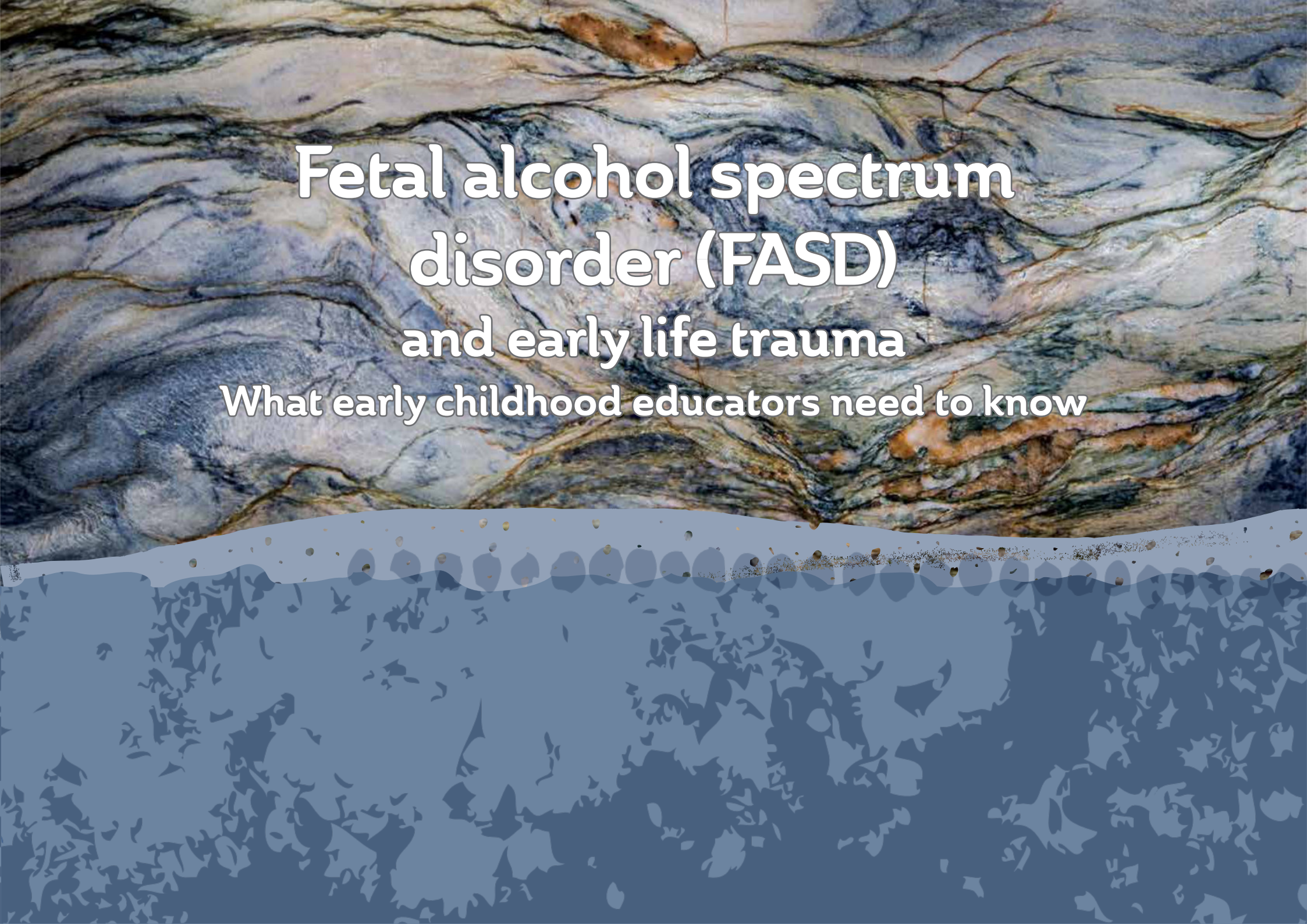

Fetal alcohol spectrum disorder (FASD)

and early life trauma

What early childhood educators need to know

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Fetal alcohol spectrum disorder (FASD) and early life trauma: What early childhood educators need to know, 2023

This resource is a revised edition of *Fetal alcohol spectrum disorder (FASD) and complex trauma: A resource for educators,* 2018.

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PO Box 43, Fitzroy Crossing, Western Australia 6765, Australia
Phone: +61 8 9191 5284
Email: marninsupport@mwrc.com.au
Website: www.mwrc.com.au

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Contents

Foreword iv
About the authors v
Background vi
Acknowledgements viii

Section 1: Understanding trauma 1

The complexity of trauma 2
Listening to lived experiences of trauma 3
Trauma within First Nations communities 4
Trauma and the developing brain 6
The importance of attachment and safety 9
The cost of caring 11
Trauma-responsive wellbeing principles and practices for early childhood 14

Section 2: About fetal alcohol spectrum disorder 21

What is fetal alcohol spectrum disorder? 22
Assessing and diagnosing FASD 23
Child development: When to be concerned 26
The importance of respectful language 29

Section 3: Early childhood educators – Taking action 33

Taking action 34
Diagnosis and referral 35
Belonging, being and becoming: A vision for children's learning 38
FASD and early life trauma: Strategies for early childhood educators 40

Section 4: Useful resources 49

Further reading 50
Australian FASD organisations 51
Other child-focused Australian organisations 51
Uluru statement from the heart 54

Foreword

The Bunuba word *baya gawiy* means freshwater whipray. *Buga yani jandu yani u* is a Bunuba phrase meaning the centre is for all children and their families.

As the CEO of Marninwarntikura Women's Resource Centre (MWRC), I am proud of the work we do to address complex challenges faced by First Nations communities like mine in the Kimberley, Western Australia. This book is no exception. Our dynamic teams deliver a range of strengths-based programs to meet the diverse needs of families with a lived experience of significant vulnerabilities. All of us are touched in some way by the intergenerational trauma that exists in our communities.

At MWRC, we respond to developmental trauma and FASD by building capacity in the community to better understand and address the needs of children, young people and families. We seek to create solutions, fill gaps and provide necessary resources to support all those working with children and families with complex needs.

The Marulu team builds knowledge and understanding of trauma-informed practices and neurodiverse conditions, such as FASD, and translates this learning into new ways of supporting children and their families. I have watched our community benefit in so many ways as we draw on the lessons from the many community members, families with lived experiences, partner organisations and experts from across Australia and globally.

While this resource is written with early childhood educators in mind, it has relevance for a much wider audience. It is the third resource of a series written and published by MWRC to assist in addressing the needs of children and young people with complex trauma and FASD.

Importantly, *Fetal alcohol spectrum disorder (FASD) and early life trauma: What early childhood educators need to know* starts from the belief that all children can learn, and will learn to the best of their abilities when there is a well-trained, knowledgeable, respectful and compassionate workforce who can identify needs and concerns early, and refer children for professional therapeutic intervention and support when required.

The series is also informed by many committed people who have generously given their time, shared their insights and provided information and perspectives gained from working with children and their families. I would like to thank Jane Weston and Sue Thomas for their incredible commitment in making these resources a reality. Their skill in bringing the research evidence and emerging knowledge together in an accessible and practical way is greatly appreciated.

I commend this resource to you. I have confidence it will help you to make a difference in the lives of young children.

Emily Carter, CEO, Marninwarntikura Women's Resource Centre

About the authors

Sue Thomas and Jane Weston

Sue Thomas is an experienced educator and strategic lead, and former remote community school principal with extensive experience living and working in the Kimberley region of Western Australia. Sue has led numerous First Nations education initiatives and is currently the Strategic Priority Lead within the Senior Leadership Team at MWRC. Sue delivers professional learning and provides leadership to build capacity and develop resources that support educators to respond to complex trauma and FASD in a range of contexts.

Jane Weston is an experienced educator, writer and project manager. Jane has worked on a range of national and international education initiatives, and has extensive experience in developing resources for educators, school leaders and other audiences. Jane has worked with First Nations education initiatives for most of her career.

Sue and Jane are committed to building knowledge and understandings about developmental trauma and FASD. They have co-written resources and professional learning materials to equip educators and the broader community. Their practical strategies are based on evidence-informed practice about developmental trauma and FASD. Their two previous publications developed from this work are:

- *Understanding and addressing the needs of children and young people living with fetal alcohol spectrum disorders (FASD): A resource for teachers*, 2014
- *Fetal alcohol spectrum disorder (FASD) and complex trauma: A resource for educators*, 2018.

The information suggested for school contexts in these two resources were predicated on the firm belief that, with the right supports, children with developmental trauma and FASD can thrive.

Consistent with these first two resources, we identified a need for a specific resource designed for early childhood educators. We hope that this resource, *Fetal alcohol spectrum disorder (FASD) and early life trauma: What early childhood educators need to know*, meets that need.

Background

The good news is that, with the right trauma-responsive practices, children can recover from the effects of trauma and thrive.

A commitment to excellence

Marninwarntikura Women's Resource Centre (MWRC) provides women and their families with a place for positive change and leadership. *Marninwarntikura* is a Walmajarri word meaning 'big mobs of women who belong together'.

The CEO, Emily Carter, is committed to ensuring that a postcode does not determine the quality of the services that women, children and families receive. *Marulu*, a Bunuba word meaning 'precious, worth nurturing', is the name given to the strategy designed to create a community response to the complex needs of children, including those with FASD and early life trauma in the Fitzroy Valley. The Marulu team champions a strategy that builds evidence and shares knowledge to inform how to work with families with complex needs. The Marulu Strategy is a community-led initiative to address FASD and early life trauma in the Fitzroy Valley through prevention, capacity-building through education, and the provision of therapy and supports.

Building the evidence

Internationally recognised research such as the Lililwan FASD Prevalence Study (2010–12) provides evidence about the prevalence of FASD. The Lililwan study, conducted in the Fitzroy Valley, was a partnership between Nindilingarri Cultural Health Services, MWRC, the George Institute for Global Health and the University of Sydney.

Grandmothers were seeing behaviours and developmental and learning difficulties never seen before in their children and grandchildren. They sought to understand what was causing this range of concerns. One hundred and eight children born in the valley in 2002 and 2003 participated in the study, building a comprehensive picture of their health and education needs at the time. The prevalence there of FASD – one in every five children – was shown to be one the highest known rates in the world.

Since this initial research, MWRC has continued to engage in research to build the evidence and gain insights into challenges the community has identified. A high level of expertise and practical specialist knowledge now exists in the community and informs ongoing work in the Fitzroy Valley.

Audience and purpose

There is a relative lack of awareness and knowledge of the effects of trauma and FASD in the broader national community. This resource therefore provides information and deeper understandings about what trauma and FASD look like and, by using practical evidence-informed strategies, aims to assist early childhood educators to best make targeted adjustments to practices and create nurturing environments to meet the complex needs of children in their care.

While the information found in this resource is relevant for Fitzroy Valley communities, it has wider application across the country and beyond, wherever alcohol is consumed.

The importance of a strengths-based approach

Our approach is centred on supporting positive and strengths-based relationships between communities, early childhood educators and parents and carers working with vulnerable children and families. It is based on the belief that all children

and families with trauma histories and experience of alcohol-related harms can learn, develop and lead successful and fulfilled lives when provided with a safe and nurturing learning environment. The importance of strength-based approaches is especially relevant for First Nations and vulnerable communities, where people's lived experiences and histories can increase their exposure to complex developmental trauma and its subsequent significant negative effects on children and families.

Early childhood educators working to support families are becoming more aware of the importance of disrupting the cycle of complex and intergenerational trauma. The good news is that, with the right trauma-responsive practices, children can recover from the effects of trauma and thrive.

The challenges of achieving and maintaining gains may at times seem overwhelming, though the evidence provides us with hope. Emerging research tells us that with early diagnosis, positive engagement, good nutrition, consistent attention to positive attachments and the provision of safe and calm environments, improved outcomes can and are being realised.

Early childhood educators who are knowledgeable and open to making adjustments to programs and learning spaces – while maintaining high expectations – can and are producing great gains with children with FASD who have experienced intergenerational and early life trauma.

The importance of a relational approach

Relationships are central to all that we do. Relationships with children, their families, communities and with each other are vital for creating a sense of safety and belonging and building a learning environment that is conducive to positive outcomes.

At the heart of a trauma-responsive approach is the emphasis on developing relationships. The ability to attach to others and form significant, positive relationships that create a sense of safety is important for all children, and is especially important for children with early life trauma or possible exposure to alcohol in utero.

Acknowledgements

Marninwarntikura Women's Resource Centre (MWRC) in Fitzroy Crossing in the Kimberley region of Western Australia is a welcoming, safe and dynamic space that delivers a range of strength-based programs to meet the diverse needs of families with a lived experience of significant vulnerabilities.

The **Marulu team at MWRC** responds to developmental trauma and fetal alcohol spectrum disorder (FASD) by building capacity in the community to better understand and address the needs of children, young people and families.

This resource has been developed with contributions from many committed people who have generously given their time, shared their insights and provided information and perspectives gained from working with children and their families.

Emily Carter, CEO of MWRC, with the support of the Board and her teams, leads the organisation and advocates for improved services in the Fitzroy Valley that address complex needs within the community. She is passionate about providing quality services by using emerging knowledge of neuroscience to inform addressing trauma to improve outcomes for children and families. Her insights in this resource provide context for some of the harms encountered in the Kimberley region of Western Australia.

June Oscar AO, Aboriginal and Torres Strait Islander Social Justice Commissioner, played a leading role in identifying and responding to the prevalence of FASD and complex trauma in the Fitzroy Valley and raising awareness in the community and across the country.

The **Marulu team** – **Jadnah Davies, Cheyenne Carter, Emelika Collard, Vondella Berringal** and **Jody Kamminga** – work to raise awareness and address FASD and complex trauma in the Fitzroy Valley and beyond. They build knowledge, understanding and wraparound supports, creating a model of care and a community-led response.

A huge thank you to **Sue Loughlin**. Sue is a specialist advisor and mentor, playing a significant role in supporting the development of the centre of excellence that Baya Gawiy has become today. Sue brings her extensive early childhood knowledge and experience in trauma-informed teaching and learning to the work she does with the Baya Gawiy team.

Vicki Hynam, Baya Gawiy Learning and Development Lead, is a highly experienced early childhood and adult educator and trauma-informed practitioner. She leads and mentors the early childhood teams across Baya Gawiy. Vicki has empowered many Aboriginal educators to play a significant role in shaping learning and development across all programs.

Aboriginal educators and language specialists are an integral part of the Baya Gawiy team and we thank them for their input.

Jane Pedersen's 2017 report to the Winston Churchill Memorial Trust (www.churchilltrust.com.au/fellow/jane-pedersen-wa-2016) was written to assist MWRC on its journey to become a trauma-responsive organisation. Key understandings from this report about trauma and its effects on First Nations communities are contributing to improved knowledge across the organisation. The learnings formed the basis of the MWRC Healing Framework, Marroorryawarrani Ngambirriyawarrani Yoowarnia.

The **Australian Childhood Foundation (ACF)** has guided our understandings about trauma and its implications for children and their families. The ACF principles of trauma-informed care have been adapted for use with early childhood educators. We thank the ACF for their support and leadership in this space.

Royal Far West provided specialist advice and support relating to complex trauma and the neuroscience behind it. Special thanks to **Verity Ashover** and **Dagney Hopp**.

Thanks go to **Claire Thistleton, Donna Stephen** and **Tyra Curley** of the Kimberley Aboriginal Medical Services for their specialist feedback.

Professor Elizabeth Elliott AM FAHMS FRSN, University of Sydney and Sydney Children's Hospitals Network, provided ongoing valuable advice and has continuously worked with MWRC on a range of community-led research projects since the Lililwan Prevalence Study (2009–12).

Dr Lauren Rice, Research Fellow, University of Sydney, Bigiswun Kid Project.

Dr Amy Finlay-Jones, Head, Early Neurodevelopment and Mental Health, Telethon Kids Institute, provided invaluable advice and guidance.

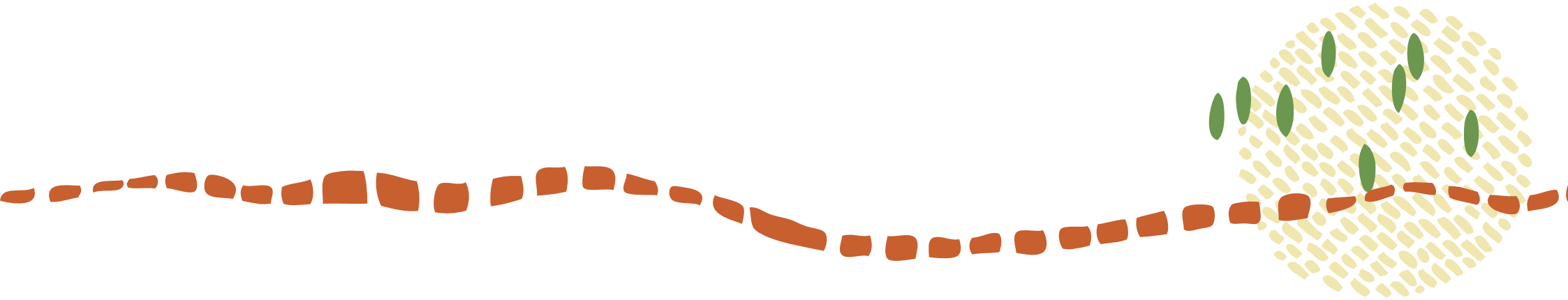
Thanks to **Kimberley educators, community members, allied health professionals, school psychologists and specialist support staff**, who have generously shared their knowledge and provided feedback. We drew heavily on their expertise to make this resource both accessible and grounded in lived experience.

