carepath

Empowering public authorities and professionals towards trauma-informed leaving care support

Toolkit Leaving Care

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Preface

This Toolkit is part of the Care Path Project ("Empowering public authorities and professionals towards trauma-informed leaving care support - CarePath", project no. 785698, submitted to the Call for proposals REC-AG-2017 (REC-RCHI-PROF-AG-2017)) funded by the European Union Rights, Equality and Citizenship Program (2014-2020). The content of the Toolkit materials are freely available on the web and like all the contents of the Care Path Mooc represents exclusively the point of view of the authors and is their sole responsibility. The European Commission cannot be held responsible for any use which may be made of the information contained therein.

The CarePath toolkit for professionals working with traumatized children has been developed for the certified CarePath professionals to be used for providing one-stop, trauma-informed aftercare support services to children. The toolkit will help professionals to follow a multi-dimensional and integrated approach for supporting traumatized children, including living and housing, healthcare, vocational training guidance, social inclusion, and psychotherapeutic services. It will also guide professionals on children's involvement in aftercare planning, as well as on the involvement of other complementary professionals such as psychotherapists, social workers, trainers, policy-makers, lawyers where necessary.

The information contained in this Toolkit is available on the web to anyone interested in the topics covered. The arguments, information and scientific theories contained in all the parts and materials of the Care Path Toolkit have been organized with the intent to be useful to all people who, in various capacities and with different professional backgrounds, offer help and services to children suffering from trauma.

The scientific knowledge contained in all the Care Path Project materials and in particular those included in this Toolkit are freely accessible in many various scientific publications around the world. The applications of these notions and knowledge are regulated in different ways in the various countries by their respective laws, regulations and codes of ethics of the various professional guilds and professional or voluntary associations, which often vary from country to country.

All the contents of this Toolkit are offered with the precise intention of respecting all the laws and regulations in force on the topics and no part of this Toolkit or of the Care Path Mooc course can be used or understood for different purposes from what has just been underlined. It remains a duty and an imperative for every professional to work always in science and conscience and this includes full compliance with the regulations in force in their country, respect for the specific competencies of other professions, awareness of their limits and knowledge and respect for the boundaries that outline their

profession and their professional or paraprofessional role and competence as well as the needed compliance with the internal rules of the organization in which one operates.
This toolkit has been assembled and is the result of a standard scientific procedure that has included some data banks searches (MEDLINE, Embase, and PsycINFO), consultation with different professionals competent and active in the various disciplines and activities covered in the Toolkit and in the Care Path Project. That included the various professional that are offering services to children's victims of trauma including directors of services or of structure in the private or public sector that are involved in the protection and promotion of rights, recovery, protection and promotion of the health well being and welfare of children affected by trauma or trauma prevention at the legislative, managerial professional, paraprofessional and voluntary level. Also materials that offer access to the victims of trauma and their families have being included as well as the voices of caregivers and the relevant aspects of their training needs and their health protection and promotion at the workplace and in particular for the prevention and management of stress, burn out, and prevention and management of vicarious tress. .
This Toolkit has been assembled giving maximum relevance to Trauma Informed Care, Children Centered Approaches, Person Centered Approach, Person centered Planning, Person Centered Care Recovery approaches, best practices, common denominators, case studies illustrations, intersectoral approaches for personnel training, continuing education, organization policies, organization development and management etc.
We have compiled this toolkit avoiding the creation of a mechanistic listing of resources, we attempted to build a toolkit with the intent to offer a panorama of resources available that is also transparent and aware of the tenets of the sociology of knowledge (Berger & Luckmann, 1966) and well aware that every therapeutic or helping approach is based on a specific vision of human nature which, in turn, is based on values, those values determine the politics of the helping relationship and influences the outcomes:
Given that any view of human nature is based on a set of values, any helping relationship it is, in reality, a political act. The client needs to develop a new way to construe experience and generate their behavior -- in other words, to internalize the helping relationship narrative. Michael Polanyi (1958) has addressed this aspect in terms of the implicit and non conscious interpersonal learnings that we continuously exchange.
Helping relationships are, for these reasons, characterized by a pronounced power differential between the professional and the patient or client (Proctor, 2002, 2004, 2005, 2006; Sanders & Tudor, 2001; Sommerbeck, 2003; Sanders 2006). This power differential is larger or smaller in different helping approaches: it is larger when the therapist's role is that of an expert who is supposed to diagnose, cure and demand compliance. In trauma informed, person-centered, recovery oriented, gender and culture sensitive approaches, where the relationship is based on the respect and trust of the helper on the client and in the innate potentialities for growth resilience and change of the client, the power differential is intended to be much smaller. Here the role of the helper is not to diagnose and cure but to support the innate formative tendency of the client, to adopt a phenomenological position that respects and trusts the client's understanding of their experience. **"***It is the client who knows what hurts, what directions to go, what problems are crucial, what experiences have been deeply buried*" (Rogers, 1961, pp. 11-12).
Rogers' view was revolutionary in its time but unfortunately it is equally relevant and needed for present day psychotherapy and helping practices. Some of the current issues and concerns in healthcare and helping relationships are not so different from those that Rogers and his colleagues grappled with in the 1940s and 1950s: today managed care, the manualization of psychotherapy, the politics and values of psychotherapy research, professional regulation and psychotherapy and helping as potential forms as social control instead of human rights protection and promotion.
We as professional helpers can make a significant contribution today to the discourse and professional politics in the field of helping relationships. In order to do so effectively we need to continue in the footsteps of Rogers and the other founding members of Humanistic Psychology like Abraham Maslow, Gordon Allport, Charlotte Butler, Bugental to address and make explicit the issues of values and of the

use of power in the helping professions. We need to engage actively with efforts to develop socially aware and democratic practices, and we should, on a scientific and political level, engage with the themes of recovery, resilience, emancipation, and empowerment.
This toolkit includes also a vast panoramic of research, case studies, best practices examples of how in different parts of the world the rights of children are protected and promoted, how children centered and trauma informed care can be the central aspects of the planning and management of person centered approaches and trauma informed care and recovery approaches in all the aspects of the social construction of reality: Trauma informed legislation, fund allotments, community organization, schools planning and management, children institutions, children oriented service planning and service offerings. If they want to be aware of the bi-psycho-social implications can not only treat effectively victims of trauma, they should prevent trauma, prevent retraumatization, prevent staff burnout and vicarious trauma. In this way they will be consciously working to be part of the solution and not of the problem.
When this toolkit was completed the Covid 19 pandemic impacted the whole world and created a traumatic impact on all the citizens and in particular to children, to children's victims of trauma, to their families and all the caregivers. This new source of vast traumatizing impact was added to the already rich list of topics and resources.
We added a long list of information, resources, toolkits on how to deal effectively with the issues brought by Covid 19 offering free linking of the best solid scientific institutions, like the World Health Organization (WHO).
This toolkit has been assembled and is the result of a standard scientific procedure that has included some data banks searches, consultation with different professionals competent and active in the various disciplines and activities covered in the Toolkit and in the Care Path Project. That included all the professional that are offering services to children's victims of trauma including directors of services or of structure in the private or public sector that are involved in the protection and promotion of rights, recovery, protection and promotion of the health well being and welfare of children affected by trauma or trauma prevention at the legislative, managerial professional, paraprofessional and voluntary level. Also material that offer access to the voices and testimonials of victims of trauma and their families have being included as well as the voices of caregivers and the relevant aspects of their training needs and their health protection and promotion at the workplace and in particular for the prevention and management of stress, burn out, and prevention and management of vicarious stress.
One of the many features of the Toolkit worth to mention is the absence of risks of copyright infringements for the consultation of the materials accessible through the web linkages or YouTube linkages available freely on the web and posted by various organizations, various professionals from many different parts of the world. In the majority of cases the materials offered are in the official languages of the Care Path Project. English, Italian, French, Magyar, and Greek, in some instances the materials available are in several different languages since they are made available by the World Health Organization or other international scientific institutions.
Another aspect worth mentioning is the fact that in several instances the web links give access to free data banks and resources of institutions, not just some single documents, so for websites connections with institutions the Toolkit will offer free access to continuously updated materials, research results, legislature and best practices that are yet to come. Last but not least the toolkit offers a facilitation not only to access precious materials and in formations but also to establish an invaluable international network with institutions and colleagues around the world.
Another feature of this toolkit is that we were able to locate several toolkits available free on line in the websites of well known scientific institutions offering a whole array of scientific validated materials and tools, so instead of writing a simple digest of the materials we have chosen to make the materials directly available to the interested professionals providing them not only with a toolkit but with an electronic depository and data bank freely available to anybody interested, in this way this toolkit offers a quite large array of tools that are scientifically validated and already well organized that are the results of the

work of thousands of professionals, countless scientific researches and well established good practices. In several cases the toolkits available in this toolkit are top level state of the art of the whole field and its different applications in the different settings and needs.

For example see the following:
Trauma-Informed Care Toolkits

Principles of trauma-informed care:

- Understanding Trauma and Its Impact
- Promoting Safety
- Ensuring Cultural Competence
- Supporting Consumer Control, Choice and Autonomy
- Sharing Power and Governance
- Integrating Care
- Healing Happens in Relationships
- Recovery is Possible

The National Center on Family Homelessness. p 17-18
View PowerPoint slides on Trauma-Informed Care from SAMHSA/HRSA:

1. Introduction

1.1 Guidelines

'The Last Frontier' Practice Guidelines for Treatment of Complex Trauma & Trauma Informed Care & Service Delivery - Adults Surviving Child Abuse (ASCA)/Australia. (2012).
National Center for Trauma-Informed Care - SAMHSA.
Tips for Staff and Advocates Working with Children Polyvictimization." The Safe Start Center, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. (ca 2011-2012).
VETO: Violence Educational Tools Online - VetoViolence has been developed by the Centers for Disease Control and Prevention (CDC) to provide grantees and partners with access to training and tools that focus on the primary prevention of violence. The portal includes free training, program planning resources, and an on-line application for the creation of success stories. There are modules/tools for Child Maltreatment Prevention, Suicide Prevention, Sexual Violence Prevention, Youth Violence Prevention, and Intimate Partner Violence Prevention. The portal will continue to evolve as additional resources are added.

1.2 Trauma informed Community

Toolkit for Starting a Link Coalition in Your Community - This toolkit outlines how communities can form coalitions by connecting officials in child welfare, animal welfare, domestic violence response and adult protective services to identify and respond to incidents of animal abuse and interpersonal violence. It includes details on how to start a coalition, along with case studies to encourage communities to take

action and urge stakeholders to collaborate and work toward a multidisciplinary approach in addressing animal cruelty and human violence. (2013). More info here.

1.3 Building Collaborations/Community

Building Collaborations - Resources from the Office of Adolescent Health, U.S. Dept. of Health & Human Services.
Community Conversations About Mental Health Discussion Guide - This 20-page toolkit for Community Conversations About Mental Health is designed to help individuals and organizations who want to organize community conversations. SAMHSA, (2013).
Community Conversations About Mental Health: Information Brief - The Information Brief is designed to be used alongside the other elements of the Toolkit for Community Conversations About Mental Health and provides data and information to help community conversations participants consider key issues of importance to their communities. SAMHSA. (2013).
Essentials for Childhood - Steps to Create Safe, Stable, and Nurturing Relationships - This document suggests strategies for communities to consider. It is intended for anyone committed to the positive development of children and families, and specifically to the prevention of all forms of child maltreatment (CM). More resources. CDC. (2013).

1.4 Child welfare/protection services

Child Welfare Trauma Training Toolkit: Comprehensive Guide - National Child Traumatic Stress Network (NCTSN). (2008). 2nd Edition (2013).
Learning Center for Child & Adolescent Trauma - National Child Traumatic Stress Network (NCTSN).
A Social Worker's Tool Kit for Working With Immigrant Families: Healing the Damage: Trauma and Immigrant Families in the Child Welfare System - American Humane Assn. (Sept. 2010).
Supporting Infants, Toddlers and Families Impacted by Caregiver Mental Health Problems, Substance Abuse, and Trauma - SAMHSA. (2012).

Trauma-Informed Care: Perspectives and Resources: The National Technical Assistance Center for Children's Mental Health at Georgetown University and JBS International created this web-based tool to support leaders and decision makers at all levels (national, state, tribal, territorial, and local) in taking steps on their journey.
This tool comprises issue briefs, video interviews, and resource lists tells a story of implementation of trauma informed services and offers guidance and resources to help you on your implementation journey. The video interviews are of national, state, tribal, and local leaders in many child-serving systems; developers of evidence-based treatments and practices; physicians; researchers; administrators of provider organizations; clinicians; youth and young adults; families; and advocates who share lessons learned and identify remaining gaps. Youth and their families provide client perspectives on the need for trauma-informed practices and the impact of trauma-informed care on their lives. Stakeholders in selected states share lessons learned over a 1-year period of intensive efforts to become more trauma informed. The issue briefs provide an introduction and overview for each of the tool's eight modules.

1.5 The comprehensive resources lists support users in understanding how to build trauma-informed systems and organizations

Trauma-Informed Care resources - Office of Adolescent Health, U.S. Dept. of Health & Human Services.
Trauma-Informed Child Welfare Practice Toolkit - Downloadable from the Chadwick Trauma-Informed Systems Project. (2013).
Trauma & Resilience: An Adolescent Provider Toolkit - This toolkit is designed for all levels of youth/young adult service providers, from front line staff, to clinicians, to administrators. We hope this toolkit will help you and your respective agencies and programs in your journey to becoming trauma-informed. St. Andrews. (2013). San Francisco, CA: Adolescent Health Working Group.
Tips for Child Welfare Staff - A brief from The Safe Start Center, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. (2011).
A Behavioral Health Toolkit for Providers working with Children of the Incarcerated and their Families - To promote understanding among social service practitioners, the Division of Behavioral Health and Recovery (DBHR) within the State of Washington Department of Social and Health Services (DSHS), Health and Recovery Services Administration, teamed with DSHS' Office of Planning, Performance and Accountability to create an online toolkit, which includes tools for professionals, information for youth and caregivers, and research on interventions. This web-based training toolkit provides practitioners with the skills required to respond to the needs of children of parents who are in prison or have an incarceration history. Washington State Dept. of Health & Human Services. (2009). More resources at FindYouthInfo.gov.
Little Children Big Challenges: Incarceration - This toolkit provides much-needed bilingual (English/Spanish) multimedia tools for families with young children (ages 3-8) who have an incarcerated parent. These FREE resources include a resource kit with A Guide for Parents and Caregivers, a Children's Storybook, and a new Sesame Street video; an Incarcerated Parent Tip Sheet; and the Sesame Street: Incarceration mobile app for smart phones and tablets. (2013).
Children in Foster Care with Parents in Federal Prison: A Toolkit for Child Welfare Agencies, Federal Prisons, and Residential Reentry Centers - The purpose of this toolkit is to help facilitate communication and cooperation between child welfare agencies and federal prisons so that parents can stay engaged in their children's lives. (2013).

1.6 Criminal Justice/Law Enforcement

The National Prevention Toolkit on Officer Involved Domestic Violence - A project of the Law Enforcement Families Partnership (LEFP) at the Institute for Family Violence Studies within Florida State University's College of Social Work. The Toolkit is part of a broad-based effort to prevent violence in the homes of criminal justice families and to support healthy families, agencies, and communities. Please note that this Toolkit is not a batterer intervention program and is not for use when violence has already occurred. Florida State University. (2013).

1.7 Domestic violence

Closing the Gap: Integrating Services for Survivors of Domestic Violence Experiencing Homelessness- A Toolkit for Transitional Housing Programs - The National Center on Family Homelessness. (2013).
The National Prevention Toolkit on Officer Involved Domestic Violence - A project of the Law Enforcement Families Partnership (LEFP) at the Institute for Family Violence Studies within Florida State University's College of Social Work. The Toolkit is part of a broad-based effort to prevent violence in the homes of criminal justice families and to support healthy families, agencies, and communities. Please note that this Toolkit is not a batterer intervention program and is not for use when violence has already occurred. Florida State University. (2013).

Real Tools: Responding to Multi-Abuse Trauma - Alaska Network on Domestic Violence and Sexual Assault. (2011).

1.8 Education

Child Trauma Toolkits for Educators - In English & Spanish (funded by CMHS, SAMHSA, HHS).
Creating Trauma-Sensitive Schools to Improve Learning: A Response to Intervention Model -- The Wisconsin Department of Public Instruction provides resources to help schools become more trauma-sensitive. The site features the Response to Intervention (RtI) model to successfully support students with a wide range of behavioral and emotional issues.
How Schools Can Help Students Recover from Traumatic Experiences (pdf) -- A tool kit put together by Rand Corporation. Many changes in students' performance and behavior stem from their experience of, for example, witnessing violence, undergoing assault or abuse, living through natural disasters, or experiencing acts of terrorism. This tool kit describes how such changes appear in the school setting and provides a compendium of programs available to schools that help support the long-term recovery of traumatized students. The tool kit describes how to select students for such programs and possible ways to fund those programs. It compares the programs with one another according to the types of trauma they address, the problems they target, the requirements for training and implementation, and evidence for a program's effectiveness. Finally, it gives a one-page information sheet on each selected program, summarizing the objective, intended population, and format of the program and providing details on implementation, personnel training and materials, and contact information. Web site that describes the book. Cognitive Behavioral Intervention for Trauma in Schools (CBITS) site from Rand Health Project.
Trauma-Informed Resources for Educators - (NCTSN).
**Helping Traumatized Children Learn* -- Vol. 1 (Purple Book) and Vol. 2 (Teal Book) How to integrate trauma-informed practices and policies into your school and school district from the people at the Trauma and Learning Policy Initiative.

1.9 Foster Care/Adoption

Trauma Informed Assessment and Preparation Toolkit - A resource center from The Ohio Trauma Consortium, a grassroots effort of social workers, therapists and trainers who provide trauma informed preparation and support of adoptive and foster families. See more resources on their Trauma Consortium Resources website (2013).
Children in Foster Care with Parents in Federal Prison: A Toolkit for Child Welfare Agencies, Federal Prisons, and Residential Reentry Centers - The purpose of this toolkit is to help facilitate communication and cooperation between child welfare agencies and federal prisons so that parents can stay engaged in their children's lives. (2013). More resources at FindYouthInfo.gov.

1.10 Health care

Health Care Toolbox for Providers - ABC and now DEF (Distress, Emotions, Family) - Center for Pediatric Traumatic Stress (CPTS).
Handbook on Sensitive Practice for Health Care Practitioners: Lessons from Adult Survivors of Childhood Sexual Abuse -
This handbook presents information that will help health care practitioners practise in a manner that is sensitive to the needs of adult survivors of childhood sexual abuse and other types of interpersonal violence. It is intended for health care practitioners and students of all health disciplines who have no specialized training in mental health, psychiatry, or psychotherapy and have limited experience working with adult survivors of childhood sexual abuse. (2009).

1.11 Homelessness

Closing the Gap: Integrating Services for Survivors of Domestic Violence Experiencing Homelessness - A Toolkit for Transitional Housing Programs - The National Center on Family Homelessness. (2013).
Trauma-Informed Care for Women Veterans Experiencing Homelessness: A Guide for Service Providers - US Dept. of Labor. (2011).

1.12 Military Families

Resources for military families facing PTSD/TBI - "Post Deployment Health and Distress Responses: Overview for Practitioners;" "The Invisible Injuries of War: Impact on Military Families and Children, for Providers," and; "The Impact of Invisible Injuries: Helping Your Family and Children, for Service Members and families," are available for download. Center for the Study of Traumatic Stress (CSTS). (2013).
Working with Military-Connected Youth - Educator's Guide with resources to help the youth from military families. Beyond the Yellow Ribbon. (Jul. 2013).

1.13 Refugee/Immigrant services

A Social Worker's Tool Kit for Working With Immigrant Families: Healing the Damage: Trauma and Immigrant Families in the Child Welfare System - American Humane Assn. (Sept. 2010).
Transcending Violence: Emerging Models for Trauma Healing in Refugee Communities - SAMHSA's National Center for Trauma-Informed Care (NCTIC). (2008). *Warning Signs of Exposure to Violence, Immigrant Families* - (Office of Juvenile Justice & Delinquency Prevention).

1.14 Youth services

**Adolescent Health Working Group (San Francisco, CA) Trauma & Resilience Adolescent Provider Toolkit. (There's also a Toolkit Tour.)* The toolkit includes more than 50 handouts on: Spectrums of trauma and resilience, trauma inequities, Adverse Childhood Experiences (ACEs), adolescent brain development, developmental trauma disorder, trauma triggers, posttraumatic growth, resilience, developmental assets, developmental competencies, provider self-care, mindfulness, trauma-informed care, trauma-informed consequences, culturally sensitive approaches to care, restorative practices, social action, and a comprehensive list of trauma-informed evidence based best practices and promising approaches.
Its content -- text, charts, graphs -- can be incorporated into advocacy efforts, policy development, clinical practices, staff development and training, classroom procedures, and peer programs.
Usage of this toolkit and the Care Path MOOC and the Care Path Project in general can shared colleagues, organizations and Institutions dealing with these issues, mentioning the origin and disseminate to but not commercialized. None of the contents can be sold or commercialized.
If you disseminate this toolkit or the Care Path Mooc is mandatory mentioning that this is part of the Care Path Project funded by the European Union Rights, Equality and Citizenship Program (2014-2020).
The information contained in this Toolkit are available on the web to anyone interested in the topics covered. The arguments, information and scientific theories contained in all the parts and materials of the Care Path Toolkit have been organized with the intent to be useful to all people who, in various capacities and with different professional backgrounds, offer help and services to children suffering from trauma.

The scientific knowledge contained in all the Care Path Project materials and in particular those included in this Toolkit are freely accessible in many various scientific publications around the world. The applications of these notions and knowledge are regulated in different ways in the various countries by their respective laws, regulations, and codes of ethics of the various professional guilds and professional or voluntary associations, which often vary from country to country.
All the contents of this Toolkit are offered with the precise intention of respecting all the laws and regulations in force on the topics and no part of this Toolkit or of the Care Path Mooc course can be used or understood for different purposes from what has just been underlined. It remains a duty and an imperative for every professional to work always in science and conscience in the best inters of their clients and this includes full compliance with the regulations in force in their country, respect for the specific competencies of other professions, awareness of their own limits and knowledge and respect for the boundaries that outline their profession and their professional or paraprofessional role and competence as well as the needed compliance with the internal rules of the organization in which they work.

