



Changing THE WAY WE careSM

Promoting Resilience- Informed Care

A PRACTICAL GUIDANCE
RESOURCE FOR FRONTLINE
WORKERS IN FAMILY-
BASED CARE

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Acronyms

ACE	Adverse Childhood Experiences
CRS	Catholic Relief Services
CTWWC	Changing the Way We Care
HIV	Human Immunodeficiency Virus
MHPSS	Mental Health and Psychosocial Support
VAC	Violence Against Children

Chapter One:

Introducing the Practical Guidance



This Practical Guidance is for anyone working with children at risk of entering, already living in, preparing or having already left care. It discusses why and how to support children who are at risk of or who have already experienced adverse experiences that might lead to distress or trauma.

The Practical Guidance provides a framework for how to support children to be **resilient** in the face of **adversity**. It describes when children may experience **Adverse Childhood Experiences (ACEs)**, what can happen to children when they do, and how it is possible for children to regain strength and recover. The Practical Guidance will help you to:

- Understand what resilience is and why it is important
- Recognize what adverse childhood experiences (ACEs) are, and the harm they can cause children both immediately and in the longer-term
- Identify where children may be at risk of facing ACEs and how to identify if a child is at risk of or has experienced ACEs
- Learn the principles and techniques of supporting children who have experienced ACEs, whether the child is at home with a family, in some form of family-based alternative care, living independently or living in residential care
- Learn how to help other people in the family and community provide support to affected children
- Apply this information in different areas of your work
- Know and use practical steps for looking after yourself and protecting and promoting your own wellbeing and mental health.

This Practical Guidance is written for any formal or informal practitioner working with children at risk of, already in alternative care or in the process of leaving care. This includes social workers, caseworkers or case managers, child protection volunteers, residential care center managers and other staff such as caregivers (i.e., house parents or foster parents), psychologists and school guidance counselors who are supporting children who face adversities, both those within their own families that might be at risk of separation as well as those in alternative care. These people are referred to as ‘frontline workers’ in the Practical Guidance.

The Practical Guidance is also of use to program managers and service directors, in order to be able to promote children’ resilience and address adversity within care reform programming, training and staff development efforts.

This Practical Guidance recognizes that every context is different – children and families live in all kinds of social and economic circumstances and cultural contexts. The services that are available may vary and social norms will differ. This Practical Guidance provides basic information that can be adapted and applied to your own context.

Core principles: A Resilience-Informed Approach to Preventing and Responding to ACEs

- There are a number of commonly referenced frameworks that all build on these principles, including the Tri-Phasic Model of Recovery (safety and stabilization, remembrance and mourning, and reintegration or re-engagement),³ Psychological First Aid (PFA) and Early Intervention often used in emergency contexts,⁴ and the Attachment, Regulation, and Competency (ARC) Treatment Framework.
- A resilience-informed approach borrows from a ‘trauma-informed framework’ (see below). The Practical Guidance uses the term resilience-informed, rather than trauma-informed, to avoid the potential assumptions that can be made about children in alternative care and children who experience violence and that label the experience as ‘trauma’. The Practical Guidance acknowledges trauma-informed care as a public health framework, rather than diagnosis or indication of trauma. Whereas, a resilience-informed approach:
 - Focuses on internal and external resources to sustain strength (resilience), not on seeing stress and trauma as a disease or pathology
 - Recognizes that the individual is part of a wider social environment, and that support to the child and family must recognize this broader social and economic context, not just focus on individual psychology or experience
 - Takes into account that stress, distress and trauma have an impact on the brain and this, in turn, has an impact on the body and development (neurobiology)
 - Acknowledges that a person’s own experience of an event determines whether an event causes distress, rather than assuming that the event itself inevitably causes or does not cause distress
 - Acknowledges the importance of considering cultural context and cultural expression of distress.

About trauma-informed frameworks:

- Menschner and Maul’s (2016) trauma-informed model of care was developed in the United States in 2016, in response to the research on ACEs.¹ The underlying principle is that the trauma-informed model of care seeks to act on the ecology surrounding the child, to promote resilience and recovery.
- The trauma-informed model of care often refers to ‘the four Rs’: realize, recognize, respond, resist re-traumatization²
- There are a number of commonly referenced frameworks that all build on these principles, including the Tri-Phasic Model of Recovery (safety and stabilization, remembrance and mourning, and reintegration or re-engagement),³ Psychological First Aid (PFA) and Early Intervention often used in emergency contexts,⁴ and the Attachment, Regulation, and Competency (ARC) Treatment Framework.⁵

Chapter Two:

Before We Start... Some Important Definitions



Here are some basic definitions that are explored in more detail throughout the Practical Guidance. For more definitions, see the Glossary at the end of the document.

Abuse: (physical, sexual, emotional): “a deliberate act of ill treatment that can harm or is likely to cause harm to a child’s safety, well-being, dignity and development. Abuse includes all forms of physical, sexual, psychological or emotional ill treatment.”⁶

Emotional abuse: “the persistent emotional ill-treatment of a child such as to cause severe and persistent adverse effects on the child’s emotional development (e.g. humiliating and degrading treatment such as bad name calling, constant criticism, belittling, persistent shaming, solitary confinement and isolation).”⁷

Physical abuse: “the use of violent physical force so as to cause actual or likely physical injury or suffering (e.g. hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, female genital mutilation, torture).”⁸

Sexual abuse: “All forms of sexual violence including incest, early and forced marriage, rape, involvement in child pornography, and sexual slavery. Child sexual abuse may also include indecent touching or exposure, using sexually explicit language towards a child and showing children pornographic material.”⁹

Adversity: difficult experiences or circumstances.

Adverse Childhood Experiences: highly stressful, potentially traumatic events or situations that occur during childhood and/ or adolescence. ACEs can be a single event or incident, or a series of threats to a child or young person’s safety, security or violence against their person.¹⁰

Distress: a range of symptoms and experiences of a person’s internal life that are troubling, confusing, or out of the ordinary occurs when external events or stressors place demands beyond our ability to cope.

Neglect: deliberately, or through carelessness or negligence, failing to provide for, or secure for the child, their rights to physical safety and development (e.g. abandonment, the failure to properly supervise and protect children from harm as much as is feasible, the deliberate failure to carry out important aspects of care which results or is likely to result in harm to the child, the deliberate failure to provide medical care or carelessly exposing a child to harm).”¹¹

Resilience: a person’s ability to find and use internal (psychological and physical) and external (social, cultural) resources that sustain their well-being, and their capacity to negotiate for these resources to be provided in ways that they can use.¹²

Resilience-informed approach: focusing on both the internal and external resources that sustain resilience, recognizing that the individual is part of a wider social environment, and that support to the child and family must recognize this broader cultural, social and economic context, and place a person's own experience of an event at the center of support.

Stress: a feeling of emotional or physical tension. It can come from any event or thought. It is the body's reaction to a challenge or demand. In short bursts, stress can act as a positive motivator. However, over time stress can be harmful.

Trauma: the response to a deeply distressing or disturbing event that overwhelms an individual's ability to cope, causes feelings of helplessness, diminishes their sense of self and their ability to feel the full range of emotions and experiences.

Trauma informed approaches / responses: approaches or responses that aim to help people and systems increase resilience and heal from the damaging impact of unmitigated stress and trauma.¹³

Violence: "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation."¹⁴

Violence against children: "All forms of physical or mental violence, injury and abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse."¹⁵

Chapter Three:

Resilience: Strong and Protected Children

Resilience is a person's ability to overcome difficult experiences or hardship and continue his or her normal development.



Resilience is not something inherent – it is not something that we are either born with or not. It is the product of an **ongoing life-long process**, in which a person's individual traits (personality or characteristics), experiences, relationships and surrounding environment are constantly providing them with messages and lessons. These lessons teach the person how to feel safe, how to get their needs met, how to interact with others and how to survive. Therefore, resilience is an interaction of the what is inherent in a person and the external.

When a person is aware of these messages and lessons and can make sense of them, the person can learn how to thrive in their lives, during times of connection and joy and during times of pain, disconnection, and challenges.

Picture these life lessons as 'savings' that are deposited in a savings group, a piggy bank, or in a bank account. If a person faces challenges, they must withdraw some of the 'savings' that they have already built up to gain strength to get through the challenging time. If the person is surrounded by support, they will be able to continue putting more savings back into the piggy bank. Think of how people who are together in a savings group help each other, or think of how you might learn a new skill during a difficult time that you know you might be able to use again in the future. In this way, savings build up and can be drawn on again when life becomes difficult. However, if life circumstances cause the person to constantly 'withdraw money', and they don't have the support or the time or energy to 'put savings back in', there will be less to draw on over time. This leaves the person able to survive but not necessarily thrive. If more is taken out of the account than is being put back in and the amount of money in the account or piggy bank remains low (that is, the person is in survival mode too long), their ability to cope and continue to survive begins to come into question.



It is important to know, however, that as long as we are still alive, we are still surviving and we are drawing on the strength of the coping strategies we have learned that have helped us to survive until this point. **As long as we are alive, we are resilient and have the ability to develop**

Families, groups of people or communities can also be resilient.

Resilience is not limited to individuals. In the same way that resilient individuals can overcome hardships and continue forward, groups of people (for example, a family or a community of people who are experiencing a common hardship) can also be resilient, by acting together to make sense of the adversity (that is, by deciding what is causing the adversity and taking action to address the adversity), and by finding ways to prevent the adversities or minimizing the harm caused by the adversity.

Resilient families and communities can work together to prevent the harm, innovate and find new shared solutions to existing problems, sometimes finding innovative new ways to thrive.

even more resilience to overcome adversity in our lives.

In thinking about resilience in this way, our starting point is to recognize the resilience and potential to survive which is inherent to everyone. Our role as frontline workers is to be able to identify resilience and to understand it from the point of view of the individual and their experience.

Understanding this idea of resilience is important when we start considering the lives of children who are either at risk of ACEs or have experienced ACEs (highly stressful, potentially traumatic events or situations that occur during childhood and/or adolescence). It is critical to understand this idea of resilience when engaging with children who are at risk of family separation or living in alternative care. A core principle of working with children and their families is to be strength-based and focused on the resilience of children and their families.

To be strengths-based and promote resilience, we need to understand what happens when children’s or families’ resilience is depleted in the face of adversity, that is difficult experiences or circumstances. With this understanding, it is possible to facilitate recovery or regaining strength by supporting the child individually, and identifying ways to build up a protective system around the child, whether that be the family, a significant adult, the school environment and or other factors or systems in the child’s world. The ways to build up a protective system are likely to involve working with a significant adult or family to facilitate recovery. and also to build up protective factors that will strengthen the overall family resilience.

The **protective and risk factors will vary for each person**. Here are some possible factors although these are just a sample of the many that exist. Everyone has them!

Figure 1 Protective factors and risk factors that affect resilience

Protective factors	Risk factors
<ul style="list-style-type: none">• Individual: healthy, optimistic, feels loved• Family: close relationships, loving and consistent caregiver• Community: settled neighborhood, caring leadership• Culture that supports child wellbeing• Peace, local economy doing well, investment in local services	<ul style="list-style-type: none">• Individual: chronic health conditions that not treated• Family: violent, no time for children, neglect• Community: communal violence, local tensions, no neighbor support• Culture that prevents children from doing well• Conflict, lack of local opportunities, poverty, no local leadership or investment

The most important things that are known to help build a child’s resiliency, putting savings aside for a rainy day, are shown below in Figure 2.

Figure 2 The factors known to help strengthen child resiliency ¹⁶

A caring and supportive relationship with an adult



Having a sense of mastery in an area or over their lives



Coping skills which help a child to manage and make sense of their feelings



An affirming faith or cultural tradition



PRACTICE REFLECTION

Think about the children and families that you are supporting. Do you know about the protective factors and the risks that might affect their resilience?

We will look more at how important this is under Section 7: Opening the Bag, Assessment.

How resilience has shaped the way that we think about working with children ¹⁷

Resilience research originated in the 1950s and 1960s from the study of trauma in adults and of developmental psychology for children and youth. Researchers began by wondering how some children who came from severely disadvantaged circumstances had positive outcomes as adults while others did not. The first resilience studies focused on resistance to negative outcomes among disadvantaged children. Early resilience research conceptualized resilience as a personality trait permitting positive outcomes under extreme hardship. The Kauai Longitudinal Study published in the 1980s conducted research with a cohort of participants born in Hawaii in 1955. The Kauai Longitudinal Study noted what was termed as the ‘resiliency’ of some children and shifted the research focus towards analyzing how these children benefited from family support, good coping and a strong sense of values.¹⁸ Studies like these have since identified key individual and family-level attributes which contribute to resilience among high-risk children across ethnic groups and socio-political contexts in the United States.¹⁹ From the 1980s on, researchers began to examine other types of factors associated with positive functioning in the face of adversity. This later research incorporated cultural context, social relationships, changes over the lifespan and neurobiological processes.²⁰ Increasingly researchers argued that, along with personality attributes, protective factors are rooted in culture, community and social relationships, social support and available resources.^{21 22} Cross cultural studies have since been done which look at various cultural expressions of resilience and identify community-specific strengths.²³ As the understanding of resilience has grown, researchers have begun to understand that resilience as a process builds on itself at different levels which interact with one another over time. It is now understood that an individual’s resilience is mutually reliant on the personal, family, and social systems which exists around them (social ecology) as well as the personality traits which are fed and sustained by their social ecology.^{24 25}

If you want to read more about research on resilience:

The Global Center for the Development of the Whole Child, University of Notre Dame, conducts research on resilience in education and community settings in many different countries: <https://iei.nd.edu/gc-dwc/resources>

The Resilience Research Centre has research on children and young people and families in many different cultural and development contexts: <https://resilienceresearch.org/our-research/>

The MHPSS Collaborative for Children and Families in Adversity is platform for research, practice, learning and advocacy with a focus on humanitarian settings: <https://www.mhinnovation.net/organisations/mhpss-collaborative>

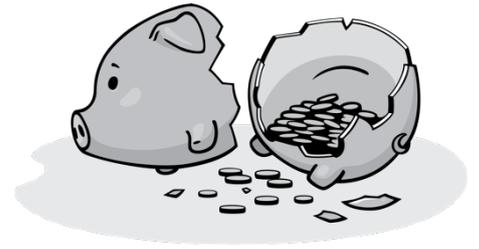
Chapter Four:

Understanding Adverse Childhood Experiences



If we understand resilience as putting savings into a piggy bank or bank account, then we can understand **adversity**, or **difficult circumstances**, as having some of those savings withdrawn.

In the same way that every positive experience adds “resilience savings,” a difficult experience means that we must use some of the money that we have put aside. With every adversity, the total amount of savings in the bank decreases, unless we are able to build up additional resilience savings to counteract the effects of adversity.

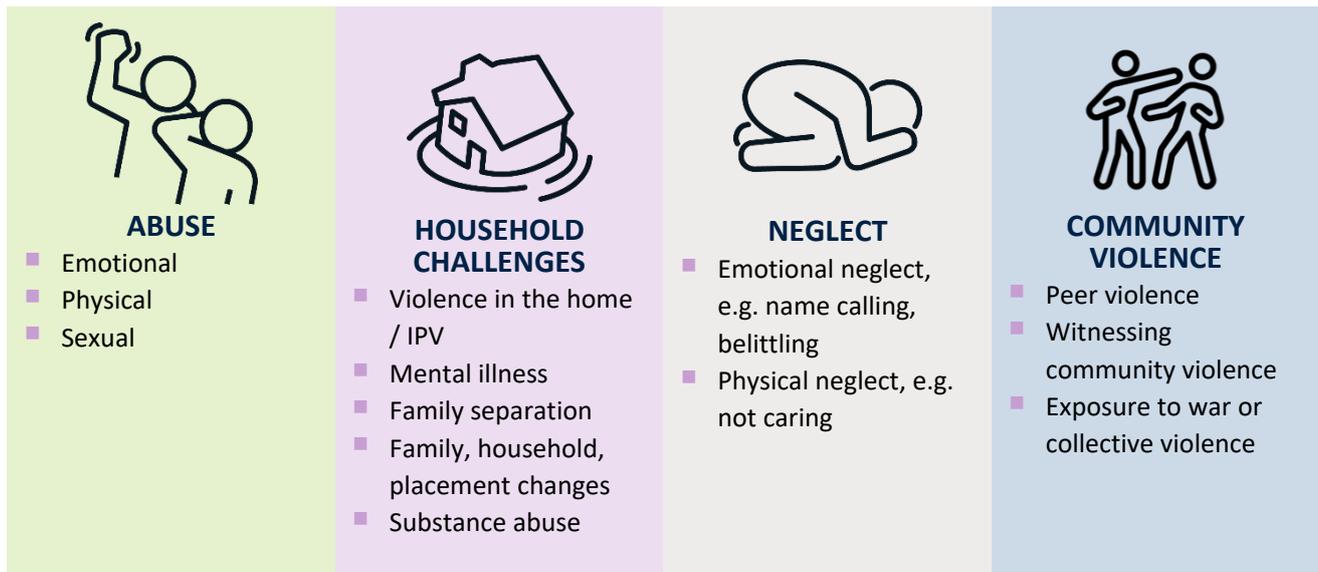


Adverse Childhood Experiences, commonly known as ACEs, are defined as **highly stressful, potentially traumatic events or situations that occur during childhood and/or adolescence**. ACEs can be a single event or incident, or prolonged threats to a child or young person’s safety, security, or bodily integrity.²⁶ ACEs impact the development of a child by diverting the experiences that go into development (the life experiences that are turned into savings that build up and are used as the child grows) into survival, which withdraws existing savings and prevents further savings from being built up.

ACEs can exist or occur in the child’s immediate household/living environment and/or in the community. These threats serve to undermine a child’s sense of safety, stability, and bonding.²⁷

ACEs are generally divided into four types: **abuse, neglect, challenges that exist in the child’s immediate environment**, and **violence that exists in the child’s community**. Each type of ACE has several ACE sub-categories, which help us to understand the kind of risks that can have a negative impact on a child’s development.

Figure 3 Categories and sub-categories of Adverse Childhood Experience ²⁸



Often **abuse, neglect and other household challenges are caused by circumstances outside the home**. Families that face poverty, discrimination, or lack of access to community resources are highly likely to be under stress, which in turn can manifest as abuse or neglect of the child, or as other forms of violence or stress within the family, that result in stress for the child.

COVID-19 is a good example of an unexpected and significant stressor in the lives of families and children. The COVID-19 pandemic affects children and families through infection with the virus itself, the impacts of measures such as control and distancing that are intended to reduce transmission of the virus, and through the potential longer-term economic impacts of the crisis.²⁹

Here are some of the ways that **external circumstances including COVID-19 might increase risks** (adverse effects that require a child to draw on the savings that have been set aside) and what might be the protective factors (putting savings into the bank account or piggy bank). These will vary for each individual child or adult.³⁰

Figure 4 How external circumstances can increase risks or enhance protective factors

Possible risks		Possible protective factors
<ul style="list-style-type: none"> • Heightened risk of violence, neglect, exploitation & psychosocial distress • Developmental delays due to stress/reduced access to stimulation • Discrimination due to gender/ disabilities. 	Child	<ul style="list-style-type: none"> • Creativity and innovation, e.g., finding a safe mental space where a child tells stories or sings to themselves, even in difficult circumstances, or by identifying a mentor outside the family when the family is not safe or protective • Knowing how to stay safe / having a protective adult • Staying in touch with friends and family • Having relevant information about COVID-19
<ul style="list-style-type: none"> • Family separation • Reduced access to social supports • Caregiver distress • Heightened risk of domestic violence, mental illness, substance use • Disrupted livelihoods, poverty 	Family	<ul style="list-style-type: none"> • Joint family activities; increased time with caregivers • Fathers more involved, if home • Access to online social support • New family rituals or routines established
<ul style="list-style-type: none"> • Breakdown of trust in communities • Competition over resources, for example in shops and markets • Limited access to services and support, such as health, education, child welfare, play and sports • Heightened stigma & discrimination against specific groups, e.g. people who travel for work, children in alternative care 	Community	<ul style="list-style-type: none"> • Formal support, e.g. food banks, cash transfers, health & protection messaging. • Informal support: neighborhood support; community kitchens, shared childcare. • Essential services available through government; support from civil society organizations. • Positive social inputs from communities e.g. collective support for front-line workers, community care and support for vulnerable members

ACEs have both **an immediate impact** as a threat or as a distressing or potentially traumatic event for the child, as well as a **potentially long-term impact** by derailing a child’s development. When the savings in the child’s ‘account’ are very low, the resources that are there have to be used for basic survival. The child cannot continue his or her normal process of development because all of the resources are going on basic survival. ACEs can curtail a child’s development further, depleting the child’s resiliency savings and causing mental, physical, and social problems for the child into the future.

Multiple ACE events in an child’s life can have a cumulative effect. When ACE events happen one after the other or several events happen at the same time, the child draws on the increasing negative balance in the ‘account’. This can weaken the child’s resolve, further derailing their development and slowly diminishing the child’s opportunities to make the most of his or her learning and development. Both

children who experience household or community adversities, for example who are at risk of violence or neglect, and children living in alternative care settings (even those that are family-based) are likely to have experienced multiple adverse childhood experiences. For example, a child in residential care could have come from a home where violence and substance abuse was present or been suddenly separated from their caregiver. A child in family-based alternative care could have been separated from parents because of a death in the family, poverty or abuse. A child in detention might have experienced violence at home or on the street before coming into contact with the law. The child might have had multiple placements resulting in ruptures or changes in household/community.

Entering alternative care, in and of itself, can be an adverse childhood experience. Separation from familiar surroundings and relationships can cause stress and/or distress to a child, even if the child is leaving distressing circumstances. For at-risk children and children in alternative care, entering care can be one of many adverse experiences. Then, the experiences that children have in care can further compound the experiences that brought them to care. This is explored more in Section 6: Where might children experience adverse childhood experiences.

ACEs, over time, can wear down a child's ability to trust others, have healthy relationships and manage their own emotions and behaviours. Each ACE event becomes an increasing burden the child must bear while trying to find their way through life to get their own developmental needs met. Studies have shown that ACEs can take a child off their developmental course, diminish their resilience and impede their life chances via the negative coping skills they have had to adopt or by negatively affecting a child's physical, emotional and mental health.³¹ This is called **toxic stress**.



PRACTICE REFLECTION

The following are all things that can help to build a child's resiliency:³²

- A caring and supporting relationship with an adult,
- Having a sense of mastery in an area or over their lives,
- Coping skills which help a child to manage and make sense of their feelings; and
- An affirming faith or cultural traditions

Think about how you might find out about, and support, a child with these four important things that help strengthen resilience.

We will look more at this when we look at Sections 7 and 8 'Practical tools for opening the bag' and 'Practical tools for unpacking the bag'.

Singing to the Lions: the tree of life³³

Another way of thinking about resilience and ACEs is to think about our lives and our experiences as our tree of life.