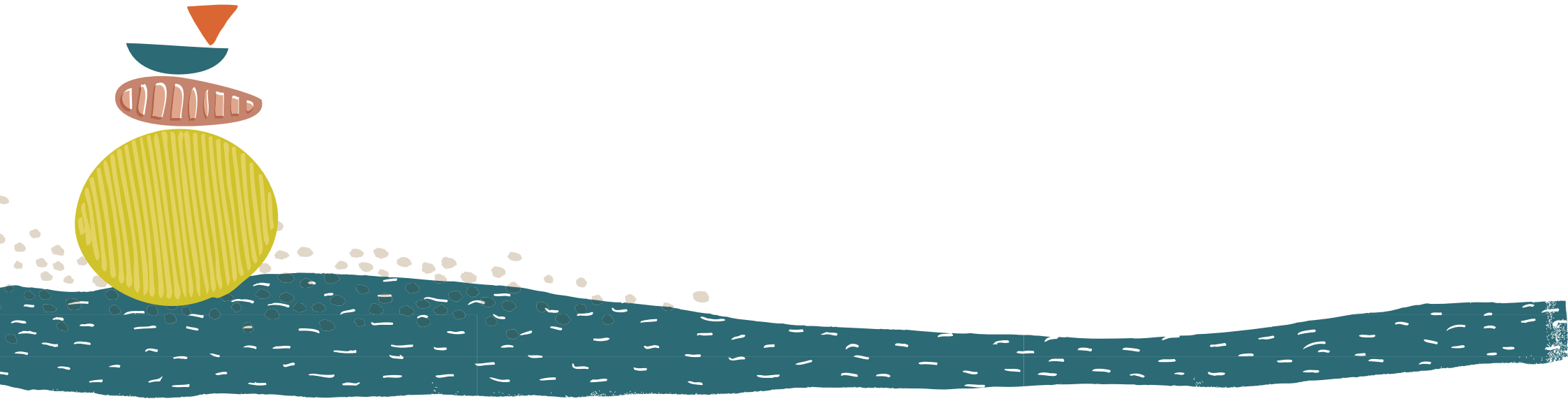
Thanks also to the following for their invaluable insights:

- **Amy Menzies**, Baya Gawiy early childhood educator
- **Jane Salt**, Principal, Bayulu Remote Community School (2021)
- **Lisa Barns**, teacher, Bayulu Remote Community School
- **Dr Bree Wagner**, Deputy Principal, Bayulu Remote Community School (2021)
- **Kym Benson**, educational consultant.

Carolyn Hartness, **Professor Barry Carpenter** and **Carolyn Blackburn**, international experts in the FASD field, for their knowledge, expertise and willingness to assist.

Lan Wang, structural editor and typesetter, for her expertise and ability to make the book both readable and accessible to all.





Section 1: Understanding trauma

The complexity of trauma

Children and young people in Australia have the right to grow up safe, connected and supported in their family, community and culture. They have the right to grow up in an environment that enables them to reach their full potential.

Children and young people in Australia have the right to grow up safe, connected and supported in their family, community and culture. They have the right to grow up in an environment that enables them to reach their full potential.[1]

Trauma is pervasive in society. Many vulnerable communities experience high levels of poverty, alcohol-related harm, increased burden of disease and mental health problems, and there are limited resources and capacity to address these harms. In many First Nations communities, the added burden of the ongoing effects of colonisation, including a poverty of investment and services, compounds layers of disadvantage.

The short- and long-term effects of trauma have been well documented. The effects of trauma can reverberate through individuals, families, communities and entire populations, resulting in a legacy of physical, psychological, and economic disparities that persist across generations.[2]

We need to increase our knowledge and understandings and ensure we do not develop negative or deficit thinking. We need to recognise the strengths and resilience required by vulnerable communities to respond to these challenges.

There are many definitions that attempt to capture the essence of what trauma looks like in different contexts. The following helpful definitions demonstrate the complexity of trauma.

Single-incident trauma

A single, direct, unexpected and overwhelming event such as an accident, natural disaster, or a single episode of abuse, assault or sudden loss.

Complex trauma

Repeated and direct exposure to traumatic events over time, such as ongoing exposure to abuse and violence.

Developmental trauma

A direct form of trauma that results from exposure to complex trauma in early childhood, including neglect, abandonment, physical abuse or assault, sexual abuse or assault, emotional abuse, witnessing violence or death, and/or coercion or betrayal. This often occurs within the child's caregiving system and interferes with healthy **attachment** and development. Identifying this type of trauma is particularly relevant in the early childhood context.

Historical trauma

A cumulative emotional and psychological wounding over the lifespan and across generations due to a massive group trauma. It can become normalised within a culture as it becomes embedded in the collective cultural memory of a people and is passed down through the generations in the same way culture is generally transmitted. For First Nations people, colonisation forms part of their families' collective memory, the effects of which continue to be transmitted through generations.

Intergenerational trauma

A form of historical trauma, this refers to psychological or emotional effects that can be experienced by people who live with trauma survivors. Coping and adaptation patterns are protective behaviours developed in response to trauma and can be passed from one generation to the next. There is evidence that an exaggerated stress response can be passed from one generation to another via epigenetic mechanisms.[3]

Traumatic experiences can disrupt development and challenge a child's ability to regulate emotions and attach to others, profoundly affecting a child's view of the world.

Attachment – Attachment theory proposes that young children should have a relationship with at least one primary caregiver in order to develop a sense of security.

Listening to lived experiences of trauma

First Nations academic Professor Judy Atkinson works in the area of healing and recovery and speaks to the ongoing effects of historic intergenerational trauma:[4]

> There is a truth in this country that we must confront as we move into maturity. [Our country] … holds the trauma of many people across many generations – the Indigenous, the invaders, the immigrants – all seeking refuge from pain and disorder that we humans are so good at creating in this world. It is time we started the work of deep listening.

Those of us working with young children and their families see these effects on a daily basis. A key skill in working with children and families in this context is **deep listening** – creating connection and safety and demonstrating empathy and compassion underpin the approaches needed to understand people's lived experiences.[5] When we truly understand, we are best placed to deliver quality care and education experiences, and to co-create healing practices that support families. This **reflective practice** requires a commitment to be curious and learn about the historical events that affect First Nations peoples. In Australia today, early childhood educators need to build upon their personal cultural intelligence and challenge the narratives they were taught in school. This involves building new understandings about what assumptions, judgements and **unconscious biases** we bring with us, and being willing to reframe our beliefs and ways of working. The key skills are to listen deeply, observe and be compassionate.

People who come to work with us bring their own expertise and assumptions. They then need to learn about our families, their histories, their lived experiences, their strengths and the challenges they face. People often look at Aboriginal people as a problem, but once they begin to understand what has happened to us and what continues to happen to us, these new understandings mean they work with us to address needs rather than doing things to us.

We are not the trauma. We have lived experiences of trauma. We are unfairly judged, often with little understanding of what has happened.

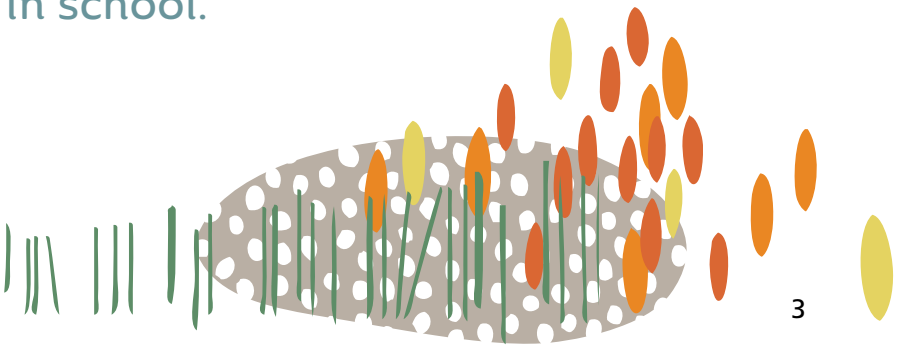
Emily Carter, CEO, Marninwarntikura Women's Resource Centre

Early childhood educators need to build upon their personal cultural intelligence and challenge the narratives they were taught in school.

Deep listening (*dadirri*) – Inner deep listening and quiet still awareness.

Reflective practice – The process of actively and continuously looking at our experiences, and learning from them in order to improve our ways of working.

Unconscious bias – Holding prejudices, below our level of awareness, in favour of or against one thing, person, or group compared with another, usually in a way considered to be unfair.



Trauma within First Nations communities

Voice, treaty, truth

> The *Uluru statement from the heart* was issued as an invitation to the Australian people to walk with us First Nations people, and to compel the politicians we elect to embrace change and not be afraid of change.
>
> *Pat Anderson AO, 2021–22 Sydney Peace Prize recipient*

The *Uluru statement from the heart* (see page 54) is a powerful expression of First Nations peoples' aspirations for formal recognition in the Australian constitution and the culturally appropriate mechanisms to achieve it. The statement has inspired many people to think big about our sense of Australian nationhood and the benefits of First Nations recognition and inclusion in Australian nation-building. Non-Indigenous people have a role to play in progressing these aspirations.

> I know Australians are ready for systemic and social change that embraces and embeds First Nations cultures and knowledge systems. Now is the time to re-set and enter a transformative relationship between Aboriginal and Torres Strait Islander peoples and settler Australia, as Indigenous and non-Indigenous peoples alike, in the face of crisis, envisage a stronger, more compassionate and caring nation.
>
> *June Oscar AO, Aboriginal and Torres Strait Islander Social Justice Commissioner*[6]

As early childhood educators, it is imperative that we understand that when First Nations people talk about their 'struggles', or we see some of the challenges they face, these are the effects of complex trauma that has been passed down from generation to generation and continues to be seen today. As educators, we have a professional responsibility to learn about First Nations peoples and their histories for our own personal and professional development. The best way to do this is by listening and observing without judgement. The 2022 updated Early Years Framework for Australia elevates Aboriginal and Torres Strait Islander perspectives in its key principles and practices.[7]

Intergenerational trauma and the Stolen Generations

> If Stolen Generations survivors don't have the opportunity to heal from trauma, they're likely to live in a state of distress, which can lead to a range of negative outcomes for themselves and their descendants.
>
> *Healing Foundation*[8]

Every First Nations person in Australia has some familial connection to children forcibly removed by government policies between 1910 and 1970. Though many of these government policies have been abolished, government agencies are still taking children away today. The 1997 *Bringing them home* report documents experiences arising from these government practices.[9] The term 'Stolen Generations' has been in use ever since.

Stolen Generations survivors can pass on the effects of institutionalisation, finding it difficult to nurture when they have experienced harsh treatment and not had much experience of nurturing themselves.[10]

We continue to remove children considered at risk of harm from their families (despite the fact that laws enabling forced removal no longer exist) and place them in out-of-home care. There are now more Indigenous children in out-of-home care than at any other time in our history.

Professor Atkinson has written powerfully about the intergenerational and transgenerational transmission of trauma, arguing that many of the challenges in First Nations communities – be it alcohol and substance use, mental health issues, poverty, family violence or contact with the justice system – are symptomatic of the effects of this unresolved trauma.[11]

The Aboriginal and Torres Strait Islander Social Justice Commissioner, June Oscar AO, makes a strong connection between trauma and other complex harms, including the prevalence of FASD in the Fitzroy Valley, Western Australia, and beyond:

> The trauma our communities have sustained has brought into being complex harms, of which FASD is one of the most damaging. With a better understanding of trauma, we will overcome its harmful effects, and make fetal alcohol spectrum disorder history. We will allow our societal strengths to flourish again as we confront, heal and put an end to all forms of harm caused by intergenerational trauma.[12]

It is important for early childhood educators to be aware of the connection between high rates of alcohol and substance use and intergenerational trauma in the communities in which they live and work. A person's trauma history can often explain patterns of behaviour.

We can't understand anything about FASD without understanding trauma. Many in the Fitzroy Valley drink so they don't have to feel the overwhelming emotions triggered by personal histories and trauma. Instead of judging people for their actions, we must start asking what has happened to them. As soon as we move beyond the judgement and seek to respond with understanding, we can create more positive futures.

Emily Carter, CEO, Marninwarntikura Women's Resource Centre

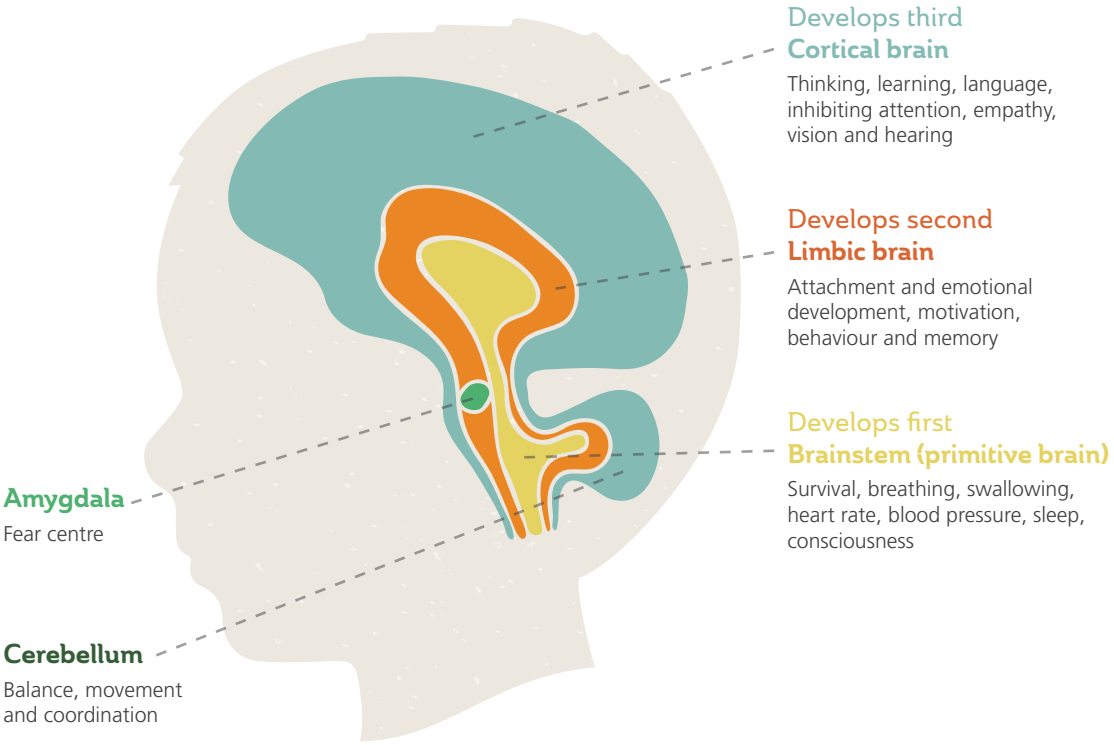
If Stolen Generations survivors don't have the opportunity to heal from trauma, they're likely to live in a state of distress, which can lead to a range of negative outcomes for themselves and their descendants.

Trauma and the developing brain

New and emerging brain science continues to inform our understanding of trauma and its profound effects on the growing child.

Each part of the brain has critical periods of development in utero, infancy, throughout childhood and into early adulthood. When trauma occurs during these crucial periods, neural pathways are disrupted, inhibiting development and diminishing brain function.

Figure 1: Three stages of brain development



Source: Adapted from Beacon House Therapeutic Services and Trauma Team, *Children's brains develop from the bottom up*, Beacon House, Cuckfield, West Sussex, 2019, accessed 3 July 2023.

Bottom-up approach

Figure 1 shows the major parts of the brain as it develops from the bottom up. The brain stem, often referred to as the reptilian brain, is the oldest part and develops first. It controls our most basic bodily functions, such as breathing and blood circulation, as well as instinctive survival thinking and behaviour. The limbic system develops next. It includes key components such as the amygdala and the hippocampus, which are involved in behavioural and emotional reactions, such as love, anger, fear and pleasure.

The part of our brain that deals with higher level cognitive skills is the **cortical brain**, or **neocortex**. By interacting with all other parts of the brain, the neocortex allows us to make sense of what we see, feel or hear, and assists with impulse control. Higher order brain functions such as attention, perception, language, thought, and decision-making are thus enabled. This part of the brain is not fully developed until early adulthood.