2. Emotional Trauma

2.1 A definition of emotional trauma

One of the most trusted scientific organizations in the field of trauma SAMHSA, the Substance Abuse and Mental Health Services Administration in the U.S. offers this definition: “Trauma is a widespread, harmful and costly public supports and intervention, people can overcome health problem. It occurs as a result of violence, traumatic experiences.6,7,8,9 However, most people go abuse, neglect, loss, disaster, war and other without these services and supports. Unaddressed emotionally harmful experiences. Trauma has no trauma significantly increases the risk of mental boundaries with regard to age, gender, socioeconomic and substance use disorders and chronic physical status, race, ethnicity, geography or sexual orientation. diseases.1,10,11It is an almost universal experience of people with mental and substance use disorders. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. *In order to maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.”…”* the advances in neuroscience, a biopsychosocial approach to traumatic experiences has begun to delineate the mechanisms in which neurobiology, psychological processes, and social attachment interact and contribute to mental and substance use disorders across the life-span.
Substance Abuse and Mental Health Services Administration. *SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
The American Psychological Association (APA) describe trauma “as the emotional response someone has to an extremely negative event. While trauma is a normal reaction to a horrible event, the effects can be so severe that they interfere with an individual’s ability to live a normal life. In a case such as this, help may be needed to treat the stress and dysfunction caused by the traumatic event and to restore the individual to a state of emotional well-being”.
Prof. Luigi Janiri, a well know psychiatrist and trauma expert of the Rome Catholic University and director of the Italian Journal of Traumatology underlines that “trauma has been studied in various ways, there are acute traumas - for example due to natural or technological catastrophes - there are chronic/repeated situations of trauma - such as children are often exposed to. But what can be said is that

the history of trauma, from a clinical point of view, begins with the study of post-traumatic neuroses, which have also been studied by Freud - and therefore in the context of psychoanalysis - and then taken up again by other others.
Trauma has also been studied from the point of view of psychological mechanisms, which are very important. What psychoanalysis has studied, since its origins, is the fact that a trauma, in particular if it occurs early in childhood - is subject to a removal process. This removal does not mean, however, that the trauma is forgotten, denied or buried. It can reappear, be reactivated at another time, for example in adult life, perhaps due to another trauma that somehow recalls the previous trauma. This is a two-stage mechanism that Freud carefully studied according to which there is a first trauma which, in a certain sense, sensitizes and a second trauma that reproduces in the subject the condition of being a victim, of powerlessness and fragility. In this way, reproducing the situation and leading to new symptoms and a clinical situation where the client feels it as though it was the first time.
This said, the trauma of post-traumatic stress disorder instead occurs in a punctual manner that endangers the subjects' life. It can be caused by war, torture, technological or environmental causes, but this trauma is a punctual type and easily recognizable in the life of the subject".
SAMSHA (2014) underlines the importance of the subjective experience of the individual, or differently stated by the person construction of the experience, where a traumatic event is experienced as .."shattering the person's trust and leaving them feeling alone. Often, abuse of children and domestic violence. Events are accompanied by threats that lead to silencing and circumstances may include the actual fear of reaching out for help or extreme threat of physical or psychological harm (i.e. natural disasters, violence, etc.) or severe, How the event is experienced may be linked to a life-threatening neglect for a child that imperils healthy range of factors including the individual's cultural development. These events and circumstances may beliefs (e.g., the subjugation of women and they occur as a single occurrence or repeatedly over experience of domestic violence), availability of time. This element of SAMHSA's concept of trauma social supports (e.g., whether isolated or embedded is represented in the fifth version of the Diagnostic in a supportive family or community structure), or to and Statistical Manual of Mental Disorders (DSM-5), the developmental stage of the individual (i.e., an which requires all conditions classified as "trauma and individual may understand and experience events stressor-related disorders" to include exposure to a differently at age five, fifteen, or fifty).1traumatic or stressful event as a diagnostic criterion. The long-lasting adverse effects of the event are the individual's experience of these events or critical component of trauma. These adverse effects circumstances help to determine whether it may occur immediately or may have a delayed onset. is a traumatic event. A particular event may be the duration of the effects can be short to long term. experienced as traumatic for one individual and not In some situations, the individual may not recognize for another (e.g., a child removed from an abusive the connection between the traumatic events and home experiences this differently than their sibling; the effects. Examples of adverse effects include an one refugee may experience fleeing one's country individual's inability to cope with the normal stresses differently from another refugee; one military and strains of daily living; to trust and benefit from veteran may experience deployment to a war zone relationships; to manage cognitive processes, such as traumatic while another veteran is not similarly as memory, attention, thinking; to regulate behavior; affected). How the individual labels, assigns meaning or to control the expression of emotions. In addition to and is disrupted physically and psychologically to these more visible effects, there may be an altering by an event will contribute to whether or not it is of one's neurobiological make-up and ongoing experienced as traumatic. Traumatic events by their health and well-being. Advances in neuroscience very nature set up a power differential where one and an increased understanding of the interaction entity (whether an individual, an event, or a force of neurobiological and environmental factors have nature) has power over another. They elicit a profound documented the effects of such threatening events.1,3question of "why me?" The individual's experience of Traumatic effects, which may range from hyper-these events or circumstances is shaped in the context vigilance or a constant state of arousal, to numbing of this powerlessness and questioning.

Feelings of or avoidance, can eventually wear a person down, humiliation, guilt, shame, betrayal, or silencing often physically, mentally, and emotionally. Survivors of shape the experience of the event. When a person trauma has also highlighted the impact of these experiences physical or sexual abuse, it is often events on spiritual beliefs and the capacity to make accompanied by a sense of humiliation, which can mean of these experiences. lead the person to feel as though they are bad or dirty, leading to a sense of self blame, shame, and guilt. In cases of war or natural disasters, those who survived the traumatic event may blame themselves for surviving when others did not. Abuse by a trusted caregiver frequently gives rise to feelings of betrayal."
To know more please go to this toolkit section on Emotional Trauma or consult the free guide:

Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

2.2 Different kinds of Trauma: differences from Simple Trauma and Complex Trauma

Luigi Janiri, Professor of Psychiatry and Primary Psychiatrist of the Gemelli Polyclinic - Catholic University of Rome, an international expert on trauma underlines that **t**he history of trauma is a complex story, made up of historical occurrences and recurrences. In fact, from the last twenty years to date, with the latest edition of the American classification system and universally known in psychiatry as DSM5, post-traumatic stress disorder has been considered as a possible trauma disorder.
In fact, the focus of researchers, primarily Van der Kolk, who launched the question of complex trauma, has turned to childhood traumas. Those which occurred at an age where the subject was in a position of weakness, of inferiority - as children normally are. This type of traumatic situation, of events that children are exposed to, from not only a psychopathological point of view, but also a neurobiological one, are the possible causes of a predisposition to the development of psychiatric disorders that go well beyond post-traumatic stress disorder.
These phenomena of childhood trauma have different types: they can be acute, they can be protracted and repeated during childhood and go under the name of abuses when traumatic phenomena are positive. For example, when something is committed against the child, such as child abuse, sexual or physical violence, or psychological violence. Or they may be omissive, they may be due to a type of *neglect*, neglect of both the psychological and physical care of the child leading to real events and situations of abuse. Thus maltreatment and abuse are the phenomena we are now dealing with when we talk about complex trauma.
Complex trauma, or primary evolutionary trauma as some call it, is often due to the failure of primary caregivers, parents for example, as well as cumulative trauma. The psychoanalyst Masud Khan deals precisely with this type of trauma - that is many small events or traumatic situations of an omissive or commissive type that were repeated during childhood and which, cumulatively, gives rise to a traumatic climate or dimension that the subject will feel during his adult life when they encounter difficulties, problems, or another trauma that recalls the previous trauma.
However this previous trauma is a complex trauma which can be extended over a very long and important period of time, even a whole childhood. Think of situations where there are families that experience a climate of fear or prolonged violence due to disturbances or problems affecting parents - of one or the other - and therefore do not guarantee that serenity, that sense of security and protection that is very important for a child to develop basic trust, which is necessary to encounter life and relationships with others in a calm, open and confident way.
The subject may not notice this, because more or less all of these situations can encounter phenomena of repression or forgetfulness, and therefore simply work from within, in an underlying way, until the "*bill is presente*d" to the subject. This is because these situations come to light, in a way that can be explosive,

due to the effect of something in the environment of the subject that in adulthood helps to deconstruct their emotional climate, contributing to the discomfort of the subject and thus reopening the scenario of the past trauma. This is because, as previously mentioned, the current trauma can attract and recall the past trauma, in a sort of fatal attraction.
Complex trauma leads to series of psychopathological consequences that go far beyond the simple, so to speak, post-traumatic stress disorder.
These are evolutionary consequences that mature over time and, precisely because they have this long gestation, which is different from post-traumatic stress disorder, they open up a much wider range of pathological possibilities.
Starting with disorders of affective regulation, emotion and behavior. This means that often these people, who have been subjected to a complex trauma, develop an impulsiveness that is not only of character, but of a disorder, a disorder that controls impulses. It can occur and be actualized in violent behaviors, towards others and towards oneself, in impulsive use of substances and therefore in drug addiction or alcoholism.
Another very important area is that of emotional self-regulation in the sense of self-esteem. The possibility that a person establishes basic trust in himself and therefore also the possible feelings of guilt that, in a more or less latent way, a person carries with them from childhood. Keep in mind that a child subjected to abuse, for example sexual, often feels guilty for having done something dirty and will not, therefore, be able to correctly attribute the responsibility for what happened to the adult, the perpetrator of the abuse.
These feelings of guilt can develop, continue and give rise to a depressive type of vulnerability. Major depression can be one of the outcomes of complex trauma in adulthood.
Other very important outcomes are psychosomatic disorders, in fact the consequences of a trauma can also be on the physical level, for example on the physiological reactivity, physiological hyper reactivity, on the cardiovascular system (for example cardiotonic, hypertensive phenomena), problems of pain regulation and its threshold (for example pain diffused through the body), hypersensitivity to painful stimuli and then various sexual disorders, which from a psychosomatic point of view, are connected to impulse-control disorders thus giving rise to forms of perversion and therefore problems of sexual-impulse control.
Finally we highlight dissociative disorders, for example depersonalization and derealization, which are phenomena that today are recognized with a certain intuitive difficulty, but which manifest themselves with a sense of extraneousness that the subject feels in front of reality and himself. These are defense mechanisms against a reality that the subject feels is, in some way, intolerable, that he cannot feel revived and therefore dissociation means distancing himself from reality.
Freud highlighted this fundamental mechanism of repetition compulsion, where a subject tries to re-encounter the trauma not so much to suffer the negative effects again, but rather to try to overcome it. This attempt to overcome the trauma means that some of the subject's behaviors lead him to relive situations: the classic situation is that of the child, the victim of a perpetrator, which can be repeated in adulthood in equal or opposite roles. The adult can try to re-legitimize himself, by creating situations in which he finds himself living as the victim of the actions of other people, or he may carry out behaviors where he himself acts as the perpetrator against a victim.
This could happen, for example, in situations of sexual violence suffered as a child and which may become more when older - in adolescence or in adulthood - a situation that recurs. For example in a rape, a sexual violence against a woman that can be experienced in first person as an executioner or recreated as a victim, creating a situation in which in each - even in opposing roles - the trauma is re-lived to try to overcome it in what Freud calls repetition compulsion.
To know more go to the toolkit section on Emotional Trauma or directly to:
Center for Substance Abuse Treatment (US). Trauma-Informed Care in Behavioral Health Services. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2014. (Treatment

Improvement Protocol (TIP) Series, No. 57.) Chapter 3, Understanding the Impact of Trauma. Available from: https://www.ncbi.nlm.nih.gov/books/NBK207191/

2.3 Adverse Childhood Experiences (ACEs)

Adverse Childhood Experience (ACES) : in a famous research promoted by Kaiser Permanente, the largest nonprofit health Managing Organization promoted an groundbreaking research involving a very large sample of the population, around 28 thousand people, measuring the incidence and results of traumatic effects on children and their negative consequences on people's lives. The ACE study, that is, the one that studied the negative childhood experiences of a large part of the population, was conducted by the largest non-profit organization of health insurance: Kaiser Permanente, a private non-profit health insurance in California. They invested many millions of dollars to conduct this study that has benefited the entire scientific community, because we now know much more about this topic, replicas of this study have confirmed the original data: on average in the population at least one third - therefore one third of citizens - is affected in their childhood at least by experiencing an adverse episode, by a trauma. A smaller number of citizens is affected by two types of trauma and an even smaller number suffers a higher number of traumas.
The more a person is affected by multiple traumas, the more they suffer from the negative consequences, as if a knife stab will hurt a lot, but being stabbed several times is even worse. Traumas are worse than stab wounds, because they not only have negative consequences - such as stab wounds - on the physical and mental appearance of the victim of such violence, but they are also - in some way - a kind of virus that brings some people affected by traumas - especially traumas in which you are a victim of violence, sexual abuse, etc.. - to become perpetrators in adulthood. It has been said, then, of mental and physical problems, that often the two things are associated. To explain better: people who are subject to trauma instinctively try to adjust to the trauma, that is to cope, to manage the event, some aspects of this type of trauma management may be effective at first, but cost a lot in the long run. For example, some people may - in order to manage the effects of trauma - mitigate their suffering with the use of alcohol or drugs, this creates another problem, aggravating the situation, because they then become alcoholics or addicts. At the behavioural level, it is known that we tend to avoid contact with others, and by isolating ourselves we are cut off from "recharging our batteries". Or becoming sexually promiscuous. In short, adverse childhood experiences are a real social scourge and very costly, because the costs for treatment and care alone are very expensive. Thus it is in the interest of everyone that we all strive to prevent and treat the trauma we have suffered from childhood effectively. This not only benefits the victims, but the whole society.
To know more go to the toolkit section on ACEs go to the toolkit section on ACEs or directly to:
Center for Substance Abuse Treatment (US). Trauma-Informed Care in Behavioral Health Services. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2014. (Treatment Improvement Protocol (TIP) Series, No. 57.) Chapter 3, Understanding the Impact of Trauma. Available from: https://www.ncbi.nlm.nih.gov/books/NBK207191/
Adverse Childhood Experiences Resources

2.4 Physical and Emotional neglect

Neglect is a form of childhood and adolescent trauma that is common but very little considered. This type of highly significant traumatic problem has only been addressed in recent times; we are talking about the neglect of neglect. For a long time this aspect was not considered a true trauma, at most a small part of the existing trauma types. In reality today we think of this as the most widespread trauma, and the one that has the worst consequences in terms of duration over time.

From this point of view, neglect indicates the perpetration of omission behaviors on the part of those who should be offering care. These omissions indicate, even if an imminent serious risk of damage is missing, a series of deficiencies that go on for a long period of time. These are deficiencies that can, for example, accompany the presence of a type I trauma. An abuse could be well tolerated, or in a sufficiently adequate way, but much less so if you do not have a parent capable of understanding and helping, supporting and protecting the child who has suffered this type of trauma. Neglect may therefore be complementary to type I trauma, but also in of itself does real damage.
There are different types of neglect that can concern healthcare, education, child supervision, protection with respect to environmental risks, physical needs, emotional support that is given mainly by the family or at least by those who take care of the child. This kind of neglect may seem of little importance, but in reality it gives the person the feeling of having no protection from others and therefore of living in a hostile environment that cannot guarantee them any kind of security.
If we talk about the different types of neglect, whether it is emotional or physical, we find two completely different aspects. In some situations the emotion is neglected as we are faced with cold, detached and poorly involved caregivers. Physical neglect may instead concern the strictly material aspect, the basic needs, and can also be extended to the educational needs of the child who may not receive from parents the information necessary to live in a relational context.
There is also medical neglect, which is when there is a need to treat an illness, but those who should take care of the child do not and consequently the illness can worsen and become particularly dangerous or harmful. There is moral neglect, or the lack of instructions for the ethical and moral aspects of a person's ethical behavior.
The consequences of these types of neglect are damages to public health that has long been underestimated. Today we know that long-term exposure to neglect can involve not only the aforementioned diseases, such as eating disorders, but also a reduction in the gray matter of the cortex and therefore a much diminished cognitive capacity compared to normal subjects. This data thus reveals how important it is to deal with neglect and try to re-stabilize the familial and individual context, to have that type of care and attention that gives security to the individual and gives the feeling of being protected and understood.
At the conclusion of the overview of treated diseases, from eating disorders to neglect, it is noted that the latter is particularly common in people who will develop an uncontrolled diet that in the end advances to a complete loss of control. It is necessary to think of a therapeutic relationship in which particular attention is paid to the person - a sincere interest in them is manifested with an empathic attitude, one of understanding. This is one of the most important aspects to effectively deal with this recently recognized, but particularly insidious trauma, which is of no less importance compared to other major traumas.

2.5 Neglect in separation conflicts

In separations conflicts parents often "make war" by investing a lot of energy in fighting the other parent, who is seen as an enemy; in these contexts, the most important thing is to win. In these wars they convey feelings of strong anger that actually indicate how complex it is for these people to face the feelings experienced and linked to the separation process; feelings of disappointment, pain, abandonment, a perception of emptiness, loneliness and a sense of failure.
These people are actually communicating how complex it is for them to process what is called psychological divorce. In this context the figure of the child emerges as the one that should be protected; unfortunately this does not always happen because in reality the minor becomes the fulcrum of the conflict. It becomes the central element and therefore the parents begin to communicate through the minor - the child becomes the bridge between the parents, the reason for discussion as each parent argues trying to declare what is good for their child. In this case the well-being of the child becomes an excuse

behind which disappointments, jealousies and personal annoyances are hidden. What is missing is the protection of the child, which must always be present, but it is essential in contexts of ruptures.
What parents could and should do is to collaborate and cooperate in all aspects related to the parenting function, with the aim of lightening the burden on the child, in reality, children are loaded with a heavy burden as they feel guilty for the separation of their parents, they feel responsible for their happiness as they are also feel guilty for being the cause of their parents quarrels. At this point what happens is that the child, in reality, is not seen. Here is where the trauma arises: in the moment of greatest vulnerability the child is not seen and therefore his needs and feelings are not recognized, accepted and fulfilled.
Separation is always a traumatic event because it is damaging, it causes a split. A parental couple in the mind of the child is a single nucleus, which in a certain way has to split. This external split of the father and mother will produce an internal split, however in the mind of the child the parental couple does not cease to exist, but remains, only that it loses strength, identity, dignity, and function as a guide.
In this case there are other factors that have a very strong negative burden. There are aspects that indicate the extent of the trauma, for example the temperament of the child and his ability to tolerate frustration, the quality of the relationship and the type of attachment that parents were able to create before their separation. The factor that tells us most about the trauma and its size, is the age of the child:
The younger the child is and greater can be the trauma; parents, even unknowingly, implement a series of dysfunctional dynamics that lock the child in a rigid role from which he is unable to free himself because, given his young age, he does not yet have that level of awareness or even a solid personality capable of freeing himself from this trap. For this reason a technical consultant intervenes in these cases, as he or she are able to identify the type of dynamics that exists in the family and to understand which interventions are needed to free the child.
To know more about this topic please consult the section on this toolkit dedicated to physical and emotional neglect, or go directly to this web site :
Neglect - Center on the Developing Child of Harvard University

2.6 Witnessing violence, natural or man made disasters

To talk about child victims of witnessed violence we need to define what is witnessed violence in the family. We refer to witnessed violence when a child experiences any form of mistreatment carried out through acts of physical, verbal, psychological, sexual and economic violence to some person very important for them or to some people that are emotionally significant for them, an adult or minor. This type of violence also includes those inflicted by minors to other minors, but also by other family members to pets; they all are highly traumatizing experiences for children.
The characteristics of these experiences may be different. Violence can be indirect: violence is perceived so it is not just a question of seeing violence, but also just hearing it. This should be emphasized because many women victims of violence report that the children, when they were beaten, were in another room; in reality even in these cases it is a form of direct violence even if the child do not see and only hears it.
The experience can be indirect when the child is aware that the violence has occurred or is about to happen; in this sense children have "antennas": they understand when there is the typical tension in a house that precedes the burst of an episode of violence.
The experience is sometimes perceived not directly or indirectly, but the child can perceive its effects; for example seeing the mother with bruises, or feeling this air of violence in the house, and so in these cases we are dealing with witnessed violence.
There are some false beliefs about witnessed violence. Children are not impervious to violence that occurs within their own family; even if the violent act does not occur in their presence, they can grasp its implementation, this because the child is never a passive and unconscious spectator.
Witnessed violence increases the risk of direct violence against children. The child who tries to defend the mother, getting in the way, can be hit by the father: in this case Dr. Annibali uses a gender perspective

to talk about witnessed violence, as in most cases violence is perpetrated by men against women. This does not exclude that violence can be perpetrated by a mother against the father, or at least by a woman against a male, but statistically it occurs less frequently.
Children exposed to violence are five times more at risk to become violent in adulthood compared to children who have not witnessed violence.

The effects of witnessed violence are:
a feeling of fear, anxiety, being overwhelmed, sadness, depression, feelings of anger, guilt, inadequacy and shame.

Children lose confidence in themselves and in others, can develop psychosomatic disorders, impulse control issues, academic difficulties, learning disabilities, language, loss of bowel control, relationship difficulties and can also develop a post-traumatic stress disorder if this traumatic experience occurs within a relationship of trust, such as the family.
At the biopsychosocial level, the effects of witnessed violence are reflected in behavior, emotions, cognition, the child's physicality, but also in relationships. What the child experiences is a world in complete turmoil, violence becomes normality and consequently normality is violence. The child will recognize violent behavior as normal and physiological or, in this sense diminishing his dramatic experience and will probably repeat these behaviors.
It is increasingly necessary to focus on witnessed violence and how it affects children in the present and in their adult lives.
To know more about witnessed violence, consult the section on this topic on the Toolkit resource section or click on this website:
The impact of children witnessing violence

2.7 Intersectionality and Trauma

The concept of Intersectionality originally developed by Kimberly Williams Chrenchsud, a black, feminist law professor, could be understood more from a geographical, geopolitical, global, transnational, and postcolonial point of view; according to those who have studied and reutilized the concept. Alice Ludvig developed elaborate multidimensional schemes that include multiple levels of difference, such as gender, sexuality, race, skin color, ethnicity, status, class, culture, and so on. This measures the innumerable levels we should take into account and pay attention to when we are in a helping relationship with people who come from what we commonly refer to as minority populations.
Internationality is increasingly an element in the development of equity policies, also thanks to the work of the United Nations and the European Union. Consider the directives to combat discrimination and all the initiatives at national, regional, and local levels, and to the policies and diversity management which are now adopted in all Western nations and in many corporations.
Dr. Maddalena Vagnarelli a well known psychotherapist and trainer in LGBTQI and Intersectoriality issues, underlines that this does not cancel out the uncertainty and suffering of those who find themselves living in conditions of multiple minority, perhaps after having experienced traumatic situations precisely because of being a minority.
LGBTQI migrants, very often, are very young. They cannot count on the support of their own community of origin, so they find themselves migrating, but they are often culturally distinguished by the homophobia or transphobia that they have escaped from. Nor can they be sure of coming into contact with multicultural realities which allow them to live their sexual orientation or identity peacefully.
In some European countries - such as Germany - there are protected structures to welcome those who flee from persecution due to their sexual orientation, where the staff have received specific training aimed at not reimposing judgmental or disparaging attitudes that would revive these people's stigma and trauma.