The roots of the tree are positive and nurturing experiences from a caregiver and/or a significant adult in our life and our cultural and spiritual beliefs and customs. Strong roots produce a healthy, strong trunk, which makes the tree stable and healthy.

A strong trunk helps the tree to grow branches, branching out higher in the sky and into its surroundings. These are the positive experiences that we have in our lives.

A tree with strong roots can weather storms and temporarily adverse conditions. The storms and adverse conditions are the adversity on our lives. Over time, having come through the storms of our lives, in conditions which allow us to cycle, developing skills which show up as leaves on our tree, growing and evolving with the seasons of our lives.

We take these skills into adulthood where they show up as fruits of our labor and the fruits of the hard work of development and life experiences.

Our tree of life will almost definitely encounter stress – that is part of the growth process. Leaves and fruits may fall away in the cold, but they return in the spring. But when the cold is strong, or the rains do not fall, the tree is no longer able to get sustenance from its roots. The tree's health begins to fail. It can no longer bloom, and it can no longer bear fruit.



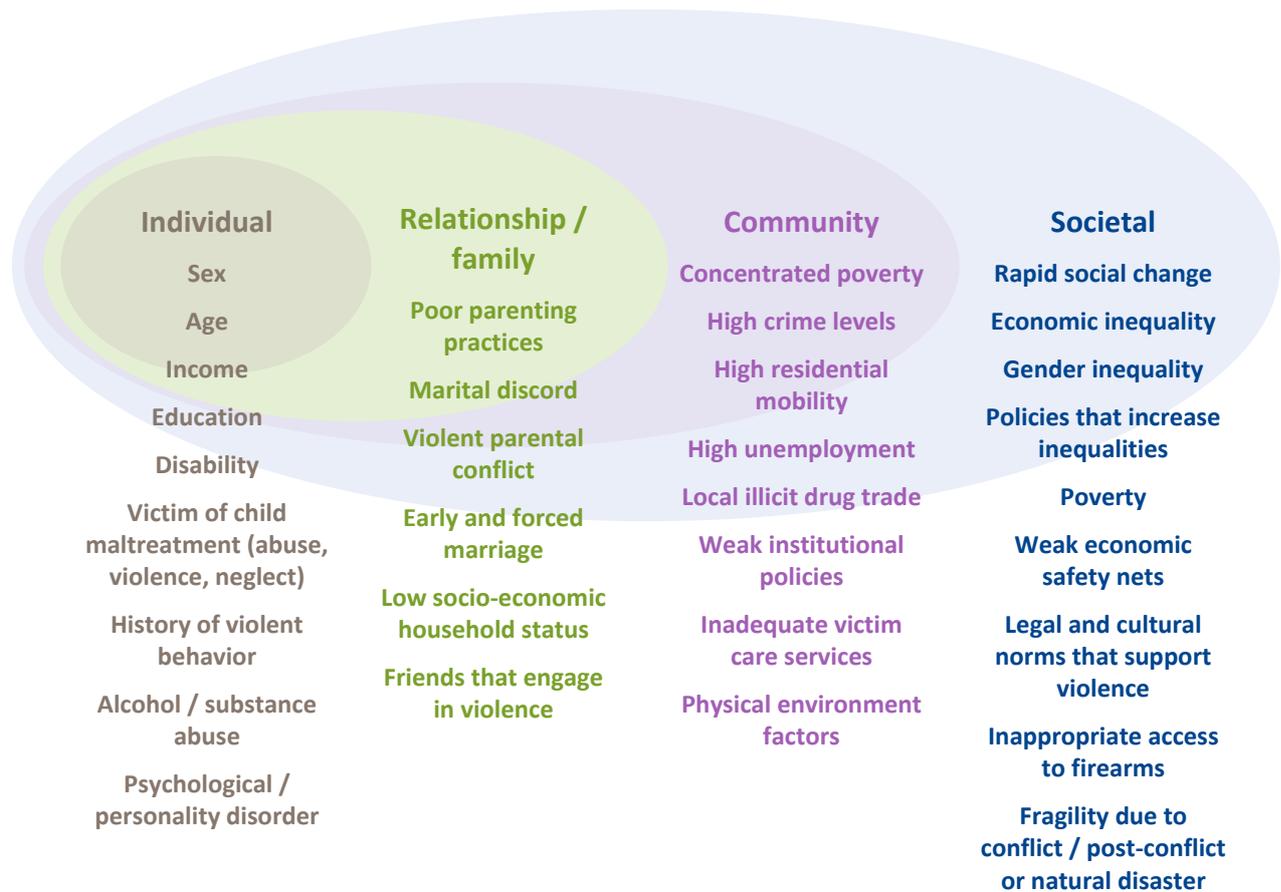
Violence – addressing a key adversity

Each child's experience is unique. It is important for anyone working with children in need of protection and care and with children at risk of or living in alternative care, to know the child's individual situation, individual experiences, needs and individual strengths.

However, there are factors that increase the risks of a child experiencing adverse childhood experiences. Knowing what increases the risks of a child to experiencing ACEs is necessary to **identify how to prevent and respond** to the child's specific adversities.

The diagram below illustrates the main factors known to increase children's exposure to adversity. The diagram was initially developed for INSPIRE, the global framework for the prevention of violence against children, and are drawn from global evidence.³⁴ The diagram shows the importance of addressing the underlying drivers of childhood adversity. Even though as frontline workers you will usually work directly with children and their families, it is always important to think about what is happening in the community around the child. Program managers and decision makers in government need to think about how to prevent and respond to ACEs at community and social level. How this can be done is addressed further in Section 10: Promoting resilience and preventing and responding to ACEs in the care system.

Figure 5 Framework for Understanding Risks for ACEs³⁵



Special considerations

Disability: Some children are more likely to face adversities due to family or community beliefs and practices. Children with disabilities, for example, are many times more likely to experience physical, emotional and sexual violence from family and community members than children who do not have disabilities.³⁶

Gender: Girls are more likely than boys to experience sexual violence from people in the home, from partners, or from other perpetrators in the community.³⁷ But boys do experience sexual violence and are much less likely to tell someone about it because of the stigma.³⁸

Age: Infants and young children are at greater risk of neglect than older children, in part because they are more powerless than older children who can possibly speak to someone for help. As children grow older, they may become more exposed to harm from violence in the community as they are expected to go out to work or study or exposed to bullying online or in real life. Girls in particular may face increased emotional or sexual violence if they are at risk of harmful practices such as female genital mutilation or child marriage.

The scale of violence, abuse and neglect faced by children

An estimated one billion (one out of two children) aged 2–17 years experience some form of violence each year.³⁹

Nearly three in four children, or 300 million children, aged 2–4 years regularly suffer physical punishment and/or psychological violence at the hands of parents and caregivers.⁴⁰

One in four children under five years lives with a mother who is the victim of intimate partner violence.⁴¹

A third of students aged 11–15 years worldwide have been bullied by their peers in the past month.⁴²

One hundred and twenty million girls are estimated to have suffered some form of forced sexual contact before the age of 20 years.⁴³

Chapter Five:

Where Might Children Experience Adverse Childhood Experiences



Every child has the right to a home and to a loving and caring family. But sometimes this does not happen. In this section, we look at the different types of adversity that children might be exposed to in different living arrangements.

In order to be able to effectively identify risk of adversity, and prevent and respond to ACEs, it is useful to be aware of the potential risks children *might* face in different types of care. Figure 6 on the following page shows **some of the most common adversities that children may experience**.

Of course, most children living in their family or in kinship care are living in loving and caring homes. However, it is important to be aware that a child who may be showing signs of stress, distress or trauma may have experienced adversities that will need to be understood to best support the child.

There are some adversities that push a child out of the home – he or she runs away or is taken away from a bad situation for safety. However, it is always important to think about the potential adversities not only that the child has experienced until now, but the risks of adversity that they may experience in the current or future care arrangement.

Promoting resilience-informed care requires always being aware of what may have already happened – what is making the child's bag heavy – and the potential adversities in the current situation. Finding the right solution requires understanding and addressing the past adversities.

Figure 6 Adversities that children may face in different care settings

Biological family
<ul style="list-style-type: none"> ■ Witnessing family violence ■ Experiencing violence in the home (physical, sexual, emotional) ■ Neglect (physical, emotional) and abandonment ■ Chronic poverty and deprivation ■ Exposure to all forms of violence in the neighborhood, school and community ■ Exposure to harmful gender or social norms
Kinship care
<ul style="list-style-type: none"> ■ Children in kinship care may be exposed to all of the adversities that they face in their biological family. They may also be exposed to the following: ■ Potential stigma / discrimination from the extended family or kinship carer ■ Potentially increased poverty and deprivation if the extended family do not want to or cannot care for the child ■ Exploitation and child labor
Kafaalah / Foster Care / Guardianship
<ul style="list-style-type: none"> ■ If the arrangement is informal, children in kafaalah or foster care may be exposed to all of the adversities that they face in their biological family or kinship care, especially if there is no oversight from child protection actors. They may also be exposed to the following: ■ Neglect or lack of nurture ■ Violence in the home (physical, sexual emotional) ■ Exploitation and child labor
Supported independent living
<ul style="list-style-type: none"> ■ Neglect and deprivation, poverty, if not supported and having access to services and income ■ All forms of violence, including gender-based violence and community violence, if unprepared and without access to services ■ Multi-generational ACE risk if have children and unsupported ■ Emotional neglect ■ Exposure to or use of drugs and alcohol
Residential facilities
<ul style="list-style-type: none"> ■ Experience of abandonment and separation from family, lack of contact with family, lack of information about future placement ■ Neglect, including lack of safe and secure caregiver ■ Abuse and neglect if previous ACEs not recognized and child not supported ■ Institution-level violence and abuse if unregulated, from adults and peers ■ Emotional violence, including exclusion from social support, stigma and discrimination



PRACTICE REFLECTION

The United Nations General Assembly signed a resolution on the rights of the child in December 2019 that recognizes that “children without parental care are more likely than their peers to experience human rights violations, such as exclusion, violence, abuse, neglect and exploitation.”⁴⁴

Can you think about the children that you are working with – are there adversities that the children you know are likely to be exposed to because of where they live and who they live with?

What the research tells us – children’s adverse childhood experiences and alternative care

There is a lot of research that shows that children who experience some forms of adverse childhood experience are at risk of entering alternative care, and especially residential care. There is also research that shows that children in all forms of alternative care, especially residential care, experience adverse childhood experiences. And children who have entered alternative care will have already experienced some and likely many adverse childhood experiences, which need to be acknowledged. The key research findings from recent years are summarized below.⁴⁵

Some of the main reasons for children running away from home, and being placed into alternative care, include neglect, discrimination, and physical and emotional abuse. The causes of violence in the home included poverty, alcohol, stress and discrimination of children. Studies from countries as diverse as Ethiopia, Malawi, Sierra Leone, South Africa, South Sudan, Tanzania, Uganda and Zambia all show that violence, abuse and neglect in the home are push factors for children entering alternative care.

Often it is pressures starting outside the family that puts pressure on a family and ultimately leads to a child running away or the family dividing up. For example, poverty leads to reduced caregiver emotional wellbeing and stability, which can lead to negative coping mechanisms such as alcohol abuse. Being unable to access social services is often the starting point that creates vulnerability within a family context.

Violence in the community can also be a reason for children entering alternative care. Family separation due to family conflict may be one reason. In some settings, families choose to place children in residential care to reduce the risk of the child’s involvement in community violence, for example in gangs.⁴⁶

Children in residential care across the world experience severe and widespread violence in many settings.⁴⁷ (for example, in one study in Tanzania 93% of children and 87% of caregivers reported physical and emotional maltreatment of children by the institution’s caregivers. Some studies have found that violence in residential institutions is six times higher than violence in foster care, and that children in group care are almost four times more likely to experience sexual abuse than children in family-based care.⁴⁸

Younger children appear to face greater risk of VAC in residential facilities, with children being in residential care from birth at greatest risk even as they grow older.⁴⁹

There is significant evidence of delays in cognitive development for children in institutions, largely because of neglect. This ‘abuse by neglect’ can be described as a form of violence against children.⁵⁰

Causes of VAC in residential care includes lack of trained caregivers, minimal or no oversight, grouping of perpetrators and survivors together, weak capacity of staff to comprehensively address the needs of children who have already experienced VAC.

Children in family-based alternative care are often well looked after and loved. Kinship care plays a significant role in ensuring children who cannot be cared for by biological parents remain in family care across the world, but children can face violence, abuse or neglect, especially when family resources are stretched thin, or family relations are weak or strained.⁵¹

Chapter Six:

Recognizing Adverse Childhood Experiences in Children

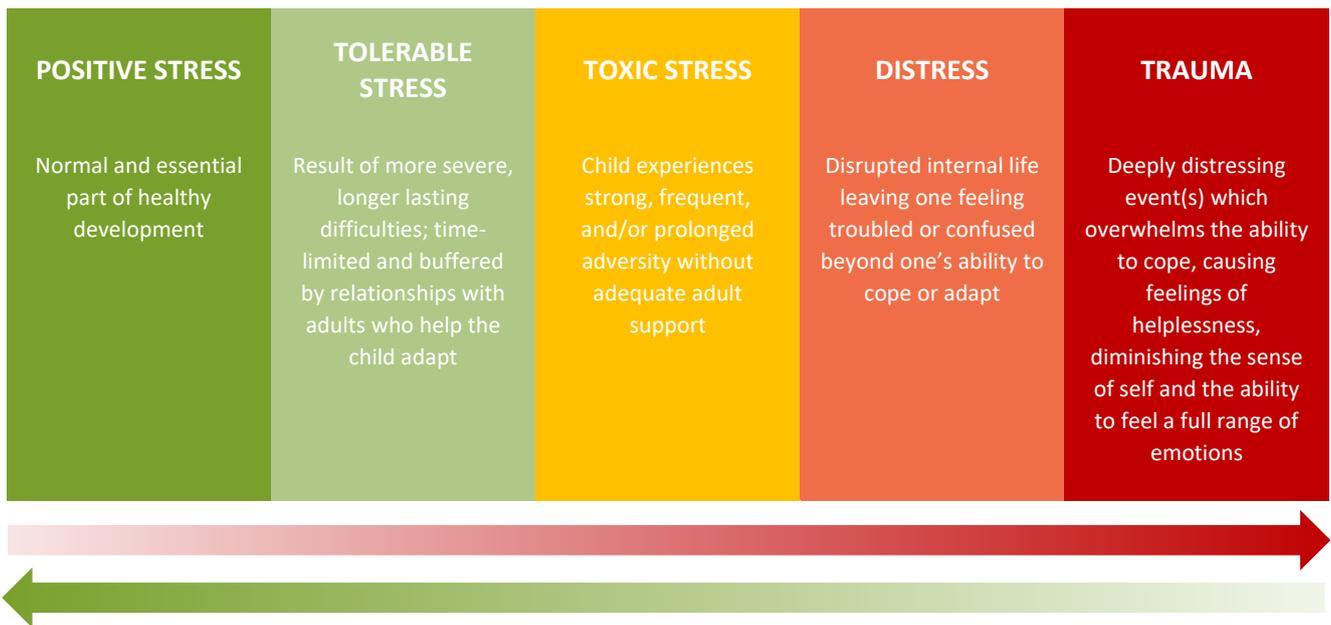


So far, we have described how external adverse circumstances and events can impact on children. Now, we will explore **how the impact of ACEs shows up in the child as behaviors or symptoms.**

To do this, first we must understand the range of potential impacts that adverse childhood experiences can have on a child.

One factor in determining the impact of adversity on a child is the level of the stress response which the ACE or series of ACEs evoke. We can think of the range of stress responses as a spectrum, ranging from positive or tolerable stress to toxic stress, distress and trauma.

Figure 7 Spectrum of stress response to an adverse experience



Positive stress might include feeling anxious before a test at school or being extra alert when learning to cross a road safely. **Tolerable stress** might be an experience of being treated unfairly at school or by friends in the playground, but with supportive family and teachers who are able to resolve the unfair treatment. Tolerable stress might become **toxic stress** (when it is cumulative) or turn into **distress** if a child receives no support to address the difficulties, or if the difficulties continue and there are no means to address them – often this is because of external circumstances, such as lack of access to community resources or support or living in a community with a high level of violence. **Trauma** might occur due to an event that is perceived by the child as life-threatening and which overwhelms all the child's coping mechanisms.

The amount of stress that a child will experience is influenced by the child's resilience. Remember that protective factors increase a child's resilience – that is, the amount of 'savings' that go into the child's account or piggy bank. Likewise, the level of the stress response experienced by the child will affect how much is withdrawn from the account – that is, the energy and personal resources the child has to draw on to cope with the ACE and whether the child has external support to top up their resilience 'credit' balance.



PRACTICE REFLECTION

Think about how you experience stress personally, for example, work-related stress. Are your responses to that stress different depending on what else is going on in your life – on whether you have a lot of 'savings' set aside?

For children, **the level of stress response is affected by the protective and risk factors around the child**, and also by **developmental factors**. Developmental factors will depend on the age of the child and whether the child's developmental needs have been met up until the point when they begin to experience ACE(s). For example, if a child experiences the loss of a parent or caregiver at an older age, but has had consistent nurturing relationships with caring adults until that point, the child is more likely to have more resilience to mourn, recover from the loss of their parent and continue on their developmental path. If a child loses a sole caregiver at a young age and is subsequently neglected, changes caregiver regularly and doesn't have a chance to develop a strong bond with a new caregiver, the child is likely to be less resilient which can show up as challenging behaviours. The consequences of the loss, instability and accompanying stress response can leave the child less likely to develop coping skills and recover. This ACE can take the child off their developmental path and potentially have long term impacts on the quality of their relationships with others.

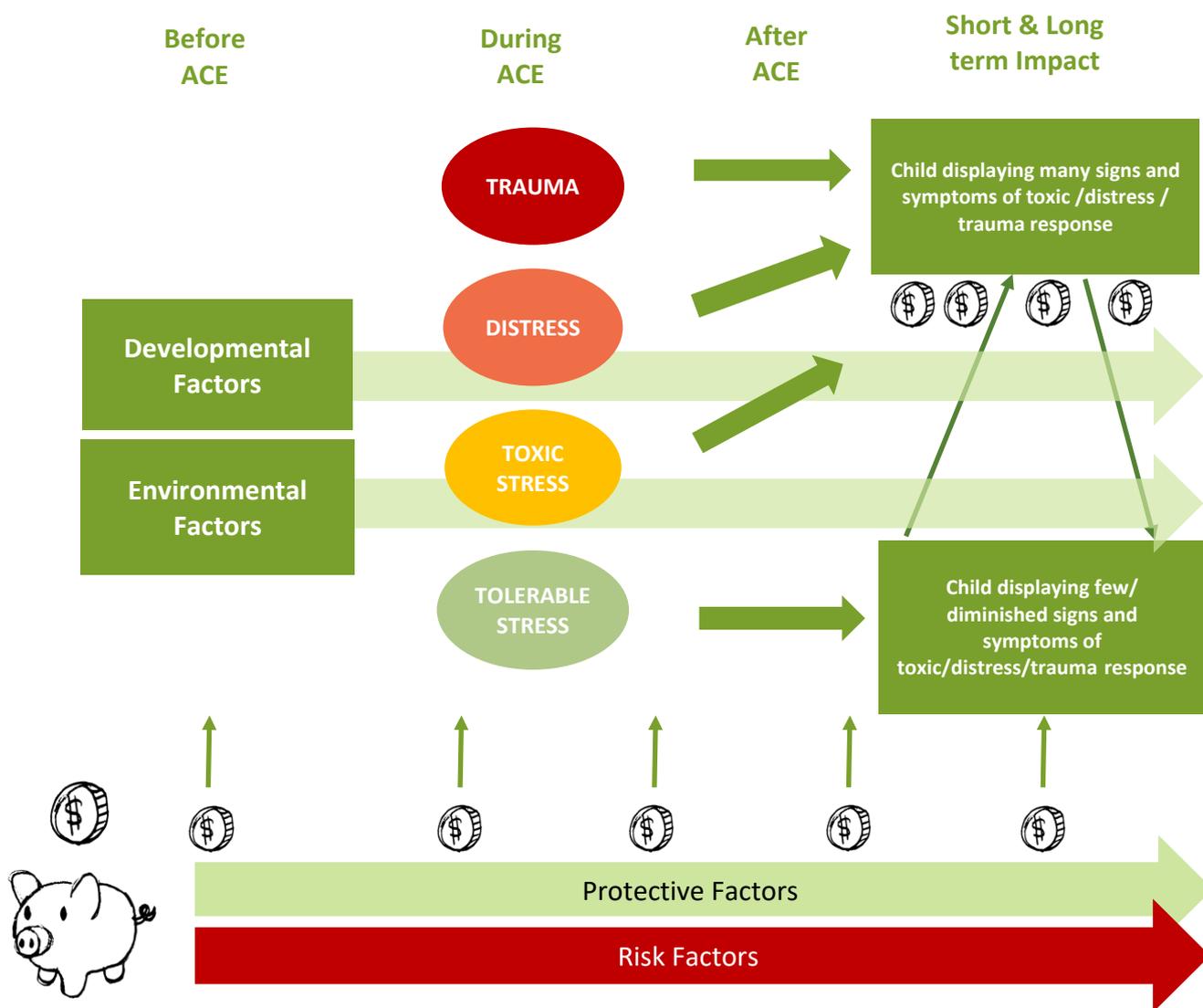
Developmental factors combine with factors in the child's environment.

Environmental factors can include circumstances in the child's life immediately before the ACE, the level of exposure to the ACE (and the accompanying stress response to the ACE), and the child's environment immediately after the ACE. For example, if a child experiences something sad or frightening but is immediately supported and knows he or she is safe and secure, then the impact will be lower than if the child is left to deal with the stress without any support.

We will look more at how important this is under Section 7: Opening the Bag, Assessment.

The illustration below shows how **developmental and environmental factors influence the impact of an ACE on a child**, and how resilience and ACEs interact. These factors interact with the child's resilience and level of stress response.

Figure 8 How resilience, level of stress response, developmental and environmental factors influence the impact of ACE(s) on children



Summary of resilience-informed care.

As the illustration shows, the amount of savings (coins) that go into the bank account or piggy bank depend on the protective and risk factors experienced by the child. The more protective factors, the more that can get put aside as savings over time. The more risk, the less goes in. But even in adversity, savings are still going into the account because the child is gaining new experiences and learning life lessons from these experiences. The savings will be needed because life always throws stressful events at us, for which we need to draw on the resources that we have saved. When the stress is tolerable (a family illness, loss of a job in the family for a short time, for example), the child has to use some of the savings to deal with the adversity but is able to keep adding more savings through the love and support that is being received. The adverse event doesn't prevent important life lessons being learned and positive experiences being gained. The stress is more likely to be tolerable if the child's development needs have so far been largely met, and the external environment is largely protective. If the child experiences many ACEs at one time, or over a long period of time, and his or her developmental needs and external supports are already insufficient, the chance of toxic stress, distress or trauma is greater.

