play partners
Early Intervention Services for Children

PLAY PARTNERS DEVELOPMENTAL TRAUMA PRACTICE FRAMEWORK

Organisation name
Play Partners Early Intervention Services for Children Pty Ltd
Summary of organisation's purpose and services
Play Partners currently provides occupational therapy, physiotherapy and speech pathology services to children and their families in the mid-North of South Australia. We also run a social detectives and PEERS group program to support children and adolescent's social and emotional development. Play Partners provides services to young adults with disability where our developmental model meets their need. **Play Partners Values:** • Dignity and choice for consumers/participants • Safe, non-judgemental relationships • Respectful, open, honest and transparent communication between staff and consumers/participants • Consistency of service provision • Feedback that contributes to quality improvement in service (Play Partners employee handbook, p2).
Framework applies to
The following framework applies to the Play Partners organisation in its entirety.
Statement of children's rights
Children have a right to adequate care and nurturing, physical protection, connection with both parents, appropriate food, and health care, as well as freedom from abuse and discrimination, on the basis of race, gender, sexual orientation, gender identity, national origin, religion, disability, ethnicity or any other characteristics (UNICEF, 2006). Play Partners is guided by the national principles for child safe organisations including: • The best interest of the child as a primary consideration. • The right of the child to survival and development. This includes the right to live a full life with the right to additional supports for children with disability. • The right of the child to express their views freely on all matters affecting them. Play Partners staff are required to be effective communication partners and utilise assistive augmentative communication where required (The Australian Human Right's Commission, 1989).

Child centred approach

Play Partners is in the centre of the Clare township (population approx. 5000) in the mid-North of South Australia. The Play Partners building and amenity spaces are disability accessible and have been designed to be child, young person and disability friendly. Play Partners acknowledges and pays respect to the traditional owners of Njaduri country, on which Play Partners was established.

Children find and experience safety in and through relationships (GCDT PP 4, slide 20). Play Partners values consistent, predictable, and safe relationships as the conduit through which therapeutic work occurs (Play Partners employee handbook, p 2). Play Partners staff are required to undertake training in attachment theory as well as trauma informed practise during their first year of employment with the organisation.

Each child has a unique story that is reflective of their care context, culture, community, and disability (GCDT PP 4, slide 13). To support the child means that a unique response to their story is imperative. Each response focuses on the individual needs of that child.

Listening to a child's story is a privilege and is the mechanism through which we can develop an understanding of the child's world and experience in that world (GCDT PP 4, slide 19). Children with disability may require communication supports to have their voice heard and so Play Partners staff are supported to develop competencies to be an effective communication partner, regardless of their specific discipline speciality.

We understand that a child's culture can provide certainty and predictability for that child and that there may be social, economic, ceremonial, and other relationships within a culture that can be a resource for the child (GCDT PP 3, slide 13). As learners as we work to understand a child's experience of their culture and the resources it may provide (GCDT PP 3, slide 6).

For a child, behaviour is a form of communication. We look to understand the meaning behind the behaviour to understand what the child is communicating to us (GCDT PP 4, slide 15).

All children will reach normal developmental milestones where they have opportunity, resources, and ability to do this. Play Partners staff are expected to have a solid understanding of child development across all areas of development and be able to identify developmental delays or developmental challenges by observation and standardised assessment.

Play Partners clinicians are required to develop and maintain positive open respectful communication within the organisation and with other providers of a child's care (Play Partners employee handbook, p 2). Multi-agency case conferences are facilitated and hosted by the Play Partners team to enable a collaborative approach to intervention. This supports the child by pooling knowledge to support recovery goals and ensuring all agencies understand their roles and responsibilities in supporting the child. (GCDT PP 9B, slide 13).

Child and young people participation

Finding a balance between the protection needs of children and supporting their active involvement in decision making about issues that involve them is an important part of a clinician's role at Play Partners. The child's participation in their care provides opportunity for a power-with relationship as well as movement towards self-determination and autonomy. It also promotes systemic thinking as we are required to consider the child's relationship with others, with their culture and with environments and systems that they live and move through (GCDT PP 9B, slide 9).