In Italy, at the moment, the hospitality model does not foresee these specificities, but there are some positive examples such as the pilot experiment launched in 2017 in Modena with a small six-person apartment reserved just for LGBTQI asylum seekers, plus an LGBTQI migrant help desk in Verona.
For these migrant children, in a developmenting age in relation to the LGBTQI community, to be part of an ethnic minority in a host country it is only part of the problem. They are in fact, very often, a silent and frightened minority, even within their own community of reference. An invisible trauma is doubled. Minority Stress there is a doubled risk for the mental and physical health of these people and thus a dramatic loss of human capital.
Getting trained in hospitality services means first of all training in human rights and the specificities that the LGBTQI migrant brings with it to the helping relationship. Training must therefore be centered on the person and welcome and knowing these specificities in order to be truly inclusive.
Moreover the services addressed to migrants, designed and provided very often without considering the variable of sexual orientation and gender identity, can reduce their effectiveness, both in regards to the relationship with the client (and therefore these children that cannot receive the welcome that they should have), but also in regards to the usefulness of the training or preventive pathways (for example, if we think of sexually transmitted diseases and, how multidimensional formation is needed when we have as clients adolescent migrants belonging to the LGBTQI community). On the other hand, the services provided by the LGBT community are strongly linked to a cultural model of Western gay men and lesbian women, and therefore very often these models do not consider a model in which these youths who come from other cultures can really recognize themselves.
The experience of the aforementioned realities has proven that the support information and counseling services provided by institutions, but also by non profit associations, may not be effective for these children.
Therefore working with these populations of multiple minorities will involve an interdisciplinary reflection on the practice of the helping relations. Training in helping relationships offered to these people should include the study of variables of homosexuality, bisexuality and transsexuality in the history of psychiatry and psychology - the concept of stigma, homophobia, internalized homophobia, but also to have a constant updating of the service providers on the legislation relating to these issues, both in the host countries and in the countries of origin of the people you are going to serve. In addition, everything related to asylum-related legislation should be continuously deepened and learnt, because it is constantly evolving and changing. Together with the more technical skills, it will be necessary to develop and consolidate, from a more personal point of view, a gender-sensitive approach and maintaining, both within oneself and the working group which offer services to these youths, a reflection on human rights.
Historical trauma**:** The collective and cumulative trauma experienced by a particular group across generations. Examples of historical trauma include violent colonization and assimilation policies; slavery; segregation; racism; homophobia; and discrimination and oppression. The negative effects of these experiences continue to impact the affected communities in the present in ways that may include struggles with violence, suicide, substance abuse, and other risk-taking behaviors; feelings of low self-worth or aggression; and a mistrust of systems, including education and behavioral health (The National Child Traumatic Stress Network, 2013a; The National Child Traumatic Stress Network, 2013b; The National Child Traumatic Stress Network, 2014).
Racial trauma**:** Potentially traumatic experiences related to race may include (1) direct experiences of racial harassment including threats of harm or injury and being humiliated; (2) witnessing racial violence toward others such as hate crimes or violence by law enforcement; and (3) experiencing discrimination and institutional racism. Racial trauma includes “microaggressions”—brief, everyday verbal or behavioral exchanges that intentionally or unintentionally communicate hostile, derogatory, or negative racial messages or insults (Bryant-Davis & Ocampo, 2005; Carter, 2007; Sue et al., 2007). Examples include racial slurs; being followed in a store; communications that convey rudeness and demean a person’s racial identity; or exchanges that negate or deny thoughts, feelings, or the experiential reality of

a person of color. Among LGBTQ youth of color, trauma may be related to both racial or cultural identity and gender identity/expression.
To know more go to the toolkit section on Intersectionality or directly to:

Center for Substance Abuse Treatment (US). Trauma-Informed Care in Behavioral Health Services. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2014. (Treatment Improvement Protocol (TIP) Series, No. 57.) Chapter 3, Understanding the Impact of Trauma. Available from: https://www.ncbi.nlm.nih.gov/books/NBK207191/

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Institute of Medicine. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. Washington, DC: National Academies Press.

2.8 Collective and intergenerational Trauma

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3. The burden of Trauma

3.1 The impacts of Trauma on the mind and the body, the personal and the social levels

Trauma has significant effects on physical and mental health and is one of the main causes of morbidity and mortality from generation to generation. The negative impact on the physical and mental health of people suffering from any form of trauma is considerable. The World Health Organization states that the various forms of trauma constitute a real social health emergency.
We see that human capital suffers greatly at the physical-mental level from trauma. The ability to contribute effectively to the prosperity of one's community is compromised because those affected by trauma are in need of care and this consume economic resources and also by trauma is impaired the ability of trauma victims to produce prosperity for themselves, their families, their communities and nations.
We can also observe another very worrying aspect for those who are victims of trauma: not only does the victim become a person with damage to their physical and mental health, but often, especially for certain types of trauma (such as being victims of violence or sexual violence) there is a high frequency of becoming perpetrators and thus traumatize other innocent people. This shift from victims to perpetrators is a terrible thing that shows how trauma is like a virus that expands if not combated, prevented, and treated effectively in the community: a real pandemia. One can speak of pandemics, that

is, as something that is transmitted from individual to individual quickly throughout the population which causes serious loss of human capital.
In a bio-psycho-social approach we cannot leave the responsibility of the prevention and treatment of trauma to the health sector alone, but it is a policy task and therefore of all the institutions - families, schools, work organizations, the world of juvenile justice, legislation must become sensitive to these problems and also become part of an effective network for the prevention and resolution of trauma. This is in the interest and for the good of all.

The neurological changes that occur when a trauma occurs (in any person, but mainly in adolescents and adults) will be treated; in adolescents they are clearly more evident than in adults.
The study is taken from neurological situations, from international neurological research and from the work done by Dr.Petrini and Dr.Mandese with the technique - mutative psychoanalytic process: a technique that has psychoanalytic and neurological aspects, in agreement with the findings of the international neurological research and the relationship between neurology and psychoanalysis.
It is well known that every individual in a healthy state develops 1400 new neurons from estrogenic stem cells on a daily basis, both at the hippocampus level and at the olfactory level. This is an important aspect because the hippocampus is the central part of the memory, the organism which recalls similar situations, thus in situations of trauma. While at the olfactory level we observe our cerebral lobes are nothing more than an outlet of our olfactory lobe.
We believe that human beings have about 30,000 genes, too few to define all situations, so family, sentimental, relational, cultural, and religious situations come into play. Research shows that only 70% of genes are genetically determined and only 30% are impacted by external factors. The difference in genes between a small man and a male bonobo is 5%, however this percentage is very important. A man and a bonobo are not comparable, at all.
For humans, culture, religion, all external situations, the family, the community in which we live, are very important for the formation of an individual.
What happens when stress occurs? A stressful or neglectful situation (neglect as we have seen is like a stress) does nothing but block the activity of stem cells at the level of the hippocampus and therefore it becomes impossible to replace neurons that are normally lost; so there is a loss of neurons in the most important and deepest part of the brain which is the hippocampus.
The cognitive emotion regulation that accompanies and sustains these brain changes is characterized by anxiety and depression related to the amygdala: a small cluster of nuclei inside the brain that supports all our emotional-affective situations, from love, to sexuality, to eating, to everything that is important from an emotional point of view. An alteration occurs in the prefrontal cortex, which are the ones that direct our goals: if I decide to go to the theater to see an actor it is the prefrontal cortex that drives me to do this action, then the frontal cortex realizes it. But the prefrontal cortex also drives impulses, for example when I have the impulse to leave or stay in one place I owe it to the prefrontal cortex that the frontal then reacts and communicates the need to remain, for instance due to a commitment.
The third part that will be damaged is the hippocampus and memory (as we have already said, the hippocampus is the seat of the memory). Longitudinal studies have shown that traumas do not express themselves through a disorder of DSM -5 or ICD - 10 which is called post traumatic stress disorder, but is transmitted through symptoms of anxiety and depression, sometimes hallucination, but is highlighted through changes in the sense of self in interpersonal relationships.
A person who has undergone a trauma has behavioral limitations and mental limitations, i.e. the person seems unable to express herself in the world of work, relationships, - it is as if he or she have fallen to a lower level of functioning.
This is due to the HPA axis - hypothalamic-pituitary-adrenal axis. At the brain-level there is a gland called the pituitary gland, which all the hormones of our body radiate from. The connection between the hormonal (endocrine) part and the nervous part is given by the hypothalamic-pituitary axis. Everything that reaches the hypothalamus - an area of central importance, almost a small brain - is transmitted to the

pituitary gland and gives rise to sensations, that is the nervous signal is transmitted with hormonal substances. These hormonal substances branch out throughout the body, from the pituitary gland, and control the thyroid, sexuality through the genital glands, male and female sexuality with the male hormone (which also determines female sexuality). Then, especially, the release of corticotrophin: the stress hormone, or rather the stress pre-hormone because the real stress hormone is ACTH - cortisol, which is why cortisone is given to help the body react when there are physical malfunctions, cortisol in fact has the same elements as cortin (POMC). Even in the case of battles and wars the human organism is prepared, in fact cortisol - ACTH to be precise - causes pain to not be felt and gives rise to mechanisms of aggression (as happens in animals).

When this mechanism of activity is repeated it becomes chronic and protracted states of anxiety and anguish occur depending on the aforementioned amygdala. The amygdala is the "chest of drawers" of our emotional memory, in the sense that it preserves all our emotional memories, as if it were a camera of emotional reality. So, for example, our first kiss, first work, first sensation of well-being, the first sporting victory - they are all photographed in the amygdala and re-emerge when similar situations arise; when the hippocampus begins to secrete cortisol. This cortisol binds to the receptors of the hippocampus, amygdala and prefrontal area and when it has reached a sufficient level, if the situation is not chronic, it lowers the ACTH and CRF level.

In this way the hippocampus regulates our responses to stress. When we are well serotonin manages the area instead - serotonin is the hormone of happiness, in fact, when a person is depressed, serotonergic drugs are prescribed. Serotonin inhibits aggressive behaviors and promotes socialization. It is produced from tryptophan and is introduced into the diet. Serotonin, together with oxytocin, which is the binding hormone, is the most positive and useful hormone for the body, in the sense that while serotonin stimulates sociality and relationship with others, oxytocin - released after 5 seconds of hugging another person - is the hormone that stimulates the bond.

The research is highlighting that loving activities, important thoughts and feelings have profound therapeutic effects on our bodies. So undoubtedly there are in our way of being, a number of reactions that change the brain and modify the body, in any situation where there are hormones related to neurohormones and linked to nervous stimuli.

Franco Baldoni professor of psychology at the Bologna University and an international expert in attachment issues has underlined that exposure to dangerous situations and to physical or psychological threats, such as illness, trauma, abandonment,, maltreatment, physical sexual abuse, are very common experiences, both in childhood and in adulthood.

These experiences do not necessarily lead to the development of a psychological trauma, as the human species has extremely sophisticated adaptive capacities, allowing us to face extreme situations without necessarily developing a condition of psychological trauma. If these dangerous situations are dealt with effectively, they become disarmed of their maladaptive potential, allowing the individual to remain in a healthy mental and psychological condition.

In particular, our species has developed, over time, interpersonal skills and very sophisticated behaviors that have the main function of protecting us against dangers. This set of behaviors and attitudes is defined as our attachment system. The word attachment comes from the attachment theory that was first proposed in the 1950s by the English psychoanalyst John Bowlby. Attachment theory holds that human beings have an innate predisposition to develop particular attachment relationships with primary figures, often parents, who perform the main function of protecting against dangers.

In this theory we talk about attachment, whose main, but not sole, function is to protect us from dangerous conditions: when a person feels they are in sufficiently safe conditions, they are supported to explore the external environment, discovering its resources and learning to prevent the dangers that can be hidden in the environment. These attachment functions have been studied in children of all ages - particularly the relationship with their mother of one and two year-olds - and in primates. There are examples of research

from the 1950s on small rhesus monkeys that demonstrate how important the protective function of the mother is, even more so than the nutritive function for primates.
Attachment is usually divided into two categories: safe and insecure. Safe attachment is characterized by a sense of security, trust in the environment, confidence in its resources and the possibility of being helped and protected in the event of danger.
Insecure attachment is classically divided into insecure-ambivalent and preoccupied attachment - in children defined as type C - characterized by an over activation of the body with an emotional emphasis; manifestations of anger, fear, complaints about one's need for protection, difficulties in separation from the mother. The other type of insecure attachment is the dismissive-avoidant attachment - also known as type A - which, unlike the previous type, is characterized by hypoactivation. In particular by distancing oneself from emotional reactions that occur in conditions of danger, hence from one's fear, anger, sense of vulnerability, and which are either inhibited in their expression (for example with an attitude of apparent indifference) or falsified and transformed into expressions of opposing emotions (for example smiling when facing a frightening topic).
When these modes of attachment are effective they protect against the dangers that come from the environment or from our relationships. If these strategies are effective and sufficiently protective, conditions of psychological trauma do not occur and the individual remains in a condition of relative safety.
The condition of psychological trauma manifests when these strategies are ineffective, for example when inhibiting the expression of fears, anger or needs is not sufficient to protect the individual from environmental threats.
In the condition of psychological trauma, all mental processing activities are negatively affected by an experience of past or present danger. This can come from a particularly intense and sudden event - for example a physical trauma or abuse - but it can also come from a repeated series of experiences that cumulatively assume traumatic value. In this case we are speaking of evolutionary trauma, a condition in which a child, for example, grows up in an inadequate and neglecting family environment and as a whole these prolonged experiences create a climate of inadequate development that can lead to a condition of psychological trauma.
Mentalization plays an important role in psychological stress and emotional trauma underlines Prof. Baldoni from Bologna University; when we talk about mentalization we talk about something that seems to be taken for granted, which comes from far away. In fact every human being, even before the development of psychology, faces mentalization problems at some point in their life. That is, the problem of reflecting on oneself and others, of considering what we and others have on our minds, the thoughts, feelings, needs, expectations, and beliefs that influence us.
A simple way to understand the concept of mentalization is to consider oneself and others in terms of mental states. These abilities begin to take shape in humans at around 4 years of age, when a child becomes aware that what they think and feel is not necessarily understood and shared by other people, for example that the mother may not know what is going on in the mind of the child. When children learn this great novelty they also learn to use a very useful and important strategic mode of adaptation to problems; they learn the importance of lying. Lying is possible if you think that others minds have a different view of the world, and therefore cannot know the thoughts of another individual.
Mentalization and its processes are based on a series of steps. The first regards our relative sensitivity to perceiving mental states, or of representing our own and others of mental states (for example to understand being cheerful, sad, having expectations, prejudices) and the ability to interpret our own or others behavior on the basis of these mental states. This is essential for our ability to be adaptive (for example if a person is standing silently before us we don’t think they don’t have anything to say, we think their mind is filled with images and thoughts, that their silence is not an expression of emptiness, but of a series of mental states that are the basis of this silent behavior).

A second important aspect of mentalization is that self-mentalization promotes the regulation of our bodies. For example if we realize we are angry and we begin to think the anger is related to something that was said, the very fact of realizing it, of remembering and making expectations and projections onto the consequences of an action, opens up a psychological path to regulating the anger that has been activated in us.
The heart, our breathing, the production of hormones linked to anger activation begin to be regulated by psychological mechanisms. For example, I could feel guilty for having felt anger towards someone I love, this inhibits the expression of anger and regulates the body. This is a fundamental function, so much so that people with poor mentalization skills are more exposed to the dysregulation of the body (the heart beats faster and in an irregular way, emotional reactions are more uncontrolled, and this can lead in the long term to diseases due to the constant dysregulation of the body).
One of the most important functions of the parents towards their children is to be mentalizing: to think about their children also in relation to their needs, feelings, fears, putting themselves - in a sense - in the shoes of their children and perceiving things from their point of view. For example, a three year old child will live certain topics and interpret certain words or speeches within their childish abilities, meaning it is important for the parent to see things through their eyes. This condition, which has been called (psychological) mindedness, is one of the conditions most closely related to the safe development of children. It the condition of a good parent being able to put themselves in the shoes of their children and perceive their needs. It is already observed in mothers of very young children who, for example, puts themselves in the shoes of their crying and agitated children, and therefore understand that they may be cold, or hungry, thus giving voice to a child's state, as if the son were able to have organized thoughts and could express them. The ability to represent the mental states of children is a basic condition of being a parent.
Mentalization is also the basis of the ability to cope with stress and potentially dangerous situations by adapting without developing conditions of psychological trauma. For example, for a child faced with the inconsistent behavior of the parent - who perhaps acts angrily or with physical violence, or says negative things towards the child - the ability of this child to imagine the mental state of the parent acts as a shock absorber and lets them consider what the parent does and says within a context. They can think, for example, "father is tired and what he says does not correspond to reality, father is usually affectionate and loves me, what is happening now has value at this time and is linked to a particular state of being, but it is not absolute." The attitude described above protects against the mental states of others and makes the situation potentially less traumatic. It is clearly observed in adults with low levels of mentalization, as in people with borderline personality disorder, that they are much more exposed to continuous psychological trauma. What happens to them is not contextualized, or subjected to a process of sufficient reflection, causing it to become total, absolute and potentially traumatic.
In some moments, the inability of parents to place themselves in their children's shoes can be particularly dangerous and produce attitudes that in a child or adolescent can manifest through highly aggressive behavior. This aggressiveness and its consequent behaviors can, in part, be interpreted through the concept of mentalization.
If parents are constantly irritated by the behavior of their child, for example, if the child poses a problem or gives an attitude, the parent begins to turn on the child in a negative way (perhaps stating that he is stupid, sick or worthless). This leads the child to have an image of themselves as a sick, disturbed, incapable person. This attitude is kept at a distance from aggressive behaviors, meaning that every time an adult approaches the child with the intention of getting to know them and getting them trust to him, the child will probably have a strong aggressive reaction, functioning to keep the adult away as potentially traumatic.
The case may be that for young people who are considered incapable in the classroom and have to repeat, the teachers consider them negative subjects and at home these children have parents who reinforce this negative idea of themselves. Therefore these children have attitudes of strong reactivity and anger

towards the adults who are trying to help them (an educator, a teacher), aiming to keep the other person away in order to not repeat the experience of being painted as negative or incapable.

To know more: to the toolkit section on the burden of trauma or directly to:

Center for Substance Abuse Treatment (US). Trauma-Informed Care in Behavioral Health Services. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2014. (Treatment Improvement Protocol (TIP) Series, No. 57.) Chapter 3, Understanding the Impact of Trauma. Available from: https://www.ncbi.nlm.nih.gov/books/NBK207191/

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3.2 Common Denominators of Effective helping professionals

There is a large body of research illustrating what professional effectiveness is for a professional who provides services in the field of helping relationships. These researches started long time ago from the hypotheses formulated by Carl Rogers, who is the founder of the person-centered approach and one of the fathers of humanistic psychology.
Starting in 1942, Rogers scientifically formulated hypotheses and then moved on to his empirical verification of what constituted the necessary and sufficient conditions for an effective professional to promote change. These were and have been confirmed until today by research: the ability to establish a trusting relationship with the user/client, with the professional having an attitude of non-judgement, acceptance and deep respect for the person of the client, a sensitive and accurate ability to listen empathetically - that is, to understand not only what the client says, but also what it means for him/her and also an attitude of authenticity, frankness and honesty in the relationship.
These hypotheses, which were validated by research on psychotherapy, where later on proven effective in all the helping relationships. Rogers gave a great contribution made a significant step forward n the helping relationships, rooted them solidly in science and not in metaphysics and made explicit the values that are at the base of any approach.
I think it will be clearer to listen directly to Carl Rogers in person, who illustrates these three necessary and sufficient conditions in one of his famous films:
"From my own years of therapeutic experience I have come to feel that If I can create the proper climate, the proper relationship, the proper conditions, the process of therapeutic movement will almost

inevitably occur in my client. You might ask, what is this climate? What are these conditions? Will they exist in the interview with the women I'm about to talk with whom I have never seen before? Well let me try to describe very briefly what these conditions are as I see them. First of all, one question is, can I be real in the relationship? This has come to have an increasing amount of importance to me over the years. I feel that the genuineness is another way of describing the quality I would like to have. I like the term congruence, by which I mean, what I'm experiencing inside is present in my awareness and comes out through in my communication. In a sense, when I have this quality, I'm all in one piece in the relationship. There's another word that describes it for me, I feel that in the relationship I would like to have a transparency, I would be quite willing for my client that sees all the way through me, that there would be nothing hidden. When I'm real in this fashion that I'm trying to describe then, I know that my own feelings will often bubble up into awareness and be expressed, but be expressed in ways that won't impose themselves on my client. Then the second question I would have is, will I find myself praising this person, caring for this person. I certainly don't want to pretend a caring that I don't feel. In fact, if I dislike my client persistently, I feel it's better that I should express it. But I know that the process of therapy is much more likely to occur, and constructive change is much more likely, if I feel a real spontaneous praising of this individual with whom I am working. A praising of this person as a separate individual. You can call it acceptance, you can call it caring, you can call it a non-possessive love if you wish. I think any of those terms tend to describe it. I know that the relationship will prove more constructive if it's present. And in the third quality, will I be able to understand the inner world of this individual, from the inside, will I be able to see it through her eyes, will I be sufficiently sensitive to move around inside the world of her feelings, so that I know what it feels like to be her. So that I can sense not only the surface meanings but some of the meanings that lie somewhat underneath the surface. I know that If I can let myself sensitively and accurately enter into her world of experience than change and therapeutic change are much more likely." Carl Rogers on the film Gloria, available here.

We know from research that in the helping relationships, the qualities of the effective professionals, regardless of the approach they use they must know how to relate with their clients with deep respect and without prejudice, to have an empathic understanding not only of what the client says, but also what she/he feels, her/his meanings, and relate to them honestly, authentically and transparently. It is also necessary, however, for this process to work that client/patient is actively involved since this is a co-construed process pf change.

In helping relationships, clients that can be defined as "effective" are the clients that are sincere and motivated to change, perhaps because they are not feeling well and want to stop suffering. They also need to have the ability to establish psychological contact with the professional working with them and to perceive the relational qualities that the professional puts into the relationship.

These capacities develop, as does the capacity to persevere, to be ready to learn from mistakes, letting mistakes become teachers of wisdom. This underlines how coping is an optimal functioning process and the result of the teamwork of the professional and the client to achieve the objectives of improved quality of life and greater realization of the intrinsic potentialities which will be developed.

Further, more or less depending also by the environmental conditions, but also moderated by the attitudes that one person has or develops, how a person faces life.

It is fundamental for any institution, service and helping professional to answer this question: What is our mission? To concentrate on disease or health? Research shows us that it is much better to concentrate on the protection and promotion of health because in this bio-psychosocial frame of reference greater successes are obtained and costs are lowered as well. Why does this happen? Because in the previous mechanistic reductionist paradigm the person who needed help was in a passive state, in fact to label somebody a patient can make him in a sense too patient, that is too passive; with an acquired passivity. This risk is less pronounced in the bio-psycho-social paradigm because the focus is on protecting and promoting individual and social health, the promotion of change is based on person centered, trauma informed, recovery focused approaches that are gender sensitive, culture sensitive it encourages the

person to use his or her own power and enter into a partnership, where even the decision-making power is shared between the professional and his or her client.
In addition, research shows us that an approach of protecting and promoting health and well-being can achieve better results for the same categories of service users. For example, a proactive relationship of patients with a good relationship with the hospital staff, in case it comes to receiving surgery. With the bio-psycho-social paradigm we achieve a lower the number of days of hospitalization and less negative consequences after surgery, greater development of immune defenses and better compliance is (i.e. the collaboration of the client with doctors and nurses to comply with their prescriptions, such as to take medication regularly). The bio-psycho-social paradigm also shows much less litigation on the part of service users towards healthcare facilities and a much less frequent doctor hopping. This paradigm not only favors results for the service user and his family, but for society as a whole, because a society where people can better develop their potential means they also get less sick, have longer lives and are less prone to diseases; it is a more prosperous society.
Protecting and promoting health and well-being is a win-win option where everyone comes out better and the results speak for themselves. The vast body of research show that effectiveness in the field of psychotherapy or of the helping relationships does not derive from the applications of a specific theoretical approach, it derives much more from the relational qualities of psychotherapists with their clients.
A psychotherapist is effective because he or she have the ability to relate to his patient/client/service user with a therapeutic alliance based of the professional capacities of profound respect, not judging, acceptance and because the therapist not only is able to listen to what his service user / patient / customer say, but also to understand emphatically what meaning the sharing of experience has for the specific person of the client as an individual. The professional is also able to relate to the client in a genuine, spontaneous and transparent way. However, this is not enough because the psychotherapeutic relationship, as with any helping relationship, is a team work, a co-construction in which the client, the service user, the patient actively contributes, otherwise it does not work.
The motivation is important, often is provided by the client' feelings of discomfort - and therefore the motivation to change - and then the capacity for psychological contact with the psychotherapist and, moreover, a third condition: being able to perceive the qualities of relationship offered by the professional possessing the fundamental qualities of deep respect, empathic listening and the authenticity.
In short, a large body of research and institutions like the World Health Organization (WHO), the Royal College of Physicians and many other scientific organizations underlines a scientific and deontological imperative, to operate in science and conscience in the best interest of service users and society in the psychotherapeutic field and in the helping professions is important to foster person centered, trauma informed, gender and cultural sensitive helping relationships; this way of helping is good medicine from any angle that is scientifically investigated.
To know more go to the World Health Organization on Person Centered Care section of this toolkit or consult this bibliography.