Within the limbic system, the amygdala acts as the 'alarm system' of the brain. If the amygdala determines we are safe, we have access to our cortical brain and can function on a high level. If the amygdala identifies a threat, it initiates the 'fear response'. This releases stress chemicals (e.g., cortisol and adrenaline) which activate the 'fight, flight, freeze' response. This can disrupt the connection to the higher level neocortex and makes thinking through or reasoning in the moment impossible. This could manifest as a child demonstrating explosive outbursts, running away, or shutting down completely and not moving. At any time, a trauma response could be triggered by events or other stimuli that are not related to their initial trauma, but are processed by the individual's amygdala as threatening, causing confusion, frustration or discomfort.

Dr Bessel van der Kolk expresses it well:

> Traumatized people chronically feel unsafe inside their bodies: The past is alive in the form of gnawing interior discomfort. Their bodies are constantly bombarded by visceral warning signs, and, in an attempt to control these processes, they often become expert at ignoring their gut feelings and in numbing awareness of what is played out inside.[13]

An early childhood educator may feel compelled in the moment, with good intentions, to ask a 'misbehaving' child to apologise for or explain their actions. However, if their behaviour was an instinctive response to a perceived threat, it may have been a trauma response. If so, at this time, the child might be unable to rationalise and make sense of what they did. Asking them to explain themselves while **dysregulated** is not a trauma-sensitive response and may cause further distress.

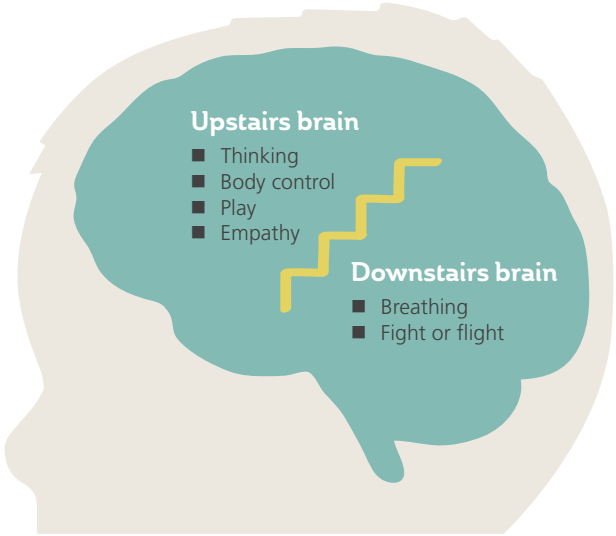
Identifying that the response might be an activation of the threat/fear part of the brain allows the early childhood educator to respond to the child with empathy and understanding, which is a trauma-informed practice. For some children, **co-regulation** through touching, hugging or rocking may meet their emotional needs in that moment. For others, sitting next to them calmly and holding the space may be enough. For others still, co-regulation may require just being in their line of vision as a reassuring presence.

A consequence of repeated exposure to trauma is that the amygdala becomes more reactive and, as a result, registers danger more frequently and with a lower threshold. This means that over time, smaller things might set off this response in a child and they may be in a state of fight, flight or shutdown more often. This makes it difficult for them to make non-emotive rational decisions and respond in ways that are seen as appropriate.

The upstairs and downstairs brain

Conceptualising the brain as two functional components, Dan Siegel and Tina Bryson introduced the concept of the 'upstairs' and 'downstairs' brain (see Figure 2).[14] The downstairs brain is more automatic and instinctive and includes the brainstem and limbic system. The upstairs

Figure 2: The upstairs and downstairs brain



Source: Adapted from DJ Siegel & TP Bryson, *The whole-brain child: 12 revolutionary strategies to nurture your child's developing mind*, Scribe, Brunswick, Vic., 2012.

Dysregulation – When a person is unable to manage their emotional states, which means they're unable to control feelings of sadness, anxiety or anger.

Co-regulation – An interactive process where parents, teachers or caregivers work together with children to help them manage their emotions.

brain, the neocortex, takes time to develop, is the area where higher order thinking and reasoning develops, and allows for complex thought. A child with developmental trauma may respond with their downstairs brain more often than a child without a history of trauma, as their threat/fear response is being triggered repeatedly, making their world a dangerous place where the fight/flight/shutdown response is a default position.

Hyperarousal – A heightened state of anxiety or arousal characterised by irritable behaviour, sleep problems, exaggerated startle response and other concentration problems.

Hypervigilance – A heightened state of awareness and expectation that something bad is about to happen. The brain is locked into permanent 'battle stations' or alert, causing inappropriate or even aggressive reactions in everyday situations.

Freeze and shutdown – A state in which a perceived threat is completely overwhelming and too much for the fight or flight system to cope with. The brain goes into a 'freeze' state, a collapse response or a 'shutdown' disassociation response.

Being able to feel safe with other people is probably the single most important aspect of mental health; safe connections are fundamental to meaningful and satisfying lives.

Bessel A. van der Kolk

The importance of attachment and safety

> Being able to feel safe with other people is probably the single most important aspect of mental health; safe connections are fundamental to meaningful and satisfying lives.
>
> *Bessel A. van der Kolk*[15]

This fundamental principle of safety highlights the importance of respectful relationships that are developed in early childhood and throughout our lives. Early relationships, such as with family members, early childhood educators and teachers, are some of the first significant relationships children develop.

Healthy attachment to primary caregivers is at the heart of a child's ability to relate to others. Children who experience ongoing and persistent exposure to complex trauma, including from their primary caregivers, will often be fearful, disorganised or avoidant or be overly affectionate or familiar or constantly hug people they do not know.

Those working on the frontline with vulnerable children often see behaviours that are the result of what is occurring in the home environment and broader community. They do not know what happens to a child between the end of one day and the beginning of the next. What is important is how those working with children see these behaviours and make meaning from them in their professional roles and how they respond to each child and their individual needs.

In an early childhood context, an understanding of what the behaviour is telling us helps us to respond appropriately. The role of the early childhood educator is paramount in creating a **felt sense of safety** to allow co-regulation and support the child's development. In order to build a safe, caring, nurturing and consistent environment for all children and their parents and carers, early childhood educators need to bring to front of mind what is happening to the child in the family context, rather than making judgements about their behaviour or reacting without understanding where it is coming from. A felt sense of safety is vital for all children to learn and thrive.

It is important that in trying to deliver quality early childhood education, we recognise the layers of trauma and disadvantage that some families experience.

Stephen Porges developed the **polyvagal theory**. It explains that young children with the lived experience of family and domestic violence are adversely affected by what they have been exposed to. Porges talks about creating a calm and regulated environment where children can feel better, think better and connect better.

According to Porges, safety is a relational experience that becomes embedded in our physiology. As children grow, they are the sum of the experiences they have in their early years. When they are surrounded by perceived danger, their development is impeded. The optimal conditions for learning require a calm, consistent and regulated environment.

The effects of complex, multiple traumas are often the underlying causes of the most chronic problems in urban, regional and remote communities. Although trauma may be central to many people's challenges, in health care, education and social service settings their trauma is often not identified, understood or acknowledged. Those affected by trauma therefore often do not receive

Felt sense of safety – A child's often unconscious feeling of physical and emotional security, which can be encouraged through having positive relationships and being calmed and soothed.

Polyvagal theory – This theory proposes that specific parts of the nervous system respond to stressful situations. The name makes reference to the vagus nerve that runs from the neck down to the abdomen, which transmits signals between our brain and various organs in the body. The hypothesis is that by better understanding the functions of our vagus nerve we will better understand why and how we respond to high levels of stress. It teaches us to use this knowledge to regulate emotions.

the appropriate care they need, and are at risk of being re-traumatised by the systems that seek to serve them. Every service and support organisation, including early childhood settings, plays an important role in supporting trauma recovery.

Essentially, the role of early childhood educators and all those working with children is to embrace collective understandings and a shared language about trauma and its effects on those living with it. Learning cannot happen until trauma is addressed and we create safe and calm environments, along with strong and nurturing relationships with the child and their families.

Vicarious trauma is defined as the process of change that happens because we care about other people who have been hurt, and feel committed or responsible to help them. Over time this process can lead to changes in our psychological, physical and spiritual wellbeing.

The cost of caring

Early childhood educators can experience vicarious trauma through being exposed to the high levels of trauma of the children and families with whom they work. Careful attention to staff health should be an essential component in all early childhood contexts, in order to promote wellbeing, create a felt sense of safety and mitigate against burnout.

The Centre for Excellence in Therapeutic Care is a partnership between the Australian Childhood Foundation and Southern Cross University. The collaboration has developed an excellent *Practice guide: Secondary traumatic stress and staff well-being: Understanding compassion fatigue, vicarious trauma and burnout in therapeutic care*.[16] Key messages from the guide include:

- The care of young children who have experienced early life trauma is complex and challenging work. The development of secondary traumatic stress – vicarious trauma, compassion fatigue and burnout – is recognised as a common occupational hazard for staff working with traumatised children and their families.
- There are many personal risk and protective factors that play an important role in a caregiver's susceptibility to secondary traumatic stress.
- Should the staff experience them, secondary traumatic stress can be resolved successfully with self-care practices and/or professional support. There are a range of effective strategies that organisations and individuals can access to support staff wellbeing.[17]

Vicarious trauma

While there is little research looking at vicarious trauma in staff who care for young children in therapeutic settings, the signs and symptoms may present in a variety of ways.

'Vicarious trauma is defined as the process of change that happens because we care about other people who have been hurt, and feel committed or responsible to help them. Over time this process can lead to changes in our psychological, physical, and spiritual well-being.'[18]

Vicarious trauma can show up in our physical, emotional and psychological states in a range of ways. We may become overly reactive, have disrupted sleep, over- or under-indulge with food and alcohol, or become irritable, anxious or depressed.

Compassion fatigue

Compassion fatigue is the emotional and physical fatigue that may be experienced due to caring too much and being overwhelmed or burdened by stories of suffering.[19] Early childhood workers are particularly vulnerable to this type of fatigue, especially since many of the children and families they are working with carry early life trauma every day and it shows up in the behaviours they see.

Symptoms of compassion fatigue include sleep disturbance, impairment of judgement, depression, anger and loss of hope.

Burnout

Burnout can arise in early childhood educators due to excessive, repeated and prolonged exposure to stories of trauma and stress among the children for whom they are caring. This can lead to feelings of exhaustion, cynicism and alienation from the workplace and may lead to being negative, unable to concentrate and lacking in creativity both at work and at home.[20]

Compassion fatigue is the emotional and physical fatigue that may be experienced due to caring too much and being overwhelmed or burdened by stories of suffering.

Burnout can arise in early childhood educators due to excessive, repeated and prolonged exposure to stories of trauma and stress among the children for whom they are caring.

Towards self-care

Sometimes those of us responsible for delivering services to children and communities where trauma is an everyday challenge may forget to look after ourselves in ways that maintain our own sense of wellbeing. Some helpful ways of working to ensure self-care are:

- **Make time to check in with how we are feeling.**

  The first component of self-compassion involves being aware of how we are really feeling, and checking in and identifying where in our body we are feeling stress. It is hard to be compassionate with ourselves if we don't know when we are struggling. Remember that stress can show up in different ways – from feeling overwhelmed and irritable, to losing appetite, struggling to sleep, and having difficulty concentrating. If we notice these signs of stress, it is important not to judge ourselves (or others) for feeling this way.

- **Remember that we're not alone in how we feel.**

  It is very natural to feel alone when we are struggling. The second component of self-compassion involves reminding ourselves that we all go through difficult times and experience feelings of stress, sadness, frustration, failure and guilt. While the details of our challenges are different, having these sorts of feelings is part of the human experience. Recognising our connection to others in this way can help us to feel less alone and make it more likely that we will stop judging ourselves for how we are feeling.

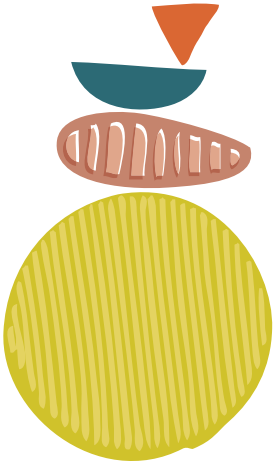
- **Treat ourselves the same way we would treat a good friend.**

  The third component of self-compassion involves being kind and understanding with ourselves when we are having a hard time. This might be as simple as being patient with ourselves, having more flexible expectations of ourselves and others, and not judging ourselves for not doing things perfectly. It can be helpful to think about what we would say and do for a loved one who was in a similar situation. Make sure to check and stop any negative self-talk. Reframe self-talk towards being compassionate towards ourselves. While it can feel self-indulgent at first, being gentle with ourselves can actually help us feel better and more able to be there for others.[21]

The Berry Street Education Model offers a range of resources and supports, including a self-care planning tool (see Figure 3 on page 13). The wellbeing schema it presents includes paying attention to physical, emotional, spiritual, energetic and cognitive needs.

Figure 3: Berry Street Education Model: Developing an effective self-care plan

Source: Adapted from Berry Street, *BSEM training course*, Berry Street, Richmond, 2023, accessed 9 March 2023.



Trauma-responsive wellbeing principles and practices for early childhood

The trauma literature can be overwhelming due to its content and basis in neuroscience, so the Australian Childhood Foundation has developed a list of accessible trauma-informed principles to assist those who work with children. The 'child's voice' section in these principles enables us to consider the lived experience through the lens of a child.[22]

These principles have then been adapted by Baya Gawiy early childhood educators, based on their experiences working with children and their families in Fitzroy Crossing, Western Australia, many of whom have lived experience of intergenerational trauma, poverty and a lack of resources in very remote communities (see Table 1). These insights will assist early childhood educators to better support vulnerable children and their families.

Table 1: Trauma-informed early childhood wellbeing principles and practices

Principle	The child's voice	Early childhood educator practices
Trauma compromises developmental trajectories in all areas The wellbeing of a child is essential to enable them to thrive and experience success as lifelong learners.	■ Break everything up into small steps so I can achieve and not be overwhelmed. ■ It is helpful if you know what I can do and help me take the next steps. ■ Go at my pace, explore with me and listen deeply to my questions. ■ I am still learning and need your help to understand. ■ I might need my arousal level toned up or down to support integration and processing. ■ Notice and acknowledge my strengths and my skills. ■ Sometimes I do better thinking when my body is active. ■ Being active, coordinated and skilful builds a bigger, stronger brain and helps me think and understand more easily. ■ Using music and movement and songs with actions connects different parts of my brain and can unlock memories held in my body. ■ I need skills to explore, discover and find out more about myself and the world I live in. ■ Help me to build my knowledge so I can be a strong independent learner. ■ When I practise my new skills and use my new knowledge, I feel strong, happy and proud.	Educators provide rich and responsive experiences to support children's learning and development by: ■ considering each child as unique ■ creating physically and emotionally safe learning environments ■ planning and implementing experiences and interventions through play-based learning, intentional teaching and establishing sensitive and inviting learning environments ■ planning around strengths and developmental and relational needs ■ providing repeated opportunities for children to practise and rehearse their newly found skills and understandings ■ observing, assessing, planning, implementing, evaluating and sharing information about children's learning and development for future implementation of interventions and healing goals.

continued on page 15

Table 1 (cont.)

Principle	The child's voice	Early childhood educator practices
Trauma affects physiological arousal levels in children Children with lived experiences of trauma need care and learning environments that are responsive to their mood and reduces sensory overload. This will help them to stay physically present, feel safe to connect with others and assist them to be less reactive, reducing 'meltdowns'.	■ I feel safe in a calm, caring and nurturing environment. ■ I need trusting relationships and safe cues from others to give me a felt sense of safety. ■ I will have more opportunities to learn and form stronger social bonds when my heart rate slows and my safety mechanisms are settled. ■ I will respond to warmth and softness in your voice and facial expressions. ■ My physiological state influences my behaviour. ■ My posture sometimes tells you how I am feeling and can indicate that I feel unsafe. ■ When I am ready, play and have fun with me. ■ Create a safe space and show me how to use it to help me calm down. ■ If you are calm, it will help me to feel calm. ■ Breathing together deeply and rhythmically can help calm me down. ■ Your actions, gestures, body language and tone of voice tell me I am safe. ■ Sometimes I am hungry, thirsty and tired. Check in and respond to my needs. ■ Help me to understand what is happening in my body by giving me the words to describe the signs. ■ When you name my emotions, I can understand how I feel. ■ When I have big feelings, put yourself in my shoes, I will feel your empathy. ■ Grounding activities help me to feel my body by noticing different parts, such as my feet on the floor and my bottom on the chair/mat. ■ Your facial expressions and calming voice can calm my physiological state.	Educators bring certainty and a felt sense of safety by: ■ building attuned relationships with children ■ providing repetition, rhythm and rituals embedded in routines ■ promoting co-regulation with a sense of calm ■ providing responsive and flexible care, and being responsive to children's needs – they may need more food, rest or connection at different times ■ supporting children's understanding of emotions by using words to describe feelings ■ providing quiet nurturing spaces for children to maintain a calm state ■ using musical resources to create a calming ambience.

continued on page 16

Table 1 (cont.)