All consumers of Play Partners services are encouraged to contribute to the planning of intervention as it relates to their goals. This looks different depending on the age and stage of the child. Where parent's/carers have low literacy levels Play Partners staff are required to facilitate understanding so that participation is enabled.

Younger children are encouraged to choose preferred activities that support parent identified goals. Therapeutic interventions are child-led and require the therapist to be flexible during sessions.

As children move to primary school age where possible they are given choice re the location of therapy sessions (school/clinic/home). The child's interests guide therapeutic intervention. Feedback re the session is encouraged, discussed, and supports future session planning.

In adolescence self-determination and autonomy guide individual therapy sessions. Where there is significant communication difficulty or cognitive challenge the therapist is required to be creative in how this is achieved. Photograph visual scheduling may provide opportunity for agency in the therapeutic space. It is important to recognise that some "risk-taking has inherent value in both achieving change and helping explore and understand the assessment and control of risk. Engaging adolescents in identification of potential risks and the measures needed to mitigate them will lead to more effective protection." (UNICEF, 2018) Identification and mitigation of risk may look different for children with disability but their involvement in this process is an essential part of the transition to adulthood.

Child and young people feedback processes

The Play Partners clinic space has been created as a child/disability friendly space that encourages children and their families to enter and move about the space freely when rooms are not occupied for therapy. This facilitates ready access to therapists and the director of Play Partner. Each therapy room has a large black board wall and children as well as their families/carers are encouraged to express their feelings, thoughts, and views, as desired on these boards. Chalk is provided for this purpose.

Children and young people are encouraged to provide feedback. Feedback can be provided anonymously, via a clinician or to the Director of Play Partners. An established feedback process that aligns with NDIS certification standards is explained at initial contact. Play Partners recognises that safe relationships and a safe space are the conduit for enabling the free expression of a child or young person's view of services that affect them, and feedback in sessions is facilitated.

Formalised feedback is requested from the child as well as parent/carer at the end of group programs and during internal audit.

All information gathered is discussed at staff meetings as an agenda item and informs changes to service delivery where possible and sustainable.

Model of change adopted by the organisation

Play Partners Early Intervention Services for Children commits to supporting children and their families to build capacity to achieve their stated goals. The transtheoretical model of behaviour change outlines 5 stage of change, pre contemplation, contemplation, preparation, action, and maintenance (Prochaska and DiClemente, 1986). Identifying the child and family's position in the change process helps determine the intervention to best support attainment of NDIS goals.

In our work with disability there are often cognitive challenges for the child and so making choices can be difficult. In our practise we often design the environment to make the option that supports skill acquisition more likely to be chosen. This is the premise of nudge theory (Arno A and Thomas S, 2016). There are many disabilities that present with a behavioural phenotype that responds

well to indirect encouragement and enablement. It helps build confidence and capacity for our children.

Risk assessment model

When working with a child we need to consider the likelihood of immediate harm to that child.

Questions we can consider are:

- Is the child safe enough to remain in their current environment?
- Are there environmental risk factors that can be decreased or managed in some way?
- To what extent is the child a danger to themselves or others?
- Are there any precipitating factors that might have prompted the behaviours considered dangerous and can any of these be mitigated? (ACF session 14 handout)

If risk is considered high, the treating GP or mental health practitioner may need to be contacted for a formal risk assessment.

Significant risk may require the clinician to call an ambulance and remain with the child until the ambulance arrives.

All staff have "Through their eyes" child safe environments training and are required to report any concerns of "risk of harm" to a child (Government od South Australia, Department of Human Services).

Under the NDIS scheme there are reportable incidents that must be reported to the NDIS commission within a defined timeframe (NDIS, Quality and Safeguards Commission).

General recovery goals adopted across the organisation

Play Partners operates from a generous space that was designed to embrace the broad concepts of inclusivity, accessibility, child and family friendly, non-clinical and fun, with the understanding that environment contributes significantly to felt safety. This environment provides the space for us to:

Create relational safety (GCDT PP 9B, slide 27), by

- Developing trusting relationships with the child and their family. Listening and responding to the child or young person's story, remembering that each child is unique and their experience of trauma is unique.
- Providing consistent, regular co-regulatory experiences for the child in relationship.
- Recognising the values in existing relationships that can support and nurture the child and make use of these.
- Identifying other resources that may be available and helpful to the child and family on their journey.