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3.3 The economic burden of trauma

The cumulative economic and social burden of complex trauma in childhood is extremely high. Based upon data from a variety of sources, a conservative annual cost of child abuse and neglect is an estimated $103.8 billion, or $284.3 million per day (in 2007 values). This number includes both direct costs—about $70.7 billion—which include the immediate needs of maltreated children (hospitalization, mental health care, child welfare systems, and law enforcement) and also indirect costs—about $33.1 billion—which are the secondary or long-term effects of child abuse and neglect (special education, juvenile delinquency, mental health and health care, adult criminal justice system, and lost productivity to society).
A recent study examining confirmed cases of child maltreatment in the United States found the estimated total lifetime costs associated with child maltreatment over a 12-month period to be $124 billion. In the 1,740 fatal cases of child maltreatment, the estimated cost per case was $1.3 million, including medical expenses and productivity loss. For the 579,000 non-fatal cases, the estimated average lifetime cost per victim of child maltreatment was $210,012, which includes costs relating to health care throughout the lifespan, productivity losses, child welfare, criminal justice, and special education. Costs for these nonfatal cases of child maltreatment are comparable to other high-cost health conditions (i.e., $159,846 for stroke victims and $181,000 to $253,000 for those with Type 2 diabetes).
In addition to these costs are the “intangible losses” of pain, sorrow, and reduced quality of life to victims and their families. Such immeasurable losses may be the most significant cost of child maltreatment.
The WHO (2013) underlines that:

- As many as 450 million people suffer from a mental or behavioral disorder.
- Nearly 1 million people commit suicide every year.
- Four of the six leading causes of years lived with disability are due to neuropsychiatric disorders (depression, alcohol-use disorders, schizophrenia and bipolar disorder).
- One in four families has at least one member with a mental disorder. Family members are often the primary caregivers of people with mental disorders. The extent of the burden of mental disorders on family members is difficult to assess and quantify, and is consequently often ignored. However, it does have a significant impact on the family’s quality of life.
- In addition to the health and social costs, those suffering from mental illnesses are also victims of human rights violations, stigma and discrimination, both inside and outside psychiatric institutions.

The costs of childhood disorders can be both large and largely hidden (Knapp et al., 1999). Early onset of mental disorders disrupts education and early careers (Kessler et al., 1995). The consequences in adulthood can be enormous if effective treatment is not provided (Maughan & Rutter, 1998). Knapp shows in figure 4 that children with conduct disorders generate substantial additional costs from ages 10 to 27 years. These are not mainly related to health, as one would expect, but to education and criminal justice, creating a serious challenge for the social capital as a whole.
In 2014 the world Health organization produced a report on Child Maltreatment.

Trauma is among the leading public health issues in economic as well as social impact:

- Adverse childhood experiences (such as abuse, neglect, loss, exposure to violence, etc.) incur risk for lifelong emotional, behavioral, and medical problems, with each additional type of adverse experience exponentially increasing risk (Anda *et al.*, 2006)

- Traumatic experiences at any age (including crime victimization, rape, motor vehicle accident, etc.) potentially cause a range of enduring symptoms such as post-traumatic stress, anxiety, depression, anger, aggression, substance abuse (Friedman *et al.*, 2007).
- Domestic abuse (domestic violence & child abuse) costs the U.S. an estimated $500 billion per year in medical expenses alone, not counting the economic impact of lost work, lost potential, family disruptions, and lowered quality of life (Goldstein, 2014).
- Trauma, broadly defined, causes or contributes to nearly every type of emotional or behavioral problem, including mental illness, suicide, school/work failure, substance abuse, aggression, and crime (*Friedman et al.*, 2007).

The Who underlines that child maltreatment is a major public health problem, a sort of pandemic affecting at least 55 million children in the WHO European Region. The impact of abuse and/or neglect in childhood is detrimental to physical, psychological and reproductive health throughout the life-course, yet the high costs to society are avoidable. There are clear risk factors for maltreatment at the level of the individual, family, community and society. Data collected through a survey of government-appointed national data coordinators of 49 participating countries in the European Region show that good progress is being made overall towards achieving the objectives. Development of national policy for the prevention of child maltreatment has increased across the Region, with three quarters of countries reporting an action plan, but these must be informed by robust national data. Surveillance of child maltreatment remains inadequate in many countries, with information systems in low- and middle-income countries most in need of strengthening. Legislation to prevent maltreatment is widespread, but better enforcement is needed. The implementation of child maltreatment prevention programs, including home-visiting, parenting education, school and hospital-based initiatives, has improved, but evaluation of impact is needed. Child maltreatment is a societal issue that crosses sectoral boundaries, needing sustained, systematic, multidisciplinary and evidence-informed approach to prevention, an important priority for governments.
To know more you can consult the section in the Toolkit dedicated to the economic burden of emotional trauma or go directly to:

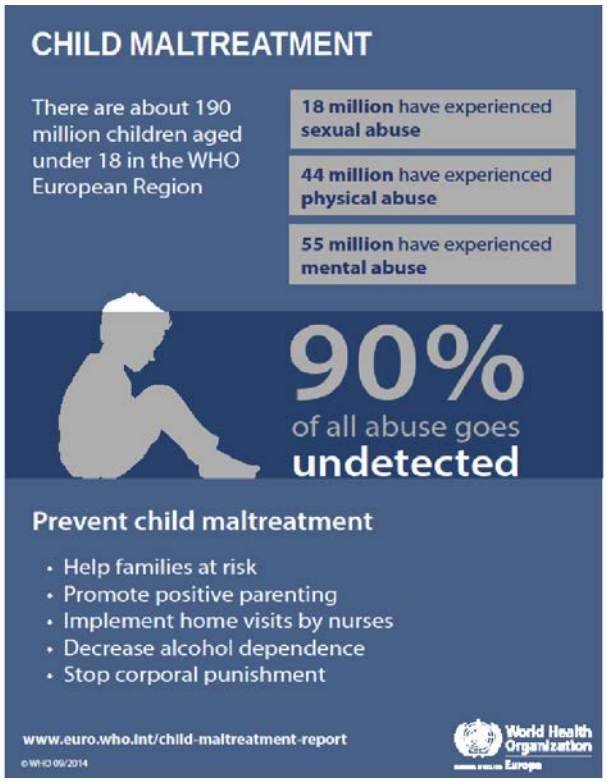
WHO (2018) European Status Report On Preventing Child Maltreatment: https://www.euro.who.int/__data/assets/pdf_file/0017/381140/wh12-ecm-rep-eng.pdf

Bromet, E., Karam, E., Koenen, K., & Stein, D. (Eds.). (2018). *Trauma and Posttraumatic Stress Disorder: Global Perspectives from the WHO World Mental Health Surveys.* Cambridge: Cambridge University Press. doi:10.1017/9781107445130

Stoltenborgh M., Bakermans-Kranenburg, M. J., Alink, L. R. A., & van Ijzendoorn, M. H. (2015). The prevalence of child maltreatment across the globe: review of a series of meta-analyses. *Child Abuse Review 2015; 24: 37–50.*

World Health Organization. Investing in mental health https://www.who.int/mental_health/media/investing_mnh.pdf

Transformative Justice approaches to addressing child sexual abuse **http://www.generationfive.org/wp-content/uploads/2013/07/G5_Toward_Transformative_Justice-Document.pdf**



3.4 The dangers of re-traumatization

Re-traumatization is an unfortunate event that sees a person who has already suffered a trauma have a relapse, this occurs mainly for two reasons. One, due to natural causes the previously traumatized person is exposed to images or events where other people are victims of trauma and this makes the subject re-live the previously experienced trauma. The other is instead a type of re-traumatization that has iatrogenic origins. That is, the treatments are delivered in a dysfunctional manner, not necessarily due to the bad intentions of the professionals or of facility administrators, but out of simple ignorance, so that instead of being helped by the treatment and care facilities, the traumatized person are further traumatized. In short, it would be like a person who arrives at an emergency room with a broken leg and the doctors handle it badly, dropping the patient from the stretcher. He then finds himself with two broken legs, thus doubling the damage; a true tragedy.
The history and the sociology of trauma treatments reveal that, unfortunately, this was not at all infrequent in the past - obviously not for bad will, but ignorance - to produce iatrogenic results. The whole world of care, because offers treatments that impact a complex and delicate system like a human being, risks not only impacting people in a good way, but - without wanting to - further damaging people; this is true for drugs, for surgical procedures and for any type of helping relationship. A service If not delivered effectively, it becomes counterproductive.
Within the specificity of trauma this is particularly serious, as a traumatized person is particularly sensitive and can be significantly damaged by a second traumatization. Today we have learned from these mistakes, research has become more numerous and accurate and we have developed significant knowledge - which of course will continue to develop in the future - thanks to which precautions have been drawn up so as not to run the risk of re-traumatizing already traumatized people. These precautions are called trauma-informed practices, they center on the person of the traumatized service user and pay attention to what causes further damages.
There are many traumatization factors, but we can mainly divide them into two groups.

Those that occur due to natural causes: when a traumatized person finds himself re-experiencing the trauma because he is exposed to traumatic external stimuli (such as a catastrophe, or he sees people being traumatized, sometimes even watching a movie or the news in TV can be retraumatising). Or those in which the trauma that is experienced and suffered by an already traumatized person, is due to being offered services or care by inexperienced people or in a non-trauma oriented organization, that even not wanting to cause re-traumatizing still not been trauma informed can damage the client. The safeguards and procedures that an operator, a professional, or an institution adopt to prevent the traumatization of their clients is called trauma-informed care. In the past, unfortunately, we have too often re-traumatized those who had already suffered a trauma, certainly not out of a bad will, but out of ignorance. It is thanks to the research and clinical evidence that we observed that these clients, if they were pressed to do things they did not want to do, if they were not respected in their own times, if they were forced to remember their traumatic experiences - obviously for a good cause - even without realizing it they received iatrogenic damage.

With the definition of informed trauma care we mean all those precautions, that safety net developed through research, which have showed us how important it is to protect already traumatized people against the danger of new traumatization. To respect their pace to offer services centered on the person, respecting their needs and sensitivity, and above all not forcing them to do something they are not yet ready to do.

The reason is very simple: we have observed that already traumatized people need acceptance, kindness and safe havens in which to regain their strength and resume their rhythm of exploration which, precisely because they are traumatized, is necessarily cautious given their previous experience. Therefore, trusting the self-regulating abilities of trauma survivors is essential aspect of effective good care.

The System of Protection for Asylum Seekers and Refugees (SPRAR), has changed name to SIPROIMI, due to the enactment of law *113/2018* - therefore very recently. After a series of changes, including regulations, that the new government which took office last May 2019 in Italy, has made to the whole issue of immigration, the right to asylum and therefore hospitality.

SPRAR was established in 2002 and is composed of a network of municipalities and local authorities, which in collaboration with third sector organizations and NGOs, manage on a voluntary basis (therefore of their own choice) hospitality and integration projects for asylum seeker applicants and refugees.

Over the years, this network has undergone a progressive and positive evolution: from the initial 1,500 hospitality places to the current 35,000. There have been several phases in the history of the SPRAR that have led to a number of changes.

The first was the moment institutionalization by means of a law, making it stable and regular as a central system of integrated reception in Italy, whereas in previous years there were no structured hospitality systems but only emergency interventions.

Another important moment was in 2003 when, during the so-called North Africa Emergency, the effectiveness and efficiency of the SPRAR model in terms of achieving social inclusion and integration objectives emerged, also at the European level.

The last phase is the most recent one, in which the identity of the SPRAR was modified, meaning it can no longer accommodate asylum seekers or humanitarian cases because humanitarian protection has been abolished) and by law we can only accommodate unaccompanied foreign minors, holders of international protection (which constitutes a small number compared to asylum requests) and some new types of residence permits, the so-called special cases. SPRAR, which is now called SIPROIMI, will now be able to accommodate special cases for medical treatment, victims of trafficking, victims of labor exploitation, domestic violence, natural disasters and people who have distinguished themselves for particular acts of heroism, always referring to foreigners, not Italian citizens, who have other social protection systems.

It can be said that SPRAR now has a welfare identity directed towards foreigners and is no longer a hospitality and protective system for people related to the theme of the right to asylum. These changes to its identity and could represent, on paper, a partially positive passage, in the sense that it is turning to

the protection of people with some type of vulnerability. At the moment, the difficulty is the fact that the person in need is required to have a residence permit but is not required in the case of a victim of trafficking, that can automatically acquire the permit by as a victim of trafficking, the same can be said for a victim of exploitation and so forth.
There are no precise criteria for how these procedures should be, or how to bring together all people with this type of vulnerability under the definition, even legal, of a special case. Only through the formalization of a special-case residence permit will a person have access to the SPRAR and be able to take advantage of all the protection services that the SPRAR can provide. The criteria and requirements for which a person may be entitled to medical care have not yet been defined - what type of mental or physical discomfort, what level of severity, and what timing does this take into account?
We are therefore in a critical transitional moment as many people who, up until a few months ago, had the right of access to SPRAR projects now no longer have it. While on the other hand, those who on paper seem to be able to have the right to access to these services, , in truth do not know how to give the "supporting evidence" to be able use this right.

To know more please go to this toolkit section on Trauma Informed Care
Or consult the free guides:

Substance Abuse and Mental Health Services Administration. (2014a). SAMHSA's concept of trauma and guidance for a trauma-informed approach (HHS Publication No. [SMA] 14-4884). Retrieved from https://www.nasmhpd.org/sites/default/files/SAMHSA_Concept_of_Trauma_and_Guidance.pdf

Substance Abuse and Mental Health Services Administration. (2014b). Trauma-Informed Care in Behavioral Health Services: Treatment Improvement Protocol (TIP) Series 57 (HHS Publication No. [SMA] 14-4816). Retrieved from https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816

3.5 Vicarious Trauma

Vicarious trauma is the trauma resulting from being in contact with traumatized people; vicarious trauma generally affects those who provide services to people affected by natural trauma (such as disasters) or people who suffer trauma as a result of violence perpetrated against them by other human beings, examples are war, terrorist attacks, but also family violence or working with victims of sexual violence etc.
In short, the helping professional relates daily to the trauma survivors with good will, offers assistance, support and psychological contact , but this, despite the profound significance of the openness, humanity and the importance at the existential level, can nevertheless affect the caregiver' mental health, and may develop in a source of real trauma with all the consequences that trauma has on people.
Is very important to prevent and abate the impact of vicarious trauma that caregivers and all the workers who are exposed to victims of trauma or violence, such as health personnel, policemen, firemen, journalists, volunteers and all those people who for various reasons are in contact with traumatized people.
It is important to prevent vicarious trauma, or the effects of burnout which also may affects people in helping relationships and that hits hard, in particular, when one cannot *recharge the batteries*, in situations where the needs well outstrip the resources and where is not easy to have a work life balance or disconnect from work that is heavy and taxating as well as beautiful. It is the responsibility of organizations, to help their caregivers basic needs, to take care of personal life, spending time with family, friends and having some recreational breaks. Is sometimes in dire conditions to put into practices

those principles but nevertheless is important to keep in mind is that if one caregiver becomes impaired will be impossible to give assistance to patients.
Preventing vicarious trauma is a big challenge for all those who offer their helping services with passion, generosity and empathy but if they are unable to also help themselves will find themselves in the predicament that you cannot give others what you do not have.
It is therefore morally, ethically and professionally necessary that caregivers promote their coping capacities, their resilience, health and wellbeing, because if we want to give a lot to people we want to help we must also take care of ourselves.

3.6 Drawing as processing of promoting healing from the vicarious trauma suffered by the children of Lampedusa.

On October 3, 2013, a particularly dramatic event took place in the island of Lampedusa. A boat with 500 migrants sank and 388 of them lost their lives. Among those who died there were women, children, many young people and for the population of the island of Lampedusa it was a particularly traumatic event because all the inhabitants found themselves rescuing people at sea and recovering hundreds of corpses and witnessing the shocking dimensions related to this tragedy. They even found a mother who was giving birth during the shipwreck with her son still attached to her umbilical cord.
An event of this kind produces a vicarious trauma on the population and therefore we tried, in some way, in the Local health Agency to offer help by listening and supporting people who had traumatic experiences. One of the most difficult situations to handle was that related to the traumatic experience perceived by children, especially in primary schools.
Immigration in Lampedusa is a multi-year experience and everyone (including young people) knows that often journeys of hope end with the loss of life, but children 6 -7 years old are particularly sensitive to this type of experience and many of them have begun to have fears, anguish, phobias, all typical reactions of people exposed to traumatic experiences where lives are endangered and lost.
For the children of Lampedusa this tragic event had happened in their sea, a sea they experienced as a source of joy, play and fun; that sea that represented for them an element of joy and lightness suddenly turned into a sea of death. One of the possibilities that were put in place to deal with the processing of the children's vicarious trauma was to propose that they make drawings, these drawings now show how the children respond and react to this kind of trauma.
A premise must be made: art, painting are powerful tools to process painful and frightening events in of itself art produces liberating effects and also can facilitate the processing of traumatic events. Next we must ask ourselves what is a traumatic event from the point of view of children. In this case it depends on the type of event, a traumatic event has different forms, it can be produced by humans (such as wars and terrorism) or by nature (hurricanes and earthquakes, tornados) and each of these events leaves specific traces and specific fears in the minds of children. In the case of the shipwreck of Lampedusa, to recompose the emotional and internal fracture that the children had experienced. These events of death at sea had the effect of producing in many children the fear of eating fish (the fish had eaten the dead children and mothers) or going to the sea side (in the sea there could be some corpses), it was necessary to facilitate them to process all this and as said, this was possible with drawing once that a safe relational climate was established.
In clinical work with traumatized children, through a model of psychotherapy based on play-therapy according to the model of Virginia Axline, a US psychotherapist, pupil of Carl Rogers, which has transposed the basic principles developed by Rogers in the field of adult psychotherapy, into clinical work with children. This work was published in her book "play therapy" in 1947.
The hypothesis postulated by Rogers are fundamental for understanding the inner world of the child, to which Axline refers; Rogers speak of a child who has an innate tendency to actualize their potential of their organism, all their behaviors are aimed at achieving this goal. A second postulate is that children's

can regulate themselves and no one knows better than them what is best for them. A third postulate is about a child who actively searches for all those experiences that may be facilitate their development, the expression of his or her potential and his or her body, while he or she will tend to reject all those experiences that he or she considers unfavorable.
From this point of view, play therapy allows the children to express themselves in the best possible conditions, thanks to a safe climate, containing and facilitating the child to have the opportunity to better express their potential. The facilitating climate that is achieved in the field of play therapy allows the child to strengthen, to know themselves better and to correctly symbolize their experience, in other words, to give expression to their emotions and feelings.
Access to the child's inner world is possible through the so-called preferential channels: play, drawing and tales. Through these channels the child is able to express themselves more spontaneously and freely, as they are channels that connect to them strongly, and thus children able to express their needs, experiences and emotions.
As part of the process of play therapy, the therapist will be careful to reflect to the child everything that emerges through the game, therefore tuning in with their emotions. This allows the child to increase awareness of his own behavior.
The construction of the setting is fundamental in play therapy because it is the way in which the child is welcomed. In this sense, for example, having a lot of play materials available allows the child to express himself freely, to move freely within the environment. This becomes a very significant experience for them: when the child feels free they are better facilitated in self-exploration and, through this, change occurs, which produces personal empowerment.
Returning to the construction of the setting, the presence of many materials, such as sheets of paper, various colors, plasticine to model, trays of sand to create scenes on, or the presence of books, fairy tales to tell or read together, along with the presence of puppets, which allow the child to express himself at best. For example, the use of two puppets that the child and therapist can wear with their hands, wearing them the child transform them into parts of himself and can thus interact with the therapist, making the puppet act as a channel of communication. This is important because in doing so the child can open up in a deeper and more effective way.
In this sense the puppets can interact as if they were autonomous entities. It is important that the therapist looks directly at the puppets and not at the child, for this makes it easier to consider them as a channel of expression that is not themselves. The fact that they represent animals is a facilitating element because it is easier for the child to identify with the animal than with the human figure.
The therapist in this process with these materials of play will only accompany the child in this path and - citing Axline - during a path of psychotherapy it will be the child who indicates the way forward rather than therapist directing it.
In fact, when the child is free to express themselves, self-regulation is possible, as stated by Rogers' postulates mentioned above. In this perspective, play therapy is effective in working with children who have suffered traumatic experiences, with the creation of a climate of safety, containment and freedom that allows the traumatized children to best express themselves and start to process their experiences in a healthy manner.

To know more please go to the section of resource under the heading: Vicarious trauma or directly consult this website:

Vicarious Trauma Toolkit

4. Trauma informed Care (TIC)

4.1 Trauma Informed Care principles and how to apply them

4.1.1 The Trauma-informed approach

What does trauma-informed mean? Simply, to be centered, to be aware, to be informed about trauma. It is an approach aimed at preventing retraumatization and at offering services and designing structures that lower the risk of retraumatization and maximize the possibility of offering effective services.
We have come to define good practices as trauma-informed practices also thanks to an attitude of openness and recognition of mistakes made in the past. Errors, of course, committed not intentionally, but out of ignorance. Precisely because we did not know that some aspects of the treatments offered at the time were part of the problem and not of the solution: for example, we did not know that pushing clients against their will to remember past traumas, re-experiencing traumatic moments and so on where iatrogenic.
Effective trauma informed care needs to be promoted within a bio-psycho-social frame, so what is needed is much more than just some trauma-informed care training for professionals and paraprofessionals, in order to deliver effective trauma informed care requires that all the aspects of services need to have a clearly defined model of trauma-informed care, with policies and procedures to support the model and processes to be monitored and measured. In other words like the burden of trauma is socially construed also trauma informed care needs to be part of the social construction of reality and encompass health services, but also parents training, restructuring schools, workplaces, juvenile justice, local community and regional and state fund allotments , regulations and laws.
Today, thanks to what we have learned from the mistakes of the past, we have a series of directives and parameters that help us to prevent damage and maximize the benefits of services offerings. This is not only valid in the field of health, mental health, but in every other field - for example, schools, organizations, juvenile justice regulations or even laws. In short, a trauma-informed school is a school sensitive to the problems of trauma and therefore the teachers will also know that not always an so called undisciplined student is somebody not respecting the rules but the student could be expressing an underlining problem due to a trauma. Knowing this will allow the teacher to manage more effectively his role as a trauma informed teacher, by referring the problematic student to the psychologist so that the student, if he or she needs help, can be helped and his problem does not become more serious.
After all, having an informed-trauma approach is not only a duty, from an ethical, clinical and mental health point of view, but it is also effective in the cost-benefit ratio, because providing treatments that reduce the damage is in the interest not only of the survivors of trauma but in the best interest of the whole society.