Being aware of the combination of the factors illustrated in the diagram above can help us to understand the impact of ACEs on individual children and help us to help them.



PRACTICE REFLECTION

Think about the children and families that you are supporting. How might you be able to explore with them how they can ‘keep putting savings in the bank’, and identifying the developmental and environmental factors that are affecting how they experience stress?

We will look at how to address this at assessment stage and review available tools in Section 7: Opening the Bag.

The impact of adverse childhood experiences on a child’s brain

In order to better understand the impact of ACEs on the child, it is important to look at the brain’s structures, a child’s development needs, and how they interact with and impact on a child’s developmental path and behavior.

The science: how brain development influences resilience and response to adversity

The brain controls a person’s ability to breathe, move, talk, see, hear, think, feel and much more. Different parts of the brain specialize in different functions. Some of these functions work right from birth, like breathing. Others are developed over time, like thoughts and feelings that control behavior.

The brain has nerve cells, called neurons – around 100 billion of them by adulthood. These neurons make connections with each other to send messages from one part of the brain to the other in order to control and coordinate different parts of the mind and body. Some of these messages go direct to different parts of the body, through eyes, ears or the spinal cord, which is how we breathe and move. Some go to centers in the brain that are responsible for feelings or thoughts.

The messages pass along “neural pathways” which are formed when a message from one neuron passes to the next. Each time a neuron is stimulated – for example, the first time a baby hears a noise – the neurons make connections. Every time the same experience is repeated – for example, if a baby feels warm, sees the same face, is cuddled – then the neural pathway is strengthened. The more times that the same stimulation happens, the stronger that particular pathway becomes. Most of the time these experiences are positive – remember the look on a child’s face the first time it tastes something completely new, like mango or ice cream – the child’s expression shows that the brain is processing something new.

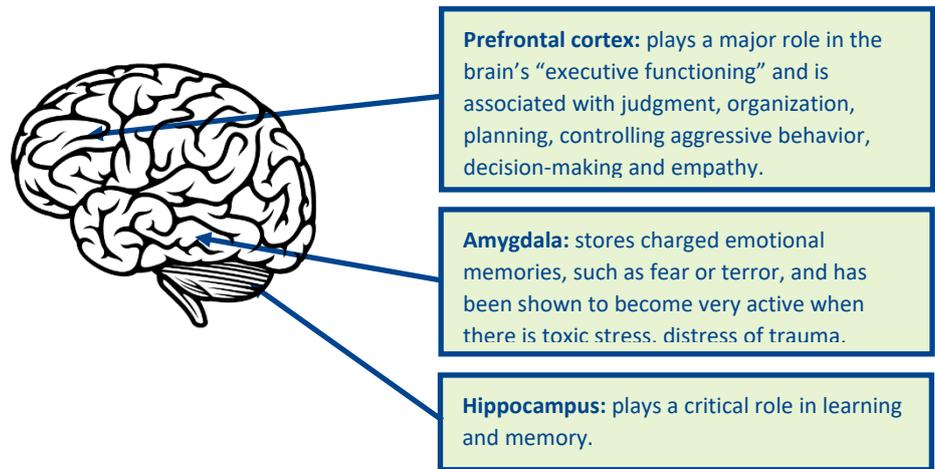
In the same way, lack of stimulation or overstimulation can also impact on how the brain develops. A child that lacks stimulation will not create or strengthen the neural pathways that are needed for learning. If a child is overstimulated – for example, is regularly made sad or scared – the neural pathways that become strongest are the ones that deal with fear and grief, while more positive experiences are not reinforced.

A child’s brain continues to develop into adolescence and beyond. In pre-teen and teen years, the brain starts to focus on strengthening the connections that are being regularly used, and ‘pruning away’ the neural pathways that have not been used. This strengthening and pruning starts in the back of the brain, where the most basic functions are. The front part of the brain, which is responsible for decision-making and judgement, is the last part to be strengthened. This is why adolescents may seem to be mature but still lack judgement or take risks. The fact that the brain continues to develop into adolescence also means that the child and their brain have a second opportunity to build up positive responses in the brain. With the right support to deal with ACEs, the teenager’s brain can adapt, integrate experiences and build up positive coping and resiliency as they continue into adulthood.

For more information on brain development, see: <https://www.firstthingsfirst.org/early-childhood-matters/brain-development/> and <https://developingchild.harvard.edu/science/key-concepts/brain-architecture/>

The three main parts of the brain that are important for understanding the impact of stress are shown in Figure 9 below.

Figure 9 The parts of the brain that are affected by stress⁵²



When we experience stress in our bodies, we experience a range of chemical, physical and emotional reactions that help the brain go into survival mode. The amygdala acts like an alarm system. It sends an immediate message to the body and brain that there is danger. The alarm overrides the hippocampus' ability to process emotions or feelings *and* the prefrontal cortex's ability to think.

Stress is not always negative. If a person experiences 'normal stress,' the brain will use its existing neural pathways (see 'The science: how brain development influences resilience and responses to adversity; box above) or adapt and build new neural pathways to help the body and mind to cope.

However, toxic stress, distress and trauma responses to ACEs overwhelm the parts of the brain that help to regulate feelings and thoughts – the hippocampus and the prefrontal cortex. When this happens, learning and the ability to adapt become impaired. The brain becomes focused on getting out of danger and keeping the body and mind safe.

Figure 10 What happens in the brain in response to stress



The physical and emotional reactions which are part of the stress response include: increased heart rate and rapid breathing or chills; being hyper attentive to everything happening around us, confusion, or numbness; fear or terror.

The combination of these reactions can be referred to as "fight or flight". When "fight or flight" is not an option, the brain processes can become so overwhelmed that they shut down or "freeze." Fight, flight and freeze are three brain and body

coping mechanisms that allow us to react automatically in dangerous situations. Typically, when the danger subsides, the amygdala, hippocampus and prefrontal cortex go back to their normal day to day functions. However, when a child experiences ACEs in the form of extreme, repeated, unrelieved stress, distress or trauma, the amygdala, hippocampus-prefrontal cortex can stop functioning properly even when the child is not in immediate danger. The “amygdala alarm” can continue constantly going off triggering the entire stress response system, with its physical and emotional reactions in the brain and body, to stay on high alert and in survival mode.



PRACTICE REFLECTION

Think about times when you have felt a bit nervous – for example, before sitting for an exam or having a job interview. Can you remember any of the physical or emotional reactions that you felt?

Do you recognize similar or more intense reactions in the children or adult that you have been supporting in your work?

In the next session, we will look more at how to identify signs and symptoms

SIGNS AND SYMPTOMS OF ACEs IN CHILDREN

A child’s physical and emotional reactions to ACEs, which can trigger their amygdala alarm over a prolonged period of time, usually present in the form of certain behaviors, signs and symptoms. Recognizing the signs and symptoms can help us identify that a child has experienced or is experiencing an ACE and start to assess its impact so that we can help them recover and build resilience.

The chart below identifies some of the signs and symptoms we can see in children who have experienced ACEs. The signs and symptoms reflect some of the impact of ACEs on the physical and emotional well-being of children. They also affect a child’s social relationships. Many of the behaviors and emotions listed below make it hard for the child to form healthy trusting relationships with adults and their peers. Some can be short term and others longer, even lasting throughout childhood and into adulthood. Some can also be normal in the child’s development and require us to be skilled at identifying where the behavior can be associated with an ACE. For example, most babies have a period during their development when they are “clingy” and fearful of strangers. As a symptom of ACE this separation anxiety may be more than normal, prolonged or extreme.

Table 1 Signs and Symptoms of ACEs ⁵³

<p style="text-align: center;">BIRTH TO 2 YEARS OF AGE</p> <ul style="list-style-type: none"> • Eating disturbance • Sleep disturbances • Somatic complaints • Clingy/separation anxiety • Feeling helpless/passive • Irritable/difficult to soothe • Constricted play, exploration, mood • Repetitive/post-traumatic play • Developmental regression • General fearfulness/new fears • Easily startled • Language delay 	<p style="text-align: center;">2 TO 5 YEARS OF AGE</p> <ul style="list-style-type: none"> • Avoidant, anxious, clingy • General fearfulness/new fears • Helplessness, passive, low frustration • Restless, impulsive, hyperactive • Physical symptoms (headache, etc.) • Difficulty identifying what is bothering them • Inattention, difficulty problem solving • Daydreaming or dissociation • Irritability • Aggressive behavior
<p style="text-align: center;">6 TO 12 YEARS OF AGE</p> <ul style="list-style-type: none"> • Anxious or fearful • Worry about own/other’s safety • Emotional swings, moody • Easily startled • Sad or angry • Difficulty sleeping, nightmares • Learning problems • Changes in school performance • Attention seeking, clingy • Revert to younger behavior • Re-enact trauma in play • Say have no feelings about event 	<p style="text-align: center;">13 TO 17 YEARS OF AGE (AND INTO ADULTHOOD)</p> <ul style="list-style-type: none"> • Feel depressed • Difficulty imagining future or planning • Eating disorders • Self-harm behavior, e.g. cutting • Over or underestimate danger • Inappropriate aggression • Learning or school problems • Reckless or self-destructive behavior • Drug or alcohol abuse • Act out sexually • Sleep disturbances • Pull away from activities, relationships • Feel numb, shut down or separated from life • Discuss traumatic events in detail

How adverse childhood experiences impact a child’s development

If we are to promote resilience and address ACEs, it is essential to understand the delicate balance between **stimulation** required to support healthy and normal child development (that is, encouraging the brain to and under or over stimulation, which derails child development).

Remember the bank account? Protective factors that stimulate positive learning and growth (e.g. family activities, spending time with friends, having a mentor) add savings to a child’s resiliency and development bank account or piggy bank. ACEs, toxic stress, distress and trauma withdraw savings from the account, with each level of stress response representing increasingly larger withdrawals until a child’s resources are depleted. The child must use their mental, emotional

‘Stimulation’ means encouraging something to make it more active. For children, this starts with interacting and responding to a child through showing love, cuddling, talking, laughing, singing, reading. This is an important part of brain development (see ‘The science: how brain development influences resilience and response to adversity’ on page 13). Under-stimulation – ignoring or neglecting a child – means that the brain does not have the same chance to make new connections. Over-stimulation is when the brain is receiving too many messages, which can be confusing and stressful (remember the amygdala!).

and physical resources to protect themselves from the dangers of ACEs and the accompanying toxic stress. When a child’s mental, emotional and physical resources are depleted, their resilience is diminished, and they are not able to easily recover and continue on their development path.

To better understand this impact on child development, let’s look at **typical development** in a protective environment – where a child has stability and strong attachment to caring adults and other significant relationships and resilience can flourish. In this protective environment, a child does not need to draw on his or her ‘savings’ so he or she can devote resources to learning and growth.

The key indicators of typical development are shown below in Table 2.⁵⁴ These indicators can serve as a reference point, in order to recognize when a child might require additional help and support either to address ACEs or other reasons for delays.

Remember that this is *typical development*. Developmental milestones will vary for individual children. ACEs may cause delays in achieving developmental milestones. However, it is important to consider potential developmental delays due to physical or intellectual disabilities if there are *significant* delays.

Table 2 Typical child development in a protective environment

<p style="text-align: center;">BIRTH TO 2 YEARS OF AGE</p> <p>Physical: the newborn infant is entirely dependent and has reflexes that enable him/her to feed and to interact with the mother/caregiver</p> <p>Cognitive: all sensory and motor skills are coordinated; most learning is non-verbal, learns through interactions with his/her environment</p> <ul style="list-style-type: none"> • At 8-9 months s/he can crawl on his/her stomach and starts to imitate sound • At 12-18 months s/he stands and works by him/herself • At 18 months, s/he can point at things s/he wants <p>Social/emotional: s/he starts to smile at 3-4 months and becomes aware of other children towards the end of this developmental period</p>	<p style="text-align: center;">2 TO 5 YEARS OF AGE</p> <p>Physical: Period of rapid mental and physical growth</p> <p>Cognitive: Begin to use language and think symbolically, but thinking is instinctive and centered on self, learns through play</p> <ul style="list-style-type: none"> • Learns right from wrong, through discipline and interaction, and is increasingly able to exercise self-control • By 3 years can talk in sentences • At 5 years, can talk about a previous occurrence <p>Social/emotional: From 3-5 years, playing is imaginative and can help children re-enact and deal with fears and anxieties; from 4-5 years, the child becomes frightened of imaginary dangers and may be fearful of unfamiliar surrounding, primary caregivers remain important while peer relationships also offer social learning</p>
<p style="text-align: center;">6 TO 12 YEARS OF AGE</p> <p>Physical: steady and sustained growth with growth spurts</p> <p>Cognitive: is able to use concepts of time, space, volume and number in simple concrete ways</p> <ul style="list-style-type: none"> • Child develops capacity for logical thought and to see things in relational terms (how one thing is connected to another) • By 6 years, starts to grasp the concept of time <p>Social/emotional: between 6 and 8, understands the concept of death</p> <ul style="list-style-type: none"> • Starts formal learning and people outside the family become important as role models and peers who help the child develop self-esteem • Social roles and responsibilities start to be learnt 	<p style="text-align: center;">13 TO 17 YEARS OF AGE (AND INTO ADULTHOOD)</p> <p>Physical: Further development/maturation of body and sexual reproductive organs</p> <p>Cognitive: thinking now involves abstract, theoretical and hypothetical ideas. Increasingly capable of independent thought and responsibility</p> <p>Social/emotional: rapid growth and changes in body and appearance can lead to strong conflicting emotions</p> <ul style="list-style-type: none"> • The adolescent’s sense of identity is consolidated, bound up in relationships with others, family history and traditions, beliefs, values and choices. Not developing a coherent sense of identity can lead to self-doubt and anti-social behavior.



PRACTICE REFLECTION

Compare the *typical* developmental stages in Table 2 with the signs and symptoms of ACEs in Table 1.

Do you recognize behaviors from either table in the children you work with? Do you recognize when you *don't* see the behaviors in Table 2 in the children you work with?

The combination of recognizing signs and symptoms of ACEs and recognizing delayed or disrupted development is important in addressing the impact of ACEs.

Many of the developmental milestones in Table 2 are met with the support and input from a caring adult and a protective environment. Table 3 provides further details for what comprises a protective environment. A child depends on their caregiver for good development, but also depends on the wider family and community environment. The caregiver in turn depends on the wider environment – the family, the community, and protective factors in wider society - to be able to best provide a child's protective environment.

Table 3 Caregiver and environmental inputs for child development

PHASE	SOCIAL MILESTONES	PRIORITIES FOR GOOD DEVELOPMENT
Infants (0-2 years)	Rapid brain development Learn to move Form attachments and express basic needs	Safety and security and love Stimulation for brain development Nutrition for growth
Preschool childhood (3-5 years)	Curiosity Communication Imagination	Reassurance Stimulation through play Developing social skills
Primary school (6-12 years)	Friendships More mobility Beginning to challenge parents or caregivers	Starting to learn skills Learning right from wrong Space to develop friendships
Early adolescence (10/12-14 years)	Peer groups Beginning to challenge adult rules Insecurity and confusion	Learning Allowing some freedom, but maintaining consistency in rules
Later adolescence (15-19 years)	Risk-taking behaviours Starting to make decisions Growing sexuality	Helping adolescent to begin taking responsibility for the future Love, support and guidance



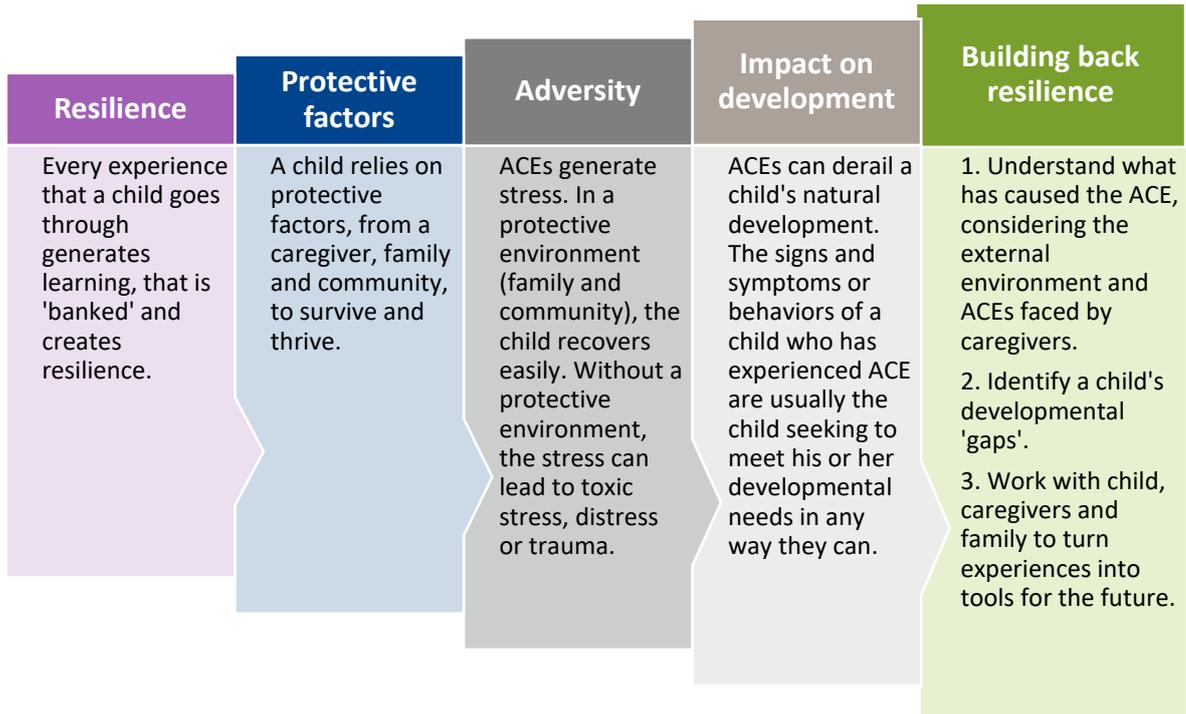
PRACTICE REFLECTION

As professionals supporting children who have experienced ACEs, one of our first tasks is to identify the priorities for development that a child may have missed because of the adversities that he or she is facing. This requires a lot of understanding about what has gone on in the child's life and also about typical development. This is why the **assessment stage** is so important, see Section 7: Opening the bag: Assessment.

We then need to identify how to create the conditions which reflect the developmental priorities he or she has missed, see Section 8: Practical tools for unpacking the bag.

Putting the information together

By creating an environment which support the priorities for good development, a child can continue on his or her developmental path. The ACE can then be transformed from being a withdrawal from the child's account to a deposit of savings which contributes to the child's resilience. This approach – which acknowledges the impact of adversity, toxic stress and trauma in a child's life – can help the child learn how to integrate adverse experiences, develop positive coping mechanisms or skills, and apply these mechanisms so that they become tools that enhance their resilience that they can use for the rest of their childhood and into adulthood.



Now, that we understand how ACEs can impact development and how developmental an environmental factors can influence the severity of ACE impact on a child, let's put it all together by looking at four children on their developmental path and how ACES might cause a detour from that path.



PRACTICE REFLECTION

Look at the case studies below and discuss the questions with your colleagues. Have you experience of similar stories with the children that you work with? See Section 7: Opening the bag, Practical tools for opening the bag to explore these questions further.

Juan

Juan is 18 months old. He lives with his mother. Juan's father abandoned his mother when she told him she was pregnant. Juan's father has moved away and Juan's mother has not seen him since he left.

Juan doesn't eat much. He is not sitting up or crawling yet. He used to have bouts of crying uncontrollably. Sometimes his mother responds, sometimes she does not. She often feels sad and has no energy. These days Juan is usually silent. He lays quietly in his crib and sleeps a lot of the time. This is a relief to his mother.

It's hard for Juan's mother. She has lost the support from her family because they threw her out when she got pregnant and she is stigmatized in the community because she is an unwed mother. So, she is very isolated. She is not working and it's hard to get enough food to eat. Juan's mother cannot see hope for the future.

What signs and symptoms do you see?

Which development milestones would you expect Juan to be experiencing?

What developmental needs are not being met?

Mercy

Mercy is five years old. Up until a year ago, Mercy lived with her mother and younger brother. Mercy's father and mother divorced and a year ago. Her father left and her mother was so sad she could not care for her children so her aunt and uncle stepped in to care for the children. Soon after the children moved in, the uncle started to sexually abuse her whenever her aunt was out of the house working at her market stall. One day, Mercy's aunt found out about the sexual abuse and sent Mercy away to live in a residential care home. Workers at the home notice that Mercy has been wetting the bed, having trouble sleeping and is often withdrawn and fearful of people, especially men. She is now going to school near her home and her teacher at school reported that she overheard Mercy having an "inappropriate" conversation with her school friend explaining how to "do it". At times, Mercy can become aggressive, getting into fights with her classmates. Mercy's teacher also thinks that Mercy may be a bit slow as she is not able to read, name colors and count. In general, she is not doing well in school.

What signs and symptoms do you see?

Which development milestones would you expect Mercy to be experiencing?

What developmental needs are not being met?

Janette

Janette is ten years old and lives with her mother and father and her three brothers and sisters. Her father is a community leader and is well respected. However, in the home he is very domineering and regularly gets angry with Janette's mother. He hits her regularly, especially after he has been drinking.

In school, Janette cries easily and finds it difficult to concentrate. Janette's teacher says that Janette jumps whenever there is loud noise and is often worried that something bad is going to happen to her classmates or to the teacher. Whenever Janette is out in the community with her parents and siblings, she makes sure that she behaves so that she does not do anything to make her father angry or get her mother in trouble. One time a neighbour asked about yelling and loud noises coming from the house. Janette explained that Daddy was angry because "I didn't do well on a test" or "I didn't do my chores." Everyone says that Janette is a good girl. They say she just lacks focus and is a bit anxious. Janette doesn't have friends that she sees outside of school.

What signs and symptoms do you see?

Which development milestones would you expect Janette to be experiencing?

What developmental needs are not being met?

Paul

Paul is 15 years old. He and his family decided to migrate abroad in order to escape the violence in his community. When Paul was three years old he saw his first dead body. Since then he has seen so much violence that it no longer bothers him. While trying to cross the border, Paul was separated from his family. He was registered as an unaccompanied separated child and returned to his country of origin. As it took time to identify extended family members for Paul to live with, he was placed in a residential care facility where he still lives. Paul is constantly being approached by local gang members who want to recruit him to become a part of the gang. Paul has tried to ignore them but the gang members have resorted to beating him up and now are threatening to hurt the extended family members with whom Paul was planning to live. Paul doesn't want to join the gang but he doesn't know how much more of being beaten and threatened he can take. At the care home, staff describe Paul as being overly aggressive, combative and very rebellious. Sometimes, staff report that Paul cuts himself with knives to show how tough he is. Paul has started carrying a knife with him everywhere. He likes getting drunk in his room and bullies other kids in the care home into getting drunk with him. He doesn't go to school or vocational training. Staff see him as a bad influence on the younger care home residents. Recently, he has started sexual relationships with several girls in the home. It is even rumoured that he might be sleeping with a female staff member. When asked why he does the things he does, he doesn't talk about his family or the gang members but says "life is messed up. So, you might as well have some fun before you die".