Principle	The child's voice	Early childhood educator practices
Behaviours associated with trauma result from a child's increased perception of threat Children with FASD and lived experiences of trauma communicate distress through their behaviours and may have a 'meltdown' for no obvious reason. They can be triggered by any number of real or perceived threats. Triggered behaviour is an unconscious attempt to create safety in an environment that feels unsafe.	■ I feel safer when you set clear and consistent boundaries. ■ I engage when I know that you are listening to me. ■ Your non-verbal communication, such as posture, facial expression and tone of voice can communicate safety to me. ■ My behaviour can be an attempt to seek interaction or attachment. ■ My behaviour is a communication tool – I am trying to tell you something but may not have the words to express how I feel. ■ I might not know what to do with big feelings on my own, and need your help. ■ When I have big feelings, my body might need to jump, hang, swing and climb high. ■ I might need other ways of expressing my feelings, like drawing, moving, using my energy and play therapy.	Educators support children with trauma-associated behaviours by: ■ sensitively and carefully understanding individual children and creating environments that adapt and respond to their individual needs ■ responding with empathy and compassion ■ understanding without judgement and blame ■ being consistent in all routines, expectations and transitions ■ demonstrating deep listening and validating the child's voice and ways of communicating.
Trauma reduces a child's capacity to focus and pay attention Children with FASD and lived experiences of trauma benefit from learning environments that focus on the here and now, and promote trust, safety and belonging. Through positive play-based experiences children find purpose and create opportunities to gain control over their learning and express themselves through play.	■ I feel good when you allow me to follow my interests. ■ My confidence will grow when you support and encourage me to try new things. ■ I can't use my social skills or learn when I'm scanning the environment for threats. ■ The lights, sounds, smells and movement might distract me when I am trying to concentrate. ■ When I have familiar things around me I feel happy and safe. ■ Giving me a simple, achievable task and acknowledging successes will help me. ■ Changes in my environment that are not familiar and predictable can overwhelm me. ■ I feel proud, needed and successful when you give me purposeful and meaningful work.	Educators support children to focus by: ■ making minimal changes to the environment to ensure that the spaces are familiar and predictable ■ being aware that lighting, smells, sounds and environmental factors can trigger some children ■ supporting children to feel safe by providing predictable routines and boundaries ■ providing opportunities for active learning through physical routines such as gardening and raking, and by adding brain breaks throughout the day ■ purposefully using music and sound to enhance the learning environment ■ providing an environment that facilitates play.

continued on page 17

Table 1 (cont.)

Principle	The child's voice	Early childhood educator practices
Trauma disconnects children from the ability to attach to others in positive and trusting ways Children with FASD and lived experiences of trauma benefit greatly from forming strong relationships. Positive attachments with educators and carers are essential to building secure and healthy relationships later in life.	■ I feel safe to engage with others when I feel calm. ■ I need to be a part of the group as well as having interactions with individuals. ■ When I see familiar faces I feel safe. ■ I will learn from how you relate to others. ■ I know that I belong and I am safe when you are engaging with me. ■ I feel valued when you share things about my day with my family. ■ I will respond in my own time when I have processed what you have said. ■ When I am trying to learn new ways to relate to my friends, you can help me to connect with them.	Educators build positive relationships by: ■ being calm and present and engaging directly with the child ■ building a relationship with the child's carers/parents and family ■ modelling appropriate social skills ■ being responsive to the child's cues for connection and nurturing ■ being nurturing and consistent with care routines ■ noticing and responding to children's communications ■ responding with positive 'back and forth' interactions ■ providing consistent and stable care.
Trauma undermines self-image and identity formation in children Trauma can disrupt a child's self-image and create a negative view in how they see themselves. An environment that reflects a child's culture and identity helps to build a positive sense of self. Children learn about themselves in the context of their families and community and are shaped by their lived experiences.	■ It makes me feel good when you give me activities that I can do with my body, like balancing, swinging and climbing. ■ It helps me to take the next steps in developing new skills when you have realistic expectations of me. ■ I will need some help to create the story of 'Me' and build stories about my life. ■ My relationships with my family and my community are part of my story. ■ Going out on country with my family and friends, I learn about my culture. ■ I like it when you check in with me.	Educators carefully consider every experience by: ■ breaking down tasks into small achievable steps ■ providing positive feedback and acknowledging the child's successes ■ providing each child with the opportunity to build their unique story ■ incorporating cultural and family values, events, rituals and traditions into the learning environment ■ providing a safe, culturally responsive environment ■ incorporating cultural knowledge within the learning and care environment through storytelling, languages and cultural practices.

continued on page 18

Table 1 (cont.)

Principle	The child's voice	Early childhood educator practices
Trauma reduces a child's capacity to self-regulate Children with FASD and lived experiences of trauma often find it difficult to use reasoning and logic to guide their behaviour or responses. The part of the brain required for reasoning, thinking, logic, memory and consequences – the upstairs brain – is affected by trauma. Feeling calm and secure is essential for young children to engage and learn. Children are unable to engage while they are dysregulated.	■ When you recognise what I see as a threat I feel safer and calmer. ■ I can be triggered and overwhelmed by too much physical attention. ■ When I am struggling, I don't hear you or make sense of your words and actions, so start by engaging my senses. ■ Your soft voice and calm face give me cues to engage. ■ When I rock, spin, sway and feel my body in space, my brain is stimulated and I feel more regulated. ■ Give me some heavy work to do – like lifting, hammering or pulling, pushing and dragging – to help me concentrate. ■ I need to see the people I know and trust. ■ I feel calm when you sing softly to me and with me. ■ Playing music and moving to the rhythm and beat can comfort and regulate me. ■ When I feel overwhelmed, let me retreat to a quiet place. ■ When you give me the words to describe how I feel, I feel validated.	Educators' interactions and calming environments help children to regulate by: ■ reducing 'visual noise' and using soft storytelling voices ■ maintaining consistency with familiar faces and people ■ providing physical activity that stimulates parts of the brain responsible for movement, play and balance ■ practising tasks and developing skills repetitively until they become automated ■ supporting children's understandings of emotions by describing how they feel in the body.
Trauma limits children's ability to adapt and be responsive to change Children with FASD and lived experiences of trauma may seem overwhelmed or unresponsive due to a range of triggers. They may enact patterns of defensive behaviour that are not immediately obvious to those around them. Educators should understand that, while triggered, children have little capacity to reshape their responses without the calming help of an empathetic adult to help them co-regulate. This will involve helping children to manage their emotions to enable them to better respond to stressful situations. Co-regulation always involves acting with tenderness, kindness and responsiveness to children.	■ I feel engaged when I participate in decisions being made for and about me when I have choice and control. ■ Boundaries keep me safe so that I don't feel overwhelmed. ■ If you want me to stop or start something, give me some time to process the request. ■ I need to know what is going to happen next to help me move from one activity to another. ■ If I have too many options, I become overwhelmed, so it is good to limit my choices. ■ Sometimes I would like to share my ideas with you. ■ I will learn from you when you model how to use problem-solving skills. ■ I like the consistency of daily routines; they make me feel secure.	Educators introduce change in small, intentional increments by: ■ supporting children to become accustomed to one change before introducing another ■ preparing children for change from one part of a routine to the next ■ including the children's ideas in any changes to be made. ■ providing flexibility in our routines so children have choices.

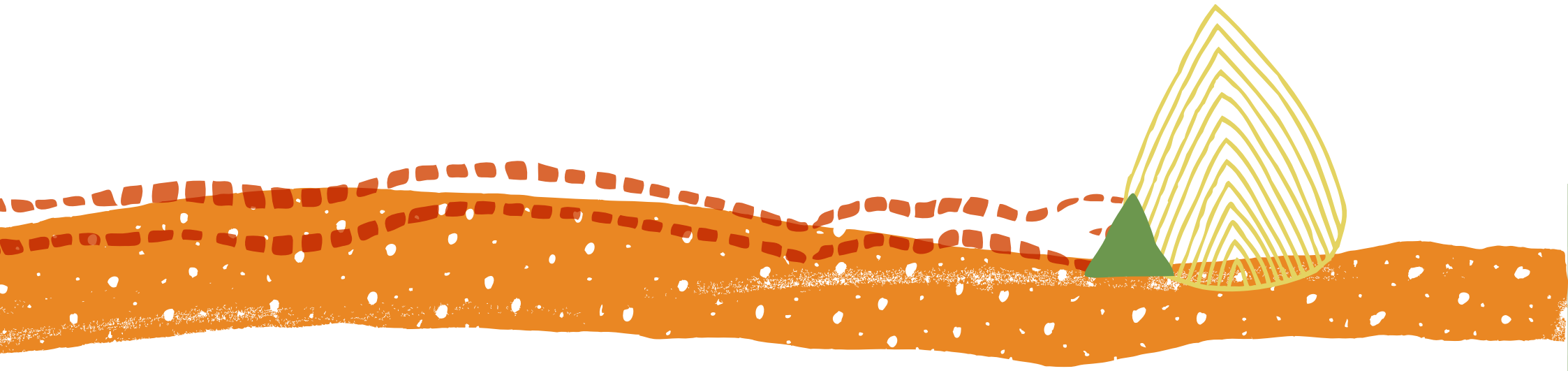
continued on page 19

Table 1 (cont.)

Principle	The child's voice	Early childhood educator practices
Trauma disrupts memory functioning Children with FASD and lived experiences of trauma may have difficulty storing and retrieving memories. They may not be able to distinguish between past and present experiences, build autobiographical stories or recount long-term memories. They may struggle to generalise learning and understandings from one situation to another.	■ I will understand better if the rules are consistent. ■ I sometimes feel unsafe and react when something triggers me. ■ I get big feelings from experiences that I may not have conscious memory of. ■ Pictures and stories about who I am and where I am from make me feel I belong. ■ I feel safe and in control when I know what is going to happen. ■ I can remember easier when I practise. ■ I will find it easier if carers/parents are using the same language.	Educators assist children with memory support by: ■ embedding the routine through repetition ■ providing regular purposeful experiences that promote the wellbeing of the group ■ providing predictable and familiar routines that help children to create, store and retrieve memories ■ prompting memory using visual, pictorial, auditory and physical cues ■ maintaining consistency of language and responses ■ being aware that for some children in care, references to 'family' and past memories may be a trigger.
Trauma disrupts the development of social skills and can cause isolation Children with FASD and lived experiences of trauma may have difficulty connecting with others. They can misinterpret social cues, compromising their ability to engage and make and keep friends. Children living with trauma need support to engage positively with others.	■ When you praise me it builds my confidence. ■ I learn social cues and behaviours from you. ■ My capacity to play and be with others varies from day to day. ■ I need you to be there when I am facing difficult social situations. ■ I might need to practise new skills before I use them as my own. ■ I will use these new skills if everybody uses them. ■ I might need you to stand by me and guide me to try new ways of being respectful with others. ■ I can learn empathy when it is unpacked through storytelling, play and puppets.	Educators support children to build social skills by: ■ modelling positive and respectful interactions with one another ■ maintaining respectful relations with all children and families ■ modelling and explicitly teaching social skills ■ responding with empathy to build resilience ■ acknowledging individual children's strengths using positive reinforcement.

Source: Adapted by Baya Gawiy early childhood educators from: Australian Childhood Foundation, *9 plain English principles of trauma informed care*, Australian Childhood Foundation, 28 April 2015, professionals.childhood.org.au/prosody/2015/04/trauma-informed-care/, accessed 28 July 2023.

Self-regulation is the ability to control your behaviour and manage your thoughts and emotions in appropriate ways.



Section 2: About fetal alcohol spectrum disorder

What is fetal alcohol spectrum disorder?

Alcohol exposure before birth may disrupt the development of the brain and other organs in the unborn child.

FASD is thought to be the most common cause of intellectual disability and birth defects in the Western world.

The National Health and Medical Research Council advises that there is no known safe amount of alcohol or safe time to drink alcohol during pregnancy.

Fetal alcohol spectrum disorder (FASD) 'is a diagnostic term for severe neurodevelopmental impairments … that result from brain damage caused by alcohol exposure before birth'.[23] This is because alcohol can cross the placenta, from the mother to the fetus and disrupt the development of the brain and other organs in the unborn child. This can lead to children with FASD experiencing lifelong difficulties with social skills and language, motor skills, paying attention, and impulse control skills that would otherwise help them learn and achieve at expected norms. The personal costs to families with FASD and neurodiverse conditions are enormous, posing challenges to young children as they grow.

The National Health and Medical Research Council of Australia advises that there is no known safe amount of alcohol or safe time to drink alcohol during pregnancy. Women who are pregnant or planning a pregnancy are therefore advised to avoid alcohol altogether.[24] In the wider community, however, there is limited knowledge about alcohol-related harms, especially the damage it can cause to the fetus in utero. Many women, their partners and their social networks believe that 'a little bit won't hurt', and join in celebrations that involve alcohol. We can all play a part in sensitively building community knowledge about alcohol-related harms in a manner that builds knowledge and empowers people to take action rather than stigmatise or judge women.

FASD occurs in all parts of the world where alcohol is consumed, and is thought to be the most common cause of intellectual disability and birth defects in the Western world. Worldwide, rates of FASD in the general population are estimated at 1–5%, although it is important to acknowledge that it is under-recognised and often goes undiagnosed, and is often referred to as a 'hidden harm'. Accurate FASD prevalence rates for the general Australian population are not available; however, conservative estimates based on international data indicate that approximately 2 per cent of the population may have FASD. Therefore, as many as 6,000 babies could be born with FASD each year in Australia. This exceeds the prevalence of many other disorders, such as autism spectrum disorder, Down syndrome, spina bifida and cerebral palsy. While no whole-of-population prevalence study has been undertaken in Australia, the population-based Lililwan study in the Fitzroy Valley region of the Kimberley, Western Australia, in 2010–12 found that 1 in 5 children received a FASD diagnosis.

Several identifiable groups of children – those in foster and adoptive care, orphanages, mental health facilities, juvenile justice system, and some Indigenous groups – are likely to have higher proportions with FASD.[25] In one study in a justice facility in Western Australia, one in three of the children in custody were diagnosed with FASD.

According to Stratton, Howe and Battaglia, 'of all the substances of abuse (including cocaine, heroin and marijuana), alcohol produces by far the most serious neurobehavioral effects in the fetus'.[26] In addition, FASD and early life trauma frequently co-occur, with the former being compounded by the latter, and therefore a therapeutic approach that is sensitive to both FASD and early life trauma is needed. In Australia, there is limited awareness and knowledge of FASD among health professionals and limited access to the specialist multi-diagnostic services that are required for a diagnosis. The *Australian guide to the diagnosis of fetal alcohol spectrum disorder (FASD)* was developed to help address this and support a multidisciplinary team approach to the diagnosis, referral and management of FASD.[27]

Assessing and diagnosing FASD

Early childhood educators need to know about and understand ten areas of neurodevelopment that are used to assess and diagnose for FASD (see Table 2).

Table 2: Areas of neurodevelopment

Area	Definition
Brain structure/neurology	The size and structure of the brain and the central nervous system, which underlies healthy or unhealthy neurodevelopment.
Motor skills	Skills related to balance, movement and coordination of the muscles of the body – fine and gross motor skills are involved in using and controlling muscles in the body.
Cognition	The process of knowing, perception, awareness and judgement, including IQ, verbal and non-verbal skills, and the ability to learn new skills.
Language	Receptive and expressive language skills – the ability to understand words and language and the emerging ability to use words to communicate.
Academic achievement	The emergence of skills in reading, mathematics and literacy – more relevant to children in older age groups.
Memory	The processes used to acquire, store, retain and retrieve information, including verbal and visual memory.
Attention	The ability to choose and concentrate on relevant information or the ability to focus.
Executive function	Higher level skills used to organise thoughts and behaviours, which help with impulse control, working memory, planning and problem solving – in the early years, these skills are emerging for all children.
Adaptive function	Skills enabling successful participation in day-to-day activities, including age-appropriate self-care, communication and socialisation skills – in the early years, these skills are emerging for all children.
Affect (emotion) regulation	The ability to control emotions, moods and feelings – in the early years, these skills are emerging for all children.

Source: Adapted from: C Bower and EJ Elliott, *Australian guide to the diagnosis of fetal alcohol spectrum disorder (FASD)*, 2020, www.fasdhub.org.au/fasd-information/assessment-and-diagnosis/guide-to-diagnosis.

FASD and early-life trauma frequently co-occur, with the former being compounded by the latter. A therapeutic approach that is sensitive to both FASD and early life trauma is needed.

Of all the substances of abuse (including cocaine, heroin and marijuana), alcohol produces by far the most serious neurobehavioural effects in the fetus.

As a lifelong condition that alters brain function, FASD requires appropriate therapeutic interventions, and allied health supports may have a dramatic positive effect on a child's development and growth if provided early in life.

According to the *Australian guide to the diagnosis of fetal alcohol spectrum disorder (FASD)*, a FASD diagnosis requires objective evidence of severe impairment of brain function in at least three of these ten specified neurodevelopmental areas. The challenges of diagnosis are increased in the case of young children who are exposed to both early life trauma and prenatal alcohol, as trauma causes or amplifies a range of impairments and delays that are seen in FASD.

The common physical characteristics associated with FASD – including abnormalities of the face or organs (heart, kidney etc.) – occur during the first twelve weeks of pregnancy, often before a woman knows she is pregnant. The spectrum of physical and neurodevelopmental disorders that occur in FASD depends on the frequency, quantity and timing of alcohol exposure, genetic and environmental influences, maternal age and health, and the use of other drugs during pregnancy.

