occur secretly and involve siblings or playmates
- loss of interest in previously pleasurable activities

- fear of trauma recurring
- mood or personality change
- loss of, or reduced capacity to attune with caregiver
- loss of, or reduced capacity to manage emotional states or self soothe
- increased self-focusing and withdrawal
- concern about personal responsibility for trauma
- wish for revenge and action oriented responses to trauma
- may experience acute distress when encountering any reminder of trauma
- lowered self-esteem
- increased anxiety or depression
- fearful of closeness and love
- child is likely to have detailed, long-term and sensory memory for traumatic event
- Sometimes the memory is fragmented or repressed
- factual, accurate memory may be embellished by elements of fear or wish; perception of duration may be distorted
- intrusion of unwanted visual images and traumatic reactions disrupt concentration and create anxiety often without parent awareness
- vulnerable to flashbacks of recall and anniversary reactions to reminders of trauma
- speech and cognitive delays

Parental / carer support following trauma

Encourage parent(s)/carers to:

- seek, accept and increase support for themselves to manage their own shock and emotional responses
- listen to and tolerate child's retelling of event – respect child's fears; give child time to cope with fears
- increase monitoring and awareness of child's play, which may involve secretive re-enactments of trauma with peers and siblings; set limits on scary or harmful play
- permit child to try out new ideas to cope with fearfulness at bedtime: extra reading time, radio on, listening to a tape in the middle of the night to undo the residue of fear from a nightmare
- reassure the older child that feelings of fear or behaviours that feel out of control or babyish eg. night wetting are normal after a frightening experience and that the child will feel more like himself or herself with time
- encourage child to talk about confusing feelings, worries, daydreams, mental review of traumatic images, and disruptions of concentration by accepting the feelings, listening carefully, and reminding child that these are normal but hard reactions following a very scary event
- maintain communication with school staff and monitor how the child is coping with demands at school or in community activities
- expect some time-limited decrease in child's school performance and help the child to accept this as a temporary result of the trauma
- protect child from re-exposure to frightening situations and reminders of trauma, including scary television programs, movies, stories, and physical or locational reminders of trauma
- expect and understand child's regression or some difficult or uncharacteristic behaviour while maintaining basic household rules
- listen for a child's misunderstanding of a traumatic event, particularly those that involve self-blame and magical thinking
- gently help child develop a realistic understanding of event. Be mindful of the possibility of anniversary reactions
- remain aware of your own reactions to the child's trauma. Provide reassurance to child that feelings will diminish over time
- provide opportunities for child to experience control and make choices in daily activities
- seek information and advice on child's developmental and educational progress
- provide the child with frequent high protein snacks/meals during the day
- take time out to recharge



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Department of **Communities**

Child development and trauma guide
7 - 9 years

Developmental trends

The following information needs to be understood in the context of the overview statement on child development:

Physical skills

- improved coordination, control and agility compared to younger children
- skilled at large motor movements such as skipping and playing ball games
- often practises new physical skills over and over for mastery
- enjoys team and competitive sports and games
- improved stamina and strength

Social-emotional development

- strong need to belong to, and be a part of, family and peer relationships
- is increasingly able to regulate emotions
- increasingly independent of parents; still needs their comfort and security
- begins to see situations from others perspective – empathy
- able to resolve conflicts verbally and knows when to seek adult help
- conscience and moral values become internalised "I want it, but I don't feel good about doing things like that"
- increased confidence, more independent and takes greater responsibility
- needs reassurance; understands increased effort leads to improvements
- humour is component of interactions with others
- peers seen as important, spends more time with them
- friendships are based on common interests and are likely to be enduring
- feelings of self worth come increasingly from peers
- friends often same gender, friendship groups small

Self concept

- can take some responsibility for self and as a family member
- increasingly influenced by media and by peers
- learns to deal with success and failure
- may compare self with others and find self wanting, not measuring up
- can exercise self control and curb desires to engage in undesirable behaviour - has understanding of right and wrong
- can manage own daily routines
- may experience signs of onset of puberty near end of this age range (girls particularly)

Cognitive and creative characteristics

- can contribute to long-term plans
- engages in long and complex conversations
- has increasingly sophisticated literacy and numeracy skills
- may be a competent user of computers or play a musical instrument

Possible indicators of trauma

- behavioural change
- increased tension, irritability, reactivity and inability to relax
- sleep disturbances, nightmares, night terrors, difficulty falling or staying asleep
- regression to behaviour of younger child
- lack of eye contact
- 'spacey' or distractible behaviour
- 'blanking out' or lacks concentration when under stress at school with lowering of performance
- eating disturbances
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Child development and trauma guide
7 - 9 years

Trauma impact

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- provide the child with frequent high protein snacks/meals during the day
- take time out to recharge

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Department of Communities

Child development and trauma guide
9 - 12 years

Developmental trends

The following information needs to be understood in the context of the overview statement on child development:

Physical skills

- large and fine motor skills becoming highly coordinated
- enjoys risk taking
- does well at games/sports requiring skill, strength and agility
- may look more adult-like in body shape, height and weight