Provide regulatory experiences (GCDT PP 9B, slide 29) for the child by

- Utilising our knowledge of interoception, sensory regulation and emotional regulation to build the capacity of the child to identify and listen to their own body responses.
- Utilising our knowledge that the child requires supports from trusted adults to build this capacity.

- Utilising the window of tolerance as a framework that allows therapists and other important adults in the child's life to build an understanding of their own need for regulation to effectively support the child's need for co-regulation and build capacity for self-regulation over time (Gill L, 2017).

Provide positive, rewarding relationships (GCDT PP 9B slide 31) for the child by

- Providing opportunity for many moments of relational repair that can become a store of compensatory relational experiences that build over time in a child's implicit memory and that can provide a shift to the experience of relational safety.

Support the child to develop empathy for self and others (GCDT PP 9B, slide 33) by

- Acknowledging the child's feelings.
- Sitting with the child with their big feelings.
- Naming emotions and linking the physiological experience to the feeling.
- Supporting the child to consider the same in others.

Support the child's processing of trauma (GCDT PP 9B, slide 35) by

- Providing all the experiences above, as well as opportunity for the child to repeatedly express trauma experiences and their impacts in their own way and time.

Assessment framework

Children who access Play Partners services privately, via Medicare and NDIS participants with EI funding undergo a comprehensive assessment at initial appointment. All domains of assessment consistent with the Trauma Assessment Pathway (TAP) are considered and a client picture is developed via client interview, observation, and standardised assessments (Chadwick Center for Families and Children, 2009 p13).
Many trauma-specific standardised assessments required administration by a psychologist, however we can use the BASC-PRQ that considers the parent view of the parent/child relationship as well as a multitude of developmental assessments in our practice.
A child over the age of 8 with a diagnosed disability has access to NDIS funding and we provide services funded by this scheme. In this instance NDIS does not fund trauma specific interventions. There may be need for further assessments that support better understanding of a child's function in the environments he/she lives and moves through however and these assessments could include trauma specific assessments.

Relationship based practices model

Play Partners acknowledges that therapeutic change can only occur in the context of safe relationships (Play Partners employee handbook, p 2).

Perry (2020 p 138) explains the impact on higher brain function when early experiences of trauma interrupt brain development in the lower brain. Perry describes the 6 R's of activities that promote lower brain organisation and are therefore helpful in the growth of neural connections that provide adequate architecture for safe relationships to be felt. Repetitive, rhythmical activities that are relevant and rewarding to the child are a good starting point to enable opportunity for felt safety in the therapeutic space.

Attachment theory underpins our understanding of felt safe relational experience.

The central theme of attachment theory is that a felt sense of security develops from a relationship with a primary caregiver who is sufficiently available and responsive to the infant/child. This dependable relationship allows the child to explore his/her world with the knowledge that he/she can return to the caregiver in times of stress. (Cherry, 2019)

The circle of security provides a framework for understanding the responsibility of the adult to repair a relationship when there are inevitable ruptures (Circle of Security International, 2019).

Supporting secure attachment with a primary caregiver as well as recognising challenges or problematic disruptions in attachment that impact on child development are a fundamental part of providing early intervention supports. Play Partners clinicians are required to facilitate secure attachment with a primary caregiver where possible as well as utilise the knowledge that attachment theory and circle of security provide for an effective therapeutic relationship.

Dan Hughes intervention Dyadic-Developmental Psychotherapy (DDP) also highlights the importance of "felt safety" in relationships and provides a mechanism to establish this in the context of care- giving relationships. DDP is based on the understanding that defensive mechanisms employed by a child to achieve survival in an unsafe, traumatic care-giving relationship are the barrier but also the conduit to developing trust, and a shift to an experience of safety in relationship (Hughes and Baylin, 2020 p 242). Play Partners clinicians can promote neurobiological safety by holding all of a child's internal states, their needs in the moment as well as their unmet needs with openness and non-judgemental interest, over and over (Hughes and Baylin, 2020 p262).