What signs and symptoms do you see?

Which development milestones would you expect Paul to be experiencing?

What developmental needs are not being met?



Juan, Mercy, Janette and Paul have all experienced adversities that might cause a disruption in their development – a detour along their developmental path. This disruption in turn can increase the severity and impact of the ACE. For example, a child who is ignored by his or her caregiver regularly, may learn to get attention by behaving badly. It is the only way to get the attention that a child needs to develop.

Whereas resilience provides tools to cope with adversity (using the savings in the bank), each adverse experience requires energy. When a child has to use energy to deal with an ACE, this energy can not be used for his or her typical development and growth. The more a child experiences ACEs, leading to toxic stress - the constant ringing of the amygdala alarm – the greater the obstacles to rebuilding a child’s resiliency.

Each ACE that a child experiences becomes a burden for them to carry as they navigate their childhood and travel along the road to adulthood. What a child gains as he or she grows and develops is like packing a bag for a trip. Each positive experience can go into the bag, which will hold useful things for the trip. When the child experiences ACEs, they not only cannot put positive experiences into the bag, but the negative ACEs go into the bag. The heavy burden of the bag of ACEs makes it difficult for the child to move forward on his or her trip.



PRACTICE REFLECTION

Remember this idea of the bag! Are there children that you know and with experiences that cause them a heavy bag that they are carrying? We will return to the idea of the bag in Sections 7 and 8.

The most important role of a frontline worker supporting children who may have experienced ACEs is to help the child to make the bag lighter and increase the resilience in their “account”, by turning the heavy burden of ACEs into experiences that the child can use for his or her positive development.

Chapter Seven:

Opening The Bag



The first step in promoting a resilience-informed care approach is **recognizing adversity, naming the experience and acknowledging its impact on the child without making a judgement.**

This part of the process can be seen as **“opening the bag of ACEs”** that the child has been carrying. Frontline workers working with children and families can apply skills and techniques to engage children to put the burdensome bag of ACEs down.

‘Opening the bag’ allows you to

- start the engagement process – develop a relationship with the child
- assess the child’s level of resilience, and how the resilience is demonstrated, reflected in the child’s ability to function on a day to day basis
- start to identify the ACEs that are affecting the child.

In “opening the bag” we will want to know things like....

- How heavy has the bag been (that is, how many ACEs has the child experienced, what is the severity of the impact)?
- How much of the child’s resources have been diverted away from their development and devoted to dealing with the ACEs (i.e. developmental delays, arrested development)?
- Are the ACEs ongoing?
- Are there risks and/or protective factors making the impact of the ACEs either worse or minimizing the impact?
- Does the child have people around him or her who are aware of the impact of the ACEs?
- Have the ACEs been internalized as personal weaknesses, deficits and/or failures of the child?

To answer these questions, we need to gather information about the child, their experiences, their development, and their environment and how these impact their life. We need to think about these at all the different levels. Remember how a child’s development and growth is influenced by connections between the individual child and his or her family, community and the wider society? This framework is also essential to be able to better understand how the experiences and circumstances in a child’s life might contribute to their resiliency or vulnerability to ACEs.

Figure 11 The interconnections between child and others that can protect or increase risk

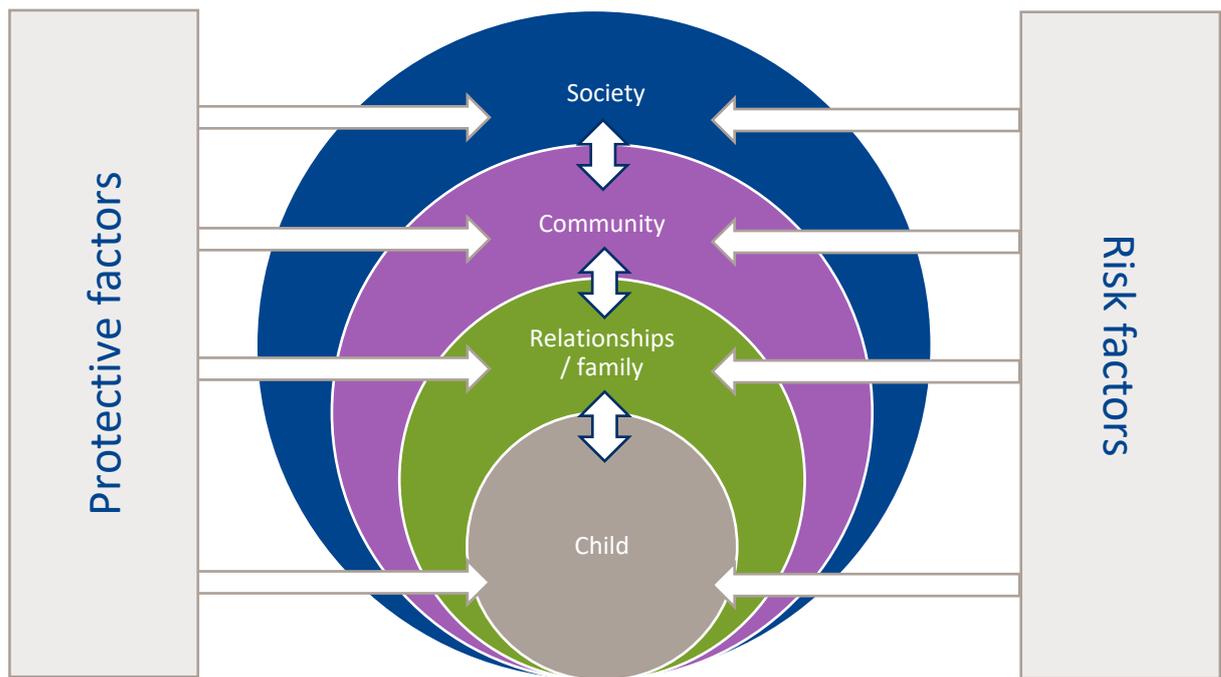


Table 4 suggests the types of questions we might ask at assessment stage to find out about the child's resiliency and vulnerabilities in relation to all levels of the child's individual characteristics and environment. The questions are all important and can be asked during assessment. Some of them are straightforward questions that we would be noting in an assessment form, such as the age of the child. Others may take longer to identify and be asked either by ourselves during observation, or during ongoing discussions with child, caregiver or family. We talk more about how to apply the questions below.

Table 4 Using the socio-ecological framework (above) for assessing children’s resilience and vulnerabilities

Level	Questions practitioners might ask	What these questions can tell the practitioner
Individual	Age of child	<ul style="list-style-type: none"> Helps set expectations of what you might expect to see in a child this age
	History related to meeting development milestones (see Table 2 Ages and Stages)	<ul style="list-style-type: none"> Helps provide context for how child may have dealt with or understood an ACE based on their level of their level of physical, cognitive, social/emotional development Helps to identifying potential developmental delays or need to adapt communication / interventions based on developmental functioning Identify potential risk or protective factors
	Current and past health functioning and history	<ul style="list-style-type: none"> Helps to highlight any developmental issues or specialized health / medical needs
	Level of education	<ul style="list-style-type: none"> Skills learned in school (i.e. literacy level, social skills, etc) / level of cognitive functioning – Familiar skills can be used as part of intervention or inform best ways to provide support or techniques used to communicate with child Identify potential risk or protective factors
	What games does the child like to play? What hobbies / things does the child like to do?	<ul style="list-style-type: none"> Identify ways to engage the child to build trust and activities which can be into 1:1 / group sessions or care plans. Identify potential protective factors
	Behaviors that may be a sign of distress	<ul style="list-style-type: none"> Signs & Symptoms of ACEs (see Table 1) Identify potential risk factors
	Abuse history	<ul style="list-style-type: none"> Identify potential risk factors

Level	Questions practitioners might ask	What these questions can tell the practitioner
Family / Significant Relationships	Family and other significant relationships (i.e. Who are the significant adults in the child’s life)?	<ul style="list-style-type: none"> Identify the relationships and interpersonal dynamics which have had the most influence on the child’s life Identify potential protective or risk factors
	Family stressors	<ul style="list-style-type: none"> Assess family / intergenerational dynamics Identify impact of interpersonal relationship dynamics at the time and to date
	Child’s peer support network (i.e. does the child have friends? Is the child connected to peers within the family system or an external social group of peers/ individual peers)?	<ul style="list-style-type: none"> Identify impact of interpersonal relationship dynamics to date Assess the child’s social skills; assess level of social integration / isolation
	Child and family economic circumstances	<ul style="list-style-type: none"> Identify potential protective or risk factors
	History of death , events / incidents of family separation (including at what age death/ separation happened and how it may have impacted the child)	<ul style="list-style-type: none"> Identify potential protective or risk factors Identify impact of interpersonal relationship dynamics at the time and to date
	Any other challenges for the household, caregiver or child which could possibly be experienced as an ACE (i.e. mental illness or separation from caregiver, abuse history of parent, school bullying of the child, etc).	<ul style="list-style-type: none"> Identify potential protective or risk factors

Level	Questions practitioners might ask	What these questions can tell the practitioner
Community	Available community resources: What community based services are available in the community?	<ul style="list-style-type: none"> Identify potential protective or risk factors Identify possible potential referral pathway resources
	Access to community resources: What is the child's / family's experience accessing services in the community?	<ul style="list-style-type: none"> Assess social connectedness / any barriers / experiences of marginalization which may impact accessing community based services
	Support network / social connectedness: What is the child's / family's support network?	<ul style="list-style-type: none"> Assess social connectedness for family and family Identify possible potential referral pathway resources
	Support network / social connectedness: What community institutions does the child / family rely upon (i.e. school, church/mosque/spiritual leader, social services, NGOs, etc.)?	<ul style="list-style-type: none"> Assess social connectedness / any barriers / experiences of marginalization which may impact accessing community based services Assess social connectedness for family and family Identify possible potential referral pathway resources
	Community environment: Does the family experience the community as safe?	<ul style="list-style-type: none"> Identify potential protective or risk factors
	Community / social connectedness: Does the family feel connected to others in the community? Does the family feel a sense of community where they live or do they feel marginalized or not connected to their community?	<ul style="list-style-type: none"> Assess social connectedness / any barriers / experiences of marginalization which may impact accessing community based services Assess social connectedness for family and family Identify possible potential referral pathway resources
	Access to community resources: Is there easy access to education, health, legal/advocacy services, services if a child has additional needs	<ul style="list-style-type: none"> Identify possible potential referral pathway resources Identify potential protective or risk factors
	Access to community resources: Is transport affordable / easily available?	<ul style="list-style-type: none"> Assess any barriers which may impact accessing community based services Identify possible potential referral pathway resources

Along with asking the right questions, it's also important to be able to effectively analyze the answers to these questions. To correctly assess the possibility of development delays, disability and/or the impact of ACEs, we must have a knowledge base of what to expect in a typically developing child growing up in a nurturing environment.

In the previous sections, there are several tables which summarize key knowledge points to aid the assessment process.

- **Table 2** (page 23) summarizes the “ages and stages,” detailing physical, cognitive, and social / emotional milestones which typically correspond to a child's age.
- **Table 3** (page 25) highlights the priorities that support and nurture development for children of different ages. This includes social milestones which can help the practitioner understand what elements in the family and community environments to look at, assess, and then perhaps use the milestones as a set of categories to plan what may need to happen in the environment to assist children and families get their needs met.

- **Table 1** (page 22) outlines behaviors and symptoms for recognizing that ACEs have occurred and the level of impact of the ACEs on the child. If a child shows atypical or problematic behavior, this can act as a sign that something that perhaps cannot be immediately seen is affecting the child. Noticing these behaviors or symptoms can prompt you to ask additional questions. Behaviors also reflect the child’s level of coping and the skills they are using to cope with adversities. This can help you to focus on supporting the child to utilize alternative, more self-affirming coping strategies, if the child has challenging behaviors or behaviors that are harmful to him- or herself.

The questions in Table 4 above can be easily fit into the existing case management assessment tools that you use when first meeting a child or family, for example during a home visit or when meeting a child who has been placed in some form of alternative care. A sample assessment form is provided in Annex 1, which includes some of the questions listed in the table above. Table 4 on the previous page can be used like an additional ‘checklist’ or ‘job aid’ and fit into the existing assessment.

Perhaps even more important than the assessment form are the **techniques used to gather the above information**. The quality of the practitioner’s engagement and ability to establish trust facilitates the gathering of information for an assessment/analysis. So, techniques and activities which engage the child, in a child-friendly manner and are aligned with the child’s likes and interests create an enjoyable experience in which to facilitate the engagement and trust building with the practitioner.

The toolbox below provides tips and techniques for gathering the information above in a child friendly manner which helps to engage and build trust with the child and with caregivers in the child’s environment. The techniques and activities in the toolbox help the practitioner to focus on:

- Establishing a helping relationship
- Helping the child to tell their story from their own point of view
- Attentive listening to the child
- Helping children make informed decisions
- Helping children build on and recognise their own strengths

See Annex 3: Counseling Communication Techniques for some tips on general approaches for working with children.

Practical tools for opening the bag

Here are some simple tools that can help in talking to children during the assessment phase. All of the examples below are child-centered. The most important thing to note is to give the child a feeling that he or she is able to lead the process and to understand that the discussion is about them, rather than the child having to answer questions and fit into a process that is managed by adults.

1. Starting the conversation

“My favorite things” This is about allowing the child to talk about themselves and exploring the child’s interests. Start by asking open questions such as: *“What kind of things do you like to do in your spare time?”*, *“What makes you laugh?”* Ask the questions and listen and also observe what the child is interested in. This helps to

relax the atmosphere and you can respond to their interests building up a connection, but also build activities around what makes them interested, so later during the 'Unpacking the Bag' phase you can choose activities that the child will enjoy – this could be story-telling, drawing, sports.

2. Exploring relationships

Genogram: A genogram is a picture of a person's family relationships and history. It is a really useful tool to help understand the key people and relationships in a child's life, and also see patterns within the relationships which are affecting the child. Because it uses pictures, it can be easier for a child to illustrate difficult or sensitive issues in a non-threatening manner. A genogram uses shapes to convey meaning. The choice of shapes can be done according to local culture or what the child chooses. Usually, squares are males, circles are females. A cross through the shape means a death. The shapes begin to tell us how many people are an important part of the child's world, and what sex they are. At this point you can start talking about names, ages, and births and deaths. The next step is to talk about how the relationships are brought together. The child can explain who is married or living together, or divorced, or who has gone away. Drawing the genogram gives space for the child to talk about the emotional nature of the relationships in his or her life. By asking simple questions about whether there are friendships or best friends, whether people in the genogram love each other or maybe there have been arguments, it is possible for the child to talk about the nature of the relationships. It is important to avoid pushing for too much information all at once. The genogram can build up little bits of information that come together to paint a picture of how a child's family and relationships affect them. It can also be useful to explore the varied groups of people that are important to a child who may have lived in many different settings, including alternative care settings. The genogram shows the patterns and the history that make a person who they are. It can be reflected on over time as the bag is being unpacked. For more information on using genograms and some practical examples, see: <https://safeguarding.network/genograms/>

Ecomap: An ecomap shows the network of people around the child or family through a diagram. The child is placed at the center of the diagram; each person and organization that forms a part of the child or young person's network is named and placed within a circle. It is a less formal way of drawing family and relationships than a genogram. It takes a relatively short period of time to complete with the child or family. Using a large piece of paper, ask the child to draw (or draw yourself if the child prefers) a circle or any other shape or drawing of the child in the middle. Then draw smaller circles (or pictures or shapes) around the child to represent the people who are significant to the child. You can ask the child to talk about who is an important part of the child's life, such as family members, pets, friends and care staff or groups that support the child. A line is drawn between the child in the middle and any of the circles or shapes with different lines indicating the nature of the link or relationship. For example, a thick line might be strong and a thin line weak, with a dotted or zigzag line indicating that the relationship is stressful. The child can choose how to illustrate, or you can check as the child is talking and get their agreement: "It sounds like there are a lot of arguments with Uncle James. Shall we give him a thick line because you live with him, but how can we show the arguments?" An alternative to drawing is to use objects – stones, buttons, clay objects, so that the child can move them around or change the nature of the relationships.

Any ecomap reflects what is happening to the child at a particular time. It can be used as part of case planning as a way of tracking change in the child's life. For example, if the child has started to find new friends or a care leaver has identified a strong mentor in their community, this is a way of tracking the child or young person seeing the network that they are developing for themselves. For more information on using ecomaps, see:

<https://www.leedsscp.org.uk/Practitioners/Toolkit/Ecomaps>.

Both genograms and ecomaps are also useful tools to use with family members. You can use these to work with the caregiver or family to explore the strengths and potential challenges in the family, for example before a child is reintegrated. Or you can use these to help family members find ways to support a child who has experienced ACEs, by talking about past adversities or thinking about how to support a child to have strong, positive and protective relationships in their life.

3. Listening and addressing immediate needs

Psychological first aid (PFA) is a way of providing humane, supportive and practical help to someone who is suffering a serious crisis – a child or adult who is in distress or experiencing trauma. It involves comforting the person and helping them to feel calm, giving practical care and support that does not intrude, assessing needs and concerns of the person at the point that they are in distress, and helping them to access further information and support. It is usually used when a person has been very recently affected by an adverse event, or has suddenly recalled an adversity. If the child, or a family member, that you are supporting is suddenly in immediate distress, it is important to help them feel calm and safe. PFA follows three main principles:

- **Look:** Check for safety (remembering that the child may be distressed about an event involving a person who is close by such as a family member or care worker who has been violent), check if there are any obvious urgent basic needs, and check if the person has a serious distress reaction. If so, make sure that the physical safety and health needs are immediately met.
- **Listen:** Approach a child or adult who may need support if you are not already supporting them, ask about their needs and concerns, and listen to them, using positive communication techniques – letting them know you are listening, giving information in a simple way, acknowledging how they are feeling, acknowledging their strengths, allowing for silence. Help them to feel calm.
- **Link:** Help them address basic needs and access services, if this is an immediate need, or make it clear that you are taking on the responsibility of helping them access what they need. Give information about what might happen next or give information about what they need, and connect them with loved ones or support.
- It is important if a person is in distress, to deal with the distress. If this means delaying your case planning session and focusing instead on the distress, that is fine! For more information on providing PFA, see World Health Organisation's *Psychological First Aid: a guide for field workers* (available in 33 languages) <https://www.who.int/publications/i/item/9789241548205>, and Save the Children's *Psychological First Aid Training Manual for Child Practitioners*, (available in English, Arabic, French and Spanish) <https://resourcecentre.savethechildren.net/keyword/psychological-first-aid>



PRACTICE REFLECTION

When do you do assessments in your own work and how might you work so that the child or the family members feel able to develop trust and start to share often sensitive feelings and experiences?

It can be just as hard, and sometimes harder, for a person who has experienced many adversities to think about their strengths, than to talk about challenges. How might you encourage a child or family member to appreciate their strengths?

Remember! It's important to remember that the assessment phase is not a single event – it may require several meetings with the child and / or with family members to gain trust and for the child or family to be ready and willing to share information.

Chapter Eight:

Unpacking The Bag



Once you have gained trust and the child and family are able to share and look at their experiences, strengths and adversities, the next phase is to help the child or family “unpack the bag”. This is the process of “unpacking” ACE experiences – taking them out and looking at them, so that they become integrated into the child’s development and sense of resilience, rather than being a burden that is a barrier to their healthy development.

Unpacking the bag allows the child (or adult) to reflect on what has happened and therefore start to recover from ACEs that have slowed or diverted the child’s child development and/or contributed to the child not being able to get their needs met.

“Unpacking” usually follows a three-part recovery process which focuses on:

1. Creating stability and safety
2. Making sense of memories and grief
3. Facilitating integration

“Facilitating integration means helping the child to create of a new explanation in his or her head of the ACE experience, which helps the child acknowledge the full range of emotions, skills and positive coping mechanisms.

Practical tools for unpacking the bag

Here are some simple tools that can help in the three phases of recovery. These ideas can all be adapted according to the child’s own needs, age and development. Effective activities all:

- Allow a child to express themselves
- Allow a child to have more awareness of their emotions
- Teach them self-control and self-soothing skills
- Allow a child to tell a story about themselves
- Allow a child to build positive self-esteem and feel good about themselves

1. Creating stability and safety

Children who have experienced adversity and show challenging behavior are often seeking a sense of safety and stability. Some of the challenging behaviors are a result of the child being in the “fight, flight or freeze” response (see Section 5). Their behavior is a way of protecting themselves from the overwhelming emotions or circumstances brought on by the adversity. When your assessment suggests that this is happening, the priority is to reassure the child that they are safe. Then you can guide the child in building skills to help them **feel calm enough so that they do not have to fight, flee, or freeze to be safe.**

Some sample activities which can help create a sense of stability and safety include:

- Predictable routines: Work with families and support networks to establish predictable routines. Having a predictable routine is reassuring and can help by the child relax by not having to be prepared for something unexpected. Many parenting programs include guidance on how to set up routines in a way that engages the child in developing and agreeing the routines. Setting predictable

routines is important for all ages of children, although it is equally important to be flexible at times. With adolescents, it can be possible to agree some of the routines together.

- Reassuring the child's physical safety: This will depend on the local context and the child's age and experience. This might include reassuring the child about their safety after leaving a place where they felt threatened, showing how you will make sure that no one will hurt the child. This can also mean creating a sense of security in the home or the building that the child is in, such as locks on the doors, information on how to get help if the child feels unsafe, meeting in a location where the child feels most comfortable. Mapping places of safety and danger can also help the child avoid places that are intimidating and have greater awareness of resources and places that help the child to feel safe.
- Providing non-judgment and confidential spaces, where appropriate, where that the child can speak knowing that they are safe.
- Psychological First Aid (PFA), if the child is in distress – see *Opening the Bag*.
- Mindfulness techniques including body scan, meditation, deep breathing.

Here are some examples of activities to help build mindfulness:

The slow-motion game: This technique is a fun way for children to learn about the concept of self-control and an opportunity for them to build it through play. For younger children, start by explaining what self-control is (for example, that it is a way of managing your thoughts, feelings and actions in a way that helps you do things well). Describe how it is sometimes difficult to maintain our self-control if we are moving very fast – ask the child to show what fast-moving looks like – encourage the child to run, or jump, or do something fast in whatever way you like, you can join in too! Now show the child a pile of cards or pictures (you can draw them or cut them out of magazines or newspapers) that have actions for the child to act out, for example, playing soccer, collecting water from a pump, drawing a picture. Ask the child to pick one card at a time and act out whatever is on it, but they must do it in slow motion! Time them for one minute. If there are groups of children, then can take turns and time each other. This is a useful way to practice self-control and think about what it feels like.⁵⁵

Five-four-three-two-one: A mindfulness activity that can work for older children and adolescents is this activity, which can help a child focus on the present 'here and now'.