Recent research data indicates that about 20 per cent of children with FASD have facial features that make their disability 'visible'. This means that the majority of children with FASD have only behavioural, developmental and learning difficulties as indicators of their disability.[28]

Figure 4 (on page 25) shows the developmental stages of a fetus and the most common sites of abnormalities that can be caused by FASD.

As a lifelong condition that alters brain function, FASD requires appropriate therapeutic interventions, and allied health supports may have a dramatic positive effect on a child's development and growth if provided early in life. Early childhood educators therefore play an important role in supporting parents and carers to sensitively identify areas of concern in any developmental area.

For more information about FASD and its diagnosis, visit FASD Hub Australia (www.fasdhub.org.au) and Learning with FASD (learningwithfasd.org.au).

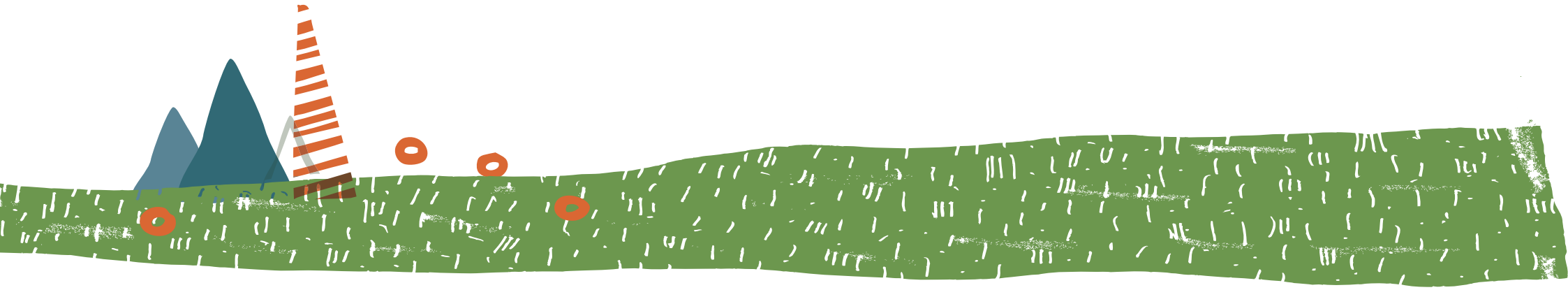
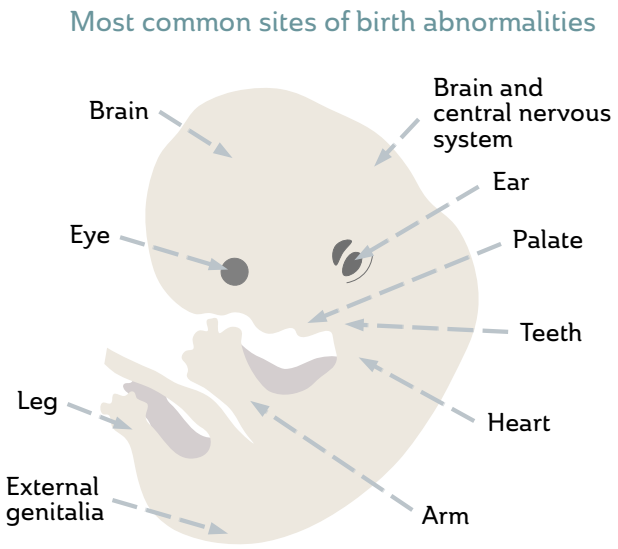
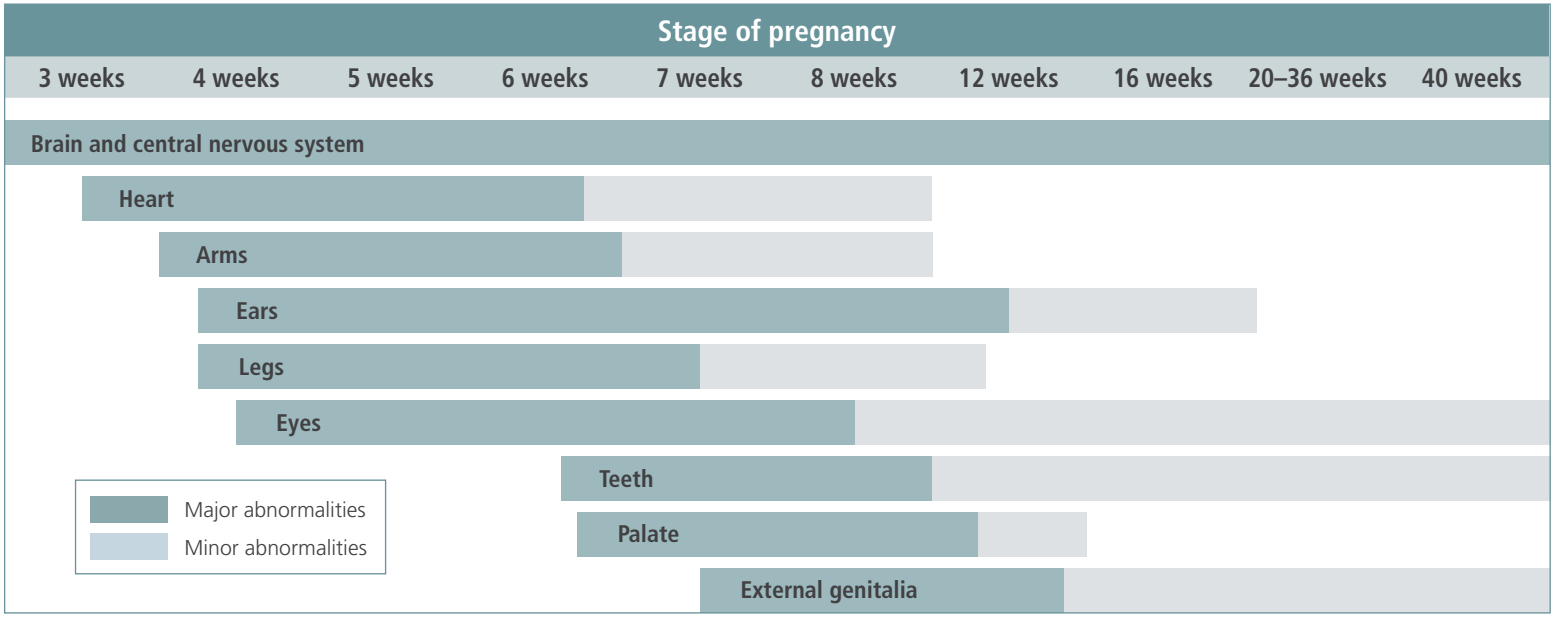


Figure 4: Most common birth abnormalities that may be seen in FASD



Source: Adapted from C Blackburn, B Carpenter and J Egerton, *Educating children and young people with fetal alcohol spectrum disorders: Constructing personalised pathways to learning*, Routledge, Abingdon, Oxon, 2012, p. 13.



Child development: When to be concerned

We need to acknowledge that children and their families in our communities are living with unique and complex needs, and that it is upon us to become informed and educated about the appropriate and respectful responses we can provide to those children.

Emily Carter, CEO Marninwarntikura Women's Resource Centre

An informed understanding of the science of early learning and development guides educators and carers on what children need to thrive.[29] Emerging evidence reveals that the human brain is biologically primed for learning, and in their early years, children's developing brains undergo rapid change. Research underscores the need for a holistic approach that concentrates on consistency and shared understandings as children move between various settings in the early years, including home, early childhood services and school. Best practice care and education for children with FASD focuses on safety, engagement, secure attachments and social and emotional development, including self-regulation and understanding boundaries. This social environment enables children to build resilience and experience success.

Best practice in addressing the needs of young children with early life trauma and FASD is built upon early diagnosis and targeted therapeutic interventions. Early childhood educators routinely focus on key milestones in a child's development to identify achievements and any concerns that may present among the children they care for. When developmental delays or other concerns are identified promptly, progress towards a comprehensive diagnosis and therapeutic supports can occur early in a child's life. Developmental delays can sometimes be missed in communities where services are not available or cannot be accessed. This can lead to children not receiving adequate supports or early interventions and can also lead to incorrect diagnoses.

Table 3 (on page 27 onwards) provides the questions about expected developmental milestones that early childhood educators can use to discuss a child's development with parents and carers. This process will highlight the child's achievements while providing opportunities for identifying any emerging concerns. It may assist with identifying the need for referral to appropriate health professionals for assessment, and influence the types of activities provided. We recognise that all children develop at different stages in different ways; therefore the behaviours listed in the table are indicative of normal developmental milestones rather than being concrete goals. A full range of environmental circumstances should be taken into account before deciding that there are concerns that need to be addressed.

Table 3: A reflective tool for assessing child development

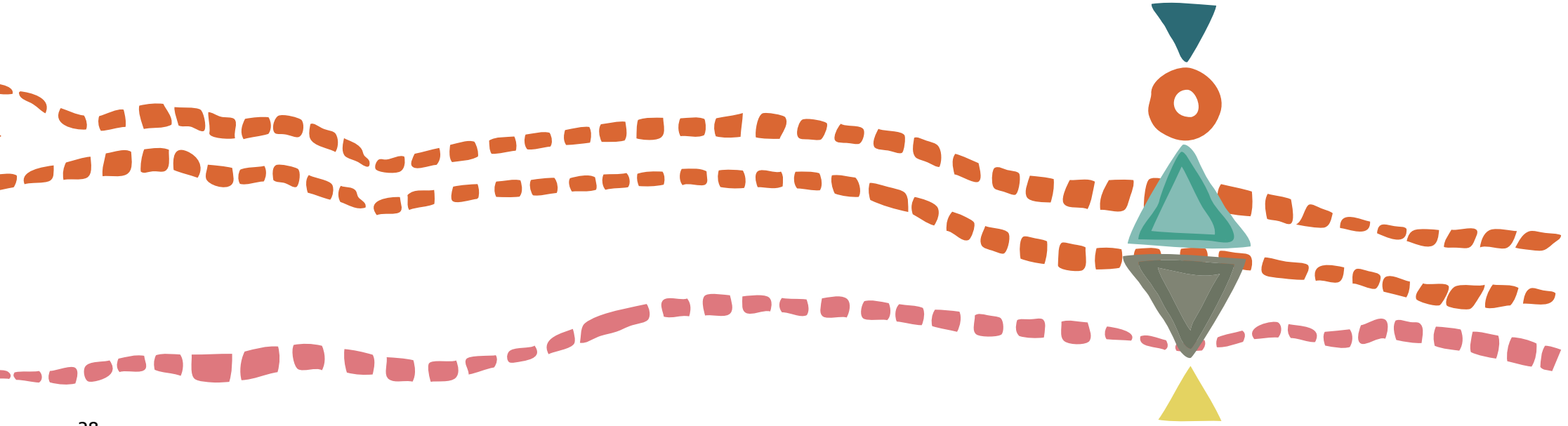
Area	6 months	9 months	12 months	18 months	2 years	3 years	4 years	5 years	Concerns at any age
Social-emotional	Do they smile and interact with other children/ adults?	Do they communicate using facial expressions? Do they make eye contact?	Do they notice someone new? Do they play turn-taking games (e.g. peekaboo, rolling a ball to others)?	Do they show interest in playing? Do they show interest in interacting with others?	Do they play with toys purposefully (e.g. cuddle toys, build with the blocks)?	Do they engage in pretend play? Do they interact with other children? Do they use words to describe feelings?	Do they play cooperatively with other children?	Do they play differently compared to their friends?	Do they arouse strong parental concerns? Have they had disrupted learning? Do they lack response to sound or visual stimuli?
Communication	Do they attempt to make sounds and noises?	Do they use gestures (e.g. pointing, waving)? Do they use two-syllable words (e.g. mama, dada)?	Do they mimic sounds like talking? Do they respond to familiar words?	Do they use words you can understand? Do they understand short requests?	Do they learn new words? Do they put words together?	Is their speech difficult for people to understand? Are they using simple sentences?	Are they able to follow simple directions with two steps (e.g. 'Put your bag away and then go and play')?	Can they communicate what is wrong? Are they able to answer questions in a simple conversation?	Do they lack interaction with adults or other children? Do they have limited responsiveness?
Cognition, fine motor skills and self-care	Do they reach to grasp objects? Do they frequently clench hands? Do they use hands, eyes, mouth to explore? Do they bring hands together at the midline?	Do they hold objects with both hands? Do they give items on request? Do they transfer objects from one hand to another?	Do they hold a bottle or cup or put finger food in their mouth? Do they pick up small items using index finger and thumb?	Do they scribble with a crayon? Do they copy you when stacking blocks?	Do they use a spoon to feed themselves? Do they help with dressing themselves?	Do they attempt everyday self-care skills (e.g. feeding or dressing)? Do they have difficulty manipulating small objects (e.g. threading beads)?	Are they toilet-trained by day? Are they able to draw lines and circles?	Is there concern from teacher about school readiness? Are they able to independently complete everyday routines (e.g. feeding and dressing)? Are they able to draw simple pictures (e.g. stick person)?	Are they developing differently between the right and left sides of their body (evident from core strength, movement and tone)? Do they have an obvious delay in functional motor skill development?

continued on page 28

Table 3 (cont.)

Area	6 months	9 months	12 months	18 months	2 years	3 years	4 years	5 years	Concerns at any age
Gross motor	Do they hold their head and shoulders up with good control when lying on their tummy? Do they hold their head with control in supported sitting?	Do they roll over? Do they sit without support? Do they attempt to move by creeping and crawling? Do they take weight on legs when held up to stand?	Do they have mobility (e.g. crawling, commando crawling, bottom shuffle)? Do they pull themselves up and stand independently and hold on for support?	Do they stand independently? Do they attempt to walk without support?	Do they walk independently? Do they walk up and down stairs holding on?	Do they walk up and down stairs independently? Do they run or jump?	Do they walk, run, climb, jump and use stairs confidently? Do they catch, throw or kick a ball?	Do they walk, run, climb, jump and use stairs confidently? Are they able to hop five times on one leg and stand on one leg for five seconds?	

Adapted from: Child Development Program and Brisbane North Primary Health Network, *Red flags early identification guide: For children aged birth to five years*, Queensland Government, Brisbane, 2016, www.childrens.health.qld.gov.au/wp-content/uploads/PDF/red-flags.pdf.



The importance of respectful language

It is important that everyone working with children and young people with FASD and their families frame their understanding about FASD in a 'no blame and no shame' context. We know that complex trauma is a powerful risk factor for alcohol use in many communities. Women should not be judged, shamed or stigmatised about alcohol use during pregnancy. Rather, we all should be empowered with knowledge about the harm alcohol causes.

The language we use when talking about children with FASD should be respectful, and promote compassion and understanding. It is important that all accommodations and strategies that address the range of complex issues at play is strengths-based and begins with the strong belief that women do not intentionally harm their babies.

The Manitoba FASD Coalition comprises a group of Canadians concerned about the relationship between stigma and FASD. They have developed a guide to respectful language to provide alternative words or phrases to those commonly used in society, and this has been adapted in Table 4 for the Australian context.

Table 4: Respectful language when talking about FASD

Referring to a person with FASD		
Please use:	**Instead of:**	**Why?**
Person/individual with FASD	Suffering with FASD	Many people who have FASD find these words offensive because they imply that they are not living happy, productive lives. People with disabilities prefer others to focus on their strengths and positive attributes. People with FASD don't perceive themselves in negative ways and are not looking for people to feel sorry for them.
	Damaged by FASD	
	Living with FASD	The FASD community has removed 'living with' to reflect the language used to describe other disabilities/conditions.
	FASD kids	The FASD community prefers to use 'person-first' language. This means that we talk about a person who has a disability (as well as many other traits) rather than presenting the disability as the whole of who they are.
	(Innocent) victims or injured	These words imply that there has been a perpetrator, and is very negative towards mothers and is loaded with judgement. This language may jeopardise both a woman's willingness to seek help and a child's future relationships with their mother.
Affected or impacted by	Afflicted by	The term 'afflicted' presumes that the person does not lead a happy, productive life. 'Affected by' presents a more neutral tone to this disability.
Support person/circle/ network/coach	External brain	The term 'external brain' was coined many years ago to give people an understanding that someone with FASD may require coaching from others at times to help with certain brain functions, like memory, problem-solving, managing money or everyday living. However, it has since been rejected by some as being offensive because it implies that they need a whole new brain to be 'normal'. A 'support person' is a more accurate and neutral term.
Cognitive or neuro-developmental disability	Mentally disabled	'Cognitive disability' or 'neurodevelopmental disability' is a more respectful terminology to describe people who may have cognitive challenges or a low IQ.

continued on page 30

Table 4 (cont.)