4.1.2 1st trauma-informed principle

The common denominators are present in each structure - no matter what - whether it is trauma-informed, that is, whether it is a territorial structure dedicated to the protection and promotion of health, or a school, a work organization, an institution for specialized treatment, or even a correctional facility part of the judicial system. A community, in order to be trauma-informed, must have these common denominators that share a thread: the common denominators are all unified in wanting to communicate to trauma survivors a feeling of security, physical and psychological - to be a safe haven.
The first trauma-informed principle is that facilities must provide physical and emotional security that allows the traumatized person to feel and experience safety, that nothing bad can happen, no attacks, no harm: This is a safe place where it is not necessary to be on edge, alert, nor living with anxiety.
The trauma-informed structure is very welcoming in all the aspect of of communication and metacommunication. Therefore the client is welcomed; you really say "welcome, or welcome back" and are truly convinced that the client is a person to whom you want to give a real welcome.

A structure, to be trusted and offer a sense of security to service users, Its messages at all levels must be congruent with their actions and over time. Only in this way will the client be able to develop real trust and feel that the structure is truly a welcoming and a safe port which one can rely on.
In a trauma-informed structure there is no space, no citizenship for violence, shame and guilt; all very problematic aspects that can exacerbate or retraumatize those who have already suffered a trauma.
A trauma-informed structure also strongly ensures confidentiality and professional secrecy, the privacy of the individual, who will not be exposed to this type of danger and violence. Moreover, the language of a trauma-informed structure is centered on the person, that is, it will speak a clear, coherent language that the service user can understand and not a cryptic professional language that will take a person with three degrees to be understood.

4.1.3 2nd trauma-informed care principle

The second principle of a trauma-informed organization is collaboration and mutuality. Mutuality means that the user is engaged actively in the co-creation of the services that are provided, and therefore the personal power is not that of the traditional approaches of the past (such as in the mechanistic reductionist models where the user is the designated patient). No, here clients have their say in the matter, and the role that they will assume is one of an active promoter of change aiming their actions to recuperate their abilities and human potential. A trauma-informed structure will promote the recovery of self-respect, a crucial aspect for those who have been victims of trauma; and also of hope; recovery, the recovery of their own potential. A structure like this will always make it clear, especially to one's self, that the recovery of health and of the functionality of a person suffering from post-traumatic stress or from trauma can only occur through effective relationships that the staff members of the structure manage to establish with the service user. In short, good team work, a working alliance.
Sharing the decision-making aspects is central to ensuring the good functioning of the service provided, firstly we know well - as is illustrated in Karasek's research on stress - that if I experience stressful stimuli but I have ample power of control, stress is lowered. If I have little control over the situation, stress rises. It is precisely this principle at work here. Therefore giving decision-making power and control to the service user is already is part of the cure.
In other words, a client, a person with more control is able to better overcome his problems and improve his condition.
The trauma-informed structure is systemic and holistic, in the sense that it is well aware that on which it must operate is precisely the social construction of a trauma-informed reality. All the aspects combined to make it as such, and will therefore take care of the alpha to the omega, from the start of the intake, to the reception and the offering of service and to the after care process

4.1.4 3rd trauma-informed care principle

The third principle is constituted by the promotion of trust and an environment of transparency - important elements for establishing a good relationship - an effective working alliance with the service user. To achieve this goal it is of primary importance that the staff also share interpersonal relationships based on trust and transparency with other staff members, with the team and the crew and also in the context of interpersonal relationships with service users and their families.
Another important aspect is to respect limits and to maintain boundaries. First of all, this is because by having clear borders, clear spaces are created, and not respecting the borders means polluting the setting and decreasing their effectiveness.
Transparency is fundamental and therefore the policies must be clear and not formulated in a bureaucratic language, but in a clear and transparent language. Another reason for clarity is that everyone must know

- most especially the service users - which place they are in, what rights and duties they have, and of every aspect of the structure and of the personnel with whom they will work with.
It is necessary to have also a lot of clarity of the roles and to know that the various professionals operating in a structure have various competences and also provide for different aspects of the treatment- nobody is a generalist and therefore, as in an articulated society, the baker makes bread, a milkman distributes milk, the engineer engages in his job and so forth.
Fundamental to a trauma-informed structure is the respect for the user's rights and the active promotion of the client's rights. It is therefore essential to receive a real informed consent explaining well to the user how the procedures are actualized, the provision of services, all the while doing everything to make sure that the comprehension and consent are genuine and not mere formalities.

4.1.5 4th trauma-informed care principle

The fourth principle of the trauma-informed structures is based on actions of empowerment, on giving the right to choose and also to the co-creation of the realities dedicated to users. Everything in the structure offers messages and meta-messages centered on promoting strengths, user resilience. The choice is to promote change by focusing on the strengths of the client and not on his weakness or dysfunction. The emphasis is on promoting awareness of how the service user has dealt with his various situations in the past, at times probably not in the most efficient way, in short - the coping. It is therefore a question of applying a mission, a l philosophy of service offerings that emphasizes the usefulness of relying on people's strengths. In other words, in the past the focus was on the pathologies and their reduction, now we have a new paradigm that it is based on health and strengths, of which we try to promote expansion and enlargement.
The social roles are also valued; because we are social mammals therefore it is of vital importance for the identity and development of our potential.
The declared and consistently pursued objective is to promote users' self-regulation, autonomy and self-management skills, therefore the possibility of growing also from traumatic experiences does not emphasize that a person is a poor victim, but his capacity for resilience.

4.1.6 5th trauma-informed care principle

The fifth principle is that of peer support, so a trauma-informed organization will do everything to encourage its users to receive the support of their peers. This is a very important variable - to establish security and hope.
First and foremost, peer support helps people feel that they are received more securely, and it also arouses their hope that there is the possibility of getting better. In short, it is important to get support from peers in order to build greater self-confidence and potential, and even self-esteem.
Peer support also promotes opportunities for collaboration and therefore all that is positive in promoting one's social role and feeling active. It is undeniable that peer support leads to interpersonal communication that can really be advantageous in the building of narratives that are a part of a much richer puzzle and that develops narratives of hope and healing.

4.1.7 6th trauma-informed care principle

The sixth principle concerns the sensitivity of a trauma-informed structure to all cultural, intercultural and gender issues or those concerning a certain part of the population or minorities, in making sure of treating everyone in a welcoming and, above all, in a democratic way.
Obviously, an effective and efficient structure will not have constructs linked to the past with unjust and destructive stereotypes towards minorities. The service provided will, for example, be very sensitive to

gender differences and to giving equal respect of gender diversity, and then such an effective exploit will efficiently facilitate the use of the cultural background, traditions, culture and country of origin of its users. It will build a reality that is loyal to its own philosophy so that the organization and procedures will all be non-discriminatory and sensitive to diversity.
Furthermore, it will also be able to recognize and deal with historical trauma efficiently. Historical traumas are mass trauma events that impact even those who have not experienced it directly. To give a dramatic example: the holocaust, not only the millions of unfortunate people have been victims of the Nazi delirium, but also their children and grandchildren bore the reverberation of this bestiality.

4.1.8 Variables of a Trauma Informed Care Service

The National Child Traumatic Stress Network (NCTSN) offers a detailed illustration of the variables of a Trauma Informed Care Service:

> "A trauma-informed child and family service system is one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system including children, caregivers, and service providers. Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the child, using the best available science, to maximize physical and psychological safety, facilitate the recovery of the child and family, and support their ability to thrive.

A service system with a trauma-informed perspective is one in which agencies, programs, and service providers:

1. Routinely screen for trauma exposure and related symptoms.
2. Use evidence-based, culturally responsive assessment and treatment for traumatic stress and associated mental health symptoms.
3. Make resources available to children, families, and providers on trauma exposure, its impact, and treatment.
4. Engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma.
5. Address parent and caregiver trauma and its impact on the family system.
6. Emphasize continuity of care and collaboration across child-service systems.
7. Maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff wellness.

These activities are rooted in an understanding that trauma-informed agencies, programs, and service providers:

1. Build meaningful partnerships that create mutuality among children, families, caregivers, and professionals at an individual and organizational level.
2. Address the intersections of trauma with culture, history, race, gender, location, and language, acknowledge the compounding impact of structural inequity, and are responsive to the unique needs of diverse communities."

To know more please go to this toolkit section on Trauma Informed Care

Or consult the free guides:

National Child Traumatic Stress Network (NCTSN)
https://www.nctsn.org/trauma-informed-care/creating-trauma-informed-systems

Substance Abuse and Mental Health Services Administration. (2014a). SAMHSA's concept of trauma and guidance for a trauma-informed approach (HHS Publication No. [SMA] 14-4884). Retrieved from https://www.nasmhpd.org/sites/default/files/SAMHSA_Concept_of_Trauma_and_Guidance.pdf

Substance Abuse and Mental Health Services Administration. (2014b). Trauma-Informed Care in Behavioral Health Services: Treatment Improvement Protocol (TIP) Series 57 (HHS Publication No. [SMA] 14-4816). Retrieved from https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816

Trauma-Informed Practice Guide -This Guide was developed on behalf of the BC Provincial Mental Health and Substance Use Planning Council in British Columbia
https://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

Becoming Trauma-Informed- Published by the Centre for Addiction and Mental Health in Ontario, this book offers examples of the ways in which practitioners have applied principles of trauma-informed practice in their work with diverse populations and in diverse settings within the MHSU field. http://knowledgex.camh.net/amhspecialists/specialized_treatment/
trauma_treatment/Documents/becoming_trauma_informed.pdf

Beyond Trauma: A Healing Journey for Women Created by Dr. Stephanie Covington, this trauma treatment manual makes the connection between women's experiences of trauma and their substance use. It can be used in a variety of settings, including residential and outpatient treatment settings, mental health programs, and criminal justice settings. www.stephaniecovington.com/b_beyond.php

Developing Trauma Informed Organizations: A Tool Kit The Tool Kit is designed to help organizations improve the quality of services offered by integrating an understanding of the impact of trauma and violence into the organization's policies, procedures, and interactions with those being served. It includes the principles for trauma-informed treatment, a self-assessment for provider organizations, an organizational assessment and instructions for using the assessments to provide trauma-informed, integrated care.
http://www.healthrecovery.org/services_and_products/products/detailTrue.asp?ProductID=30

4.1.9 Trauma informed services for LGBTQI adolescents

The complex narrative that sees LGBTQI adolescents grow up in family and social contexts that often ignore them, denigrating fundamental dimensions of their identity, such as sexuality and affectivity, may be present in a variety of psychological disorders.
A wide range of scientific literature shows that in a non-clinical population these individuals suffer significantly more from anxiety disorders, substance abuse, post-traumatic stress disorder and have an increased risk of suicide. Researchers correlate this increased incidence of mental distress with the dimensions of minority stress and social homophobia; therefore invisibility and silence emerge as causes and consequences of traumatic experiences.

Within the experience of these individuals acquire traumatic realities, concepts of cumulative trauma, relational trauma and complex traumatic disorders.
There is, therefore, a circular relationship between social prejudice, the aspect of feeling dissociated, invisibility, but also resilience, in a population that is denied not only this dimension but also that of citizenship, belonging and inclusion.
It is therefore necessary, for those who are responsible for the hospitality and support of these children, to ask themselves how to facilitate and assist these individuals to win the right to exist, to dignity and the right to love.
The reciprocal relations that have been sustained over 50 years and continue today, the documents, vademecum, guidelines produced as a result of these researches refer to the dimensions that follow:

- Homosexuality is a normal and positive variant of human sexuality and does not in of itself constitute an indicator of mental or developmental disorders
- Homosexuality and bisexuality are subject to social stigma, this can have many negative consequences in evolutive processes and pathways
- Homosexual effects and behaviors can be present in various sexual orientations
- LGBT people can lead satisfying and happy lives, establish lasting relationships as a couple, form families as strong as heterosexual ones
- There is no scientific research that links homosexuality to trauma or to dysfunctionality
- There is no evidence that all therapeutic attempts aimed at modifying the sexual order are effective or risk-free.

The guidelines issued by the APA in 2012 with respect to psychological practice with LGBTIQ emphasizes the importance of taking into account the attitudes of the helping relationship administrator towards homosexuality and bisexuality. Understood not only as the knowledge of the effects of stigma on these people, but also the awareness of their implicit and explicit attitudes regarding homosexuality or bisexuality. So both the personal expertise on these issues as well as the personal view of them, can affect the field of evaluation and intervention.
The recommended common denominators that can be extrapolated from all the documents produced so far can be summarized as follows:

- Offer acceptance and support by listening respectfully, non-judgmentally and empathically to help the user to overcome the discomfort caused by minority stress
- Adopt appropriate measures in the knowledge phase of these individuals: evaluation should be directed to the knowledge of the subject in all its complexity, considering the interactions and interconnections between minority stress, mental health and the spiritual and inner dimension, as well as the position that sexual orientation occupies in the general functioning of the individual.
- Encourage and support active coping: we know that for adolescents in general it is important to feel proactive agents in their lives, in particular when coping with stressful events the helping relationship provider should help the user and encourage strategies that facilitate cognitive and emotional processing of the stressor.
- Understand the role played by friendships and the LGBTIQ community. Considering that minority stress can lead to marginalization and isolation, a key element is to increase the ability to benefit from social support.
- Explore and develop identity. Identity dynamics are an important and fundamental aspect in adolescence and in that of LGBTIQ individuals, so it is important that these people can explore and integrate without necessarily having to choose one identity at the expense of the other as in the case of the male-female dichotomy.

- Understand conflicts and promote their integration. The helping relationship should promote dialogue and integration between parties of any conflict, as is the case, for example, with sexual orientation and religious beliefs.
- Understand the underlying meanings of requests to change sexual orientation or to undergo remedial therapy. In these cases it is important that an expert therapist conducts an analysis of the appropriate question, accepting meaning and exploring this desire and leading it back to complex family and social dynamics that could lead the subject to consider unacceptable this element of his own identity.
- Understand and explore the coming out process
- Capture levels of minority stress in conditions of dual minority relationships, where the individual is discriminated against not only because of homosexuality or bisexuality but also because of other conditions subject to social stigma
- Taking into account the weight that minority stress has in couple dynamics, it is important to remember that gay and lesbian couples are not recognized by the main religions or in the legal system of many countries. In connection with this, it is necessary to consider all that is related to homogeneity and the lack of legal regulation of this type of family formation.

To know more about this topic you can consult:

Rollè L, Giardina G, Caldarera AM, Gerino E and Brustia P (2018) When Intimate Partner Violence Meets Same Sex Couples: A Review of Same Sex Intimate Partner Violence. *Front. Psychol. 9:1506. doi: 10.3389/fpsyg.2018.01506*

https://healthysafechildren.org/sites/default/files/Trauma_Informed_Approach_LGBTQ_Youth_1.pdf

4.1.10 Trauma-informed schools

Schools can do a lot for the prevention and effective management of traumas and above all in preventing retraumatization. Schools are a neuralgic point of the community, teachers in particular because they continually see their students and have frequent contact with their families. Furthermore, teachers enjoy a certain social prestige, deriving from their role in the community. So if the teachers and all the school staff are sensitized on the parameters of a trauma-informed school, then maybe they would have asked to an expert consultant to improve from a problem-ignorant school to a well-informed school about the problem of trauma. Now, this school would not be part of the problem, but part of the solution not only because teachers who are sensitized to trauma problems may be well prepared to pick up signals. If they do not have a trained eye they could interpret some of their students' behaviors as mere disciplinary problems, but instead being Trauma informed teachers , they may be sensitive enough to act as a reference to students and have assessments if one of their students needs support as a victims of trauma. Teachers can have a significant influence on parents, who can gradually become trauma-informed parents and can make a significant contribution to this type of problem.
In short, a trauma-informed is a complement to the vocation of a school, which is effectively disseminating knowledge and promoting learnings to empower people to function as proactive citizens of their *polis*.
Children's reactions to trauma can interfere considerably with learning and behavior at school. Schools serve as a critical system of support for children who have experienced trauma. Administrators, teachers, and staff can help reduce the effects of trauma on children by recognizing trauma responses, accommodating and responding to traumatized students within the classroom, and referring children to outside professionals when necessary. The National Child Traumatic Stress Network has developed tools

and materials to help educators, school staff, and administrators understand and respond to the specific needs of traumatized children.
To know more please go to this toolkit section on Trauma Informed schools
Or consult the free guides:

The National Child Traumatic Stress Network- Trauma informed Schools
https://www.nctsn.org/trauma-informed-care/creating-trauma-informed-systems/schools

https://www.nctsn.org/trauma-informed-care/trauma-informed-systems/schools/nctsn-resources

https://www.nctsn.org/resources/addressing-race-and-trauma-classroom-resource-educators

https://www.nctsn.org/resources/psychological-first-aid-schools-pfa-s-field-operations-guide

https://www.nctsn.org/resources/it-adhd-or-child-traumatic-stress-guide-clinicians

https://www.nctsn.org/resources/educator-sexual-misconduct-schools-guidelines-staff-volunteers-and-community-partners

https://www.nctsn.org/resources/when-child-alleges-sexual-abuse-educator-or-other-school-staff-educators-guide-appropriate

https://www.nctsn.org/resources/understanding-intersection-between-cyberbullying-and-trauma

https://www.nctsn.org/trauma-informed-care/creating-trauma-informed-systems

http://www.nea.org/home/62845.htm
stopbullying.gov

NCA website to locate CACs
http://www.nationalchildrensalliance.org/

National Center for Victims of Crime:
https://victimsofcrime.org/media/reporting-on-child-sexual-abuse/child-sexual-abuse-statistics

Rape Abuse & Incest National Network RAINN
https://www.rainn.org/statistics

Darkness to Light, D2L.org
http://www.d2l.org/site/c.4dICIJOkGcISE/b.9314267/k.3928/Child_Sexual_Abuse_Statistics.htm?gclid=CMWa26C6itACFVclgQod32QHTQ

Sexual Assault and Prevention Awareness Center @ Univ of Michigan
https://sapac.umich.edu/article/52

WomensHealth.gov
https://www.womenshealth.gov/publications/our-publications/fact-sheet/sexual-assault.html

NCTSN school webpage

http://www.nctsn.org/resources/audiences/school-personnel
CSA webpage
http://www.nctsn.org/trauma-types/sexual-abuse

PFA for Schools
http://www.nctsn.org/content/psychological-first-aid-schoolspfa

Substance Abuse and Mental Health Services Administration. (2014a). SAMHSA's concept of trauma and guidance for a trauma-informed approach (HHS Publication No. [SMA] 14-4884). Retrieved from https://www.nasmhpd.org/sites/default/files/SAMHSA_Concept_of_Trauma_and_Guidance.pdf

Substance Abuse and Mental Health Services Administration(SAMHSA) (2014b). Trauma-Informed Care in Behavioral Health Services: Treatment Improvement Protocol (TIP) Series 57 (HHS Publication No. [SMA] 14-4816). Retrieved from https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816

Creating Trauma-Informed Systems https://www.nctsn.org/trauma-informed-care/creating-trauma-informed-systems

4.2 Recovery

The World Health Organization, as well as the large body of research in the field of helping relationships, suggests that in order to develop more effective and efficient treatments it is recommended to focus on the individual client that we are taking care of. In short, it is important to customize the treatments, not as if they were just a tin of white paint which allows us to paint white everybody, regardless of who the users are.
Just as psychotherapy must be personalized, helping relationships must also be personalized, because this best helps Gino, Maria, Joseph, Mary, etc. Because we must establish strong work alliances and engage in narratives that sees the client as the protagonist in this adventure of change.
The Task Force 29 of the American Psychological Association (APA) shows the importance of centering treatments on people and also recommends another important aspect: that treatments and their philosophy must be based concepts of recovery and development of potentialities instead of as was previously done - with a pessimistic vision of pathology and chronicity.
What is recovery? In recent decades, recovery has developed a capacity - of being more helpful by supporting and empowering clients - and has dispelled some myths, such as that schizophrenia is a chronic pathology. This was thought previously, but the very fact of thinking in this way also becomes to a certain extent a self-fulfilling prophecy, a phenomena of social construction which - if we think about it - is rather obvious. Using the example of schizophrenia, we know that it exists in every country, yet no culture treats it just the same way. In some societies and cultures the schizophrenic is considered as a person touched by the gods and therefore the community treats them with respect, benevolence and offers him food and shelter; in other societies they are instead treated as outcasts, banned from the community and chained to a tree in the forest. In our western culture, at different times, we treated these people in a very different way, sometimes cruelly, but obviously we did it for their own good, as when we believed in turn that it was a phenomenon caused by a devil's possession and so we tortured these poor people with hot irons, thinking that if their bodies are possessed by a devil, if me make the body uncomfortable by torture the devil would come out. We treated people by many other means, but always making the prophecy of pathology and chronicity and punctually these prophecies come true.

With a vision of recovery, which postulate that whatever your situation, even as a serious one as in schizophrenia, you can recover your capacities to function and be part of the community, in this way a positive prophecy is formulated and realized: Like all prophecies, to some extent come true. So today we see that when people are viewed with greater optimism, they satisfy these prophecies. We therefore can witness people who still see things that others do not see, hear voices that others do not hear, but nevertheless are working as paid consultants in an Local Health Agency advising how to treat people with their afflictions in a more human and positive way, and to be able to realize - instead of negative prophecies - positive prophecies that are also self-fulfilling. With prophecy, we must be careful what to choose and where this leads us.

SAMHSA definition of recovery (SAMHSA , 2010) is defined as " A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential".

The Consensus Statement defines mental health recovery as "a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her potential."

The 10 fundamental components of mental health recovery include the following principles:

- **Self-Direction.** Individuals determine their own path of recovery with autonomy, independence, and control of their resources.
- **Individualized and Person-Centered.** There are multiple pathways to recovery based on an individual's unique strengths as well as his or her needs, preferences, experiences, and cultural background.
- **Empowerment.** Consumers have the authority to participate in all decisions that will affect their lives, and they are educated and supported in this process.
- **Holistic.** Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, social networks, employment, education, mental health and health care treatment, and family supports.
- **Non-Linear.** Recovery is not a step-by step process but one based on continual growth, occasional setbacks, and learning from experience.
- **Strengths-Based.** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
- **Peer Support.** Mutual support plays an invaluable role in recovery. Consumers encourage and engage others in recovery and provide each other with a sense of belonging.
- **Respect.** Eliminating discrimination and stigma are crucial in achieving recovery. Self-acceptance and regaining belief in oneself are particularly vital.
- **Responsibility.** Consumers have a personal responsibility for their own self-care and journeys of recovery. Consumers identify coping strategies and healing processes to promote their own wellness.
- **Hope.** Hope is the catalyst of the recovery process and provides the essential and motivating message of a positive future. Peers, families, friends, providers, and others can help foster hope.