- Sit still for a look around at the first five things that you see and count them
- Touch four objects that you have around you
- Listen to three sounds that are making noise right now
- Smell two smells
- Identify the taste that you have inside your mouth.⁵⁶

Bubble breaths: This technique helps children build mindful breathing and is a good mechanism for dealing with intense emotions like anger or anxiety. This activity may be better for younger children, but is also relevant for older children who are struggling with panic breathing. Start by blowing bubbles with the child. At first, just allow the child to blow the bubbles. After a while, explain to the child that he or she can make the bubbles bigger by taking deep breaths and blowing slowly into the hoop. Explain that these are "Bubble Breaths," and they have the power to chase away worries and anxiety too. Encourage the child to practice Bubble Breaths and make the bubbles as big as possible by taking deep, slow breaths.⁵⁷

Yoga, movement and/or exercise: For some children, using movement or exercise can help the child redirect their energy and focus on connecting to their bodies. When you exercise, your body releases “feel good” chemicals in the body called endorphins. Endorphins reduce the perception of pain. This can help in making feelings of sadness feel less intense. Exercise can also help children expend surplus energy which may otherwise be directed towards antisocial behaviours. The energy release and endorphins after movement and exercise can have a calming effect on the child, which help to turn off the stress response and increase a feeling of safety and being in control of oneself. Yoga can have a similar effect to movement and exercise, with the added focus on the breath and mastering yoga poses. Resources for yoga techniques and exercises for children of all ages can be found at:

- <https://www.kidsyogastories.com/kids-yoga-poses/>
- <https://www.yogajournal.com/poses/5-kid-friendly-animal-poses-to-introduce-children-to-yoga>
- <https://www.yogajournal.com/poses/yoga-for/kids>
- https://www.youtube.com/watch?v=iHoErQuFw_4

2. Making sense of memories and grief

As we learned earlier, toxic stress, distress and trauma responses overwhelm the parts of the brain that help to regulate feelings and thoughts. When a child experiences ACEs in the form of extreme, repeated, unrelieved toxic stress, distress or trauma, these parts of the brain can stop functioning properly even when the child is no longer in immediate danger.

Once the child is able to learn skills and have regular experiences that will help them to feel calm and safe, then the child can engage in activities that will help them to explore and understand their feelings about the ACE experience itself.

During this phase of recovery, it is helpful for the child to learn and engage in activities which promote becoming aware, expressing and making sense of emotions. Some of the activities in the assessment toolbox above can also be used to help the child make sense of memories and grief. For example, when talking about what is happening in the ecomap. In this phase, however, the themes and content of the activities are more directly related to the ACE experience(s).

It is extremely important to carefully pace and sequence activities used to help children make sense of their emotions, memories and grief. Be careful to observe and look out for any signs of distress or overwhelm (see Table 1: Signs and symptoms of ACE) because pushing a child to talk, express or process their emotions and memories before they are ready can easily trigger the stress response.

Below is a group of ideas that make up a ‘recovery toolbox’. The key to knowing which activity to use, and when, is being guided by the child – listening to what they choose and honoring their choices and being respectful of how engaged they want to be. If the child is not willing to talk on a particular day, that must be honored. Maybe they just want to play or listen to music. It is all about building up trust. The activities below will need to be adapted according to individual children’s own circumstances. Although factors such as age and ability should be taken into account, every individual child’s experience of ACEs and their resilience will influence the type of activity for the child.

You can start by using activities to explore more general themes, then allow the child to naturally focus on themes they prioritize for themselves. (See “Starting the

Conversation” in Opening the Bag, Assessment Toolbox.) This strengths-based approach focuses on a child’s strengths, favorite activities, hobbies and interests and will provide a safe space for building trust, safety and stability. This will then serve as a bridge to deeper engagement, acknowledgment and processing of emotions, memories and grief.

Body Mapping: There are many variations to the body mapping activity. Here are a few:

- Assist the child to draw an outline of their body on big sheet of paper (Note: You can assist the child or you can pair the child with another child or caregiver). Drawing on the outline can be a fun activity for the child. If the child wants to, allow them to spend time drawing the hair, the eyes, etc. This part of the body mapping activity can be a calming and relaxing activity for the child.
- When the child is ready, you can start adding emotions to the body map. You can use this worksheet to help the child decide where and how they would like to draw different emotions that they associate with different parts of their body: <https://www.therapistaid.com/worksheets/where-do-i-feel.pdf>
- Once you have built sufficient trust and a sense of safety with the child, gently ask the child where they feel may feel stress or unhappiness in their body. Depending on the age and ACE experience, it may be appropriate to refer to a known event, e.g. a time when the child was angry. An alternative is to give an example of stress that is not directly linked to the ACE, e.g. if you are watching a film with your friends and it gets a bit scary. Ask the child in simple questions and ask them to notice what they feel where, for example, starting to breathing heavily, feeling breathless, sweating. This will help the child to build awareness of what it feels like when they go into a stress response. You can also reinforce skills practiced in the “Stability and Safety” phase to help the child remain calm and feel safe.
- You can also use body mapping to reinforce positive self esteem and positive thoughts. For example, ask the child to use crayons, marker pens, or sticky notes to write down their positive qualities or traits (like “I am kind to my classmates” or “I’m good at running”). Once the child has several positive quality sticky notes ready, you can ask them to stick the notes on their body map outline. This will help the child make a physical connection between their body and these positive traits.

Emotion faces: This activity is one of several about building emotional literacy by learning how to name emotions. The purpose of this activity is to assist younger children in identifying and discussing their feeling responses to a variety of experiences (usually around ages 4-8 years). First create a series of faces depicting a variety of feelings. You may like to create a set of cards or a large poster, using clip art images or cuttings from magazines. You can also use the following worksheet: <https://www.therapistaid.com/worksheets/printable-emotion-faces.pdf>. Show the feeling cards to the child and talk about the faces and feelings depicted in each face. Next, ask the child to pretend to be feeling one of the feelings on the cards or poster and you can try and guess which feeling the child is demonstrating. (If the child is shy, you can do the first act and make it funny!). Once you have built an adequate amount of trust and the child has demonstrated that they feel safe with you, you can invite the child to discuss an incident in which they felt like one of the faces. Ask the child not to reveal which feeling they experienced yet. Guess which of the feelings the child may have been feeling during the incident that they describe. Reverse roles so that you are describing an incident and the child is guessing the

feeling. You can return to this activity to discuss other events or feelings. You could also come back to this feeling later and see if the child now has feelings of pride or happiness because they have learned a new skill, or feel more able to cope with the experience.

Feeling Thermometer: This technique is a way of talking about how intensely a child is feeling different emotions. This can be used for children of all ages – for younger, they can use faces to discuss. For older children, they can use this tool themselves or you can discuss at the beginning of the conversation. You or the child can draw a series of simple thermometers numbered 1 to 5 with some emotions below – if you are focusing on some specific emotions, you can choose these, or choose a number of positive and negative emotions (for example, one thermometer each for ‘happy’, ‘sad’, ‘angry’, ‘worried’, ‘tired’, ‘annoyed’. You can use the thermometer at the start of your session with the child as a way of checking in. Or you can use it at the end of the session or after the child has talked about an experience, by asking “How did you feel when that happened?”. It is also a useful way to teach empathy by exploring the emotions of others, using the thermometer to explore how someone else might feel. You can see worksheets for this activity at:

<https://www.therapistaid.com/therapy-worksheet/emotion-thermometers>

Anger Stop Signs: This drawing activity helps children to recognize when their anger is growing, and take steps to stop it before their anger grows out of control. The activity uses the metaphor of anger as a car which continuously gains speed, until it grows out of control. Ask the child to first think about how anger starts small – maybe not even noticeable but just feeling annoyed. Ask the child to draw what he or she looks like when the anger is small. Then talk about how anger can be like a car without brakes, crashing into everything. Ask the child to draw what what he or she looks like when the anger is really big. Then ask the child to think about the signs that he or she feels when the anger is starting to grow. These might be: starting to shake, face feeling hot, raising the voice, wanting to hit somebody or something. Now draw these signs in a big ‘stop sign’ and talk about how to recognize these while the anger is still small, and how to stop the signs growing. This and similar activities can be found at:

<https://www.therapistaid.com/worksheets/anger-warning-signs-children.pdf>

Use of Creative Activities: Using creative activities can be helpful in allowing the child to express him or herself beyond the use of language. Activities can include the use of play, art, music, drama, storytelling and other creative activities and can be adapted for age. The use of creative activities is helpful for:

- expressing feelings or events in a non-threatening way, for example drawing events or emotions that do not have to be explained in words;
- facing fears in a non-threatening way, for example ‘Drawing Party Hats on Monsters’ is where a child draws something that is nice and you discuss how the child feels, then the child is asked to draw something just a little bit scary, and then you ask the child to change the drawing so it changes from being scary to silly (a party hat on a monster, a superhero changes the monster into a mouse, etc.) This can be continued over time to address greater fears at the child’s pace;
- express feelings of grief or loss that can be hard to talk about, for example through choosing a play list and talking about what the lyrics mean, or enacting dreams or ‘magic stories’ that allow the child to talk about loss – it is important that activities that talk about loss are lead at the child’s pace and he or she is not forced to talk about painful memories when not ready.

3. Facilitating integration

This third phase of the recover process involves helping the child to create of a new narrative (the child's explanation in his or her head) of the ACE experiences, which helps the child acknowledge the full range of emotions, skills and positive coping mechanisms. Integration allows the child to continue along their development and renewed life journey with the ACE experience adding to their resilience rather than taking away from it.

Rocks and flowers: Ask the child to collect stones or small rocks. The child can paint and decorate these rocks. Then ask the child to draw and decorate flowers or collect small items that they like and make them happy. Explain to the child that the rocks can represent rocky or difficult times in their life and the flowers can represent happier times. Ask them to line up the rocks and flowers in an imaginary timeline they can use to tell a story about their life. As the child tells the story of the rocks and flowers, they can gain a new perspective about their ability to overcome rocky times and that their life has had flower moments. This can help the child and family tell a new story of the child's life, once which refocuses the child and family on the child's resilience. This activity can also be adapted for use with older children by simply story telling, or changing the imagery to a positive image and a barrier image that suits the child.

Use of Creative Activities: The activities above can also be applied in positive ways, such as telling stories that create new realities – drawing your own superpowers, acting out positive outcomes, using drawings or cutting out pictures to write a 'lifeline' that includes what has happened in the past but also includes positive hopes and aspirations for the future. Creative activities also mean that the child is able to have colors and images that are positive and attractive that they can keep. For adolescents, they can talk about images from music or film that make them feel positive, that show what they would like for the future.

For further ideas, see:

- Hall, T.M., Kaduson, H.G., Schaefer, C.E. (2002). Fifteen Effective Play Therapy Techniques.
<https://pdfs.semanticscholar.org/2643/fcb4210b558d5cad28458d889b9075534366.pdf>
- Liana Lowenstein. (2011). Favorite Therapeutic Activities for Children, Adolescents and Families: Practitioners Share Their Most Effective Interventions.
<http://www.lianalowenstein.com/e-booklet.pdf>



PRACTICE REFLECTION

Remember Juan, Mercy, Janette and Paul (the four case studies on page 23)?

Choose one or more of the case studies and think about how you might practice the three steps with one of these children – what activities might be suitable for (a) creating stability and safety, (b) making sense of memories and grief, and (c) facilitating integration?

Chapter Nine:

Working With Families and Communities to Promote Resilience and Prevent and Respond to ACEs



We have already talked about how a resilience-informed approach takes a holistic view of the child in his or her environment.

One of the most important elements of promoting resilience is to work with families and communities to identify and support children at risk of or experiencing ACEs. This work includes both **supporting families to recognize and know what to do for children experiencing stress, and working directly with the family to reduce stress and build up protective factors**. Strong families are less likely to have children experiencing ACEs!

The techniques and tools described above are largely for use with individual children who may be experiencing distress, while table 5 below shows the Strengthening Families Approach,⁵⁸ which has identified five protective factors, to suggest some ways in which to work with families to promote resilience and prevent and respond to family stress and ACEs. **Family strengthening** refers to programs, strategic approaches and deliberate processes of empowering families with the necessary capacities, opportunities, networks, relationships and access to services and resources to promote and build resilience and the active engagement of parents, caregivers, children, youth and other family members in decisions that affect the family's life.

Table 4 How the Protective Factors Framework can promote child resilience

PROTECTIVE FACTORS	DESCRIPTION	EXAMPLES OF HOW TO USE THIS APPROACH TO PREVENT AND RESPOND TO ACES
Parental resilience	<ul style="list-style-type: none"> ■ Working with the family to find ways to solve problems ■ Working with family members to build and sustain trusting relationships ■ Helping the family to seek help when necessary 	<ul style="list-style-type: none"> ■ Identifying parental and family strengths during assessment phase (see Section 7: Opening the bag) ■ Ensuring ongoing focus on family resilience during development and review of case plans
Social Connections	<ul style="list-style-type: none"> ■ Encouraging links with friends, family members, neighbors and community members ■ Supporting the family to find ways to ‘give back’ to family and communities to build self-esteem ■ Supporting isolated families to build positive relationships 	<ul style="list-style-type: none"> ■ Using a geomap with parents and families, not only children, and updating to identify support ■ Mediating with community groups to encourage parental, child and family involvement in community activities e.g. encouraging a reintegrated child to support the local football club, involving the family under strain in a religious support group ■ Linking isolated families with specialist home visiting or similar activities, for example, HIV support groups
Concrete support in times of need	<ul style="list-style-type: none"> ■ Facilitating the family’s ability to meet basic economic needs like food, shelter, and health care ■ Facilitating access to services and support when families encounter a crisis such as domestic violence, mental illness or substance abuse 	<ul style="list-style-type: none"> ■ Actively facilitating access to social protection ■ Linking with household economic support activities ■ Referrals to, and ongoing engagement with, violence prevention or self-help and survivor groups
Knowledge of parenting and child development	<ul style="list-style-type: none"> ■ Providing accurate information about child development and appropriate expectations for children’s behavior at every age ■ Supporting parents and caregivers who experienced harsh discipline or other negative childhood experiences to change the parenting patterns they learned as children. 	<ul style="list-style-type: none"> ■ Teaching parents about the basics of recognizing ACEs and how ACEs impact development ■ Delivery of or referral to positive parenting interventions, with a focus on promoting attachment and providing security
Social and emotional competence of children	<ul style="list-style-type: none"> ■ Facilitating early identification of children’s challenging behaviors or delayed development 	<ul style="list-style-type: none"> ■ Regular monitoring of children’s developmental milestones as part of case management ■ Discussion and support around challenging behaviors that focus on promoting resilience and avoid punishment

More information about providing ongoing support to families is suggested in Section 10, Table 6: Promoting resilience and tackling ACEs throughout the alternative care case management process.

It is equally important to **work with local communities** to raise awareness of the risks of ACEs and promote a resilience-informed approach. Children do well when their families do well, and families do better when they and communities. Many of the ACEs that cause harm to children occur in the community. This might include direct harm, such as through community violence, or through social norms and practices that can condone violence against women and children, for example, or that lead to family separation, child abandonment, and a reliance on residential care as the dominant alternative care option.

One way to promote resilience for children is to work with others in the community to promote a **safe and enabling environment**.

This first involves understanding the local causes of violence against children, or against certain sectors of the community.

There are a number of community activities that can promote physical and emotional safety in public spaces.

The *INSPIRE Implementation Handbook* gives examples of initiatives to reduce violence by addressing “hot spots”, interrupting the spread of violence in communities, and improving the built environment.

Initiatives to **prevent violence against children or gender-based violence** can be useful allies in addressing children’s exposure to ACEs.

For more examples, see World Health Organization. (2018). *INSPIRE Handbook: action for implementing the seven strategies for preventing violence against children*. <https://www.who.int/publications/i/item/inspire-handbook-action-for-implementing-the-seven-strategies-for-ending-violence-against-children>.

Harmful norms and practices are themselves a cause of stress, toxic stress, distress and trauma. Positive norms and practices play a key role in building resilience – putting savings in the bank. Promoting positive norms and practices, and challenging harmful norms and practices, can play an important role in:

- Reducing the pressures in families that might lead to family separation or breakup, leading to children being placed in alternative care – for example, by challenging gender norms that condone violence against women or that condone heavy alcohol use;
- Promoting existing family and community values about children being cared for within families and communities, and challenging norms that promote placement of children in residential care;
- Challenging harmful attitudes and practices that lead to violence, abuse or exploitation of children (ACEs), leading to them choosing to leave the family home or be removed from a home and placed into care;
- Promoting acceptance of children and adults with all forms of ability and experience, for example by removing taboos around mental illness or around

A strengths-based approach should start by understanding and encouraging the existing norms and practices that can promote resilience and assist in helping with harmful for others and it is always important to think about the impacts of possible stigma and discrimination based on factors such as race or ethnicity, disability, or

social or economic circumstances.

Although social norms and attitudes are an important part of a resilience building approach, they should always be seen alongside other factors that protect or increase risk, such as poverty, lack of access to services, structural inequalities.

It is also possible to directly work with communities **to explicitly reduce the impacts of stress and trauma**. For example, the Global Trauma Project (<https://www.globaltraumaproject.com/>) works in partnership with local community groups to strengthen the capacity of local community providers/ leaders to: (1) reduce the impacts of trauma and compounded stress, and (2) increase leadership and empowerment amongst community members. **The five core components of their Trauma-Informed Community Empowerment (TICE) approach are those that are most greatly affected by the effects of trauma: safety, regulation, connection, identity, and empowerment.** After a training in the effects of trauma, community providers develop their own local responses based on their specific needs, contexts, and capacity. The approach has been proven effective at addressing different experiences of violence and adversity together. In South Sudan, for example, the programme found that over half of surveyed adults reported PTSD symptoms, half of the surveyed adults had depression and over 70% of women had experienced some form of domestic and/or sexual violence. After training and mentorship in the TICE approach, there were very significant decreases in PTSD, emotional dysregulation (which leads to aggression and violence, for example), and in critical heart stress, for up to and beyond one year after the intervention. As one community facilitator noted: *"Before this training, I was so traumatized. I was living with my 'survival brain' and always becoming aggressive with people. Fighting with my wife and family. I didn't know that it was because of everything I have been dealing with. Even we were going to divorce. But now I am different. I've learned how to deal with my emotions, and how to calm myself. I am talking with my wife, instead of fighting her. Our family is much happier now and we feel hope."*



PRACTICE REFLECTION

If you are working with children living in residential care or other forms of alternative care, or working with care leavers, are you able to spend time with the family and community before reintegration to build up their own resilience and ensure they are a protective environment around the child?

Do you have links with community initiatives that are promoting positive social norms on violence or promoting family care?

Chapter Ten:

Promoting Resilience and Preventing and Responding to ACEs Within the Care System



When we support children to build up resilience, we do so within a larger system.

The different parts of the system all need to fit together to be able to provide a 'resilience-informed approach'. Figure 12 shows the main components of a care system. The care system in turn fits into a larger child protection system. Helping a child 'unpack the bag' is easiest done when the whole care system promotes resilience, prevents a child from experiencing adversities where possible, and helps children, families and communities stay strong.

Figure 12 Care system components⁵⁹

System Components:



Areas of Care:

- Prevention of unnecessary child-family separation
- Child-family reunification and reintegration
- Kinship care
- Foster care
- Other forms of alternative care
- Independent living
- Adoption
- Residential care
- Deinstitutionalization

Source: adapted from Evaluation. Cannon, M; Hickmann, M. MEASURE Evaluation. Alternative Care System Assessment Framework. 2017.

Country-specific context + broader child protection system + the U.N. Guidelines on Alternative Care

More information on the system is in Annex 4: Building a resilience-informed care system. This Practical Guidance focuses on the social service workforce and ensuring service delivery through case management.

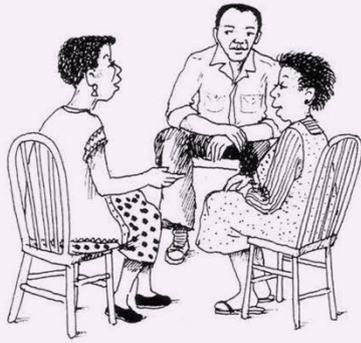
Building skills for providing resilience-informed care

Frontline workers – YOU! – are at the center of a resilience-informed care system. Figure 13 summarizes the core skills that you will need, depending on your role.

Figure 13 Summary of core competencies for social service and allied workforce



Supportive supervision is especially important for front-line workers who are using a resilience-informed approach to addressing ACEs. A frontline worker who is working with a child (or an adult) to ‘open the bag’ and ‘unpack the bag’ needs to be able to **self-reflect** to provide good care. Self-reflection means thinking about what the child is saying, exploring your reactions to what the child is saying, and then being able to separate what the child is saying from your own experiences. This is important in order to be able to fully listen to the child. Supportive supervision provides a chance to reflect and to think and prepare for the next time that you spend time with the child. Supportive supervision also provides an opportunity to regain a sense of distance from the experiences that are being shared with you by a child who has experienced violent or upsetting events. We may all find that talking to children who are experiencing adversity may recall our own adversities and raise intense emotions about our own lives. Supportive supervision provides a space to seek support for dealing with personal stresses.



PRACTICE REFLECTION

Do you have opportunities to discuss your work with colleagues or a supervisor? If you support other staff, might you be able to put some of the following actions in place?

- Conduct regular individual supervision meetings, prioritizing staff who are at the frontline and who may be experiencing additional stressors or trauma
- Apply a coaching attitude and skills to provide support – see the box below
- Recognize signs of stress and burnout in caseworkers and respond, making sure that you can refer people to counselling or medical support in cases of trauma
- Hold group stress days – work together on a self-care plan - and don't forget to include yourself!⁶⁰
- Set realistic expectations of team
- Promote respectful and effective communication within the teams
- Acknowledge and validate the experience of caseworkers

Coaching competencies⁶¹

The following are the supervisor competencies that are considered good practice:

Skills

- Building trust with team and external actors
- Leadership
- Group facilitation
- Non- judgmental
- Ability to consider multiple perspectives
- Encourages reflective practice
- Identifies and builds upon caseworkers' strengths (strengths-based approach)
- Excellent communication and active listening
- Ability to distinguish between the roles of manager vs. supervisor
- Ability to manage expectations about what is possible in an individual case

Attitudes/Behaviors

- Highly regarded professional skills and ethics
- Commitment to the team
- Focused on improving results for children
- Present, reliable, responsive and consistent
- Patient and empathetic

Knowledge

- Recognizes common concerns/themes among caseworkers
- Knowledge of the functions, practices and skills of supervision
- Case management expertise (at least 2 years of experience)
- Knowledge of the Guiding Principles of case management
- Knowledge of group or team dynamics

Using a case management approach for promoting resilience and addressing adverse childhood experiences

This Practical Guidance has given information on how to recognize and respond to adverse childhood experiences for individual children. The table below gives examples of where and how these approaches can be used within case management with children and families.