Attachment theory, Circle of Security, Bruce Perry's 6 R's and DDP provide theory and way of working and being with children that appreciates that children behave in a way that has allowed them to survive and that they rely on adults to be aware of and resource themselves adequately so that they can adapt their own internal responses so the chid can experience calm and connection with another person (GCDT session 19 handout "Relational Merging"). A requirement of the Play Partner's clinician is to participate in relationship with a child with this intention. The more often the experience of felt safety is achieved for the child the larger the bank of experience and the easier it becomes for the child to access and co-regulate in times of relational disruption (GCDT session 19 handout "Reciprocal Consolidation").

Intervention strategy selection process

With the information gathered from the assessment process (interview assessment, standardised testing, observation of the child in different environments and by talking with parents, carers, teachers and other significant adults in the child's life we can consider how this information may be interpreted with respect to a child's unmet needs (GCDT PP13, slide 6). We understand that for children and young people behaviour is a form of communication (GCDT PP 4, slide 15). It is an expression of what they need from relationships as well as a response to the demands of the environments they move through (GCDT PP14, slide 11). For children who have experienced relational trauma current behaviours may be reflective of protective strategies that have kept that child safe in the past. Patterns of behaviour can give us information about the child's unmet needs which can be framed as what is the child telling us he/she needs (GCDT PP14, slide 58).

Example

Behaviour: Disruptive behaviour in classroom

Need: Containment and felt safety in classroom.

The ACF model of intervention organises the identified needs into themes that can be aligned with recovery goals.

Example
Theme: Feeling unsafe around others and relying on hypervigilance as a protective strategy.
Goal: The child experiences co-regulation and feels safe/calm in the classroom.
When we have established the goal of intervention a strategy to achieve this can be developed.
Example
Strategy: Connect with the child and help them to access a calm, quiet space while they de-escalate and return to their window of tolerance. (ACF handout example).

It is important to acknowledge past relational resources and identify those available in the here and now.
Where current relationships are supportive of a child's healing goals, they may be a useful resource in strategy implementation (GCDT PP13, slide 23).

In addition to trauma informed assessment providing the framework for trauma informed intervention, in our work with children it is helpful to remember the work of Bruce Perry. Repetitive, rhythmical activities that are relevant and rewarding to the child are a good starting point for any therapeutic work with children (Perry B 2020 p 138)

Supporting staff to implement trauma responsive practice

Regular trauma informed supervision is implemented at Play Partners. Where internal supervision arrangements do not meet the needs of the clinician, external supervision is funded by the organisation.

Supervision must:

- Provide the opportunity to engage in relationship with a supervisor, that is supportive and free of judgement.
- Incorporate mindful practices by the supervisor and supervisee to facilitate thoughtful decision making.
- Allow the supervisee to develop an understanding of the personal impact of their work, and better access their own internal and external resources to support them in their work. This will be achieved by a supervision relationship that provides felt safety, mindfulness, and reflective practices that improve capacity for openness, curiosity, and reflection (GCDT PP23, slide 11).

Reflective practise is encouraged during:

- informal conversations between clinicians that support consideration of the meanings behind children's behaviour.
- Individual supervision sessions, guided by a list of reflective practise questions.
- Monthly case discussions that incorporate reflective practise questions.

Monitoring and reviewing service provision

Staff are provided with training in developmental trauma during their first year of employment at Play Partners. There is an organisational expectation that a part of continuous professional development includes building knowledge of developmental trauma. Staff participate in an annual PR&D process that considers this training.

Client caseloads are reviewed on a termly bases to ensure spread of challenging caseload between workers that considers workers experience and confidence.

Monitoring of service provision occurs continuously via informal conversation between director, staff, and clients. This conversation may be in person or via email.

There is an established organisational feedback process that explains how Play Partners receives and reviews feedback as well as how clients are involved in the review process. Feedback forms offer opportunity for compliments, complaints and feedback that inform service improvements following discussion at staff meetings.

External NDIS audit requires that the organisation provides evidence of working to NDIS certification practise standards. Organisational strengths and areas for improvement are identified in the audit report. The audit is conducted every 18 months and paid for by the organisation.

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