To know more about recovery go to the Toolkit section on recovery or consult these organizations websites:

The National Alliance on Mental Illness (NAMI) **https://namitm.org/mhr/10fcr/**

SAMHSA's WORKING DEFINITION OF RECOVERY (2010).
https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf

SAMHSA's Recovery Support Initiative http://www.samhsa.gov/recovery

4.3 Guidelines for foster youths' care empowerment

These guidelines are intended to enhance the empowerment of foster care youth recommending the active participation of youth in child welfare advisory groups as well as child welfare and court proceedings which relate to their care. These guidelines also emphasize the responsibilities of child welfare agencies to facilitate the optimization of youth's skills in school, social and employment related domains; they were developed in 2007 by Best Practices for Mental Health in Child Welfare Consensus Conference that brought together parent and youth child welfare advocates as well as research, policy, and services experts in the fields of child welfare and mental health.

4.3.1 Embed Youth Empowerment into the Mission of Child Welfare Agencies

Child welfare agencies and their partners (the court, mental health, education, and health systems, etc.) incorporate the objective of empowering children and youth in their missions, values, and practices to enhance the mental health and functioning of children and youth. To empower youth in child welfare settings, assessments of child and youth services need and the planning and implementation of these services are trauma informed strengths-based and focus on engaging children and youth to enhance their mental health and functioning in multiple domains. These domains include school attendance and performance, employment education and experience, and post–high school educational and vocational training, preparation, and attainment. In addition, youth will be provided, while in care, with opportunities to enhance their peer and family relationships and recreational and spiritual participation and accomplishments (National Foster Youth Advisory Council).

Rationale. For youth in foster care, empowerment represents a vital process and outcome. The active involvement of youth in care, the opportunity to participate in the development of their transition plans is at the same time a process and a product . The empowerment of youth in foster care involves them being given opportunities to test and assert themselves beyond the foster care system. It also requires that the caregivers to be aware their responsibilities to contribute to youths' empowerment (Krebs & Pitcoff, 2004, 2006).

4.3.2 Legal Advocates for Children and Youth

Courts and child welfare agencies need to ensure that in all legal proceedings every child and youth has a qualified legal advocate with training in child and youth mental health and domains of functioning. Consistent with their developmental capacities, all children and youth are informed about their legal proceedings and legal rights and are provided with opportunities to appear and be heard during their legal proceedings.

Rationale. Legal proceedings involving children and youth in foster care offer significant opportunities for youth empowerment, but involve complicated leg al issues with life-altering outcomes. For youth to be empowered, to protect their legal rights and promote their mental health, every child and youth needs an attorney with training in child and youth mental health issues and services. Significant benefits of having youth heard in court include enhancing youth's sense of control, adding understanding of the process, and providing additional information to the court Representation by an attorney and the opportunity to be heard in court does not mean that a youth's stated wishes should or

will override the legal standard. The court's decision will always be guided by what is in the best interests of the minor.

4.3.3 Youth Advocate Involvement in Child Welfare Agencies

Child welfare agencies utilize youth and youth alumni in services planning and evaluation and staff development and as providers of direct youth services. These youth advocates can help youth entering and those already in foster care to navigate the child welfare and mental health systems.
Rationale. Youth in child welfare face unique life circumstances that may be best understood by their peers who are dealing with similar issues or who experienced these issues in the past. By utilizing youth advocates, child welfare agencies offer youth in their care opportunities to make important connections with peers who can provide support, empathy, and hope for the future.

4.3.4 Multicultural Competence

Child welfare agencies exhibit multicultural competence by providing opportunities for youth empowerment and engagement in ethnic, cultural, and religious activities and in the development of their personal identities consistent with the cultural traditions of their families and communities.
Rationale. Multicultural competence involves:
a) an ability to increase one's awareness about personal biases, assumptions, attitudes and worldviews,
(b) specific knowledge of cultures, history, worldviews, languages, and diverse experiences,
(c) a repertoire of skills that allow one to effectively intervene in personal and professional domains (Jacoby, 1996).
By demonstrating multicultural competence, especially in the areas of race, religion, gender, and sexual orientation, and encouraging it in youth, child welfare agencies will contribute to the healthy development of youth in their care.

4.3.5 Youth Understanding of Their Rights and Entitlements

Child welfare agencies and their partners strive to help children and youth understand, at their level of functioning, their rights, entitlements, and opportunities, by providing a range of communications, engagement, and support. These efforts include the provisions of information regarding access to services and assistance in completing applications for schools and employment opportunities, scholarships, legal documents, and references while in care and when exiting the system.
Rationale. Research shows that placement stability, educational supports, and employment experience were all associated with adult success (Pecora, Williams, Kessler, Hiripi, O'Brien, Emerson, Herrick, & Torres, 2006). By helping youth to understand their rights and entitlements and providing them with concrete assistance in accessing educational and employment opportunities, child welfare agencies can increase the likelihood of a successful transition to adulthood for these clients.

4.3.6 Adequate Support for Youth Aging Out of Care

Child welfare agencies and their partners provide adequate support to youth who are aging out of or who have aged out of foster care, until at least age 21. These supports include focusing on accessing health and health insurance, housing, higher education, career development, and attaining a permanent, significant connection to an adult.
Rationale. Providing ongoing supports to foster youth after age 18 is critical to ensuring positive outcomes. Youth remaining in state custody for an additional year after age 18 are more likely to advance

their education, have stable housing, stay out of the juvenile justice system, receive independent living services, and have access to health and mental health services (Courtney et al., 2005).
Given the significant medical and mental health needs of these youth, Independent living services should be provided to youth as early as age 13 and continued through their early- to mid-20s (Eyster & Oldmixon, 2007). Strong, stable relationships also promote a sense of normalcy and security for youth. Those involved with foster care youth should ensure that these youth have a lifelong connection to a caring adult in their life (Eyster & Oldmixon, 2007).

4.3.7 Accountability for Youth Empowerment Outcomes

The child welfare system needs to be accountable for measurable outcomes related to youth empowerment.
Rationale. National, state, and local data intended to measure the outcomes for children connected with the child welfare system should include data relating to youth empowerment. This could be accomplished by including in the child and family services review (CFSR), as well as state and local quality service reviews, measures of the rates of child welfare youth involvement with a youth advocate and engagement in a youth empowerment service strong emphasis of the second CFSR round on the involvement of youth in the CFSR process at all levels and tool kits to facilitate this process.

To know more about transiting out of care consult the toolkit section of Trauma informed social work or directly to:

Supporting young people leaving out-of-home care

Courtney, M. E., Dworksy, A., Terao, S., Bost, N., Cusick, G. R., Keller, T., & Havlicek, J. (2005). *Midwest evaluation of the adult functioning of former foster youth*. Chicago: Chapin Hall.

Eyster, L., & Oldmixon, S. L. (2007). *State policies to help youth transition out of foster care.* Retrieved October 8, 2019, from www.nga.org/Files/pdf/0701YOUTH.pdf.

Krebs, B., & Pitcoff, P. (2004). Reversing the failure of the foster care system. *Harvard Women's Law Journal, 27*, 357–366.

Krebs, B., & Pitcoff, P. (2006). *Beyond the foster care system: The future for teens.* New Brunswick, NJ: Rutgers University Press.

Jacoby, B. (1996). *Service-learning in higher education: concepts and practices.* San-Francisco: Jossey-Bass.

4.4 Trauma informed Care in Communities

The social construction of reality in which traumatized people live I an important determinant. SHAMSA (2014) underlines that many individuals cope with their trauma in the safe or not-so safe space of their communities, it is important to know how communities can support or impede the healing process. Trauma does not occur in a vacuum. Individual trauma occurs in a context of community, whether the community is defined geographically as in neighborhoods; virtually as in a shared identity, ethnicity, or experience; or organizationally, as in a place of work, learning, or worship. How a community responds to individual trauma sets the foundation for the impact of the traumatic event, experience, and effect.
Communities that provide a context of understanding and self-determination may facilitate the healing and recovery process for the individual. Alternatively, communities that avoid, overlook, or

misunderstand the impact of trauma may often be re-traumatizing and interfere with the healing process. Individuals can be re-traumatized by the very people whose intent is to be helpful. This is one way to understand trauma in the context of a community. A second and equally important perspective on trauma and communities is the understanding that communities as a whole can also experience trauma. Just as with the trauma of an individual or family, a community may be subjected to a community-threatening event, have a shared experience of the event, and have an adverse, prolonged effect. Whether the result of a natural disaster (e.g., a flood, a hurricane or an earthquake) or an event or circumstances inflicted by one group on another (e.g., usurping homelands, forced relocation, servitude, or mass incarceration, ongoing exposure to violence in the community), the resulting trauma is often transmitted from one generation to the next in a pattern often referred to as historical, community, or intergenerational trauma. Communities can collectively react to trauma in ways that are very similar to the ways in which individuals respond. They can become hyper-vigilant, fearful, or they can be re-traumatized, triggered by circumstances resembling earlier trauma. Trauma can be built into cultural norms and passed from generation to generation.

Communities are often profoundly shaped by their trauma histories. Making sense of the trauma experience and telling the story of what happened using the language and framework of the community is an important step toward healing community trauma. Many people who experience trauma readily overcome it and continue on with their lives; some become stronger and more resilient; for others, the trauma is overwhelming and their lives get derailed. Some may get help in formal support systems; however, the vast majority will not.

The manner in which individuals and families can mobilize the resources and support of their communities and the degree to which the community has the capacity, knowledge, and skills to understand and respond to the adverse effects of trauma has significant implications for the well-being of the people in their community.

To know more please go to this toolkit section on Trauma Informed Care Communities

Or consult the free guides:

Substance Abuse and Mental Health Services Administration. (2014a). SAMHSA's concept of trauma and guidance for a trauma-informed approach (HHS Publication No. [SMA] 14-4884). Retrieved from https://www.nasmhpd.org/sites/default/files/SAMHSA_Concept_of_Trauma_and_Guidance.pdf

Substance Abuse and Mental Health Services Administration. (2014b). Trauma-Informed Care in Behavioral Health Services: Treatment Improvement Protocol (TIP) Series 57 (HHS Publication No. [SMA] 14-4816). Retrieved from https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816

Toolkit

1. Emotional Trauma

1.1 Different kinds of Trauma - Simple Trauma and Complex Trauma

- (PDF) Complex Trauma in Adolescents and Adults
- Understanding Children's Exposure to Violence.pdf
- How Does Domestic Violence Affect Children?
- Corrigendum to “Impact of childhood adversities on depression in early adulthood: A longitudinal cohort study
- Developmental Trauma Disorder: Toward a rational diagnosis for children with complex trauma histories
- (PDF) Complex Trauma, Complex Reactions: Assessment and Treatment
- Ending all forms of violence against children by 2030: The Council of Europe's contribution to the 2030 Agenda and the Sustain

1.2 Adverse Childhood Experiences (ACEs)

- ACEs and counter-ACEs: How positive and negative childhood experiences influence adult health
- Positive and Adverse Childhood Experiences and Adult Mental and Relational Health
- Adverse childhood experiences and the risk of depressive disorders in adulthood
- Adverse Childhood Experiences International Questionnaire (ACE-IQ) Rationale for ACE-IQ
- Preventing Adverse Childhood Experiences (ACEs)
- Adverse Childhood Experiences Resources
- Adverse Childhood Experiences: National and State level prevalence

1.3 Physical abuse

- Off the books! Guidance for Europe's parliaments on law reform to eliminate corporal punishment of children
- Abolishing corporal punishment of children
- Protecting children against corporal punishment
- Eradicating violence against children - Council of Europe actions

1.4 Sexual abuse

- Sexual abuse?
- PDF - Protecting children from sexual violence - A comprehensive approach
- Kiko and the hand
- Child sexual abuse in Europe (2003)
- Responding to children and adolescents who have been sexually abused

1.5 Physical and Emotional neglect

- Child neglect: developmental issues and outcomes
- A Conceptual Definition of Child Neglect
- An ecological analysis of infant neglect by adolescent mothers
- Cognitive processes associated with child neglect
- The Effects of Early Neglect on Cognitive, Language, and Behavioral Functioning in Childhood
- Neglect - Center on the Developing Child of Harvard University

1.6 Verbal abuse

- What is Verbal Abuse?
- Preliminary Evidence for White Matter Tract Abnormalities in Young Adults Exposed to Parental Verbal Abuse
- Does Verbal Abuse Leave Deeper Scars: A Study of Children and Parents

1.7 Witnessing violence, natural or manmade disasters

- Children who witness domestic violence
- The impact of children witnessing violence
- Witnessing Violence Project
- The Needs of Children in Natural or Manmade Disasters
- Among the Most Vulnerable: Women and Children in Global Disasters
- After the Crisis Initiative: Healing from Trauma after Disasters

1.8 Intersectionality and Trauma

- Bringing Gender-Responsive Principles into Practice
- The cultural context of trauma recovery: Considering the posttraumatic stress disorder practice guideline and intersectionality.
- Marginalized identities, discrimination burden, and mental health: Empirical exploration of an interpersonal-level approach to modeling intersectionality
- Intersectionality and Trauma-Informed Applications for Maternal and Child Health Research and Evaluation

1.9 Collective and intergenerational Trauma

- Intergenerational Trauma
- Collective Victimization
- Intergenerational Trauma

2. The burden of Trauma

2.1 The impacts of Trauma on the mind and the body, the personal and the professional effectiveness of individuals

- Traumatic stress: effects on the brain
- The impact of traumatic events on mental health
- Toward understanding the impact of trauma on the early developing human brain
- Center for Substance Abuse Treatment (US). Trauma-Informed Care in Behavioral Health Services. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2014. (Treatment Improvement Protocol (TIP) Series, No. 57.) Chapter 3, Understanding the Impact of Trauma. Available from: https://www.ncbi.nlm.nih.gov/books/NBK207191/

2.2 The burden of Trauma on the effectiveness of working teams, and the local community

- Teamwork in Healthcare: Key Discoveries Enabling Safer, High-Quality Care
- Mental health and work: Impact, issues and good practices

2.3 The economic burden of trauma

- How Adverse Childhood Experiences Cost $1.33 Trillion a Year
- Estimating the financial costs of adverse childhood experiences (ACES) in europe | Request PDF
- Life course health consequences and associated annual costs of adverse childhood experiences across Europe and North America
- Long-Range Planning for Health, Equity and Prosperity

2.4 The dangers of re-traumatization how to prevent the risks of re-traumatization

- Preventing Retraumatization: A Macro Social Work Approach to Trauma-Informed Practices & Policies
- Supporting Survivors of Trauma: How to Avoid Re-traumatization
- Retraumatization: Assessment, Treatment, and Prevention | Request PDF
- Clinical Issues Across Services - Trauma-Informed Care in Behavioral Health Services

2.5 Vicarious Trauma: helping professionals′ effective prevention, self-care and effective recovery

- The role of self-care on compassion satisfaction, burnout and secondary trauma among child welfare workers
- Reliability and Validity of the Vicarious Trauma Organizational Readiness Guide (VTORG)
- Vicarious traumatization among child welfare and child protection professionals: A systematic review
- Vicarious Trauma Toolkit
- The Vicarious Trauma Toolkit | What Is The VT–ORG?

3. Trauma informed Care (TIC)

3.1 Trauma Informed Care principles and how to apply them

The following includes resources offering a selection of treatment related resources and curricula.

- SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach
- (PDF) Tangible trauma informed care.
- Systemic Self-Regulation: A Framework for Trauma-Informed
- NGA Center for Best Practices
- Laying the Groundwork for Trauma-Informed Care
- NCTSI Infographic
- A TREATMENT IMPROVEMENT PROTOCOL Trauma-Informed Care in Behavioral Health Services
    - https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816
- WHO Guidelines for the health sector response to child maltreatment
- **Trauma-Informed Practice Guide** -This Guide was developed on behalf of the BC Provincial Mental Health and Substance Use Planning Council in British Columbia
    - https://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf
- **Becoming Trauma-Informed-** Published by the Centre for Addiction and Mental Health in Ontario, this book offers examples of the ways in which practitioners have applied principles of trauma-informed practice in their work with diverse populations and in diverse settings within the MHSU field.
    - http://knowledgex.camh.net/amhspecialists/specialized_treatment/trauma_treatment/Documents/becoming_trauma_informed.pdf
- **Beyond Trauma**: A Healing Journey for Women Created by Dr. Stephanie Covington, this trauma treatment manual makes the connection between women's experiences of trauma and their substance use. It can be used in a variety of settings, including residential and outpatient treatment settings, mental health programs, and criminal justice settings.
    - www.stephaniecovington.com/b_beyond.php
- **Developing Trauma Informed Organizations**: A Tool Kit The Tool Kit is designed to help organizations improve the quality of services offered by integrating an understanding of the impact of trauma and violence into the organization's policies, procedures, and interactions with those being served. It includes the principles for trauma-informed treatment, a self-assessment for provider organizations, an organizational assessment and instructions for using the assessments to provide trauma-informed, integrated care.
    - http://www.healthrecovery.org/services_and_products/products/detailTrue.asp?ProductID=30

3.2 Recovery

- Supporting the recovery and reintegration of trafficked children
- Universal Design for Underserved Populations: Person-Centered, Recovery-Oriented and Trauma Informed

- Facilitators and Barriers to Person-centred Care in Child and Young People Mental Health Services: A Systematic Review

3.3 Human rights protection and promotion

- Compasito Manual on human rights education for children
- Passport to your rights (2013)
- Tell someone you trust - Make use of your Lanzarote Convention Rights
- Report on the protection of children's rights
- Challenges to children's rights today:Wath do children think?

3.4 Trauma Informed Care in health organizations

- Implementing a Trauma-Informed Approach in Pediatric Healthcare Networks
- Adverse childhood experiences and trauma informed care: the future of health care
- Innovations in Implementation of Trauma-Informed Care Practices in Youth Residential Treatment
- Trauma informed care and agency staff
- Trauma-Informed Care in Behavioral Health Services

3.5 Trauma Informed Care in Schools

- The National Child Traumatic Stress Network- Trauma informed Schools https://www.nctsn.org/trauma-informed-care/creating-trauma-informed-systems/schools
- https://www.nctsn.org/trauma-informed-care/trauma-informed-systems/schools/nctsn-resources
- https://www.nctsn.org/resources/addressing-race-and-trauma-classroom-resource-educators
- https://www.nctsn.org/resources/psychological-first-aid-schools-pfa-s-field-operations-guide
- https://www.nctsn.org/resources/it-adhd-or-child-traumatic-stress-guide-clinicians
- https://www.nctsn.org/resources/educator-sexual-misconduct-schools-guidelines-staff-volunteers-and-community-partners
- https://www.nctsn.org/resources/when-child-alleges-sexual-abuse-educator-or-other-school-staff-educators-guide-appropriate
- https://www.nctsn.org/resources/understanding-intersection-between-cyberbullying-and-trauma
- https://www.nctsn.org/trauma-informed-care/creating-trauma-informed-systems
- http://www.nea.org/home/62845.htm
- stopbullying.gov
- NCA website to locate CACs
  - http://www.nationalchildrensalliance.org/
- National Center for Victims of Crime
  - https://victimsofcrime.org/media/reporting-on-child-sexual-abuse/child-sexual-abuse-statistics
- Rape Abuse & Incest National Network RAINN
  - https://www.rainn.org/statistics
- Darkness to Light, D2L.org

  - http://www.d2l.org/site/c.4dICIJOkGcISE/b.9314267/k.3928/Child_Sexual_Abuse_Statistics. htm?gclid=CMWa26C6itACFVclgQod32QHTQ
- Sexual Assault and Prevention Awareness Center @ Univ of Michigan
  - https://sapac.umich.edu/article/52
- WomensHealth.gov
  - https://www.womenshealth.gov/publications/our-publications/fact-sheet/sexual-assault.html
- NCTSN school webpage
  - http://www.nctsn.org/resources/audiences/school-personnel
- CSA webpage
  - http://www.nctsn.org/trauma-types/sexual-abuse
- PFA for Schools
  - http://www.nctsn.org/content/psychological-first-aid-schoolspfa
- Substance Abuse and Mental Health Services Administration. (2014a). SAMHSA's concept of trauma and guidance for a trauma-informed approach (HHS Publication No. [SMA] 14-4884). Retrieved from
  - https://www.nasmhpd.org/sites/default/files/SAMHSA_Concept_of_Trauma_and_Guidance.pdf
- Substance Abuse and Mental Health Services Administration(SAMHSA) (2014b). Trauma-Informed Care in Behavioral Health Services: Treatment Improvement Protocol (TIP) Series 57 (HHS Publication No. [SMA] 14-4816). Retrieved from
  - https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816
- https://www.nctsn.org/trauma-informed-care/creating-trauma-informed-systems
- Simple Versus Complex Trauma
- Addressing violence in schools through education for democratic citizenship and human rights education
- Violence reduction in schools - How to make a difference (2006)
- A handbook on planning projects to prevent child trafficking
- Using Trauma Informed Strategies to De-Escalate Classroom Conflict
- Helping Traumatized Children Learn
- Moving From Evidence to Action: The Safe Start Center Series on Children Exposed to Violence
- Trauma-Sensitive Remote Learning: Keeping Connections Strong
- Students' Voices: Their Perspectives on How Schools Are and Should Be
- Beyond the Rhetoric: Strategies for Implementing Culturally Effective Practice with Children, Families, and Community

3.6 Trauma Informed Social Work

- Trauma-Informed Social Work Practice
- (PDF) Trauma-Informed Social Work Practice: Practice Considerations and Challenges
- Trauma-Informed Social Policy: A Conceptual Framework for Policy Analysis and Advocacy
- Trauma-Informed Social Work Practice: What Is It and Why Should We Care?
- PDF - Children's rights and social services (2016)
- Using Trauma-Informed Child Welfare Practice to Improve Placement Stability Breakthrough Series Collaborative

- Services in Residential Juvenile Justice Programs
- Facts on Traumatic Stress and Children with Developmental Disabilities
- Two year impact findings from the youth villages transitional living evaluation
- The Role of Risk
- Supporting young people leaving out-of-home care
- A best fit model of trauma informed care for young people in residential and secure services
- Reducing inequities in health across the life-course
- Health Care Issues for Children and Adolescents in Foster Care and Kinship Care

3.7 Trauma informed Care in Communities

- 3 Principles to Improve Outcomes for Children and Families
- A Framework for Two-Generation Policy and System Reform
- Building Trauma-Informed Schools and Communities
- Healing Ethno-Racial Trauma in Latinx Immigrant Communities: Cultivating Hope, Resistance, and Action
- Child Family Community Australia

3.8 Trauma informed workplaces

- Reducing workplace violence by creating healthy workplace environments
- Organizational and provider level factors in implementation of trauma-informed care after a city-wide training: an explanatory mixed methods assessment
- Transforming the Way We Provide Services: Becoming a Trauma Informed Workplace
- Building a Trauma-Informed Workforce - Trauma-Informed Care in Behavioral Health Services

3.9 Trauma informed penitentiary system

- Recommendation CM/Rec(2018)5 of the Committee of Ministers to member States concerning children with imprisoned parents
- Exploring Women-Centred, Holistic, and Trauma-Informed Programming for Provincially Incarcerated Women in Canada
- Creating trauma-informed correctional care: a balance of goals and environment

3.10 Trauma informed legislation

- Handbook on European law relating to the rights of the child
- The best interests of the child – A dialogue between theory and practice
- Guidelines of the Committee of Ministers of the Council of Europe on child-friendly justice
- 47 states, one Organisation.... the Council of Europe (2015)
- The Council of Europe - Unlimited Connections (2013)
- Travel the universe of Greater Europe (2016)

3.11 Vicarious Trauma Informed Care

- From Best Practices to Breakthrough Impacts
- Child Trauma Toolkit for Educators
- Trauma and Resilience
- Reducing the Trauma of Investigation, Removal, & Initial Out-of-Home Placement in Child Abuse Cases Project Information and
- Measuring and monitoring national prevalence of child maltreatment: a practical handbook
- Guidelines of the Committee of Ministers of the Council of Europe on child-friendly health care
- A Future for the World's Children?