Table 5 Promoting resilience and tackling ACEs throughout the alternative care case management process⁶²

Case management step	Purpose of the step	Considerations for promoting resilience and addressing ACEs
All case management steps	*Purpose of individual steps explained below.	<p>As far as possible, present information in the words of the child, family members, other community members who are supporting the child and family. This validates their perspectives which, in itself, builds resilience (e.g. in child and family assessments, Case Plans).</p> <p>Provide continuity wherever possible. This includes ensuring clear and consistent two-way communication when making referrals, to avoid children and families having to repeat experiences.</p> <p>Remember that resilience and protecting against ACEs depend on the connections between individuals and families and their communities. If any assessments or plans exclusively focus on an individual or small family, the chances of long-term stability and wellbeing are reduced.</p>
Identification of the child	Collect basic information of a child who is at risk of separation or outside of parental care, to ascertain whether interventions are needed to protect the child, including determination of need for reintegration to family/ community-based care.	<p>Include exploration of potential risks and protective factors as part of basic information, noting the importance of not assuming that adversity or stress inevitably leads to individual harm (keep the focus on the positives)</p> <p>In gathering of basic information, prioritize inclusion of information about strengths within family (not just biological family) and community – this is important to avoid referring to distant ‘specialist’ services that make it hard for a child to return</p> <p>Be aware of signs and symptoms of ACE, be prepared to provide or refer (locally) for psychological first aid or use of basic therapeutic techniques. Be aware of potential developmental milestone delays or behavioral signs and note these for Step 2: Child assessment.</p>
Child assessment	Complete a child identification and assessment form that provides initial information from the child and significant others concerning the child’s background, strengths, needs as well as information regarding the child’s family, perceptions about his or her family, and any perceived barriers to reintegration, etc. where relevant, to be used to support tracing, reunification, placement, and later guide the goal setting and action development during case planning.	<p>For all assessments, be aware of signs and symptoms of ACE, be prepared to provide or refer (locally) for psychological first aid or use of basic therapeutic techniques</p> <p>For children who have already disclosed distressing or traumatic experiences, or where these experiences have been identified in Step 1, do not ask child to repeat distressing experiences, unless as part of a longer-term therapeutic approach. See Section 7: Opening the Bag.</p> <p>Take the time to ensure that the child is contributing fully, using techniques described in Section X: Opening the Bag. The recommended minimum is 2 to 3 sessions, but may take more. It is not a checklist exercise.</p> <p>Before any decision to remove child from home / local community, make sure that local contacts are documented through use of e.g. eco-map.</p>

Case management step	Purpose of the step	Considerations for promoting resilience and addressing ACEs
Family tracing and assessment	<p>Gather information and locate the child’s parents and/or extended family (or legal guardian of a separated or lost child) and their willingness and ability to receive the child. If no family or extended family can be identified, the purpose is to trace additional individuals connected to the child.</p> <p>Determine the family’s capacity and willingness to provide care and protection to the child, and views around reunification/ placement.</p>	<p>Keep the child informed at all stages, so he or she is not presented with a decision taken without his or her involvement.</p> <p>Contact with family should include quick assessment of local context, e.g. if a child has already experienced violence through involvement in gang culture, explore whether he or she will continue to be exposed.</p> <p>Ensure inclusion of not only members of the household, but of the wider family and community (i.e. anyone who is of influence or importance to the family as well as those who know the family, building on the child’s own inputs ideally).</p> <p>In the contact with families, include context-appropriate discussions about relevant experiences, e.g. disability, experience of ACEs. Using a strengths-based approach, explore potential protective factors at individual, family and community level, identifying local sources of support for potential risks.</p> <p>Engage with family, if relevant, on the importance of supporting children to develop resilience, and identifying local sources of support to build up resilience, involving wider family and community if and where appropriate.</p>
Case Planning	<p>An agreed upon Case Plan that summarizes and prioritizes needs, strengths, and proposed action(s) to be implemented for successful placement or reintegration of a child in a family, including shared goals that the child, family and caseworker will work on together; a series of actions or interventions to be taken to address needs, and/or the resources or services that will be needed; specified roles and responsibilities for each person, time frame for actions, and indicators for determining when actions have been completed and when the goal has been accomplished.</p>	<p>Where relevant, involve specialized mental health professional or social worker or psychologist experienced in trauma-informed approaches, to ensure that the Case Plan includes relevant support.</p> <p>Identify manageable time-bound steps that have been identified as ways of bridging developmental gaps and rebuilding resilience (see Section 8: Unpacking the Bag).</p> <p>The Case Plan should consider all potential family and community actors who can play a role in promoting resilience. For example, if the child is at school, it will be important to include teachers or guidance counselors, who should receive basic awareness raising in the principles of trauma-informed care.</p> <p>If the child is a survivor of violence and there are ongoing police, justice or health support, it will be important to work with these providers to ensure that all stakeholders are promoting resilience / avoiding retraumatization.</p> <p>The Case Plan may need to identify steps in achieving developmental delays that are linked to disability and/or toxic stress or other impact of adversity. This will need regular review, to ensure that referrals and support remain relevant.</p>
Reunification (pre-placement case review and approval, child preparation, family preparation Referrals to services	<p>Final determination of placement.</p> <p>Support the child to consider the various aspects of transitioning to the family and into community life (both pros and cons, their hopes and fears), to help the child prepare for the reunification/placement and set realistic expectations.</p> <p>Help prepare the family and household members to receive the child, while considering the various aspects of reintegration (i.e. permanency as the end goal) and setting realistic expectations.</p>	<p>It is important that the case review fully considers the importance of the child being near to ongoing support that is as close as possible to the proposed placement.</p> <p>The need for ‘treatment’ for trauma shouldn’t be a reason to avoid reintegration; the priority should be to invest in local community awareness and family support.</p> <p>Sections X and X: Opening / Unpacking the Bag includes a range of tools that can be used to support the child to explore his or her feelings about the process. Other tools include, for example, books that children can use to understand and record their own questions, thoughts and feelings. Lumos has developed two books for children (in the context of transitioning from institutions that are closing) that could be adapted for local context: Moving to My New Home (Young Children / Early Reading) and Moving to My New House (8-16 years old).</p>

Case management step	Purpose of the step	Considerations for promoting resilience and addressing ACEs
	<p>Ensure that children and families access appropriate and timely services to support the reunification/placement and reintegration process as stipulated on the case plan.</p>	<p>Continued support with the Case Plan if required. This should not be ‘stopped’ when a child moves; the Case Plan should transition with the child’s movement but some elements are likely to continue.</p> <p>Share information about the child that is relevant and that the child has agreed to be shared; consider what and how to share any information about how the child is showing signs and symptoms of ACEs and how to present this information in a positive way.</p> <p>Support the family to understand and know how to support the child experiencing ACEs (see Section X: Unpacking the Bag). Explain basic concepts of child development, attachment, simple neurobiology (e.g. as explained in this Practical Guidance).</p> <p>Begin with local sources of support. These will often not be formal services, but are likely to have the most important benefits for long-term development of resilience of child and family.</p> <p>Prioritize locally available services that are coordinated, rather than referral to a distant specialist provider. If specialist care is required, promote involvement of</p> <p>Provide basic awareness raising on resilience and addressing ACEs through local coordination mechanisms, so that referrals are provided consistently and in a trauma-informed way.</p>
<p>Case closure i.e. sustainable reintegration</p>	<p>After regular monitoring and case reviews</p> <p>To ensure that the family is able to continue caring and providing for the reintegrated child independently, or that the young adult is able to continue caring for themselves independently, without case management support.</p>	<p>Care leavers are likely to need ongoing access to support as they become used to living independently – referrals and access to ongoing peer support are a priority; consider running support groups or identifying access to support groups, ideally led by careleavers / survivors of violence, etc.</p> <p>For children entering new communities, case closure may be a long time, until community support networks are fully established.</p> <p>Where appropriate, support children, young people, caregivers to become advocates in their own communities for promoting resilience, addressing trauma.</p>



PRACTICE REFLECTION

Think about Juan, Mercy, Janette and Paul (page 23)– and of the children and adolescents that you are already working with.

Think about at what point on their journey they were identified by a case worker. What would have helped so that they would have been found earlier and could have the most support possible?

Are some of the systems components above already in place, and, if not, what can you do to set them in place? Are there additional suggestions for your context?

Chapter Eleven:

Taking Care of You So You Can Take Care of Others



This Practical Guidance focuses on the crucial support that you are providing to children and adolescents, and their caregivers and families.

To do this work well, and to be able to care for ourselves and our own families and others we are close to, it is important to take the time to look after our own wellbeing.

Self-care is important for everyone, but especially important when we are supporting children and families who are facing adversities and when we are trying to provide support in situations which are often stressful and frustrating.

We all have our own bag that we are carrying, just like the children we are talking about in this Practical Guidance. Every one of us will have experienced adversities that weigh down our bag (*Think about what you have in your bag today*). These weights may sometimes be the same as those of the children we are supporting – loss of family, our own family stress, difficult relationships, childhood violence or neglect or abandonment, adult experiences that have caused stress, distress or trauma.

The first step to self-care is being aware of the stress in our own personal and professional lives. Remember what we learned about stress and distress. As professionals, we will also have a similar reaction to stressors as the children and families we work with.

- It is normal and healthy for us to experience some stress in our lives, including in our professional lives. It helps us to focus on the work that we are doing. However, we will be less effective if the stress is cumulative (for example, we are constantly faced with extreme challenges at work and our case load is too high to handle). This is very common amongst frontline workers dealing with clients who have experienced trauma. If not recognized and managed, it can lead to burnout.
- Critical incident stress (such as a violent episode in a family we are supporting, or a shock at home) can have the same results for us as professionals as for the children and families we work with, and our reactions will be similar.
- Vicarious trauma is the result of witnessing or learning about others' traumatic experiences that causes a reaction that mirrors that of the survivor. This is a form of stress that frontline workers are especially susceptible to. Over time, this can impact our own physical, psychological, emotional, and spiritual well-being.

Here are some signs of stress that are commonly experienced – but remember that everyone does react in a different way.⁶³

Physical	Emotional	Cognitive/ psychological	Social	Spiritual
<ul style="list-style-type: none"> • Sleep disturbance or insomnia • Palpitations, muscle twitches, feeling sick, sweating, breathlessness. • Fatigue • Vague aches and pains • Increased use of vices (alcohol, drugs, gambling) to cope with everyday stressors • Skin irritation or rashes, susceptibility to allergies • Clenched fists or jaw • Rapid weight gain or loss • Appetite changes 	<ul style="list-style-type: none"> • Anxiety • Feeling alienated from others • Desire to be alone • Negativism/cynicism • Suspiciousness/paranoia • Depression/chronic sadness • Feeling pressured/overwhelmed • Diminished pleasure • Self-blame, shame • Anger, sadness • Helplessness/feeling overwhelmed • Detachment, feeling unreal • Feeling out of control • Mood swings, feeling unstable 	<ul style="list-style-type: none"> • Problems with decision/priorities • Loss of concentration, easily distracted, difficulty making decisions • Tunnel vision/Constricted thoughts • Bad dreams or nightmares • Worrying • Persistent negative thoughts, obsessive thinking • Impaired judgement, hasty decisions • Memory problems • Flashbacks, intrusive images 	<ul style="list-style-type: none"> • Anger displacement, blaming others • Social withdrawal • Absenteeism • Unwillingness/refusal to take leave • Substance abuse, self-medication • Disregard for safety/risky behaviour • Arguments • Withdrawal • Slowed reactions/accident proneness • Avoiding reminders of an event • Lowered activity level 	<ul style="list-style-type: none"> • Feelings of hopelessness • Doubting value system/religious belief • Questioning major life areas (Profession, employment, lifestyle) • Feeling threatened and victimised • Disillusionment • Self-preoccupation • Profound loss of trust • “Why me” struggle • Increased cynicism • Loss of self confidence • Loss of purpose

If you are in a situation where you are currently exposed to violence, or you are feeling afraid of the reactions you are having to childhood trauma, look for support to take the steps to care for yourself and, if necessary, move away from the danger. This will depend on your local situation, but might include talking to your supervisor, or going to a counselor or health care worker.

Once we have identified stressors, there are many important ways in which we can help ourselves and each other. Below are some ideas that work for people – but everyone is different. Look at these examples and then look at the self-care plan for yourself.

It may be helpful to share these ideas with your co-workers to encourage each other to look after ourselves:

Physical self-care: Activities that help you to stay fit and healthy, and with enough energy to get through your work and personal commitments.

- Develop a regular sleep routine
- Aim for a healthy diet
- Take lunch break
- Go for a walk at lunchtime, even if it just down the street and back, and take the time to look around you and appreciate the small things that you see, like the sky, leaves, children playing
- Use your sick leave
- Get some exercise before/after work regularly

Psychological self-care: Activities that help you to feel clear-headed and able to intellectually engage with the professional challenges that are found in your work and personal life.

- Keep a reflective journal – write down what you feel at the end of the day, including positive feelings
- Seek and engage in external supervision or regularly consult with a more experienced colleague
- Turn off your email and work phone outside of work hours
- Make time for relaxation
- Make time to engage with positive friends and family

Emotional self-care: Allowing yourself to safely experience your full range of emotions.

- Develop friendships that are supportive
- Write three good things that you did each day
- Play a sport and have a coffee together after training
- Go to the movies or do something else you enjoy
- Keep meeting with your parents' group or other social group
- Talk to your friend about how you are coping with work and life demands

Spiritual self-care: This involves having a sense of perspective beyond the day-to-day of life.

- Engage in reflective practices like meditation
- Go to new places out of work – go to the local park that you've always walked past and never stopped and sat in, go on a bike ride at the weekend
- Go to church/mosque/temple
- Do yoga
- Reflect with a close friend for support

Relationship self-care: This is about maintaining healthy, supportive relationships, and ensuring you have diversity in your relationships so that you are not only connected to work people.

- Prioritize close relationships in your life e.g. with partners, family and children
- Attend the special events of your family and friends
- Arrive to work and leave on time every day

Professional self-care: This is about having a healthy and supportive workplace. If you are lucky to have a supportive supervisor, you can discuss this with him or her. If you do not, it may be useful to talk to your colleagues and find ways of providing mutual peer support.

- Ask for regular individual supervision meetings with your supervisor
- Recognize signs of stress and burnout in yourself and colleagues, and take action
- Find out whether there is already a protocol for workers who are showing signs of stress/burnout. If not, find ways to raise this with your managers
- Set up a team support network or buddy system
- Share what you are feeling and the successes in your work and encourage others to do so – model the trauma-informed approach that you apply with your clients



PRACTICE REFLECTION

A good way to start is to create your own self-care plan – see the sample plan in the box below. Fill it in and put it in a place where you will see it every day.

If you want, share it with work colleagues or your supervisor, or with friends and family, who can support you.

Sample self-care plan⁶⁴

Write down at least one thing in each box – feel free to add or change!

Physical	Psychological / cognitive
Emotional	Spiritual
Relationships	Professional / workplace
Overall balance: (what can I do to get a good work / life balance?)	
What might get in the way (and how can I try to avoid these)?	
What negative strategies do I need to avoid?	

Glossary

Abuse: (physical, sexual, emotional): “a deliberate act of ill treatment that can harm or is likely to cause harm to a child’s safety, well-being, dignity and development. Abuse includes all forms of physical, sexual, psychological or emotional ill treatment.”⁶⁵

Emotional abuse: “the persistent emotional ill-treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development (e.g. humiliating and degrading treatment such as bad name calling, constant criticism, belittling, persistent shaming, solitary confinement and isolation).”⁶⁶

Physical abuse: “the use of violent physical force so as to cause actual or likely physical injury or suffering (e.g. hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, female genital mutilation, torture).”⁶⁷

Sexual abuse: “All forms of sexual violence including incest, early and forced marriage, rape, involvement in child pornography, and sexual slavery. Child sexual abuse may also include indecent touching or exposure, using sexually explicit language towards a child and showing children pornographic material.”⁶⁸

Adversity: difficult experiences or circumstances.

Adverse Childhood Experiences: highly stressful, potentially traumatic events or situations that occur during childhood and/ or adolescence. ACEs can be a single event or incident, or a series of threats to a child or young person’s safety, security or violence against their person.⁶⁹

Alternative Care: a formal or informal arrangement whereby a child is looked after at least overnight outside the parental home, either by decision of a judicial or administrative authority or duly accredited body, or at the initiative of the child, his/her parent(s) or primary caregivers, or spontaneously by a care provider in the absence of parents.⁷⁰

Distress: a range of symptoms and experiences of a person's internal life that are troubling, confusing, or out of the ordinary occurs when external events or stressors place demands beyond our ability to cope.

Ecosystem: a connected group of living organisms, that rely on each other to survive.

Family-based care: short-term or long-term placement of a child in a family environment with one consistent caregiver and a nurturing environment where the child is part of a supportive family and the community.⁷¹

Family strengthening: Programs, strategic approaches and deliberate processes of empowering families with the necessary capacities, opportunities, networks, relationships and access to services and resources to promote and build resilience and the active engagement of parents, caregivers, children, youth and other family members in decisions that affect the family’s life.

Gatekeeping: a key process to ensure that alternative care for children is used only when necessary and that the chosen setting is the most appropriate for each child.⁷²

Neglect: deliberately, or through carelessness or negligence, failing to provide for, or secure for the child, their rights to physical safety and development (e.g. abandonment, the failure to properly supervise and protect children from harm as much as is feasible, the deliberate failure to carry out important aspects of care which results or is likely to result in harm to the child, the deliberate failure to provide medical care or carelessly exposing a child to harm).”⁷³

Resilience: a person’s ability to find and use internal (psychological and physical) and external (social, cultural) resources that sustain their well-being, and their capacity to negotiate for these resources to be provided in ways that they can use.⁷⁴

Stress: a feeling of emotional or physical tension. It can come from any event or thought. It is the body's reaction to a challenge or demand. In short bursts, stress can act as a positive motivator. However, over time stress can be harmful.

Strengths-based: focusing on the positive aspects of an individual or a group, actively building on those strengths to address adversities.

Stress response: how stress influences the body and the brain, moving from basic body signals of "fight or flight", to feelings, thinking, and actions.

Toxic stress: when healthy development is derailed by excessive or prolonged activation of stress response systems in the body and brain, which can disrupt the development of brain architecture and other organ systems, and increase the risk for stress-related disease and cognitive impairment, well into the adult years.⁷⁵

Trauma: the response to a deeply distressing or disturbing event that overwhelms an individual's ability to cope, causes feelings of helplessness, diminishes their sense of self and their ability to feel the full range of emotions and experiences.

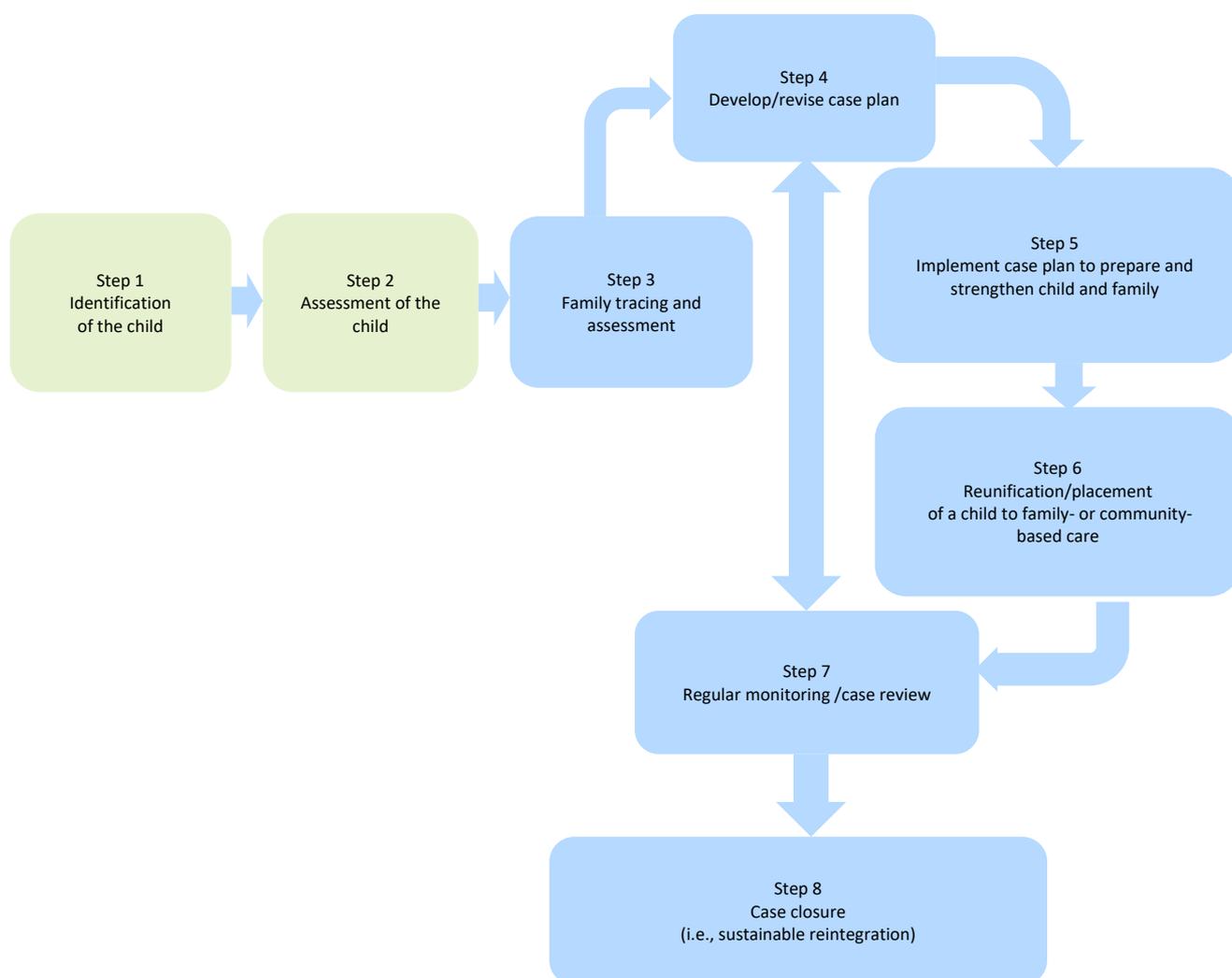
Trauma informed care / responses: approaches or responses that aim to help people and systems increase resilience and heal from the damaging impact of unmitigated stress and trauma.⁷⁶

Violence: "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation."⁷⁷

Violence against children: "All forms of physical or mental violence, injury and abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse."⁷⁸

Annex 1:

Sample Child and Family Alternative Care Assessment



CHILD/YOUNG ADULT IDENTIFICATION AND ASSESSMENT

WHAT is a child assessment? A *child assessment* is a two-way interactive conversation with the child that helps determine the feasibility and desirability of reintegrating the child with family, or placing the child into alternative family care in view of the child’s best interests.