Social-emotional development

- growing need and desire for independence and separate identity
- may challenge parents and other family members
- parents and home important, particularly for support and reassurance
- growing sexual awareness and interest in the opposite gender
- may experience embarrassment, guilt, curiosity and excitement because of sexual awareness
- girls may reach puberty during this time
- belonging to a group is extremely important; peers largely influence identity/self-esteem
- often interact in pairs or small groups; each member has status and position
- groups generally one gender, although interact with the other
- strong desire to have opinions sought and respected

Social-emotional development

- beginning to think and reason in a more logical adult-like way
- capable of abstract thinking, complex problem solving, considers alternative possibilities and broadening perspectives
- concentrates for long periods of time if interested, but needs worries to be sorted
- may have sophisticated literacy and numeracy skills
- popular culture of great interest and major influence
- uses language in sophisticated ways; for example, tells stories, argues, debates
- knows the difference between fantasy and what is real
- has some appreciation of the value of money

Possible indicators of trauma

- increased tension, irritability, reactivity and inability to relax
- sleep disturbances, nightmares, night terrors, difficulty falling or staying asleep
- regression to behaviour of younger child
- reduced eye contact
- 'spacey' or distractible behaviour
- toileting accidents/enuresis, encopresis or smearing of faeces
- eating disturbances
- bodily aches and pains - no reason
- accident proneness
- absconding or truanting from school
- firelighting, hurting animals

- obvious anxiety, fearfulness and loss of self-esteem/self confidence
- frightened by own intensity of feelings
- specific post-traumatic fears
- efforts to distance from feelings of shame, guilt, humiliation and reduced capacity to feel emotions
- reduced capacity to feel emotions - may appear 'numb' or apathetic
- vulnerable to anniversary reactions caused by seasonal events, holidays, etc.
- repeated retelling of traumatic event
- 'frozen watchfulness'
- withdrawal, depressed affect, or black outs in concentration
- 'blanking out' or lacks concentration when under stress at school with lowering of performance
- explicit, aggressive, exploitative, sexualised relating/engagement with other children, older children or adults
- verbally describes experiences of sexual abuse and tells 'stories' about the 'game' they played
- excessive concern or preoccupation with private parts and adult sexual behaviour
- hinting about sexual experience and telling stories
- verbal or behavioural indications of age-inappropriate knowledge of adult sexual behaviour
- sexualised drawing or written 'stories'
- running away from home

Child development and trauma guide
9 - 12 years

Trauma impact

- changes in behaviour
- hyperarousal, hypervigilance, hyperactivity
- regression in recently acquired developmental gains
- sleep disturbances due to intrusive imagery
- enuresis and encopresis
- eating disturbances
- loss of concentration and memory
- post-traumatic re-enactments of traumatic event that may occur secretly and involve siblings or playmates
- trauma driven, acting out, risk taking behaviour
- flight into driven activity or retreat from others to manage inner turmoil
- loss of interest in previously pleasurable activities

- fear of trauma recurring
- mood or personality changes
- loss of, or reduced capacity to attune with caregiver
- loss of, or reduced capacity to manage emotional states or self soothe
- increased self-focusing and withdrawal
- concern about personal responsibility for trauma
- wish for revenge and action oriented responses to trauma
- may experience acute distress when encountering any reminder of trauma
- lowered self-esteem
- increased anxiety or depression
- fearful of closeness and love
- child is likely to have detailed, long-term and sensory memory for traumatic event. Sometimes the memory is fragmented or repressed
- factual, accurate memory may be embellished by elements of fear or wish; perception of duration may be distorted
- intrusion of unwanted visual images and traumatic reactions disrupt concentration and create anxiety often without parent awareness
- vulnerable to flashbacks of recall and anniversary reactions to reminders of trauma
- speech and cognitive delays

Parental / carer support following trauma

Encourage parent(s)/carers to:

- seek, accept and increase support for themselves to manage their own shock and emotional responses
- listen to and tolerate child's retelling of event – respect child's fears; give child time to cope with fears
- increase monitoring and awareness of child's play, which may involve secretive re-enactments of trauma with peers and siblings; set limits on scary or harmful play
- permit child to try out new ideas to cope with fearfulness at bedtime: extra reading time, radio on, listening to a tape in the middle of the night to undo the residue of fear from a nightmare
- reassure the older child that feelings of fear or behaviours that feel out of control or babyish eg. night wetting are normal after a frightening experience and that the child will feel more like himself or herself with time
- encourage child to talk about confusing feelings, worries, daydreams, mental review of traumatic images, and disruptions of concentration by accepting the feelings, listening carefully, and reminding child that these are normal but hard reactions following a very scary event
- maintain communication with school staff and monitor how the child is coping with demands at school or in community activities
- expect some time-limited decrease in child's school performance and help the child to accept this as a temporary result of the trauma
- protect child from re-exposure to frightening situations and reminders of trauma, including scary television programs, movies, stories, and physical or locational reminders of trauma
- expect and understand child's regression or some difficult or uncharacteristic behaviour while maintaining basic household rules
- listen for a child's misunderstanding of a traumatic event, particularly those that involve self-blame and magical thinking
- gently help child develop a realistic understanding of event. Be mindful of the possibility of anniversary reactions
- remain aware of your own reactions to the child's trauma. Provide reassurance to child that feelings will diminish over time
- provide opportunities for child to experience control and make choices in daily activities
- seek information and advice on child's developmental and educational progress
- provide the child with frequent high protein snacks/meals during the day
- take time out to recharge