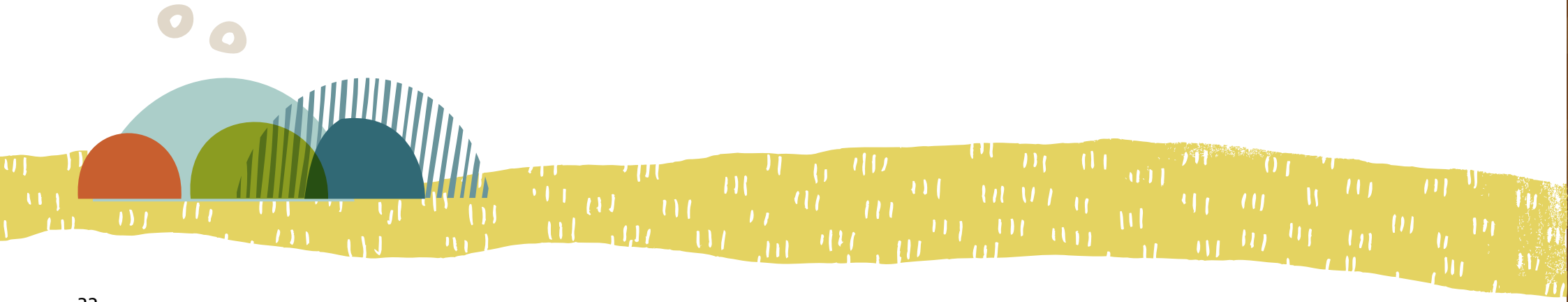
Women who use alcohol during pregnancy		
Please use:	**Instead of:**	**Why?**
Confirmed alcohol use	Admitted to alcohol use	The term 'admitted' implies that this is a confession of wrongdoing, and has a morally judgemental overtone. The term 'confirmed' is neutral.
Women who use alcohol or drugs	Alcoholics/addicts	Research tells us that women do not intentionally seek to drink to harm their unborn child. Some women may be unaware of their pregnancy when drinking heavily. Some women have addictions and mental health challenges and find quitting extremely difficult, despite pregnancy. Some women have partners or other influences who pressure them to drink. Alcohol use is often a symptom of a person's trauma. Shaming women with these words does not promote prevention or empower women, but rather makes them afraid to seek support.
	Women who choose to drink	
Parents/caregivers	Bad parents	
Do* NOT *use these terms. There are no replacements.	Poor choices	
	Irresponsible	
	Child abuser	

continued on page 31

Table 4 (cont.)

FASD in general		
Please use:	**Instead of:**	**Why?**
Preventable *Use with caution:* Think carefully about the context and audience in which the term 'preventable' is being used as it can have negative effects.	100% preventable	Saying '100% preventable' oversimplifies a complex issue. While theoretically possible, totally eradicating alcohol use during pregnancy is unlikely. This oversimplification removes all context in a woman's life and defines the issue as a single, easy choice, which is not possible for many women with high alcohol use or dependency. In turn, this erodes society's understanding and compassion for such a complex set of factors.
It is recommended not to drink during pregnancy	Just one drink can cause FASD	In Australia the accepted health messaging is that alcohol should be avoided during pregnancy. There is no clinical evidence that having one drink during an entire pregnancy causes significant harm. However, there is also no clinical evidence proving lower levels of alcohol use during pregnancy is safe.
A balanced strengths-based approach focusing on how supports/adaptations have made good things possible	Focusing mostly on challenges	The public understands that people with FASD have many different challenges. It is best to take a strengths-based approach, using positive reinforcement and focusing on abilities and positive outcomes.
Focus on neurodevelopmental disability	Focus on facial differences	Everyone diagnosed with FASD has a neurodevelopmental disability, the effects of which can vary from person to person. Only about 20% of individuals with FASD have any physical signs, such as facial differences. Focusing on those with physical differences implies that they have a more severe form of FASD, which is not accurate.
FASD with three sentinel facial features **FASD with fewer than three sentinel facial features**	FAS, pFAS, ARND, FAE	A FASD diagnosis requires evidence of severe impairment of brain function in at least three of ten specified neurodevelopmental areas. All acronyms other than FASD are no longer used for diagnostic purposes.
Secondary challenges/effects/risks	Secondary disabilities	'Secondary disabilities' is a term that was first used several decades ago to describe the adverse life experiences that were documented to occur in individuals, particularly adults, with FASD at a disproportionately higher rate (e.g. substance abuse or mental health disorder), and were thought to be secondary to the functional disabilities in people with FASD. New evidence suggests that mental health concerns and addictions may be primary disabilities associated with prenatal alcohol exposure. Concerns like disengaging with school and contact with the juvenile justice system are more likely to occur in any individual who has not been provided with adequate supports and understanding.
FASD is caused by prenatal alcohol exposure/when a fetus is exposed to alcohol in utero/before birth	FASD is caused by maternal alcohol use/ maternal alcohol exposure/maternal drinking	When describing or defining FASD, the least stigmatising approach is to move the emphasis away from the behaviour of the birth mother and shift the emphasis towards the substance and harm caused by alcohol.

Adapted from: Manitoba FASD Coalition, *Language guide: Promoting dignity for those impacted by FASD*, Manitoba FASD Coalition, Manitoba, 2017, www.fasdcoalition.ca/looking-after-each-other-project/fasd-language-guide.



Section 3: Early childhood educators – Taking action

Taking action

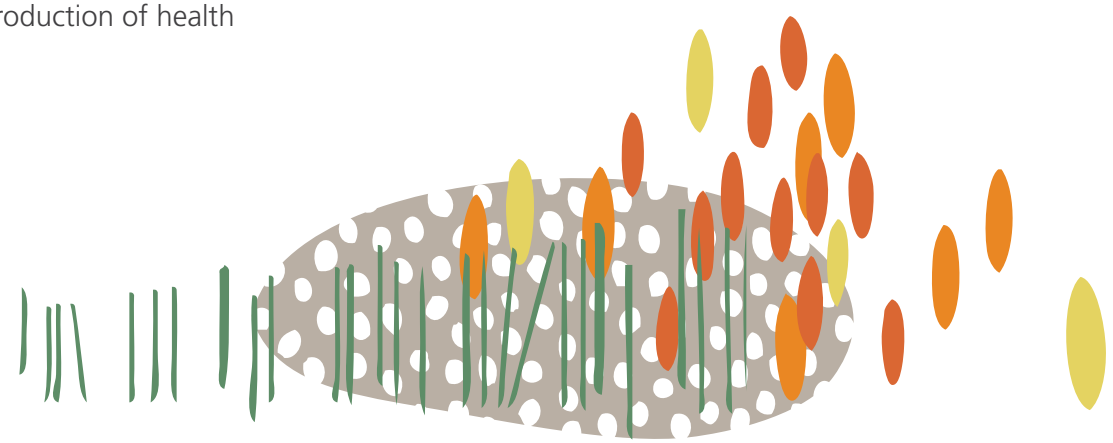
Early childhood educators often work collaboratively with professional allied health and specialist support services to meet the needs of children with early life trauma and FASD. When professional relationships and referral protocols are in place and working well, early childhood educators:

- have an understanding of FASD, its cause and what it looks like in young children
- recognise developmental delay, learning and behavioural challenges
- identify children in need of referral for assessment.

When a need is identified, the early childhood educator engages with allied health professionals and specialist support services to seek advice to determine if a formal assessment is required. In the early years, parents and carers are beginning to become aware of signs of their child's possible developmental challenges. Empathy and sensitive communication is needed, as some parents and caregivers may find the need for a professional assessment confronting. This is understandable, as some parents may have had previous negative experiences of health and education services. Hence, there is a need to build strong and trusting relationships with a child's family and support networks before navigating the introduction of health professionals.

Speech is often the first area of concern raised with parents and caregivers. Once parents and carers can see the benefits of early intervention with the help of a speech therapist, they are usually more willing to engage with a multidisciplinary team to assist with other developmental challenges a child may demonstrate.

We need to have high expectations for children with early life trauma and FASD, always conscious that with the right supports, they can learn. Early childhood educators are often the first supports encountered outside the family so it is vital that they use their knowledge and increased understanding of developmental trauma and FASD to inform practice. Great gains can be achieved when early childhood educators learn about developmental trauma and FASD, engage effectively with a range of specialist support services, and adjust both the learning environment and their practice to meet the needs of this vulnerable cohort of children.



Diagnosis and referral

The importance of early diagnosis

> Early diagnosis of children with FASD is important for the child and their families, so that everyone around them understands their strengths and needs, as well as how best to support them. The growing community knowledge about the prevalence of FASD in our community can help to ensure fewer children are impacted by alcohol-related harm.
>
> *Jadnah Davies, Marulu Senior Project Lead*

Research shows us that diagnosis in the early years, along with appropriate wraparound supports, can produce significant improvements to the quality of life of a child with FASD. Early childhood centres play a vital role in connecting families and health services in ways that enable families to navigate the referral and diagnosis processes. When working effectively with families, early childhood educators can draw on collective knowledge of the child and inform the process on accessing a range of therapeutic supports.

Without a comprehensive diagnosis based on known alcohol exposure, children with FASD might be judged as being non-compliant, uncooperative or unmotivated, when the behaviours are actually the result of a brain-based disability. An inaccurate diagnosis may also be harmful; for example, stimulant medications for attention deficit hyperactivity disorder (ADHD) may not help a child whose attention deficits stem from prenatal alcohol exposure and subsequent brain damage.

Steps to diagnosis and support

The steps and processes required to diagnose children with FASD will vary from centre to centre, depending on the access to resources and available local health services. Typically, paediatric and allied health services work together in multidisciplinary teams to establish the evidence required for a diagnosis, including functional capacity (see Figure 5 on page 37). This multidisciplinary team will usually include an occupational therapist, speech pathologist and psychologist trained to work with children. Early childhood educators can provide vital observations that inform the diagnosis. As we have seen, diagnosis can give parents, carers and early childhood educators insights into why a child responds in certain ways, and provide an evidence base from which to plan interventions.

Parents, carers and early childhood educators describe behaviours rather than interpret why these behaviours occur.

1. Screening and referral

Concerns raised by parents, carers and/or early childhood educators often result in a referral to local health services for screening and assessment about neurodevelopmental concerns.

Early childhood educators do not make the diagnosis, but rather raise concerns and work with the family and health professionals to inform a diagnosis. Parents, carers and early childhood educators describe behaviours rather than interpret why these behaviours occur. Often, a parent or carer may not be concerned about their child's development until they see them in an early childhood setting and compare them to other children. Therefore, raising issues with parents, carers and family members needs to be done sensitively and from a strengths-based perspective. Common concerns might include a child's ability to communicate, understand, pay attention or recall recent experiences and learning.

Educators play an important role in identifying challenging behaviours that indicate a need for further investigation. Allied health professionals and support services can be informed by the child's profile, documented evidence and observations that early childhood educators provide. This information is often held within the child's profile, individual portfolios and throughout the learning spaces. They contain different perspectives and include the voices of the child, carers and families collected over time. This documentation makes learning visible for any further investigation.

2 Multidisciplinary assessment and diagnosis

Once a referral is made, a multidisciplinary team conducts an intake meeting and makes a series of assessments prior to diagnosis. This initial meeting is often with a speech pathologist, who will flag any communication issues which then lead to onward referral to other therapeutic interventions.

This assessment and diagnosis stage is informed by early childhood educators, parents and carers, and the quality of the evidence can greatly assist the assessment process. Information from these meetings is shared with the early childhood setting when the parents and carers give consent. It is vital to build relationships with families to ensure there is no shame or judgement, but rather a shared willingness to work together to find the best early interventions possible.

One Aboriginal educator and grandmother cautioned that it was important to get to know the parents and carers before coming to them with concerns or recommending a referral. Her advice was that they see their children as normal and accept them without judgement. Early childhood educators need to build relationships and trust with parents and carers and ensure it is clear we are seeking solutions and being supportive rather than judgemental. We should take the time to make sure parents and carers understand the assessment process and are fully informed. A diagnosis emerges from the combined knowledge and understandings of parents, carers and early childhood educators informing the multidisciplinary team.

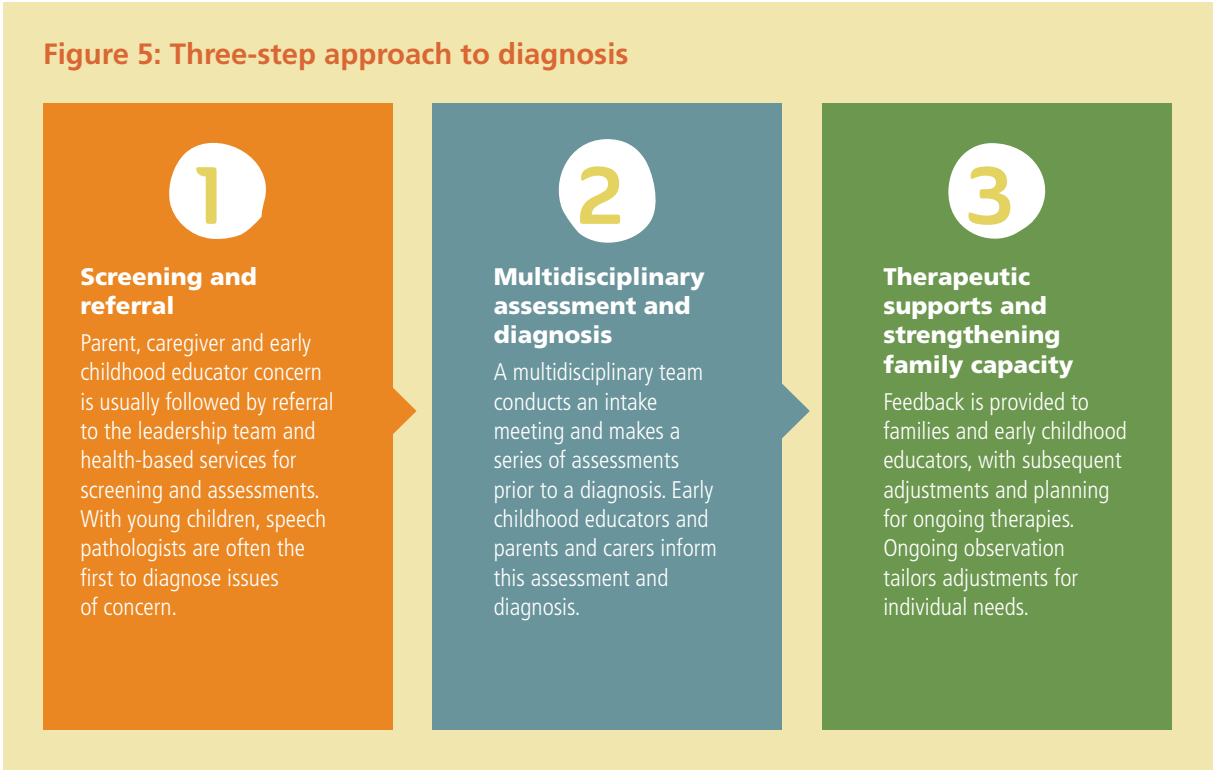
3 Therapeutic supports and strengthening family capacity

Once a diagnosis is made, individualised support plans are developed. Based on these plans, educators make adjustments to programs and environments to meet children's needs.

Educators play an important role in building on the knowledge of what works with individual students and making sure these understandings inform parents and other health and education professionals.

The importance of obtaining an early diagnosis for a child with early life trauma and FASD cannot be overstated. Parents and carers are often relieved when a diagnosis is achieved because it explains a range of behaviours and learning challenges. A diagnosis can provide hope and helps us respond with insight. It is the starting point for a plan to meet the child's needs in a coordinated, compassionate and understanding manner.

Figure 5: Three-step approach to diagnosis



Belonging, being and becoming: A vision for children's learning

All children engage in learning that promotes confident and creative individuals and successful lifelong learners. All children are active and informed members of their communities with knowledge of Aboriginal and Torres Strait Islander perspectives.

The 2022 Early Years Learning Framework for Australia sets out broad objectives designed to extend and enrich children's development and learning from birth to five years and through the transition to school. Its vision is that: 'All children engage in learning that promotes confident and creative individuals and successful lifelong learners. All children are active and informed members of their communities with knowledge of Aboriginal and Torres Strait Islander perspectives.'[30]

The framework was developed following extensive national and international research and proposes that early childhood is a vital period in children's learning and development. Engagement with the early childhood sector, early childhood academics and the Commonwealth and state and territory governments is at the heart of the ongoing development and maintenance of the framework. It is the basis for training early childhood educators across Australia.

Early childhood educators guided by the framework will reinforce in their daily practice the principles laid out in the United Nations Convention on the Rights of the Child.[31] The convention states that all children have the right to an education that lays a foundation for the rest of their lives, maximises their ability, and respects their family, cultural and other identities and languages. The convention also recognises children's right to play and be active participants in all matters affecting their lives.

Fundamental to the framework is that children's lives be characterised by the words *belonging, being* and *becoming* (see Table 5 on page 39). From before birth children are connected to family, communities, cultures and place. Their earliest learning, development and wellbeing takes place through these relationships, particularly within families, who are children's first and most influential educators.[32] As children participate in everyday life, they develop interests and construct their own identities and understandings of the world.

The framework is built on play-based learning and recognises the importance of communication and language (including early literacy and numeracy) and social and emotional development.