Child assessments are an opportunity to build rapport and trust with the child, and to better get to know the child and understand his/her experiences, which enables us to support the child throughout the reintegration process. Child assessments are **not** interviews or “tick box” activities. Rather, they are an interactive conversation with the child and his/her supportive adults.

WHEN should a child assessment take place? An assessment should begin only once the caseworker has built rapport and trust with the child and the child shows key signs of willingness to participate (e.g., the child recognizes the caseworker, seems excited to engage or come physically close without prompting). The child’s right to cease participation at any time should be respected. The time it takes to trust a new person will vary—anywhere between 3 to 10 visits may be needed to complete an assessment.

It is critical that child assessment starts only after a clear process is in place to report and appropriately respond to any protection issues that the child discloses (e.g., appropriate psychosocial support, referral pathways for legal and medical attention).

WHERE should a child assessment take place? An assessment should occur at a time and location where the child feels most at ease (e.g., where they usually play) and where it is convenient. It is not appropriate to pull a child away from school for an assessment. Schedule according to what works best for the child, not the caseworker. Depending on the child's age and evolving capacities, the child might suggest a time and place.

WHO should conduct a child assessment, and who else should participate? A caseworker trained in case management and who can commit to working with the child (and family) throughout case management process until reintegration is achieved (a minimum of 18 months monitoring) conducts the assessment. Throughout the assessment process, the child should be actively engaged. Include individuals who are close to the child and know him/her well; older sibling(s) also can be included, as can the current primary caregiver, teachers, friends, health service providers. Such inclusion is important to help triangulate information to fill any gaps or to address inconsistencies.

WHY should a child assessment take place? A child assessment is important and reflects good practice. It is the right of the child to participate in the process. Providing a safe space in which the child can share information related to his/her case is a critical piece of the bigger puzzle. Use information shared by the child to inform the case plan and process. Assessment helps the caseworker identify why the child left home or separated with the family (noting if any harm was done to the child at home), identify the child's strengths and needs, and understand the child's thoughts about and wishes for reunification and reintegration.

Form 1:

Sample Child and Family Assessment tools

CHILD/YOUNG ADULT IDENTIFICATION AND ASSESSMENT

Instructions: Multiple sessions might be required to complete the assessment. Sessions should first focus on building trust and rapport with the child. Before meeting with the child, the caseworker should **prefill** any information that is available in the child’s case file. It is expected that the social worker will engage with the child in a participatory and conversational manner. Therefore, the caseworker should review the information in this form in advance and not carry the form during the assessment. Store the form in the child’s case file. The findings from this tool will help inform the development of a case plan or refinement of an existing case plan.

1. CHILD BIOGRAPHICAL INFORMATION

(Attach full-length photo of child on the day of admission to care; also attach an updated photo biennially.)

Child’s case number:	Child’s current location:
Date assessment started:	
First name:	Middle name:
Surname:	Nickname or likes to be called:
Sex:	Date of birth (DOB): ____ DD ____ MM ____ YYYY Estimate of approximate age if DOB unknown: _____
Current age: _____ Months (if < 1 year) OR _____ Years	Birth registered? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, birth registration no.: _____ <i>(If possible, attach a copy.)</i>
Place of birth: County: _____ Subcounty: _____ Village: _____ <input type="checkbox"/> Not known	
Height:	Weight:
Complexion:	Religion: <input type="checkbox"/> Christian <input type="checkbox"/> Muslim <input type="checkbox"/> Hindu
Ethnicity:	
Distinguishing physical features (e.g., scar or birthmark)	Languages:

Does the child (*tick the one response that applies*):

Have difficulty seeing, even if wearing glasses?

No Yes, some difficulty Yes, a lot of difficulty Cannot do it at all

Have difficulty hearing, even if using a hearing aid?

No Yes, some difficulty Yes, a lot of difficulty Cannot do it at all

Have difficulty walking or climbing steps?

No Yes, some difficulty Yes, a lot of difficulty Cannot do it at all

Have difficulty remembering or concentrating?

No Yes, some difficulty Yes, a lot of difficulty Cannot do it at all

Have difficulty (with self-care, such as) washing all over or dressing?

No Yes, some difficulty Yes, a lot of difficulty Cannot do it at all

Have difficulty communicating, (for example understanding or being understood by others)?

No Yes, some difficulty Yes, a lot of difficulty Cannot do it at all

(If "yes" to any of these questions, please administer the "Disability and Functioning Assessment Tool.")

2. DETAILS OF ADMISSION TO CARE

(Attach admission documents, such as committal order, Children's Officer/Chief/Police letter or hospital referral.)

Date of admission:

Age of child at admission:

Other forms of admission:

Self-referral Abandoned at CCI

Was admission order issued? Yes No N/A

If yes: Committal Order #: _____

Date of committal: _____

Who referred the child?

Name: _____

Title: _____

Relationship to the child: _____

Contact phone or other: _____

Location: _____

Name and address of current care provider:

Phone no.: _____ Registration status:

Current alternative care placement type:

Kinship care

Foster care

Temporary shelter

CCI

SCI

Supported child-headed household

Supported independent living (SIL)

Guardianship

Kafaalah

Other (*specify*)

Reasons for admission (*tick all that apply*):

- | | |
|---|--|
| <input type="checkbox"/> School/education access | <input type="checkbox"/> Poverty/family vulnerability |
| <input type="checkbox"/> Abuse or neglect at home | <input type="checkbox"/> Child abandoned |
| <input type="checkbox"/> Child on the street | <input type="checkbox"/> HIV & AIDS or other chronic illness |
| <input type="checkbox"/> Special needs (disability) | <input type="checkbox"/> Child victim of human trafficking |
| <input type="checkbox"/> Orphan | <input type="checkbox"/> Child lost and found |
| <input type="checkbox"/> Separated/unaccompanied ^{lxxix} | <input type="checkbox"/> Child of imprisoned parent |
| <input type="checkbox"/> Other (<i>specify</i>) _____ | |

(*Confirm reason with the child, if age and stage appropriate*)

Previous history of placements

Type of placement

To (day, month, year)

From (day, month, year)

- | | | | |
|---|---|---------------------------------|-----------------------------------|
| <input type="checkbox"/> CCI | <input type="checkbox"/> Kinship | <input type="checkbox"/> Foster | <input type="checkbox"/> Kafaalah |
| <input type="checkbox"/> Guardianship | <input type="checkbox"/> Temporary shelter/safe place | | |
| <input type="checkbox"/> Other (e.g. SIL or supported child-headed household) _____ | | | |

If the child has been in several types of care (e.g. various CCIs), please indicate the types and/or names of CCIs:

If child is not in any institution, indicate the type of vulnerability:

Street-connected child Location: _____

Child at risk of separation Location: _____

Other: _____

With whom and where was the child living before admission to care?

(*Hint: Look for tracing clues.*)

Name(s):

1. _____
2. _____
3. _____
4. _____

Phone no.: _____

Relationship(s) to child:

1. _____
2. _____
3. _____
4. _____

(*Specify if this placement was in CCI*)

County: _____ Subcounty: _____ Location: _____

Sub-location: _____ Village/estate: _____

Landmark (e.g., school, church, mosque, market): _____

Are there other sibling(s) living with the child now in this form of care? Yes No

Name of sibling(s):

Are there other sibling(s) admitted into care elsewhere? Yes No

Name of sibling(s): Place of admission:

1. _____
2. _____
3. _____
4. _____

3. STATUS OF FAMILY (Hint: Look for tracing clues.)				
Name	Other names	Last known location	Phone no.	Alive (yes/no/unknown)
Mother:				
Father:				
Are mother and father living together? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "yes," complete section below.</i>				
Mother's current residence County: _____ Subcounty: _____ Location: _____ Sub-Location: _____ Village/estate: _____		Father's current residence County: _____ Subcounty: _____ Location: _____ Sub-Location: _____ Village/estate: _____		
Name(s) of other siblings currently living with caregiver	Nickname	Education/employment	Class	Age
Name(s) of other relatives:	Relationship to the child:	Last known location:	Phone no.:	
Contact with family				
Is there any contact with family? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, with whom:</i> _____ <i>If yes, does the child remember the date (or how long ago) the last visit occurred?</i> _____ Does child go home on school holidays? <input type="checkbox"/> Yes <input type="checkbox"/> No Does family visit? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, who, and how often do they visit?</i> _____ Does the child express a preference for a caregiver? <input type="checkbox"/> Yes <input type="checkbox"/> No (Hint: Do not directly ask the child. Use child-friendly methodologies like drawing or storytelling.)				

4. CHILD WELL-BEING

(Hint: It is important to attain this information via varied sources: child's feedback, direct observation, current caregivers' perception, teacher's perception, medical service provider's perception, and so forth.)

A. HEALTH AND DEVELOPMENT

Is the child growing appropriately for his/her age? For example, is he/she walking, speaking, developing self-help skills? (Describe physical skills and needs, intellectual skills and needs, social skills and needs.)

Any history of medical issues/hospitalization? Frequency? (Explain and attach records.) _____

Any current health conditions? Yes No Specify: _____

Any chronic health conditions^{xxxx}? Yes No Specify:

Currently on any medication? Yes No If yes, specify: _____

Has the child been fully immunized? Yes No If no, what is the reason?

Any allergy? Yes No If yes, specify:

Feeding routine and special needs:

(Attach copy of clinic card, if available.)

B. EDUCATION

Previously attended any school? Yes Public Private Day Boarding No

If yes, name and location of school: _____

Child currently attending school? Yes Public Private Day Boarding No

If yes, name and location of school: _____

Current education level: ECD/ Class/Form/Vocational/Tertiary: _____

Attendance, performance, extracurricular activity, and behavior (Hint: Contact school directly.):

(Attach copy of most recent report card/book.)

C. PSYCHOSOCIAL AND EMOTIONAL WELLBEING

Who are the child's friends? What kinds of things do they do together? How often do they interact?

What are the child's views of these peer friendships?

What is the quality of these friendships (i.e., do they encourage positive or negative behavior)?

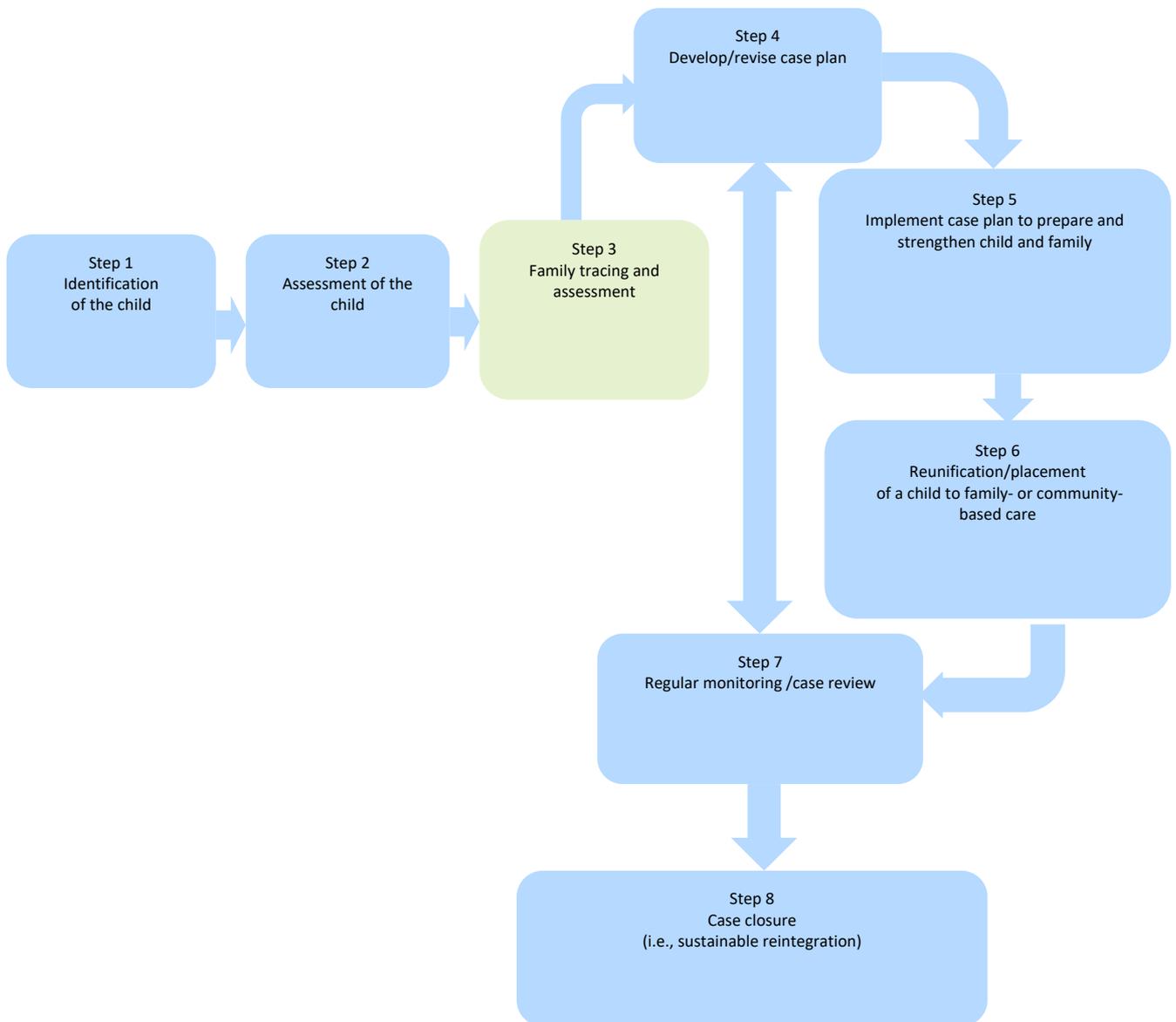
Are the perceived friends much older, younger or same age?

Level of attachment between the child and current caregiver: High Medium Low

Describe the relationship:

<p>Level of attachment to previous primary caregiver: <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low</p> <p>Describe the relationship:</p> <p><i>(Hint: Ask child open-ended questions about his/her relationships; observe who the child spends time with; ask caregivers who they spend time with.)</i></p>
<p>Does the child exhibit any of the following? <i>(tick all that apply)</i></p> <p><i>(Hint: Observe, ask caregivers, ask other children. Describe examples of the child's reactions to situations.)</i></p> <p><input type="checkbox"/> Self-harm <input type="checkbox"/> Known history of abuse</p> <p><input type="checkbox"/> Inappropriate sexual behavior <input type="checkbox"/> Drug and/or substance abuse</p> <p><input type="checkbox"/> Displays potential symptoms of abuse <input type="checkbox"/> Displays signs of emotional distress</p> <p><input type="checkbox"/> Exhibits risk <input type="checkbox"/> Any unexplained recent change in behavior</p>
Daily routine:
Degree of independence (i.e., what can the child do for himself/herself and what help does the child need?):
Likes:
Dislikes:
Fears:
Skills/strengths:
<p>5. CHILD PERSPECTIVE ON REINTEGRATION</p> <p><i>This information should be attained later in the process (e.g., at the end of the assessment or during planning). Use caution: Do not to make promises about reunification to the child. The information is gathered via indirect and age-appropriate means (e.g., music, singing, dancing, storytelling, drawing, writing a story/poem). Listen for clues about how the child generally speaks about family members or alternative care placement option.</i></p>
<p>Does the child express a preference for reunification/placement? Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/></p> <p>Does the child express concerns about reunification/placement? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><i>If yes, specify:</i> _____</p>
<p>6. ASSESSMENT CONCLUSION AND ACTIONS TO ADDRESS CHILD'S NEEDS</p> <p><i>In this section, provide a summary of the child's strengths and needs based on the information gathered above. The desired change should be identified for each need/concern to be addressed.</i></p>
Strengths and resources:
Needs or concerns:
Additional observations:
Things to be achieved:
<p>Caseworker's name: _____ Signature: _____</p> <p>Date: _____</p> <p>Caseworker's name: _____ Signature: _____</p> <p>Date: _____</p>

FAMILY ASSESSMENT



WHAT is a family assessment? A *family assessment* gathers in-depth information on the family circumstances to determine the family’s capacity and willingness to provide care and protection to the child. Family assessments provide an opportunity to build rapport and trust with the family, and to understand how best to support them throughout the reintegration process. A family assessment is **not** an interrogation, interview or “tick box” activity. Instead, it is an interactive engagement with a family and their full, active participation.

WHEN should a family assessment take place? The Family Assessment should occur each time a potential family for the child has been traced/identified. More than one family (household) can be assessed, to later determine which would be best suited to the child.

WHERE should a family assessment take place? A family assessment should be in the family’s primary residence, and community (e.g., church, school)—a place where the family feels comfortable and is able to talk with some privacy.

WHO should conduct the family assessment, and who else should participate? A caseworker trained in case management and who can commit to working with the family throughout the case management process until reintegration of the child is achieved conducts the assessment. The family should be actively engaged throughout the assessment process. Other individuals who are close to the family can be engaged in the process, too (e.g.,

relatives, neighbors, local council officials, church or mosque, friends, service providers). Such inclusion is important to help triangulate information to fill any gaps or to address inconsistencies.

WHY should a family assessment take place? It is important to understand the strengths, perception and needs of the family members to best support families through the reintegration process. Assessments should identify and build on the family's strengths, and identify areas for development and for addressing the child's needs on both a short- and long-term basis. A comprehensive family assessment should be conducted to ascertain the ability of parents/caregivers to ensure that the child's developmental needs are being appropriately and adequately responded to and adapted to meet the child's changing needs over time.

Family Assessment Form

Instructions: The family assessment builds on the basic family tracing information gathered in the child assessment, supplemented and completed as contact is made with family. The assessment can be completed at the same time as the child assessment, if appropriate. The assessment should include information on the family bio data, strengths, needs and acceptance to reintegration. It is expected that the caseworker will engage with the family in a participatory, conversational and nonjudgmental manner. Store the form in the child’s case file. The findings from this tool will help inform the development of a case plan or refinement of an existing case plan.

1. FAMILY BIOGRAPHICAL INFORMATION

Child’s name: _____ Child’s case number: _____ Date of assessment: _____

Number in the Household ^{xxxxi}:

Name	Relationship to child	Age	Alive? yes/no	Gender: male/female	Location	Level of education	Occupation	Did child ever live with this person?

Are mother and father (*tick the responses that apply*): Married Living together but not married
 Separated Divorced Remarried

If family of origin, what is the family’s perspective on the reasons for the separation?

How does this family/household feel about potential reunification/placement with the child?

2. FAMILY STRENGTHS AND NEEDS

(This information will help determine the family's willingness and ability to provide care for the child.)

Number in the Household:

A. HEALTH AND HOME ENVIRONMENT

Food and nutrition

Number of meals per day: _____ Variety of food (s) consumed: _____

Source of food: _____ Reliability of source: _____

Hygiene and sanitation

Describe the latrine (shared, distance from house, pit/flush/none):

Describe access to and source of clean water: _____

Describe the home environment (inside, outside and surrounding— ventilation, cleanliness, size of the house, rooms, roof, walls and floor, including materials used):

Describe the bathing arrangements/habits (including hand-washing): _____

Describe the availability, disposal, knowledge of sanitary items: _____

Basic health

Does the family have access to health services? Yes No

Does the family have medical insurance? Yes No

Is there any household member with a chronic illness (e.g., diabetes, hypertension)? Yes No
If yes, who, and what type?

Is there anyone in the family who (*tick one response that applies*):

Has difficulty seeing, even if wearing glasses?

No Yes, some difficulty Yes, a lot of difficulty Cannot do it at all

Has difficulty hearing, even if using a hearing aid?

No Yes, some difficulty Yes, a lot of difficulty Cannot do it at all

Has difficulty walking or climbing steps?

No Yes, some difficulty Yes, a lot of difficulty Cannot do it at all

Has difficulty remembering or concentrating?

No Yes, some difficulty Yes, a lot of difficulty Cannot do it at all

Has difficulty (with self-care, such as) washing all over or dressing?

No Yes, some difficulty Yes, a lot of difficulty Cannot do it at all

Using their usual language, has difficulty communicating (e.g., understanding or being understood by others)?

No Yes, some difficulty Yes, a lot of difficulty Cannot do it at all

Is the household able to take care of a child with a disability (if child returning home has a disability)?

Yes, without any additional support Yes, if given additional support No

What type of additional support does the household need? Special education Assistive device

Sign language Braille Support group Accessibility in the house Accessible transportation Other (*specify*):

Are there religious/cultural practices that hinder/could hinder children from accessing health services?

Yes No

If yes, please explain: _____

Are there functional community services (tick all that apply): Schools Health facilities Religious places Market Others

Are these community services easily accessible? Yes No

B. EDUCATION

Is there access to education facilities? Yes No

Distance to school? (Walking: ___minutes/ ___hours OR Driving: ___minutes/ ___hours)

The school is: Public Private Informal

Is the school inclusive and able to meet unique needs of child Yes No

If no, describe child's unmet needs:

Are children in the household currently attending school? Yes No

If yes, is their class appropriate for their age and evolving capacity? Yes No

Do caregivers show interest in children's education? Yes No

C. ECONOMIC STABILITY

Who in household is involved in economic activity?

Type of employment: Casual Informal Formal Estimated income per month: _____

Are there any financial/material support provided by people living outside of the household? Yes No

If yes, by whom: _____

Assets owned by family (list all you can observe, including land):

D. PROTECTION AND SAFETY

Are there signs of violence (including harsh physical punishment), abuse or neglect in the home? Yes No

Please describe: _____

Are there signs/reports of drug / alcohol abuse in the family? Yes No

Are there concerns of potential violence or abuse in community or school environment? Yes No

Please describe: _____

Is there an accessible local administrative office (e.g., Chief, Assistant Chief, village elder, *nyumba kumi*)?

Yes No

Describe the condition of the household (i.e. level of safety, roof/wall/floor, ventilation, number of rooms?)

Does the family live in a rented home/living on the land legally? _____

E. CHILD– CAREGIVER/YOUNG ADULT-MENTOR RELATIONSHIP AND ATTACHMENT

Are there signs of tension and/or conflict within family? Yes No Describe:

Are there mental health concerns? Yes No (*Hint: Use indirect methodologies: Observe, probe neighbors and children, etc.*)

Describe:

Has the family been through a significant life event recently? Yes No

Describe both positive and negative events: _____

Describe the relationship between adults in the house. (*Hint: Engage support people.*)

How do the children currently living with the caregiver describe their relationship with caregiver?

Do the children confide in caregiver if having challenges? Yes No

Do the children seek comfort from caregiver (*Observe.*)? Yes No

How do the children react when separated from caregiver?