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Child development and trauma guide
12 - 18 years

Developmental trends

The following information needs to be understood in the context of the overview statement on child development:

Physical skills

- significant physical growth and body changes
- develops greater expertise/skills in sport
- changing health needs for diet, rest, exercise, hygiene and dental care
- puberty, menstruation, sexuality and contraception
- nutritious balanced diet including adequate calcium, protein and iron

Self concept

- can be pre-occupied with self
- secondary sex characteristics affect self concept, relationships with others and activities undertaken
- dealing with own sexuality and that of peers
- developing identity based on gender and culture
- becoming an adult, including opportunities and challenges

Social-emotional development

- empathy for others
- ability to make decisions (moral)
- values and a moral system become firmer and affect views and opinions
- spends time with peers for social and emotional needs beyond parents and family
- peer assessment influences self concept, behaviour/need to conform
- girls have 'best friends', boys have 'mates'
- may explore sexuality by engaging in sexual behaviours and intimate relationships
- develops wider interests
- seeks greater autonomy personally, in decision making
- more responsible in tasks at home, school and work
- experiences emotional turmoil, strong feelings and unpredictable mood swings
- interdependent with parents and family
- conflict with family more likely through puberty
- able to negotiate and assert boundaries
- learning to give and take (reciprocity)
- focus is on the present - may take significant risks
- understands appropriate behaviour but may lack self control/insight

Cognitive and creative characteristics

- thinks logically, abstractly and solves problems, thinking like an adult
- may take an interest in/develop opinions about community or world events
- can appreciate others' perspectives and see a problem or situation from different angles
- career choice may be realistic, or at odds with school performance and talents

Child development and trauma guide
12 - 18 years

Possible indicators of trauma

- increased tension, irritability, reactivity and inability to relax
- accident proneness
- reduced eye contact
- sleep disturbances, nightmares
- enuresis, encopresis
- eating disturbances/disorders
- absconding or truanting and challenging behaviours
- substance abuse
- aggressive/violent behaviour
- firelighting, hurting animals
- suicidal ideation
- self harming eg. cutting, burning

- efforts to distance from feelings of shame and humiliation
- loss of self-esteem and self confidence
- acute psychological distress
- personality changes and changes in quality of important relationships evident
- increased self-focusing and withdrawal
- reduced capacity to feel emotions – may appear 'numb'
- wish for revenge and action oriented responses to trauma
- partial loss of memory and ability to concentrate
- trauma flashbacks
- acute awareness of parental reactions; wish to protect parents from own distress
- sexually exploitative or aggressive interactions with younger children
- sexually promiscuous behaviour or total avoidance of sexual involvement
- running away from home

Trauma impact

- sleep disturbances, nightmares
- hyperarousal, hypervigilance, hyperactivity
- eating disturbances or disorders
- trauma acting out, risk taking, sexualised, reckless, regressive or violent behaviour
- flight into driven activity and involvement with others or retreat from others in order to manage inner turmoil
- vulnerability to withdrawal and pessimistic world view
- vulnerability to depression, anxiety, stress disorders, and suicidal ideation
- vulnerability to conduct, attachment, eating and behavioural disorders

- mood and personality changes and changes in quality of important relationships evident
- loss of, or reduced capacity to attune with caregiver
- loss of, or reduced capacity to manage emotional states or self soothe
- lowered self-esteem
- flight into adulthood seen as way of escaping impact and memory of trauma (early marriage, pregnancy, dropping out of school, abandoning peer group for older set of friends)
- fear of growing up and need to stay within family orbit

Memory for trauma includes:
- acute awareness of and distress with intrusive imagery and memories of trauma
- vulnerability to flash backs, episodes of recall, anniversary reactions and seasonal reminders of trauma
- may experience acute distress when encountering any reminder of trauma
- partial loss of memory and concentration

Parental / carer support following trauma

Encourage parent(s)/carers to:
- seek, accept and increase support for themselves to manage their own shock and emotions
- remain calm. Encourage younger and older adolescents to talk about traumatic event with family members
- provide opportunities for young person to spend time with friends who are supportive and meaningful
- reassure young person that strong feelings - whether of guilt, shame, embarrassment, or wish for revenge - are normal following a trauma
- help young person find activities that offer opportunities to experience mastery, control, and self-esteem
- encourage pleasurable physical activities such as sports and dancing
- monitor young person's coping at home, school, and in peer group
- address acting-out behaviour involving aggression or self destructive behaviour quickly and firmly with limit setting and professional help
- take signs of depression, self harm, accident proneness, recklessness, and persistent personality change seriously by seeking help
- help young person develop a sense of perspective on the impact of the traumatic event and a sense of the importance of time in recovering
- encourage delaying big decisions
- seek information/advice about young person's developmental and educational progress
- provide the young person with frequent high protein snacks/meals during the day
- take time to recharge

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