Early childhood educators know and understand that children's learning is dynamic, complex and holistic. The experiences they have at home and in early childhood settings are the sum of their development, be it physical, social, emotional, personal, spiritual, creative, cognitive or linguistic.

Figure 6 (on page 39) shows the integrated elements of a holistic approach and is child-centred. The strength-based approach is central to working with all children, including those with early life trauma and/or FASD.

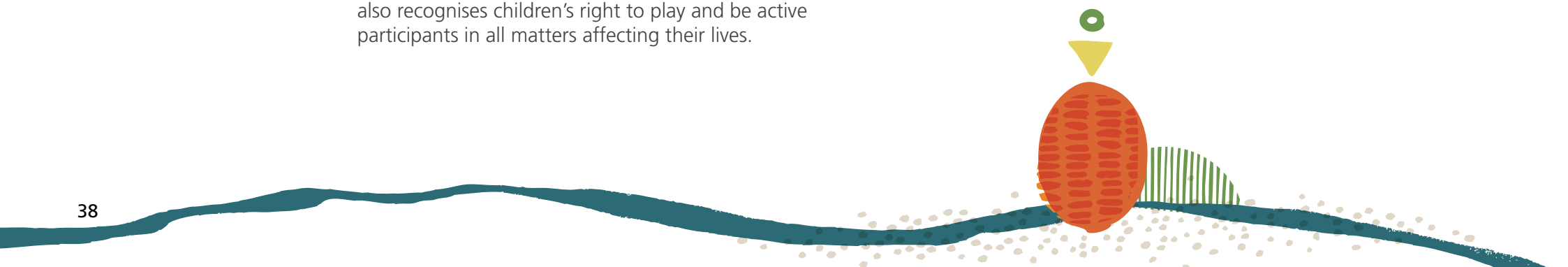
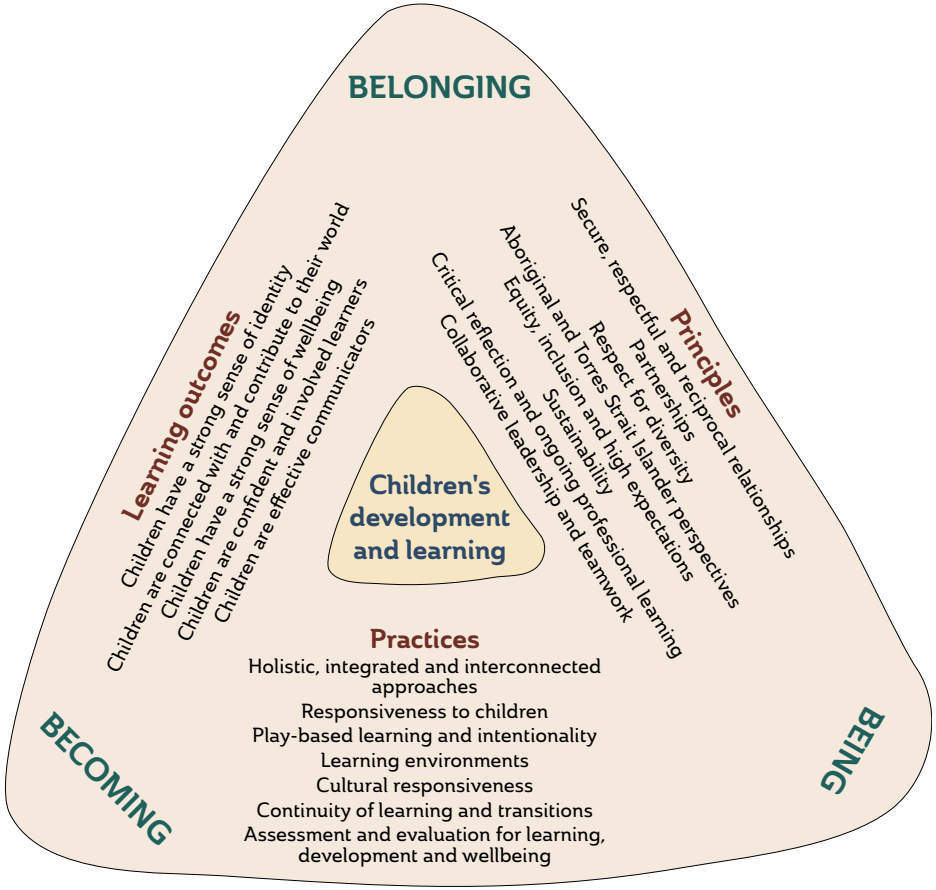


Table 5: Belonging, being and becoming vision statements

Vision	Definition	This means …
Belonging	Experiencing *belonging* – knowing where and with whom you belong – is integral to human existence. Children belong to a diverse array of groups, such as families, neighbourhoods, local and global communities. *Belonging* acknowledges children's interdependence with others and the basis of relationships in defining identities. In early childhood, and throughout life, trusting relationships and affirming experiences are crucial to a sense of *belonging*. *Belonging* is central to *being* and *becoming* in that it shapes who children are and who they can become.	Our relationships with children and families are at the centre of the work we do in early childhood and create affirming experiences.
Being	Childhood is a time to be, to seek and make meaning of the world. *Being* recognises the significance of the present, as well as the past in children's lives. It is about children knowing themselves, developing their identity, building and maintaining relationships with others, engaging with life's joys and complexities, and meeting challenges in everyday life. The early childhood years are not solely preparation for the future but also about children *being* in the here and now.	Our learning spaces and the ways we work support children to make meaning of their world and create a felt sense of safety.
Becoming	Children's identities, knowledge, understandings, dispositions, capabilities, skills and relationships change during childhood. They are shaped by different events and circumstances. *Becoming* reflects this process of rapid and significant change that occurs in the early years as children learn and grow.	Our environments and interactions shape a child's wellbeing and create a sense of calm.

Adapted from: Australian Government Department of Education, *Belonging, being & becoming: The Early Years Learning Framework for Australia V2.0*, Department of Education for the Ministerial Council, Canberra, 2002, p. 6, www.acecqa.gov.au/sites/default/files/2023-01/EYLF-2022-V2.0.pdf.

Figure 6: Elements of the Early Years Learning Framework



Adapted from: Australian Government Department of Education, *Belonging, being & becoming: The Early Years Learning Framework for Australia V2.0*, Department of Education for the Ministerial Council, Canberra, 2002, p. 10, www.acecqa.gov.au/sites/default/files/2023-01/EYLF-2022-V2.0.pdf.

FASD and early life trauma: Strategies for early childhood educators

> Relationships are at the heart of everything that we do in early childhood. A warm and genuine welcome to the day elicits a strong sense of safety and belonging and promotes wellbeing.
>
> *A Kimberley childhood educator*

Early childhood educators know and plan for scaffolded learning, creating safe and secure environments. Many early childhood practices, approaches and ways of working are inherently trauma-responsive. Even before we understood the neuroscience of trauma, quality early childhood practice championed the need to:

- provide safety and consistency
- cater to individual needs
- implement child-centred activities involving movement and physical activity
- ensure predictable routines
- provide music and learning experiences that build on children's interests and strengths.

Challenging behaviours in children triggered by early life trauma, or exposure to alcohol in utero, and the demands of the environments around them need to be handled in a calm, sensitive and non-judgemental manner. Children scan their environment for any perceived threat, looking for safety in their relationships. It is important that they feel safe, listened to, and not feel judged or punished. Children who experience early life trauma or have particular learning challenges associated with FASD and trauma experience high levels of anxiety, stress and frustration. Parents and carers also experience an added burden of concern as they navigate the emerging awareness of the child's challenges and the possible need for professional interventions and supports.

The following strategies have been written to assist early childhood educators with adapting their practice to meet the needs of vulnerable children. These strategies are often embedded in the way that early childhood educators work, and support all children to learn. However, it is especially important to understand that the challenges faced by children with FASD and early life trauma will require accommodations well beyond early childhood. The 'notes' format on the following pages enables observations that can be used in planning, including individual education plans, individual support plans and inclusion support plans.

Learning, identity and cultural safety

Strategy	Notes
Consider family and community in all that you do. Use the children's own life experiences and knowledge when introducing new ideas. Build from children's experiences and relationships.	
Set up your environment so that it provides a mirror to the child's sense of identity.	
Provide opportunities for children to work in calm, therapeutic environments. These environments regulate sensory input, including reducing visual and auditory stimuli to assist with self- and co-regulation.	
Be inclusive of the child's linguistic and cultural background and engage with families to enrich everyone's learning.	
Communication should be short and simple, and be reinforced with visual cues and prompts.	
Model tasks and allow time and space for processing information. Be comfortable with a child's processing time. Repeat information in a calm tone of voice with a warm facial expression.	
Break tasks into small achievable steps, starting with what the child can already do.	
Prepare the learning environment for the unique needs of the child and be responsive to any known triggers.	
Provide opportunities for small group work in order to provide a secure environment that increases engagement and confidence.	
Provide opportunities for the child to learn and be mindful that some children may have sensory challenges that become triggers.	
Provide visual aids to reinforce predictability, safety and security.	
Use photos of the children doing activities as visual prompts.	
Focus on achievements and use praise as positive reinforcement (e.g. say 'Look at you walking inside safely' rather than 'Don't run').	
Use simple, direct language. Instead of saying 'Do you know where your hat is?', say 'Where is your hat?'.	
Scaffold and model tasks before you begin an activity, including breaking down key actions, words, skills and concepts.	
Ensure that repetition is central to the way we work with children, building on previously learned skills and embedding these into daily routines. This can reduce possible overload.	
Use well-established rituals to create predictability for transitions.	
Set up the environment to promote physical activity and movement through play.	

Communicating: Make it interactive and engaging

Strategy	Notes
Use familiar song, rhyme, rhythm and storytelling to engage children.	
Support children's receptive and expressive language development through social engagement and play.	
Use consistent language and non-verbal communication, such as hand gestures, to support children's language development.	
Language and literacy should be embedded and visible in all learning environments. Build a repertoire of literacy experiences that are predictable and visual.	
Immerse children in literacy rich environments that engage them with words, books, stories and pictures. Reading words is important but engaging children in the story behind the pictures and creating meaning is powerful and promotes a love of reading.	
Provide children with a 'books I love' visual journal that can be added to over time. Journals can be a valuable memory aid. Use open-ended questioning – such as what, who, when and where questions – to encourage reflection.	
Reinforce directionality of text using left-to-right-hand actions or coloured stickers to indicate the correct direction: ■ use finger plays and action songs that cross midline and move left to right ■ use bean bags to toss from hand to hand following with eye tracking ■ hang a ball with a face or spot and track the face side to side across the midline ■ use mirror clapping, tapping and other rhythmic gestures.	
Provide opportunities to tell stories. Storyboards, puppets and concrete materials are helpful tools to support storytelling. Repeat these stories daily as a ritual.	
Create pictorial dictionaries and journals capturing children's stories and interests. Encourage children's drawings and get them to tell you about them in their words. Use photographs to capture meaning of concrete activities (e.g. block constructions, clay modelling).	
Create opportunities for listening to a variety of literacy activities, books and social stories. Be aware that children with complex needs may be sensitive to certain noises and visual stimuli. At times, a child with FASD/early life trauma may enjoy the listening experience and on another occasion be unable to participate.	
Provide a laptop or mobile device to support understanding of the written word and to make learning visible. Headphones can be useful to assist with minimising distraction, blocking noise and promoting calm.	
Use visuals that step out a sequence – such as photos reflecting a process – to assist in organising thoughts and tasks.	
Use pictures of a shared experience or event to create class-made books.	
Create a common language between the home and the centre to assist with consistency and reinforce meaning and understanding.	

Abstract concepts: Make it concrete

Strategy	Notes
Demonstrate a concept (show rather than tell), and be prepared to repeat the demonstration consistently, doing it the same way every time. Each child will learn at their own pace.	
Use expressive language, including body language, facial expressions and gestures to describe concepts.	
Allow time for repeated playful explorations to develop conceptual understandings (e.g. use playdough to explore properties of materials – stretch, change shape).	
Abstract concepts like cause and effect are best reinforced by using three-dimensional tactile resources (e.g. pop-up toys, jigsaw, water play, musical instruments and wind chimes).	
Develop understandings of mathematical concepts like size, measurement, quantity, by using concrete materials.	
Use open-ended questions to generate conversations about abstract concepts such as feelings. Give children the words to describe emotions during play activities.	
Use physical activities or movement to demonstrate mathematical concepts such as number, positional language and shape. The movement can assist with memory.	
Use consistent language to describe concepts in practical everyday routines and tasks throughout the day.	
Use one concept at a time within a game or activity.	
Watch what the children are doing – how they are playing with objects, adding, sorting etc. – and give them the words to describe the process.	
Use role-play sessions for everyday activities like shopping, using money to mimic real-life experiences.	
Use body-based movement to reinforce concepts like stop, go, fast, slow, still, high, low, strong, gentle, far, near etc.	
Highlight opportunities to count within children's play. Relate numbers to meaningful concrete objects to enable children to view numbers as a value.	
Create a large number line across the indoor and/or outside space that children can physically move along.	
Provide children with opportunities to estimate number in a range of situations (e.g. 'I wonder how many frogs we will see today?').	
Provide a range of materials that involve number and number representations, such as dice, dominos, playing cards, coins, clocks and rulers. Use concrete materials for classification and sorting.	
Personalise learning by incorporating individual children's interests and strengths.	

Supporting memory: Reinforce and repeat

Strategy	Notes
Know a child's health profile, as it will frame the supports you plan for each child.	
Provide clear, consistent routines to support learning.	
Repeat instructions and consistently explain expectations, checking for understanding to create a felt sense of safety.	
Use short, simple sentences to support comprehension and understanding and success with completing tasks.	
Be sensitive to the time needed for children to process information. Children with FASD/early life trauma can become overwhelmed when we rush them.	
Engage children using sensory and concrete materials and experiences to help them with their attention and focus.	
Provide visual cues/memory prompts of sequences and processes to enable children to see what is happening over a period of time.	
Use constant positive reinforcement to support children's learning and recognise achievements.	
Use photos in visual timetables as a concrete representation of process. When children can read, some words can be attached to images.	
Regularly remind children of routines and expectations, including indirect prompting such as 'The pack up song is playing!'.	
Check for understanding by asking children to repeat an instruction in their own words. You might do this in a playful way, using concrete objects.	
Build relationships with parents and carers to communicate progress and share and build on successes. Share positives before raising concerns.	
Promote curiosity by incorporating a child's interest in learning. This increases engagement and the ability to learn and retain information.	
Use portfolios to record a child's learning journey over time. This will be a visual resource to prompt memory. Constantly ask the family and carers to add information to enhance the resource.	

Emotional regulation and feeling safe: Make it flexible and responsive

Strategy	Notes
Conduct a sensory audit of the environment to reduce distractions and discomfort. Seek advice from an occupational therapist about the child's sensory needs.	
Create environments that reduce sensory overload. This might include turning off fans and fluorescent lights.	
Ensure children have appropriate access to water, snacks and routine meal breaks.	
Provide opportunities for children to be physically active, and provide fidget toys and sensory furniture to promote regulation.	
Observe children's behaviours and reactions to identify triggers and make accommodations that reduce their effects.	
Create learning environments that are intentional and calming by removing distractions and using props or curtains to create separate spaces.	
Make changes to the environment one at a time to maintain safety and predictability.	
Provide a calm environment and a quiet space where children can go if they become overwhelmed.	
Minimise surrounding sounds by cushioning the legs of tables and chairs with carpet or tennis balls.	
Create spaces and routines, such as providing individual cushions that help children identify personal space and maintain boundaries.	
Ask children to do heavy work carrying or moving equipment or objects to help them regulate and activate the limbic system.	
Make a visual chart showing personal achievement and tracking progress while ensuring a positive rather than competitive focus.	
Use percussion instruments and drumming to create rhythms and patterns that are regulating and calming.	
Provide music and movement therapy sessions that enable children to explore and express emotions and feelings.	
Give children time to explore instruments and provide props like fabric to cover themselves. This can help them feel secure.	
Explicitly teach and support children's emotional literacy by naming feelings and talking about how these emotions can feel in the body.	
Choose sounds and music carefully, observing children's responses. Fast, loud, overly energising music generates what appears to be excitement and joy in some children, but can be triggering and dysregulating in others.	
Provide weighted lap bags, fabric, headphones, eye masks, dark sunglasses, essential oils and calming music. Ensure child has the strength and cognitive capacity to remove any weighted product independently.	
Provide visual prompts for children that showcase desired behaviours. Use familiar photographs rather than pictures or symbols.	
Provide activities to release and/or redirect energy and strong emotions. This might be a quiet space or it might be a physical activity such as riding a bike, tossing bean bags or jumping on a trampoline. At times, a quiet soothing space might be required.	
Keep calm, use a soft tone of voice and a relaxed facial expression to enable the child to co-regulate – mirror the calmness.	