3.12 Trauma informed Prevention and treatment of sexual violence against women, children and men

- Needs Assessment and Service Gap Analysis: Supporting Male Survivors of Violence
- Implementation of a workforce initiative to build trauma-informed child welfare practice and services: Findings from the Massach
- Protection of children against sexual exploitation and abuse - Child-friendly, multidisciplinary and interagency response inspired by the Barnahus model
- Preventing child maltreatment: a guide to taking action and generating evidence
- Challenges of operationalizing trauma-informed practice in child protection services in New Zealand

3.13 Trauma Informed management of refugees and migrants

- Visiting places where children are deprived of their liberty as a result of immigration procedures
- Age assessment for children in migration
- We are children, hear us out! Children speak out about age assessment
- How to convey child-friendly information to children in migration

4. Resilience and Growth After Trauma

4.1 Resilience

- Social support and negative and positive outcomes of experienced traumatic events in a group of male emergency service workers
- Stories from the road of recovery – How adult, female survivors of childhood trauma experience ways to positive change
- Sources of childhood and adult resilience and their impact on harms associated with adverse childhood experiences | Request PDF

4.2 Growth After Trauma

- Spotlight: Building Resilient and Trauma-Informed Communities – Walla Walla, WA: Mobilizing the Community for Resilience
- How clients make therapy work: The process of active self-healing.
- Spotlight: Building Resilient and Trauma-Informed Communities – San Francisco, CA: Aligning the Workforce to Create a Trauma-Informed System
- Spotlight: Building Resilient and Trauma-Informed Communities – Philadelphia, PA: Public Health Partnerships for Trauma Transformation

5. Covid-19

- The psychological impact of quarantine and how to reduce it: rapid review of the evidence
- Trauma-Informed Resources Available During COVID-19 Quarantine
- How to talk to children about the coronavirus - Harvard Health Blog
- Coping with coronavirus anxiety - Harvard Health Blog
- Coronavirus Anxiety: Coping with Stress, Fear & Uncertainty
- Resources for Parents During COVID-19 School Disruption
- Coronavirus: What Child Welfare Systems Need to Think About
- The Lancet COVID-19 Content Archive

6. Trauma informed International organizations

- Care Leaver Network
  - Community
- Needs Analysis report
  - Current situation on CLN and needs analysis report

- The European Expert Group on the Transition from Institutional to Community-based Care
  - The European Expert Group on the Transition from Institutional to Community-based Care: From institutions to living in the community
- SOS Children Villages: Child-Centered Education.
  - Child-centered education
- International Society for the Prevention of Child Abuse and Neglect (ISPCAN)
  - ORGANIZATION & LEADERSHIP
- SAMHSA's National Center for Trauma-Informed Care
  - Trauma Resource Center Websites
- National Child Traumatic Stress Initiative (NCTSI)
  - National Child Traumatic Stress Initiative
- National Child Traumatic Stress Network (NCTSN)
  - https://www.nctsn.org/treatments-and-practices/core-curriculum-childhood-trauma
  - https://www.nctsn.org/trauma-informed-care/creating-trauma-informed-systems
- American Professional Society on the Abuse of Children (APSAC). The leading national organization supporting professionals who serve children and families affected by child maltreatment and violence.
  - APSAC: American Professional Society Abuse Children

- The Leadership Council. An independent organization that provides the latest scientific information on issues related to child abuse and interpersonal violence
  - . http://leadershipcouncil.org/
- Center for Judicial Excellence (CJE) . CJE is dedicated to public education and community outreach about protecting the rights of children and vulnerable populations in the court system.
  - https://centerforjudicialexcellence.org/
- California Protective Parents Association (CPPA). CPPA works to protect children from incest and family violence through research, education and advocacy.
  - California Protective Parents Association
- Courageous Kids Network. An organization by and for young people who were court-ordered to ongoing abusive situations, now joining together to find strength, support and healing.
  - CKNW
- National Partnership to End Interpersonal Violence. The NPEIV is an overarching group of individuals, organizations, agencies, coalitions, and groups that embraces a national, multidisciplinary and multicultural commitment to violence prevention across the lifespan.
  - National Partnership to End Interpersonal Violence
- Stop Abuse Campaign. Promoting the Quincy Solution of law reform and enforcement to reduce domestic abuse.
  - Home » Stop Abuse Campaign
- Harvard University Center of the Developing Child. From Best Practices to Breakthrough Impacts A science-based approach to building a more promising future for young children and families.
  - Center on the Developing Child at Harvard University
- Terre des Hommes. International federation for children, their rights and equitable development
  - TDHIF - Terre des Hommes International Federation Home - Terre des Hommes - For children, their rights and equitable development
- World Health organization (WHO) on prevention of children maltreatment. WHO Global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children.
  - Child maltreatment
  - WHO Guidelines for the health sector response to child maltreatment
- WHO- Person Centered and People Centered Approaches. The vision for the Framework on Integrated people-centered health services.
  - What are integrated people-centered health services?
  - The way forward
  - Strategic approaches, potential policy options and interventions
  - IPCHS - Integrated People-Centered Health Services Resources
- WHO global strategy on integrated people-centered health services 2016-2026
- Executive Summary Placing people and communities at the center of health services.
  - Community engagement for quality, integrated, people-centered and resilient health services
  - Innovations from BRICS countries on people-centered health reforms at 70th World Health Assembly
- Better Care Network. Children need and have a right to be cared for by their parents and to grow up in a family environment. This has been recognized through years of experience and research as well as formally recognized under national and international laws, including the United Nations Convention of the Rights of the Child (UNCRC).
  - Welcome to the Better Care Network! | Better Care Network

- American Red Cross. Focuses on meeting people's immediate emergency needs after a disaster, providing shelter, food, and physical and mental health services.
  - Disaster Relief | About Us
- National Center for Post-Traumatic Stress Disorder (NCPTSD). This website is provided as an educational resource for PTSD and other consequences of traumatic stress.
  - http://www.ncptsd.org
- National Institute on Mental Health (NIMH). Is part of the U.S. government's National Institutes of Health. NIMH is responsible for research on mental health and mental disorders, and the mental health consequences of and interventions after disasters and acts of mass violence.
  - NIMH » Home
- MadCovid. is a shared space for survivor / service user led projects and initiatives that started during the COVID19 pandemic. Here we tell you a bit about who we are. If you have a project that could be hosted at MadCovid.com please get in touch!
  - https://madcovid.com/about/

7. Video, YouTube sources

- Center on the Developing Child at Harvard University
- Trauma Informed Care Champions: From Treaters to Healers
- Transforming Trauma Podcast: The Blind Spots of Privilege and Complex Trauma in Marginalized Communities
- The Solution: Trauma Sensitive Schools
- How We Get There: Whole School Effort
- Benjamin Fry, Founder of Khiron Clinics discusses the up and coming Virtual Trauma Conference with bestselling author and trauma expert, Dr. Bessel van der Kolk.
- 3 Things Bessel van der Kolk Did To Help Him Through His Recent Trauma - Smart Couple Podcast 191
- Episode 47: Healing Trauma/Creative Activities

8. Patient/Person/People Centered Health

- Royal College of Psychiatrists (2013b) *Whole-Person Care: From Rhetoric to Reality Achieving Parity between Mental and Physical Health*. RCPsych.
  - https://www.rcplondon.ac.uk/news/person-centred-care-working-patients-partners-webinar
- Person Centered Care
  - https://www.rcplondon.ac.uk/projects/outputs/top-tips-person-centred-care
- Royal College of Physicians, clinical vice president Professor David Oliver gives an introduction to person-centered care.
  - https://www.rcplondon.ac.uk/projects/outputs/top-tips-person-centred-care
- Royal College of Physicians. *The Royal College of Physicians' response to the* Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: RCP, 2013. Putting Patients First
  - https://www.rcplondon.ac.uk/guidelines-policy/francis-inquiry-rcp-response
- What are integrated people-centered health services?

- From “patient” to “person” to “people”: the need for integrated, people-centered healthcare
- Is Patient-Centered Care the Same As Person-Focused Care?
- (PDF) Patient-centered care and people-centered health systems in sub-Saharan Africa: Why so little of something so badly needed?
- Understanding Person-Centered Care

8.1 Organizational Policies for the protection of children and adolescents

8.1.1 IACP Policy for the Protection of Children and Adolescents *

* approved and enforced in all the IACP offices on January 1, 2015, this version of IACP Policy replaces all the previous versions

The Person centered Approach Institute (IACP) hereafter simply referred as IACP is committed with this Policy to pursuing and achieving the following purposes.
The general purpose of the Policy is to promote and guarantee the right of children and adolescents to protection from all forms of maltreatment, neglect, exploitation and violence. The Policy defines the procedures that IACP pursues to increase its ability to manage and reduce the risks of maltreatment or abuse in carrying out the organization's activities. With the awareness that it is not possible to completely eliminate the risks, we believe it is imperative to do everything in our power to reduce them to a minimum.
The IACP adopts and implements this Policy because it undertakes to take care of girls, boys and teenagers and protect them from any form of violence or mistreatment. This task is called Duty of Care, a concept that refers to the responsibility of organizations and associations to protect minors by ensuring an adequate level of protection.
The IACP wants to be a very safe ORGANIZATION FOR CHILDREN AND TEENAGERS, an association that respects them, protects them and enhances, welcomes and listens to their ideas and opinions. The IACP strongly believes that if an organization values children and adolescents, it is more likely to protect them at the same time. For this reason, it adopts a preventative and participatory approach to childhood and adolescent protection.

8.1.2 Purpose and guiding principles

The IACP is committed to ensuring a safe environment for children, girls and teenagers through the active involvement of all stakeholders in the definition of policies and procedures of protection.

The Policy is to be considered binding for:

- All the staff and the members of the Board of Directors:

The IACP provides, through the dissemination of clear and precise guidelines, to the training of staff, and members of the Board of Directors on issues related to maltreatment and abuse, on possible risks and ways of prevention, and on behaviors to be implemented and boundaries within which to stay when working in contact with children and adolescents. This aims to reduce the risk of potential damage and contributes to the creation of a respectful, safe and child-friendly environment. Staff, and members of the Board of Directors are required to comply with the Policy and in particular with the IACP Code of Conduct.
The IACP policy is shared with:

- children and teenagers:

Children and teens participate in the policy audit process. Creating an open and responsive culture requires that:

1. children and adolescents have the right of being listened;
2. the expression of their ideas, opinions, fears and concerns are encouraged and taken seriously into consideration;
3. children and adolescents know the maltreatment phenomenon and what they can do if they realize unacceptable behavior;
4. children and adolescents are aware of their rights and protection strategies so that they can play an active role in protecting themselves and their peers.

The Policy will be shared with all children and adolescents who are receiving services from IACP in ways that are easily understandable to them.

Families and guardians of children and adolescents:

So that they can play an active role in protecting themselves and peers.
The Policy will be shared in ways that are clearly understandable to them with all children and adolescents who are the service users of IACP interventions.
In order for an organization to be safe for children and teenagers, it is necessary for all those involved, including children and their families, to have the capacity and the will to implement the IACP Policy in practice. Families and guardians will be involved in the final audit and the Policy will be shared in ways that are clearly understandable to them.

Partners:

The IACP believes that every organization has the responsibility to reduce the risks associated with any forms of abuse and abuse against children and teenagers. For this reason, IACP shares this Policy with all the Partner organizations that are required to respect its principles and to provide full support and collaboration.

- colleagues, government officials and stakeholders:

IACP announces its commitment to the protection of children and adolescents to all stakeholders.

8.1.3 Understanding children and teenagers

Understanding children and young people and knowing the forms of violence and the harm associated with them are the starting point for creating and maintaining a safe environment.
Violence is any behavior that may be caused by parents, guardians, other adults, teenagers or children, resulting in potential or real injury to the child's health or development or dignity. Such behaviors may be intentional or unintentional and include both negligence and committing acts of abuse.
Within this broad definition, five main categories of maltreatment can be identified: physical maltreatment, sexual abuse, psychological maltreatment, neglect or negligent treatment, and exploitation. Although there is broad consensus about the existence of such maltreatment categories, there is no unanimity of opinions on their definitions.

The IACP uses the terminology used by most International Agencies, the United Nations and other organizations that deal with child and adolescence protection.

8.1.4 Child maltreatment

Any act deliberately put in place by a parent or a person with a position of power, responsibility, and trust in the child that can give rise to a potential or actual damage to his or her safety, well-being, dignity and her/his development. It encompasses all forms of physical and psychological prejudice, an abuse of power and betrayal of the child's trust by the adult.

8.1.4.1 Physical maltreatment

Physical maltreatment means any conduct that causes physical or potential physical damage to a child or a teenager and is carried out by an adult or a peer.
Unlike other forms of maltreatment, physical maltreatment has the following elements:

- the unpredictability of conduct: the child or teenager does not know what can trigger anger and aggression and is so is pushed to be in a constant state of uncertainty.
- attacks of anger: aggressive behavior is determined by anger and the desire to exercise strong control over the child or teenager, greater the anger, the more intense it will be the maltreatment.
- fear as a tool for controlling the behavior of a child or adolescent: it is not unusual for the ill-advised to believe that the child or teenager must be afraid to learn to behave properly and thereby create a climate of intimidation to correct behavior and to gain respect and obedience. However, in this way the child does not learn to behave properly and to grow but only to try to avoid the beatings.

8.1.4.2 Sexual Abuse

Sexual abuse means the involvement, as a subject of gratification, of a child or an adolescent in sexual activity, with or without physical contact, by an adult or a peer.
Some examples of sexual abuse: touching the genitals, masturbation, oral sex, vaginal or anal penetration, exposure to pornography etc.

8.1.4.3 Psychological maltreatment

Psychological maltreatment means a repeated behavior over time that affects the affective, cognitive and relational development of the child or teenager and its perception of self. Can take different forms and often is accompanied by other kinds of ill-treatment. Since psychological maltreatment does not show any physical injury is more difficult to detect nd sometimes requires the intervention of public authorities.
Some examples of psychological maltreatment:

- diminish, humiliate and constantly criticize a child or an adolescent;
- ridicule it to diminish its personality, physical appearance, or abilities;
- make him/her feel inadequate and unloved;
- let him/her live in a climate of intimidation and anguish and make him a victim of bullying;
- expose the child or adolescent to the violence and abuse of other persons, such as parents, brothers or even pets.

8.1.4.4 Neglect

With neglect we mean inadequate attention to the material and emotional needs of the child or the teenager, by the parents or those who have the task of taking care of them while having the means. This involves the inability to protect the child or the teenager from potential dangers and to safeguard its primary needs such as medical care, education and adequate emotional growth, often to the point of exposing the minor to the risk of physical and emotional injury.

8.1.4.5 Exploitation

The use of the child or teenager for the benefit, reward or profit of third parties. Such activities expose the child to unfair, cruel and dangerous treatment and affect their emotional, social, moral development and their psycho-physical health. We can identify two main categories of exploitation of childhood and adolescence:

- **Sexual exploitation of children and adolescents**. Sexual exploitation means any activity where a person takes advantage of his or her position of power against a child or an adolescent, of the trust and vulnerability of the minor for sexual purposes and for sexual exploitation profit from economic, social or political profits. The child is therefore exploited both as a sexual object or as a commercial object. Some examples of sexual exploitation: child prostitution, juvenile trafficking for sexual abuse and exploitation, child pornography, sexual slavery.
- **Economic exploitation of children and adolescents**. With economic exploitation, we mean the use of a child or adolescent in some particularly risky work activities that compromise his psycho-physical well-being and undermine his right to education, health and family. Economic exploitation implies the revenue generation for the production, distribution and consumption of goods and services, which has an impact on the economic outlook of a specific social variable, whether it be the state, the community, or the family. Some examples of economic exploitation: exploitation of child labor, recruitment of children and young people as soldiers in armed conflicts, juvenile slavery, use of children or teenagers for criminal acts, including the sale and distribution of narcotic substances, involvement of minors in risky jobs.

8.1.5 Damage

By harm or damage we mean the consequences of exploitation, violence, maltreatment and neglect on children and adolescents that are prejudicial to their psycho-physical, affective and behavioral development, their health, social and family relations, their right to education and to their aspirations.
In all the countries where the IACP operates, many have ratified the international tools for the protection of children and adolescents, including the 1989 UN Convention on the Rights of Children and Adolescents. Although the Convention and other international instruments exert a profound influence on the laws of the single states, some countries in which the IACP operates have some difficulties in fully enforcing and ensuring effective protection of the rights of Children and Adolescents. The IACP sees with concern the high number of violations of the rights of children and adolescents, often victims of physical and psychological abuse, corporal punishment, sexual abuse and sexual and economic exploitation as well as the absence, in some of the countries where it operates of measures alternative to the family for the care and protection of children and adolescents.
The IACP staff at each branch, in Italy and abroad and also all the IACP Partner organizations are aware of the legal status and of the effective protection of protected and promoted rights. The IACP staff is also required to monitor periodically the regulatory framework, the effective status of the rights and the effectiveness of the social bodies responsible for the protection of the rights of children and adolescents.
IACP is committed to protecting children, children and adolescents by adopting the following measures:

1. **Awareness:** The IACP ensures that all the member of staff, managers, coordinators and members of the Board of Directors, are aware of the maltreatment, neglect and exploitation of children and adolescents and the potential risks associated with them.
2. **Prevention:** The IACP aims to ensure risk reduction through the dissemination of good practices, the creation of a safe and child-friendly environment and the encouragement of the active participation of children and adolescents.
3. **Reporting:** The IACP ensures that people involved in the IACP projects and activities are clear about the measures to be taken and aware and alert to potentially hazardous situations for children and adolescents.
4. **Answer**: The IACP is fully committed to supporting and protecting children and adolescents when needed.

8.1.6 The rights of children and adolescents to protection against ill-treatment, neglect, exploitation and violence

The articles of the UN Convention on the Rights of the Child and Adolescents relating to the protection of children and adolescents are:

- art. 9 (separation from parents),
- art. 10 (family reunion),
- art. 11 (transfers and non-return),
- art. 16 (protection of private life),
- art. 19 (protection against maltreatment, abandonment, neglect and exploitation),
- art. 20 (child protection outside her family environment),
- art. 21 (adoption),
- art. 22 (Refugee Children),
- Art. 23 (disabled children),
- art. 24 (right to health and care),
- art. 25 (review and monitoring of forms of assistance), a
- art. 32 (economic exploitation of minors),
- art. 34 (child sexual exploitation),
- art. 35 (sale, traffic and abduction),
- art. 37 (protection against torture, cruel, inhuman and degrading treatment and the forms of illegal deprivation of liberty),
- art. 38 (armed conflict), art. 39 (reintegration), art. 40 (juvenile jurisdiction and minors in conflict with the law).

Articles not directly related to protection but which are essential elements to ensure the protection of children's rights and adolescence are:

- art. 2 (prohibition of discrimination),
- art. 3 (best interest of the child),
- art. 4 (implementation of rights and cooperation),
- art. 5 (development of the child's ability and support to the parent, the extended family and the community), art. 6 (right to life),
- art. 7 (right to a name and a nationality),
- art. 8 (protection of identity),

- art. 18 (parental responsibility),
- art. 26 (security and social security),
- art. 27 (adequate standard of living and social protection),
- art. 28 and art. 29 (education),
- art. 31 (play, rest and leisure).

8.1.6 Risk assessment

The purpose of IACP Policy is to foster a deeper awareness of tall he issues and specific risks to the safety and well-being of children and adolescents in order to minimize chances of abuse as these risks are not completely eliminable.
The IACP defines, evaluates and manages the potential risks with a participatory approach that takes into account the types of risk associated with the intervention area (education, health, participation and protection) and the recipient country of intervention. For each project, program, and activity, IACP assesses the potential impact to children and adolescents involved and identifies appropriate strategies to minimize risks. Impact indicators measure how much the unwanted situation, identified at project start-up, has been reduced.

8.1.7 Prevention of risks

8.1.7.1 For job ads and recruitment: measures to be implemented while staffing

To ensure the safety of children and adolescents, it is crucial to select staff who respect and reflect the commitment of IACP to the protection of children and teenagers. From the very beginning, in the selection of staff one can start to prevent or reduce potential damage.

In recruiting new staff, IACP evaluates:

- the motivation to work with programs focused on childhood and adolescence;
- the intentionality and ability to respect the rights of children and adolescents;
- the understanding of the material and emotional needs of children and adolescents in local contexts;
- the knowledge of international debates on sensitive issues such as international adoption;
- Introjected values such as honesty, non-discrimination, trustworthiness and loyalty;
- good references;
- absence of criminal records: It is necessary to check the absence of criminal records for each candidate to hold a position within the IACP staff.

8.1.7.2 Creating partnerships: measures to be implemented when selecting partners and collaborating with them

To ensure the safety of children and adolescents, it is crucial to select suitable partners to work with. In the selection of partners, the IACP evaluates:

- knowledge of the material and emotional needs of children and adolescents in local contexts;
- shared mission, values and common strategies.

Partner agreements include:

- the ongoing open discussion on issues related to the protection of children and adolescents and their approaches;
- support, if necessary, in the drafting of a child protection policy and adolescence;
- involvement of the partner in the analysis of the child protection and child protection policy.

8.1.7.3 Principles of correct communication

All the IACP forms of communication whatever their purpose (fundraising, awareness campaigns, conferences, workshops, publications and magazines, case presentations, etc.) must be respectful of the dignity of children and adolescents. Their stories and images must be selected in the best interest of the child and published only after receiving the consent of the child or teenager and the parent or legal guardian. Images should portray children and adolescents with appropriate clothing and attitudes. In each publication, language is required to imply a power relationship that children and adolescents are not presented as victims but that their dignity is promoted and respected. Project titles should highlight objectives and results rather than problems and vulnerabilities.
Organizations, groups and individuals outside the IACP who intend to make use of the dissemination materials must sign an agreement on the correct and appropriate use of such materials.
As far as donor relations are concerned, prior to signing a collaboration agreement, IACP will evaluate ethical values.

8.1.7.4 Training on the rights of children and teenagers

1. **Training of the IACP's technical staff in each country, on the child-based approach (Child Rights-Based Approach).**

   The approach based on the rights of children and adolescents is a conceptual framework for the human development process which, at the regulatory level, is based on international standards and principles on the rights of children and adolescents and that, at the operational level , is aimed at promoting, protecting and guaranteeing these rights through projects, policies and development processes. The IACP is committed to providing support, supervision and periodic training, appropriate to the staff knowledge levels and local context, and the training must be offered with participatory modes, in order to encourage staff members to manifest any problems and critical issues.