Does caregiver spend time with their children? Yes No

Describe how the caregiver communicates with children: _____

Does caregiver encourage the child positively? Describe:

How does the caregiver respond to a child's misbehavior? (including type of discipline)?:

Are the children free around the caregiver (*Observe.*)? Yes No

Are the children involved in decision on matters concerning them? Yes No

F. PSYCHOSOCIAL WELL-BEING AND COMMUNITY BELONGING

Does the family feel connected to the culture of the community? Yes No

Does the family feel socially connected? (*Hint: participate in community activities.*) Yes No

Provide examples:

Does the family have relatives and/or friends living in close proximity? Yes No

Describe the family's relationship with their extended family(ies):

Describe the family's relationship with neighbors: _____

Describe the level of acceptance of relatives and the community toward the child:

Do local leaders know the family? Yes No

3. FAMILY'S PERSPECTIVE ON PLACEMENT/REINTEGRATION

Does the family want reunification/placement with the child? Yes No Unsure

Recommendations:

What other information does the family need?

What support does the family need? *(information gathered here should be used to develop the case plan.)*

Other(s):

4. RECOMMENDATION FOR PLACEMENT/REUNIFICATION

(To be determined via supervision or case Conference).

(Circle the response below that applies.)

High	Family expresses strong desire to reunify, visits child regularly; no known history of child abuse, domestic violence or substance abuse. Poverty may be an issue but there is good potential to improve their economic condition. The family is able and motivated to access services necessary to raise the child.
Medium	Family expresses moderate desire to reunify, has visited child occasionally; there may be some concerns with domestic violence, mental health or substance abuse, but the family is amenable to treatment and is able and motivated to access necessary services.
Low	Family's motivation to reunify is difficult to read or very low, has seldom visited the child; there may be significant issues of violence, neglect or substance abuse in the home. The family seems minimally motivated to address its vulnerabilities.

Caseworker's name: _____ Signature: _____ Date: _____

Case Manager's name: _____ Signature: _____ Date: _____

Annex 2:

Job Aid for Assessment Phase

A. Typical development with milestones and signs and symptoms of ACEs at different ages

AGE	BIRTH TO 2 YEARS OF AGE	2 TO 5 YEARS OF AGE	6 to 12 YEARS OF AGE	13 to 17 YEARS OF AGE (AND INTO YOUNG ADULTHOOD)
<p>Typical development in a nurturing environment</p>	<ul style="list-style-type: none"> • Physical: the newborn infant is entirely dependent and has reflexes that enable him/her to feed and to interact with the mother/caregiver • Cognitive: all sensory and motor skills are coordinated; most learning is non-verbal, learns through interactions with his/her environment <ul style="list-style-type: none"> • At 8-9 months s/he can crawl on his/her stomach and starts to imitate sound • At 12-18 months s/he stands and works by him/herself • At 18 months, s/he can point at things s/he wants • Social/emotional: s/he starts to smile at 3-4 months and becomes aware of other children towards the end of this developmental period 	<ul style="list-style-type: none"> • Physical: Period of rapid mental and physical growth • Cognitive: Begin to use language and think symbolically, but thinking is instinctive and centered on self, learns through play <ul style="list-style-type: none"> • Learns right from wrong, through discipline and interaction, and is increasingly able to exercise self-control • By 3 years can talk in sentences • At 5 years, can talk about a previous occurrence • Social/emotional: From 3-5 years, playing is imaginative and can help children re-enact and deal with fears and anxieties; from 4-5 years, the child becomes frightened of imaginary dangers and may be fearful of unfamiliar surrounding, primary caregivers remain important while peer relationships also offer social learning 	<ul style="list-style-type: none"> • Physical: steady and sustained growth with growth spurts • Cognitive: is able to use concepts of time, space, volume and number in simple concrete ways <ul style="list-style-type: none"> • Child develops capacity for logical thought and sees things in relational terms (how one thing is connected to another) • By age 6, starts to grasp concept of time • Social/emotional: between 6 and 8, understands concept of death <ul style="list-style-type: none"> • Starts formal learning and people outside the family become important as role models and peers who help the child develop self-esteem; social roles and responsibilities start to be learnt 	<ul style="list-style-type: none"> • Physical: Further development/maturation of body and sexual reproductive organs • Cognitive: thinking now involves abstract, theoretical and hypothetical ideas. Increasingly capable of independent thought and responsibility • Social/emotional: rapid growth and changes in body and appearance can lead to strong conflicting emotions <ul style="list-style-type: none"> • The adolescent's sense of identity is consolidated, bound up in relationships with others, family history and traditions, beliefs, values and choices. Not developing a coherent sense of identity can lead to self-doubt and anti-social behavior.

AGE	BIRTH TO 2 YEARS OF AGE	2 TO 5 YEARS OF AGE	6 to 12 YEARS OF AGE	13 to 17 YEARS OF AGE (AND INTO YOUNG ADULTHOOD)
Signs and symptoms of ACEs	<ul style="list-style-type: none"> Eating disturbance Sleep disturbances Somatic complaints Clingy/separation anxiety Feeling helpless/passive Irritable/difficult to soothe Constricted play, exploration, mood Repetitive/post-traumatic play Developmental regression General fearfulness/new fears Easily startled Language delay 	<ul style="list-style-type: none"> Avoidant, anxious, clingy General fearfulness/new fears Helplessness, passive, low frustration Restless, impulsive, hyperactive Physical symptoms (headache, etc.) Difficulty identifying what is bothering them Inattention, difficulty problem solving Daydreaming or dissociation Irritability Aggressive behavior 	<ul style="list-style-type: none"> Anxious or fearful Worry about own/other's safety Emotional swings, moody Easily startled Sad or angry Difficulty sleeping, nightmares Learning problems Changes in school performance Attention seeking, clingy Revert to younger behavior Re-enact trauma in play Say have no feelings about event 	<ul style="list-style-type: none"> Feel depressed Difficulty imagining future or planning Eating disorders Self-harm behavior, e.g. cutting Over or underestimate danger Inappropriate aggression Learning or school problems Reckless or self-destructive behavior Drug or alcohol abuse Act out sexually Sleep disturbances Pull away from activities, relationships Feel numb, shut down or separated from life Discuss traumatic events in detail

B. Caregiver and environmental inputs for child development

PHASE	SOCIAL MILESTONES	PRIORITIES FOR GOOD DEVELOPMENT
Infants (0-2 years)	<ul style="list-style-type: none"> Rapid brain development Learn to move Form attachments and express basic needs 	<ul style="list-style-type: none"> Safety and security and love Stimulation for brain development Nutrition for growth
Preschool childhood (3-5 years)	<ul style="list-style-type: none"> Curiosity Communication Imagination 	<ul style="list-style-type: none"> Reassurance Stimulation through play Developing social skills
Primary school (6-12 years)	<ul style="list-style-type: none"> Friendships More mobility Beginning to challenge parents or caregivers 	<ul style="list-style-type: none"> Starting to learn skills Learning right from wrong Space to develop friendships
Early adolescence (10/12-14 years)	<ul style="list-style-type: none"> Peer groups Beginning to challenge adult rules Insecurity and confusion 	<ul style="list-style-type: none"> Learning Allowing some freedom, but maintaining consistency in rules
Later adolescence (15-19 years)	<ul style="list-style-type: none"> Risk-taking behaviours Starting to make decisions Growing sexuality 	<ul style="list-style-type: none"> Helping adolescent to begin taking responsibility for the future Love, support and guidance

C. Checklist of questions that can be asked to assess potential developmental delays and/or adverse childhood experiences

Level	Questions practitioners might ask	What these questions can tell the practitioner
Individual	Age of child	<ul style="list-style-type: none"> Helps set expectations of what you might expect to see in a child this age
	History related to meeting development milestones (see Table 2 Ages and Stages)	<ul style="list-style-type: none"> Helps provide context for how child may have dealt with or understood an ACE based on their level of their level of physical, cognitive, social/emotional development Helps to identifying potential developmental delays or need to adapt communication / interventions based on developmental functioning Identify potential risk or protective factors
	Current and past health functioning and history	<ul style="list-style-type: none"> Helps to highlight any developmental issues or specialized health / medical needs
	Level of education	<ul style="list-style-type: none"> Skills learned in school (i.e. literacy level, social skills, etc) / level of cognitive functioning – Familiar skills can be used as part of intervention or inform best ways to provide support or techniques used to communicate with child Identify potential risk or protective factors
	What games does the child like to play? What hobbies / things does the child like to do?	<ul style="list-style-type: none"> Identify ways to engage the child to build trust and activities which can be into 1:1 / group sessions or care plans. Identify potential protective factors
	Behaviors that may be a sign of distress	<ul style="list-style-type: none"> Signs & Symptoms of ACEs (see Table 1) Identify potential risk factors
	Abuse history	<ul style="list-style-type: none"> Identify potential risk factors
Family / Significant Relationships	Family and other significant relationships (i.e. Who are the significant adults in the child's life)?	<ul style="list-style-type: none"> Identify the relationships and interpersonal dynamics which have had the most influence on the child's life Identify potential protective or risk factors
	Family stressors	<ul style="list-style-type: none"> Assess family / intergenerational dynamics Identify impact of interpersonal relationship dynamics at the time and to date
	Child's peer support network (i.e. does the child have friends? Is the child connected to peers within the family system or an external social group of peers/ individual peers)?	<ul style="list-style-type: none"> Identify impact of interpersonal relationship dynamics to date Assess the child's social skills; assess level of social integration / isolation
	Child and family economic circumstances	<ul style="list-style-type: none"> Identify potential protective or risk factors
	History of death , events / incidents of family separation (including at what age death/ separation happened and how it may have impacted the child)	<ul style="list-style-type: none"> Identify potential protective or risk factors Identify impact of interpersonal relationship dynamics at the time and to date
	Any other challenges for the household, caregiver or child which could possibly be experienced as an ACE (i.e. mental illness or separation from caregiver, abuse history of parent, school bullying of the child, etc).	<ul style="list-style-type: none"> Identify potential protective or risk factors

Level	Questions practitioners might ask	What these questions can tell the practitioner
Community	Available community resources: What community based services are available in the community?	<ul style="list-style-type: none"> • Identify potential protective or risk factors • Identify possible potential referral pathway resources
	Access to community resources: What is the child's / family's experience accessing services in the community?	<ul style="list-style-type: none"> • Assess social connectedness / any barriers / experiences of marginalization which may impact accessing community based services
	Support network / social connectedness: What is the child's / family's support network?	<ul style="list-style-type: none"> • Assess social connectedness for family and family • Identify possible potential referral pathway resources
	Support network / social connectedness: What community institutions does the child / family rely upon (i.e. school, church/mosque/spiritual leader, social services, NGOs, etc.)?	<ul style="list-style-type: none"> • Assess social connectedness / any barriers / experiences of marginalization which may impact accessing community based services • Assess social connectedness for family and family • Identify possible potential referral pathway resources
	Community environment: Does the family experience the community as safe?	<ul style="list-style-type: none"> • Identify potential protective or risk factors
	Community / social connectedness: Does the family feel connected to others in the community? Does the family feel a sense of community where they live or do they feel marginalized or not connected to their community?	<ul style="list-style-type: none"> • Assess social connectedness / any barriers / experiences of marginalization which may impact accessing community based services • Assess social connectedness for family and family • Identify possible potential referral pathway resources
	Access to community resources: Is there easy access to education, health, legal/advocacy services, services if a child has additional needs	<ul style="list-style-type: none"> • Identify possible potential referral pathway resources • Identify potential protective or risk factors
	Access to community resources: Is transport affordable / easily available?	<ul style="list-style-type: none"> • Assess any barriers which may impact accessing community based services • Identify possible potential referral pathway resources

Annex 3:

Counseling Communication Techniques

USING SILENCE

At times, it's useful to not speak at all. Deliberate silence can give both practitioners and children and families an opportunity to think through and process what comes next in the conversation. It may give children and families the time and space they need to broach a new topic. Practitioners should always let children and families break the silence.

ACCEPTING

Sometimes it's necessary to acknowledge what children say and affirm that they've been heard. Acceptance isn't necessarily the same thing as agreement; it can be enough to simply make eye contact and say "Yes, I understand." Children who feel their practitioners are listening to them and taking them seriously are more likely to be receptive to care.

GIVING RECOGNITION

Recognition acknowledges a child's behavior and highlights it without giving an overt compliment. A compliment can sometimes be taken as condescending, especially when it concerns a routine task like making the bed. However, saying something like "I noticed you took all of your medications" draws attention to the action and encourages it without requiring a compliment.

GIVING BROAD OPENINGS

Therapeutic communication is often most effective when children direct the flow of conversation and decide what to talk about. To that end, giving children a broad opening such as "What's on your mind today?" or "What would you like to talk about?" can be a good way to allow children an opportunity to discuss what's on their mind.

ACTIVE LISTENING

By using nonverbal and verbal cues such as nodding and saying "I see," practitioners can encourage children to continue talking. Active listening involves showing interest in what children have to say, acknowledging that you're listening and understanding, and engaging with them throughout the conversation. Practitioners can offer general leads such as "What happened next?" to guide the conversation or propel it forward.

SEEKING CLARIFICATION

Similar to active listening, asking children for clarification when they say something confusing or ambiguous is important. Saying something like "I'm not sure I understand. Can you explain it to me?" helps practitioners ensure they understand what's actually being said and can help children process their ideas more thoroughly.

PLACING THE EVENT IN TIME OR SEQUENCE

Asking questions about when certain events occurred in relation to other events can help children (and practitioners) get a clearer sense of the whole picture. It forces children to think about the sequence of events and may prompt them to remember something they otherwise wouldn't.

MAKING OBSERVATIONS

Observations about the appearance, demeanor, or behavior of children can help draw attention to areas that might pose a problem for them. Observing that they look tired may prompt children to explain why they haven't been getting much sleep lately; making an observation that they haven't been eating much may lead to the discovery of a new symptom.

ENCOURAGING DESCRIPTIONS OF PERCEPTION

For children experiencing sensory issues or hallucinations, it can be helpful to ask about them in an encouraging, non-judgmental way. Phrases like "What do you hear now?" or "What does that look like to you?" give children a prompt to explain what they're perceiving without casting their perceptions in a negative light.

ENCOURAGING COMPARISONS

Often, children can draw upon experience to deal with current problems. By encouraging them to make comparisons, practitioners can help children discover solutions to their problems.

SUMMARIZING

It's frequently useful for practitioners to summarize what children have said after the fact. This demonstrates to children that the practitioner was listening and allows the practitioner to document conversations. Ending a summary with a phrase like "Does that sound correct?" gives children explicit permission to make corrections if they're necessary.

REFLECTING

Children and caregivers can sometimes ask practitioners for advice about what they should do about particular problems or in specific situations. Rather than providing advice, practitioners can ask the child or caregiver what they would like to do or think they should do. This encourages children and caregivers to take more ownership of their decisions / actions and helps them come up with solutions themselves.

FOCUSING

Sometimes during a conversation, children mention something particularly important. When this happens, practitioners can focus on their statement, prompting children to discuss it further. Children don't always have an objective perspective on what is relevant to their case; as impartial observers, practitioners can more easily pick out the topics to focus on.

Annex 4:

Building a Resilience-Informed Care System

SYSTEM COMPONENT	CORE ELEMENTS THE COMPONENT	EXAMPLES OF A RESILIENCE-INFORMED SYSTEM
Leadership and governance	<ul style="list-style-type: none"> • Laws and policies that promote family-based care and prevent separation • Coordination mechanisms at all levels, that are accountable (i.e., have roles and responsibilities, reporting requirements across all sectors involved in the care system) • Leaders at all levels (government, traditional, informal) committed to promoting family-based care 	<ul style="list-style-type: none"> • Laws and policies connect violence and care components, for example by addressing violence in the care system • Laws and policies define ‘resilience’ and include commitments to building resilience in all sectors. For example, juvenile justice reflected in laws and policies in what that minimize ACEs e.g. having an advocate adult present when children are in contact with the law, separating children from adults in detention, child friendly courts • National and local coordination mechanisms are accountable for family strengthening efforts, including prevention of family separation and violence and actively engages and promotes universal services, as well as core child protection services • Leaders who understand the importance of promoting resilience, and who promote family- and community-based care • Leaders committed to placing violence prevention at the center of care reform
Social norms and practices	<ul style="list-style-type: none"> • Evidence about the social norms and practices that can lead to family separation, child abandonment, and a reliance on residential care as the dominant alternative care option • Programs that promote positive social norms and practices and tackle harmful social norms and practices 	<ul style="list-style-type: none"> • Gather evidence and support programs that address the social norms and practices that result in violence or other adverse childhood experiences, for example, finding out what beliefs people have about protecting and caring for children who lose their primary caregiver, whether and how those beliefs are made stronger or weaker, and why a community has either continued to care for children who lose a caregiver or where families are encouraged to place children in residential care • Actively identify and build in support for children and families who face violence or discrimination because of social norms that stigmatise based on factors such as race or ethnicity, disability, or social or economic circumstances • Link promotion of positive social norms with programs that reduce poverty, lack of access to services and structural inequalities
Social Service Workforce	<ul style="list-style-type: none"> • Skilled workforce, in sufficient numbers to promote family-based care • Social service workforce that focuses on preventive and responsive services to promote family-based care • System that supports all workforce, with supportive supervision and professional development 	<ul style="list-style-type: none"> • Workforce core competencies reflect a resilience-based approach (e.g. see children and families as part of larger community, link violence and care, promote protective factors), see Figure X below • Investment in mental health expertise as part of core competencies of the care sector, and sufficient specialist expertise • Supportive supervision to strengthen workforce resilience and address secondary trauma, in recognition of the intensity of supporting children at risk of and experiencing ACEs • Basic understanding of resilience-informed approach for all multi-disciplinary teams, e.g. health, justice, police, education

SYSTEM COMPONENT	CORE ELEMENTS THE COMPONENT	EXAMPLES OF A RESILIENCE-INFORMED SYSTEM
Service Delivery	<ul style="list-style-type: none"> • Family-strengthening services • Services to support family- and community-based alternative care, and reduce reliance on residential care • Services that support children living with disabilities, unaccompanied and separated children and others at risk of family separation 	<ul style="list-style-type: none"> • Ensuring that there are a range of (universal, primary) core services that strengthen protective factors and reduce risk to all forms of ACEs • Targeted (secondary) services to reach children and families that are at increased risk of adversity with a strong focus on prevention • Ensuring access to specialist services (for example, trauma-informed care for children who have experienced ACEs, referrals for survivors of violence)
Monitoring and Evaluation	<ul style="list-style-type: none"> • Information management system that has data on all forms of family and alternative care • Indicators to monitor prevention services and all forms of care 	<ul style="list-style-type: none"> • Evidence about the adversity that affect children (including all forms of abuse, household challenges, neglect and community violence) • M&E system that tracks progress and results of programs that prevent and respond to the ACEs • M&E system that can measure progress for individual children and families receiving resilience-informed support
Financing	<ul style="list-style-type: none"> • Mechanisms to reduce investment in residential care and increase investment in family-based and community-based care 	<ul style="list-style-type: none"> • Investment in the family strengthening support and services that are necessary to promote resilience, including positive parenting, family support services such as alcohol or drug services or mental health support, and household economic strengthening • Linking violence prevention and care budgets, ensuring investments are geared towards promoting resilience

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- ⁵³ Adapted from Center for the Study of Social Policy’s Strengthening Families: A Protective Factors Framework. Trauma and Brain Development – a Protective Factors Approach. <https://cssp.org/resource/trauma-brain-development-protective-factors/>
- ⁵⁴ International Rescue Committee. (2010). Training of Care Workers and Foster Parents. <https://resourcecentre.savethechildren.net/library/training-care-caseworkers-and-foster-carers>
- ⁵⁵ Hall, T.M., Kaduson, H.G., Schaefer, C.E. (2002). Fifteen Effective Play Therapy Techniques. Available at: <https://pdfs.semanticscholar.org/2643/fcb4210b558d5cad28458d889b9075534366.pdf> Other similar play activities are described in this article.
- ⁵⁶ UNHCR KRCT Albania. One Breath at a Time Illustration Booklet. https://childhub.org/en/system/tdf/childfriendly/attachments/krcr_illustration_booklet-en_2020.pdf?file=1&type=node&id=43551
- ⁵⁷ As above.
- ⁵⁸ Center for the Study of Social Policy’s Strengthening Families Approach has developed the Protective Factors Framework: https://www.flgov.com/wp-content/uploads/childadvocacy/strengthening_families_protective_factors.pdf
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- ⁶⁰ Case Management Task Force (CMTF) of the Alliance for Child Protection in Humanitarian Action. (2018). *Case Management Supervision and Coaching Training Package*. Module 4, Self Care includes activities for supporting your staff to develop self care
- ⁶¹ Case Management Task Force (CMTF) of the Alliance for Child Protection in Humanitarian Action. (2018). *Case Management Supervision and Coaching Training Package*. Module 3, Supervision and Coaching Skills.
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- ⁶³ Case Management Task Force (CMTF) of the Alliance for Child Protection in Humanitarian Action. (2018). *Case Management Supervision and Coaching Training Package*.
- ⁶⁴ <https://schools.au.reachout.com/articles/developing-a-self-care-plan>
- ⁶⁵ Better Care Network (2015) Toolkit – Glossary of Key Terms. Accessed at <https://bettercarenetwork.org/toolkit/glossary-of-key-terms>
- ⁶⁶ Ibid.
- ⁶⁷ Ibid.
- ⁶⁸ Ibid.
- ⁶⁹ Brennan, R., Bush, M., Trickey, D., Levene, C., and Watson, J. (2019). Adversity and Trauma-Informed Practice: A short guide for professionals working on the frontline. Published by YoungMinds. Available at: <https://youngminds.org.uk/media/3091/adversity-and-trauma-informed-practice-guide-for-professionals.pdf>
- ⁷⁰ United Nations General Assembly 64/142, *Guidelines for the Alternative Care of Children*, 2010. Available at https://www.unicef.org/protection/alternative_care_Guidelines-English.pdf.
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- ⁷⁴ Adapted from the Resilience Project: <https://resilienceresearch.org/about-resilience/>
- ⁷⁵ Harvard Center for the Developing Child: <https://developingchild.harvard.edu/science/key-concepts/toxic-stress/>
- ⁷⁶ U.S. Centers for Disease Control (2020). Six guiding principles to a trauma-informed approach.
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⁷⁸ UN Commission on Human Rights. (1990). *Convention on the Rights of the Child.*, 7 March 1990, E/CN.4/RES/1990/74, <https://www.unicef.org/child-rights-convention/convention-text>

^{lxxxix} *Separated children* are those who are separated from a previous legal or customary primary caregiver but who may nevertheless be accompanied by another relative. *Unaccompanied children* are those not cared for by another relative or an adult who, by law or custom, is responsible for doing so.

^{lxxx} A *chronic health condition* is a condition or disease that is persistent or otherwise has long-lasting effects (e.g., diabetes, hypertension, cancer, HIV).

^{lxxx} Use the “Case Notes Form” for additional households to assess, as needed.