Supporting relationships: Engage and enable

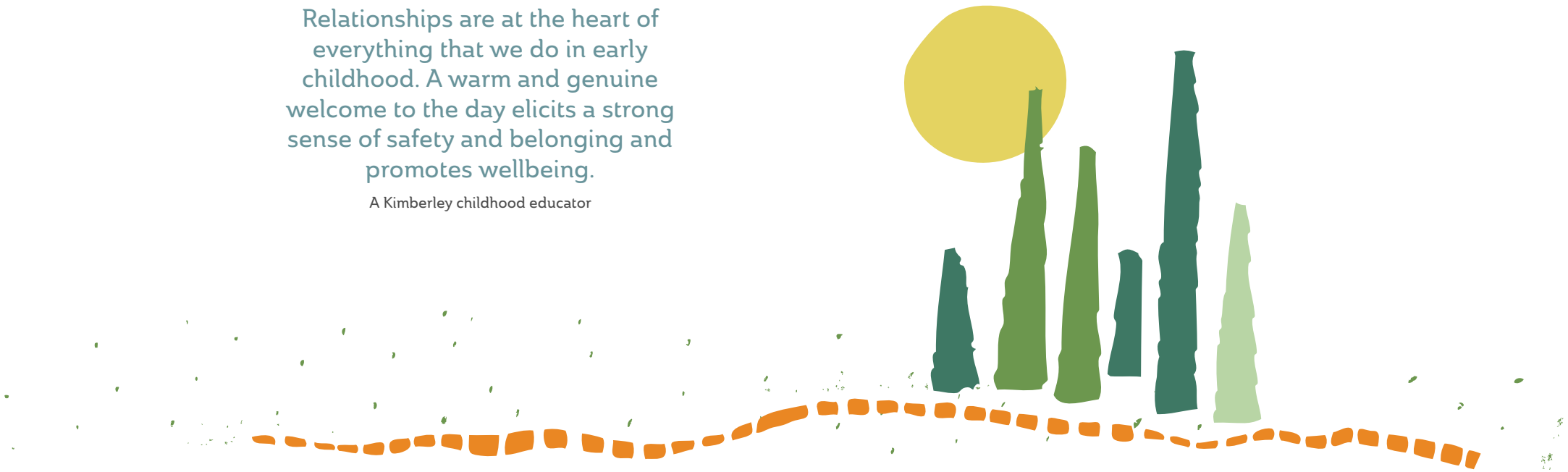
Strategy	Notes
Provide opportunities for children to share ideas and support them to contribute in safe and trusting spaces. Model and guide respectful engagement using turn-taking, deep listening, facial expressions, receptive postures and open body language.	
Engage in safe and meaningful interactions by sitting with children at their level.	
Use role play, social stories and photographs to prepare children for special events.	
Engage children in excursions by co-creating a book with photographs and pictures depicting what to expect during the trip.	
Engage in playful interactions using sounds, rocking and rhythms, especially with young babies and children who are non-verbal.	
Use role play, puppetry and social stories to model respectful responses and problem-solving in social settings.	
Use interactive games or activities to develop language that gives children the words to describe a range of feelings and emotions.	
Explicitly teach skills that demonstrate positive interactions with other people, including setting personal space, boundaries and sharing.	
Look for positive interactions and provide feedback that encourages and reinforces positive behaviours.	
Share children's personal stories. Create a shared language by looking at family and community photographs, and co-create new narratives to capture learning and recall and reinforce positive messages.	

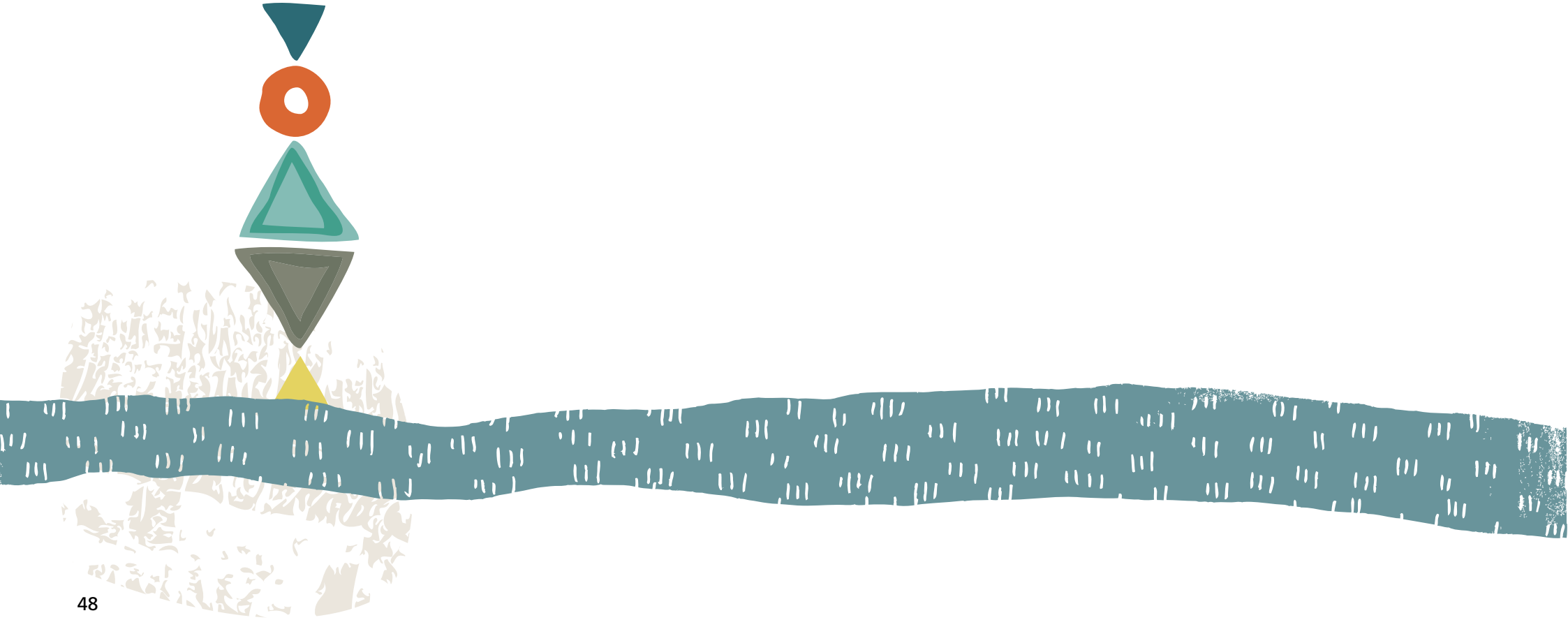
Time and routine: Make it predictable and safe

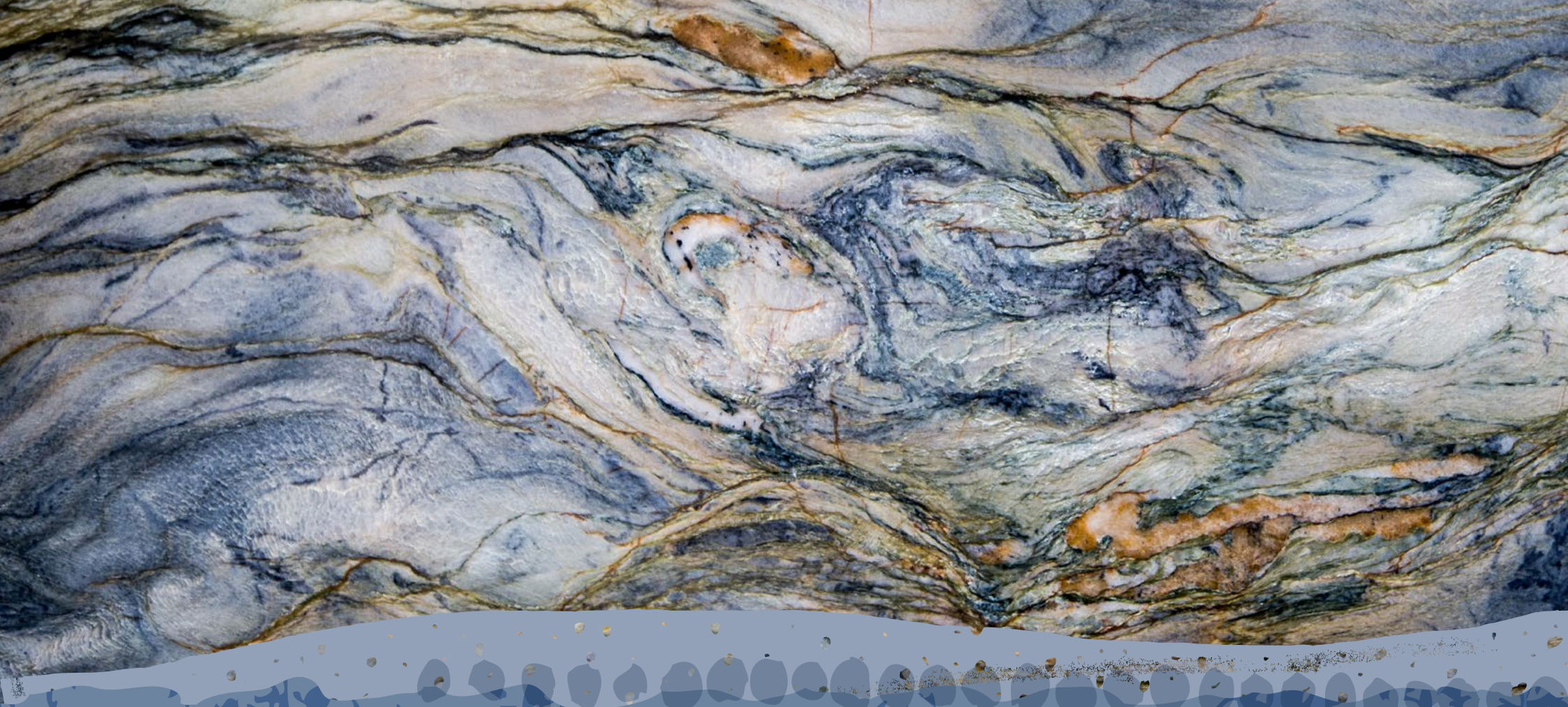
Strategy	Notes
Create a warm, welcoming and safe gathering space for group time.	
Support the child with a routine that feels safe. Consistently implement predictable routines, including transitions. Using familiar songs and movement activities can guide transitions.	
Use auditory cues like songs and rhymes to signal transitions, and talk about what comes next (e.g. 'After lunch we have a rest') to make the routine predictable.	
Use visual aids such as egg timers and daily calendars to help children understand time.	
Use cues to help children predict the routine and understand transitions (e.g. sing a transition song). When the song ends, everyone knows it is time for lunch.	
Embed rituals into daily experiences by following step-by-step sequences that have a start and a finish.	

Relationships are at the heart of everything that we do in early childhood. A warm and genuine welcome to the day elicits a strong sense of safety and belonging and promotes wellbeing.

A Kimberley childhood educator







Section 4: Useful resources

Further reading

Practice guide: Secondary traumatic stress and staff well-being: Understanding compassion fatigue and vicarious trauma in therapeutic care, 2nd edn

www.cetc.org.au/wp-content/uploads/2022/07/secondary-traumatic-stress-practice-guide.pdf

Published by the Centre for Excellence in Therapeutic Care.

Trauma-Informed Self-Care Boot Camp

trackingbetter.lpages.co/bootcamp

For teachers and mental health clinicians who work with children and young people who have been exposed to trauma.

Dadirri: Inner deep listening and quiet still awareness

youtu.be/tow2tR_ezL8

Prepared by the Miriam Rose Foundation.

National Fetal Alcohol Spectrum Disorder (FASD) Strategic Action Plan 2018–2028

www.health.gov.au/sites/default/files/national-fetal-alcohol-spectrum-disorder-fasd-strategic-action-plan-2018-2028.pdf

The Department of Health's strategic action plan aims to reduce the prevalence of FASD and the effects it has on individuals, families, carers and communities. It provides a clear pathway of priorities and opportunities to improve the prevention, diagnosis, support and management of FASD in Australia.

Trust, safety and participation: Supporting children and young people affected by domestic and family violence. A Western Australian practice guide

professionals.childhood.org.au//app/uploads/2022/05/1316_ACF_Practice-Guide_web_final_sml-edit2.pdf

A practice guide and training series from the Australian Childhood Foundation for individuals or organisations who work with children and young people who have been affected by domestic and family violence during the COVID-19 pandemic.

Improving wellbeing outcomes for First Nations children

healingfoundation.org.au/intergenerational-trauma/childrenswellbeing

These Emerging Minds and Healing Foundation resources seek to improve social and emotional wellbeing outcomes for Aboriginal and Torres Strait Islander children to ensure they grow up culturally strong, healthy, happy, and safe.

Understanding FASD

learningwithfasd.org.au/understanding-fasd

Evidence-based resources to help educators understand and support children with FASD in Australian primary schools.

Australian FASD organisations

Be You Early Learning

www.earlychildhoodaustralia.org.au/our-work/beyou

Be You is a national initiative that equips educators to support the mental health and wellbeing of children and young people from birth to 18 years. It provides an end-to-end approach for early learning services, school-age care services, primary schools and secondary schools across Australia.

NoFASD Australia

www.nofasd.org.au

NOFASD Australia is a family-focused organisation and a bridge linking those with lived experience with researchers and clinicians.

FASD Hub Australia

www.fasdhub.org.au

A leading source of high quality, evidence-based content about alcohol and pregnancy and FASD in Australia.

Strong Born Campaign, National Aboriginal Community Controlled Health Organisation

www.naccho.org.au/fasd/strong-born

Strong Born is a communications campaign for Aboriginal and Torres Strait Islander peoples in rural and remote communities designed to raise awareness of FASD and the harms of drinking alcohol while pregnant and breastfeeding.

Russell Family Fetal Alcohol Disorders Association

rffada.org

A national not-for-profit health promotion charity dedicated to prevention and ensuring that individuals with FASD or at risk of fetal alcohol exposure have access to diagnostic services, post-diagnostic multidisciplinary management planning and parent peer support.

Other child-focused Australian organisations

Australian Children's Foundation

www.childhood.org.au

The foundation was established to give children a voice to ensure their safety and care is a priority within the community.

Healing Foundation

healingfoundation.org.au

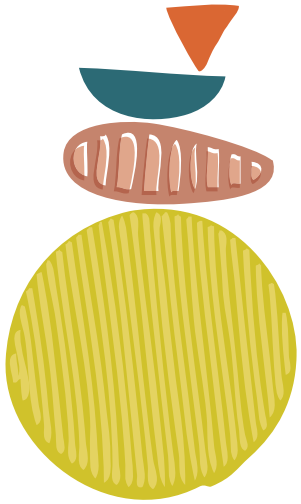
A national Aboriginal and Torres Strait Islander organisation that provides a platform to amplify the voices and lived experience of Stolen Generations survivors and their families.

The Healing Foundation has developed a timeline of trauma and healing in Australia (healingfoundation.org.au/timeline-trauma-healing-australia/) that is an extremely useful resource for all wishing to understand trauma in First Nations communities.

Berry Street

www.berrystreet.org.au

Berry Street provides a wide range of programs that focus on reorientating the child and family system, family violence services and education system towards early intervention and prevention.



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Uluru statement from the heart

**We, gathered at the 2017 National Constitutional Convention,
coming from all points of the southern sky, make this statement from the heart:**

Our Aboriginal and Torres Strait Islander tribes were the first sovereign Nations of the Australian continent and its adjacent islands, and possessed it under our own laws and customs. This our ancestors did, according to the reckoning of our culture, from the Creation, according to the common law from 'time immemorial', and according to science more than 60,000 years ago.

This sovereignty is *a spiritual notion: the ancestral tie between the land, or 'mother nature', and the Aboriginal and Torres Strait Islander peoples who were born therefrom, remain attached thereto, and must one day return thither to be united with our ancestors. This link is the basis of the ownership of the soil, or better, of sovereignty.* It has never been ceded or extinguished, and co-exists with the sovereignty of the Crown.

How could it be otherwise? That peoples possessed a land for sixty millennia and this sacred link disappears from world history in merely the last two hundred years?

With substantive constitutional change and structural reform, we believe this ancient sovereignty can shine through as a fuller expression of Australia's nationhood.

Proportionally, we are the most incarcerated people on the planet. We are not an innately criminal people. Our children are aliened from their families at unprecedented rates. This cannot be because we have no love for them. And our youth languish in detention in obscene numbers. They should be our hope for the future.

These dimensions of our crisis tell plainly the structural nature of our problem. This is *the torment of our powerlessness*.

We seek constitutional reforms to empower our people and take a *rightful place* in our own country. When we have power over our destiny our children will flourish. They will walk in two worlds and their culture will be a gift to their country.

We call for the establishment of a First Nations Voice enshrined in the Constitution.

Makarrata is the culmination of our agenda: *the coming together after a struggle*. It captures our aspirations for a fair and truthful relationship with the people of Australia and a better future for our children based on justice and self-determination.

We seek a Makarrata Commission to supervise a process of agreement-making between governments and First Nations and truth-telling about our history.

In 1967 we were counted, in 2017 we seek to be heard. We leave base camp and start our trek across this vast country. We invite you to walk with us in a movement of the Australian people for a better future.

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www.mwrc.com.au
www.marulustrategy.com.au