2. **Training of each new member of the IACP staff, which consists of some essential components:**

   1. the key elements of the Policy for Childhood and Adolescence;
   2. the definitions of the possible forms of maltreatment and exploitation and the signals by which they are recognized;
   3. reporting procedures in case of suspected policy violation.

8.1.7.5 Code of Conduct

8.1.7.5.1 Staff behavior at work

Staff are required to comply with the IACP Code of Conduct. Each new member of the staff will take vison of the IACP Code of Conduct and sign it with the agreement to respect it before signing the employment contract.

8.1.7.5.2 Staff behavior outside working hours

The IACP is committed to ensuring that the IACP staff has high standards of behavior towards children and adolescents both in professional life and in private life. Although the IACP does not intend to impose values that affect staff in conducting private life, the IACP's position in the world depends on its reputation. It will not be allowed, either on working hours or outside, unlawful behavior or inappropriate attitudes by staff, which may adversely affect the reputation of the IACP as ethical standard promoting organization.

8.1.7.5.3 Visitors to IACP projects sites

In order to facilitate IACP to promote a positive climate and a safe environment for children and adolescents, visitors to IACP projects are required to register and comply with some behavioral norms.

8.1.8 Child-friendly environment

An environment is child-friendly when

1. Takes into account the opinions and needs of children and adolescents;
2. Peace and gender equality are respected and any class, caste and religion differences are accepted and respected;
3. Children and adolescents participate;
4. Participation opportunities are promoted;
5. Promoting healthy lifestyles and the acquisition of cognitive, relational and emotional skills;
6. The work sites are accessible to everyone, including people with disabilities or special needs;
7. There are absolutely no forms of violence, abuse, exploitation and trafficking of children and adolescents;
8. The premises are decorated with children's colors and includes the ideas and suggestions from children;
9. Children and adolescents are actively involved in the person centered learning process
10. In the case of activities where a business is being conducted, a code of conduct must be established and shared with children and adolescents.

At the center of all efforts is paramount to put an end to violence against children, the children and adolescents every level, must be adequately involved in the process, acquiring awareness of their rights and responsibilities.

8.1.9 How to deal with suspected abuse

Reporting and investigation procedure
In order to guarantee the right of children and adolescents to protection, it is essential to provide for a simple and transparent procedure to report any suspected abuse.

For this purpose, in each country where IACP operates, a child protection officer (CPO) must be appointed within the organization: The CPO is responsible for handling any reports of abuse against children and adolescents.
The reporting procedure must be clear, easily accessible and must ensure the respect of the child's higher interest and two key values:

- confidentiality: the names of the persons who reported, the subject of the report and the identity of the accused person will not be disclosed unless the case comes before the judge and is required to hear the witnesses.
- loyalty: the accused person who is part of the staff, and members of the Board of Directors will find support from the organization in the maximum of its capabilities and, by virtue of the legal principle of presumption of non-guilt, will be held innocent until the contrary is proven.

8.1.9.1 Who can make a report

A child or teenager, a parent, a family member, a staff member, a volunteer, a member of the Board of Directors, the partners.

8.1.9.2 What can be reported

Any suspicion of behavior prejudicial to the right of children and adolescents to protection, any concerns about the safety of the child or teenager, any breach of the Code of Conduct of the IACP.

8.1.9.3 How to report

With a verbal or written document, with a phone call, an email, an interview, a letter, and any other valid form so that children and adolescents are also able to report.

8.1.9.4 The officer to whom a report should be addressed

To the Child Protection Officer (CPO), appointed by IACP in each country it operates.

8.1.9.5 Final Policy Audit

IACP will evaluate the application of this Policy annually and in a participatory manner.

Approved and enforced in all the IACP offices on January 1st, 2015, this version of IACP Policy replaces all the previous versions.

- What are integrated people-centred health services?
- From “patient” to “person” to “people”: the need for integrated, people-centered healthcare
- Is Patient-Centered Care the Same As Person-Focused Care?
- (PDF) Patient-centered care and people-centered health systems in sub-Saharan Africa: Why so little of something so badly needed?
- Understanding Person-Centered Care

8.1 World Health Organization (WHO) guidelines for Patient/Person/People Centered Health

- Strengthening people-centred health systems in the WHO European ...
- Towards people-centred health systems - an innovative approach. European Observatory on Health Systems. WHO/Europe
- Public health services - Towards people-centred - WHO/Europe
- Health services delivery - People-centred health- WHO/Europe
- EUR/RC66/15 Strengthening people-centred health - WHO/Europe
- Health services delivery - Strengthening people - WHO/Europe
- Strengthening people-centred health services delivery in the WHO ...
- Transforming health services delivery towards people-centred ...
- EUR/RC65/Inf.Doc./5: Global Strategy on Integrated, People-centred ...
- Achieving Person-Centred Health Systems
- Enhancing people-centred health services through ... - WHO/Europe
- Transforming health services delivery towards people ... - WHO/Europe
- Joint statement on strengthening people-centred health systems
- Health systems - Engaging people in every step ... - WHO/Europe
- People-centred health systems in the WHO European Region
- People-centred health systems: voices of patients ... - WHO/Europe
- Primary health care - Sweden takes action towards ... - WHO/Europe
- WHO/Europe | 66th session - WHO/Europe
- WHO/Europe | 65th session - WHO/Europe
- European Observatory on Health Systems and ... - WHO/Europe
- WHO/Europe - Make health systems people centred - WHO/Europe
- WHO/Europe - Health systems - WHO/Europe
- Health services delivery - Transforming integrated ... - WHO/Europe
- Public health services - Engaging people in every ... - WHO/Europe
- Framework for Action towards Coordinated/Integrated Health ...
- About us - WHO European Centre for Primary Health ... - WHO/Europe
- Health 2020: the European policy for health and well ... - WHO/Europe
- Nursing and midwifery - Engaging people in every ... - WHO/Europe
- Health 2020: the European policy for health and well ... - WHO/Europe
- European Observatory on Health Systems and ... - WHO/Europe
- Health systems for health and wealth in the context of ... - WHO/Europe
- Primary health care - European framework (EFFA ... - WHO/Europe
- Health systems response to NCDs - Population ... - WHO/Europe
- Laboratory services - Time for integrated and people ... - WHO/Europe

TOOL KIT LEAVING CARE

Versione Italiana

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1. Prefazione del Care Path Toolkit

Questo Toolkit fa parte del progetto Care Path ("Empowering public authorities and professionals towards trauma-informed leaving care support – Care Path", progetto n. 785698, presentato al Bando REC-AG-2017 (REC-RCHI-PROF-AG-2017)) finanziato dal Programma dell'Unione Europea Diritti, Uguaglianza e Cittadinanza (2014-2020).
I contenuti e i materiali di questo Toolkit sono disponibili gratuitamente sul web e come tutti i contenuti del Corso online Care Path. I contenuti rappresentano esclusivamente il punto di vista degli autori ed è di loro esclusiva responsabilità. La Commissione Europea non può essere ritenuta responsabile per qualsiasi uso che possa essere fatto delle informazioni in esso contenute.
Il toolkit Care Path per i professionisti che lavorano con bambini traumatizzati è stato sviluppato per i professionisti Care Path certificati per fornire servizi di assistenza post-traumatica ai bambini. Il toolkit aiuterà i professionisti a seguire un approccio multidimensionale e integrato per il sostegno dei bambini traumatizzati, inclusi i servizi residenziali e abitativi, l'assistenza sanitaria, l'orientamento alla formazione professionale, l'inclusione sociale e i servizi psicoterapeutici. Questo toolkit guiderà inoltre i professionisti nel promuovere il coinvolgimento dei bambini nella pianificazione della erogazione di servizi dopo le cure e sul coinvolgimento, se necessario, di altri professionisti: psicoterapeuti, assistenti sociali, formatori, decisori politici, avvocati ecc.
Le informazioni contenute in questo Toolkit sono disponibili sul web. Le informazioni e le teorie scientifiche contenute in tutte le parti del Care Path Toolkit sono state organizzate con l'intento di essere utili a tutte le persone che, a vario titolo e con diversi background professionali, offrono aiuto e servizi ai bambini vittime di traumi.
Le conoscenze scientifiche contenute in tutti i materiali del Care Path Project e in particolare quelle incluse in questo Toolkit sono liberamente accessibili in varie pubblicazioni scientifiche in tutto il mondo. L'applicazione di queste nozioni e conoscenze è regolata in modi diversi nei vari paesi dalle loro rispettive leggi, regolamenti e i codici etici dei vari Ordini professionali, associazioni professionali o di volontariato, che spesso variano da paese a paese.
Tutti i contenuti di questo Toolkit sono offerti con la precisa intenzione di rispettare tutte le leggi e i regolamenti in vigore sugli argomenti trattati e nessuna parte di questo Toolkit o del corso Care Path Mooc può essere utilizzata per scopi diversi da quelli appena sottolineati. Rimane un dovere e un imperativo per ogni professionista lavorare sempre in scienza e coscienza e questo include il pieno rispetto delle normative vigenti nel proprio paese, il rispetto delle competenze specifiche delle altre professioni, la consapevolezza dei propri limiti e delle proprie conoscenze e il rispetto dei confini che delineano la propria professione e il proprio ruolo e competenza professionale o para professionale, nonché la necessaria osservanza delle norme interne dell'organizzazione in cui si opera.
Questo toolkit è stato assemblato ed è il risultato di una procedura scientifica standard che ha incluso la ricerca su banche dati (MEDLINE, Embase, e PsycINFO), la consultazione con vari professionisti competenti e attivi nelle varie discipline e attività trattate nel Toolkit e nel Progetto Care Path. Tra questi sono inclusi professionisti che offrono servizi ai bambini vittime di traumi, tra cui direttori di servizi o di strutture del settore privato o pubblico che si occupano della tutela e della promozione dei diritti, del recupero, della tutela e della promozione della salute e del benessere dei bambini vittime di traumi o della prevenzione

intersettoriale dei traumi a livello legislativo, manageriale, clinico, professionale, para-professionale e di volontariato. Sono stati inclusi anche materiali che offrono l'accesso alle dichiarazioni pubbliche e volontarie di alcune vittime di traumi e delle loro famiglie, nonché le voci di alcuni professionisti chi si prendono cura ti detta utenza inclusi gli aspetti rilevanti dei loro bisogni formativi professionali, la tutela e promozione della salute sul posto di lavoro e in particolare per la prevenzione e la gestione dello stress, del burn-out e del trauma vicario. Questo Toolkit è stato assemblato dando la massima importanza alla Trauma Informed Care, agli approcci centrati sui bambini, all'approccio centrato sulla persona, alla pianificazione centrata sulla persona, agli approcci di recovery centrati sulla persona, alle buone pratiche, ai denominatori comuni, alle illustrazioni dei casi clinici, agli approcci intersettoriali per la formazione del personale, alla formazione continua, alle politiche organizzative, allo sviluppo e alla gestione organizzativa di strutture e servizi dedicati all vittime di traumi.
Abbiamo compilato questo toolkit evitando di creare un elenco meccanicistico delle risorse, abbiamo costruito questo toolkit con l'intento di offrire un vasto panorama delle risorse disponibili che sia anche trasparente e consapevole dei principi della sociologia della conoscenza (Berger & Luckmann, 1966) e ben consapevole che ogni approccio terapeutico o di aiuto si basa su una visione specifica della natura umana che, a sua volta, si basa su valori, tali valori determinano le politiche delle relazioni di aiuto e ne influenzano gli esiti (Foucault, 1971,1976, 1977, 1980).
Dato che ogni visione della natura umana è basata su un insieme di valori, ogni relazione di aiuto è, in realtà, un atto politico (Zucconi, 2001, 2003, 2008). L'utente deve sviluppare un nuovo modo di interpretare la sua esperienza e di generare i suoi comportamenti - in altre parole, interiorizzare la narrazione della relazione di aiuto. Michael Polanyi (1958) ha affrontato questo aspetto in termini di apprendimento interpersonale implicito e non consapevole che ci scambiamo continuamente.
Le relazioni di aiuto sono, per queste ragioni, caratterizzate da un differenziale di potere tra il professionista e il paziente/ cliente/utente (Proctor, 2002, 2004, 2005, 2006; Sanders & Tudor, 2001; Sommerbeck, 2003; Sanders 2006). Questo differenziale di potere è maggiore o minore nei diversi approcci di aiuto: è maggiore quando il ruolo del terapeuta è quello di un esperto che dovrebbe diagnosticare, curare ed esigere compliance. Negli approcci trauma informed, centrati sulla persona, orientati alla recovery, sensibili alle tematiche di genere, di orientamento sessuale e alle diversità culturali, ove la relazione si basa sul rispetto e la fiducia del professionista nei confronti del cliente/utente e sulle innate potenzialità di resilienza e di cambiamento del cliente, il differenziale di potere è destinato ad essere meno sproporzionato. In questo caso il ruolo del professionista è quello di sostenere l'innata tendenza formativa e di resilienza del cliente, di adottare una posizione fenomenologica che rispetti e si fidi della comprensione della propria esperienza da parte del cliente/utente (Zucconi, 2003).
"*È il cliente che sa cosa fa male, quali direzioni prendere, quali problemi sono cruciali, quali esperienze sono state profondamente sepolte*" (Rogers, 1961, pp. 11-12).
Il punto di vista di Rogers era rivoluzionario a suo tempo (Rogers, 1939,1942,1946,1951,1956,1957,1959,1961) ma purtroppo è altrettanto rilevante e necessario per le attuali pratiche di psicoterapia e le varie relazioni di aiuto. Alcune delle problematiche attuali nel campo della sanità e delle relazioni di aiuto non sono così diverse da quelle che Rogers e i suoi colleghi affrontarono negli anni '40 e '50: oggi il settore sanitario, la manualizzazione della psicoterapia, le politiche della ricerca psicoterapica, la regolamentazione delle professioni di aiuto tutt'ora suscitano interrogativi e preoccupazioni circa i valori sottostanti della ricerca psicoterapica, la regolamentazione professionale e la psicoterapia e le relazioni di aiuto come forme potenziali di controllo sociale, invece di

essere efficaci aspetti della protezione e promozione dei diritti umani e della salute individuale e sociale.
I professionisti delle relazioni di aiuto, possono dare oggi un contributo significativo al dibattito sulle politiche professionali nel campo delle relazioni d'aiuto. Per farlo in modo efficace è necessario seguire le orme dei fondatori della Psicologia Umanistica come Carl Rogers, Abraham Maslow, Gordon Allport, Charlotte Butler, James Bugental per affrontare e rendere esplicite le questioni dei valori e dell'uso del potere nelle professioni di aiuto. Dobbiamo impegnarci attivamente per sviluppare pratiche socialmente consapevoli e democratiche, e dovremmo, a livello scientifico e politico, impegnarci sui temi della recovery, della resilienza, dell'emancipazione e dell'empowerement.
Questo toolkit comprende anche una vasta panoramica di ricerche, casi clinici, esempi di buone pratiche di come, in diverse parti del mondo, i diritti dei bambini sono protetti e promossi, come l'assistenza centrata sui bambini e la Trauma Informed Care possono essere gli aspetti centrali della pianificazione e della gestione di approcci efficaci che siano centrati sulla persona e di recovery in tutti gli aspetti della costruzione sociale della realtà: Legislazione Trauma Informed, finanziamenti di progetti, organizzazione della comunità, pianificazione e gestione delle scuole, strutturazione delle istituzioni per l'infanzia, pianificazione dei servizi orientati ai bambini e offerte di servizi efficaci. Se siamo consapevoli delle implicazioni bi-psico-sociali possiamo non solo erogare servizi efficaci alle vittime di traumi, ma anche prevenire i traumi, prevenire la ritraumatizzazione, prevenire il burnout e i traumi vicari del personale che eroga i servizi. In questo modo lavoreremo consapevolmente per essere parte della soluzione e non del problema.
Quando questo toolkit è stato completato, la pandemia del Covid-19 ha avuto un drammatico impatto in tutto il mondo, un impatto traumatico su tutti i cittadini e in particolare sui bambini, sui bambini vittime di traumi in particolare, sulle loro famiglie e su tutti i professionisti delle relazioni di aiuto. Questa nuova fonte di trauma è stata aggiunta con una sezione specifica alla già ricca lista di argomenti e risorse comprese in questo toolkit.
Per tale motivo abbiamo incluso una lunga lista di informazioni, risorse, e vari toolkit su come affrontare efficacemente le problematiche causate dalla pandemia Covid-19 offrendo il collegamento gratuito con le migliori e più solide istituzioni scientifiche, come l'Organizzazione Mondiale della Sanità (OMS).
Questo toolkit è il risultato di una procedura scientifica standard che ha incluso ricerche su banche dati, la consultazione con diversi professionisti competenti e attivi nelle varie discipline e attività trattate nel Toolkit e nel progetto Care Path. Sono stati inclusi tutte le categorie professionali che offrono servizi ai bambini vittime di traumi, compresi i direttori dei servizi o delle strutture del settore privato o pubblico che si occupano della protezione e della promozione dei diritti, del recupero, della tutela e della promozione della salute e del benessere dei bambini vittime di traumi o della prevenzione dei traumi a livello legislativo, manageriale, professionale, paraprofessionale e volontario. Sono stati inclusi anche dei materiali che offrono l'accesso alle testimonianze dirette delle vittime di traumi e delle loro famiglie, nonché testimonianze di operatori e agli aspetti principali dei loro bisogni formativi e dei loro bisogni riguardo alla difesa e promozione della loro salute sul luogo di lavoro e in particolare per la prevenzione e la gestione dello stress, del burn out, della prevenzione e della gestione dello stress vicario.
Una delle varie caratteristiche di questo Toolkit è l'assenza di rischi di violazione del diritto d'autore per la consultazione dei materiali accessibili attraverso i link web o i link di You Tube disponibili gratuitamente sul web e pubblicati da varie organizzazioni e vari professionisti operanti in diverse parti del mondo. Nella maggior parte dei casi i materiali offerti sono nelle lingue ufficiali del progetto Care Path. Inglese, italiano, francese, magiaro

e greco, in alcuni casi i materiali disponibili sono in molte altre lingue poiché sono messi a disposizione dall'Organizzazione Mondiale della Sanità o da altre istituzioni scientifiche internazionali.
Un altro aspetto degno di nota è il fatto che in diversi casi i collegamenti web danno accesso a banche dati e risorse gratuite delle istituzioni, non solo ad alcuni singoli documenti, quindi per i collegamenti web con le istituzioni il Toolkit fornirà l'accesso gratuito ai materiali continuamente aggiornati, ai risultati delle ricerche, alla legislazione e alle migliori pratiche che devono essere ancora pubblicate, uno strumento di aggiornamento continuo prezioso per un professionista e una organizzazione interessati a queste tematiche. Inoltre questo Toolkit offre una facilitazione non solo per accedere a materiali e in formazioni, importanti ma offre anche ai professionisti e alle loro organizzazioni la possibilità concreta di stabilire un prezioso network internazionale con istituzioni e colleghi di tutto il mondo.
Un'altra caratteristica di questo toolkit è che siamo stati in grado di individuare diversi toolkit disponibili gratuitamente on-line nei siti web di note istituzioni scientifiche che offrono tutta una serie di materiali e strumenti scientifici convalidati, così invece di scrivere una semplice elencazione dei materiali esistenti abbiamo scelto di rendere questi strumenti scientifici direttamente disponibili ai professionisti interessati fornendo loro non solo un toolkit ma anche un deposito elettronico e una banca dati liberamente disponibile per chiunque sia interessato, In questo modo, questo toolkit offre una gamma piuttosto ampia di strumenti scientificamente validati e già ben organizzati che sono il risultato del lavoro di migliaia di professionisti, di innumerevoli ricerche scientifiche e di buone pratiche ben consolidate. In diversi casi i toolkit disponibili in questo toolkit sono lo stato dell'arte dell'intero settore e delle sue diverse applicazioni nei diversi setting in termini bio-psico-sociali (Engel, 1977).
L'Organizzazione Mondiale della Sanità (OMS) nell'International Classification of Disease-9, già nel 1996 inquadrava la violenza e il maltrattamento sui bambini tra le patologie diagnosticabili; progressivamente ha dettagliato le tipologie di violenza, chiarendo che per maltrattamento all'infanzia s'intendono "tutte le forme di cattiva salute fisica e/o emozionale, abuso sessuale, trascuratezza, negligenza o altro, che comportino un pregiudizio reale o potenziale, per la salute del bambino, per la sua sopravvivenza, per il suo sviluppo o per la sua dignità, in una relazione caratterizzata da responsabilità, fiducia e potere" (OMS, 2002). In considerazione della portata del fenomeno, l'OMS (2006) considera la violenza un problema di salute pubblica, che richiede massima priorità, con interventi urgenti e corrette diagnosi precoci; l'Organizzazione delle Nazioni Unite (2006) aggiunge che la violenza rimane in gran parte «nascosta, non denunciata e sottostimata, e che si consuma prevalentemente tra le mura domestiche».

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2. Siti utili

Pubbliche amministrazioni ed enti che operano nel settore delle politiche per l'infanzia e l'adolescenza:

- Commissione parlamentare per l'infanzia e l'adolescenza
- Ministero del lavoro e delle politiche sociali
- Ministero dell'interno - Minori e disagio giovanile
- Ministero della giustizia - Minori
- Ministero dell'istruzione, dell'università e della ricerca
- Ministero per i beni e le attività culturali
- Ministero della salute - Salute dei bambini

SOS Villages-Italia

https://www.sos-childrensvillages.org/where-we-help/europe/italy

Agevolando
http://www.agevolando.org/
Agevolando opera nell'ambito del disagio sociale e della promozione del benessere, in particolare quello dei minori e dei neomaggiorenni "fuori famiglia", ovvero bambine e bambini, ragazze e ragazzi allontanati dalla loro famiglia a causa di negligenze, trascuratezze, maltrattamenti o abusi subiti oppure ragazze e ragazzi provenienti da altri Paesi e arrivati in Italia da soli quando ancora minorenni.
Il nostro obiettivo è limitare i danni che possono derivare dall'assenza di supporto sociale per tutti questi ragazzi/e che, una volta divenuti maggiorenni, si trovano a dover fare i conti con la conclusione del loro percorso residenziale in comunità e/o in affido familiare privi o carenti di risorse personali e sociali necessarie per raggiungere un sufficiente grado di autonomia dal punto di vista abitativo, lavorativo e relazionale.
I giovani-adulti di cui Agevolando si occupa vengono sostenuti attraverso progetti e iniziative che mirano a garantire diversi benefici quali:

- la casa con canone d'affitto agevolato;
- il lavoro attraverso una rete di imprese "inclusive";
- l'assistenza e l'istruzione nell'espletamento delle procedure burocratiche relative alla casa, al lavoro, ai documenti personali, alla formazione personale, ecc.;
- il sostegno e l'incoraggiamento nello studio per il completamento delle scuole superiori o per il superamento degli esami universitari;
- la promozione di relazioni sociali e di prossimità utili per un affiancamento rassicurante capace di garantire ascolto, affetto, presenza emotiva;
- la promozione dell'empowerment personale, ovvero del rafforzamento delle capacità dei giovani adulti di padroneggiare e superare le difficoltà quotidiane autonomamente.

Ci occupiamo anche di progetti a favore di minorenni "fuori famiglia" come l'organizzazione di eventi a loro dedicati (feste, tornei, incontri nelle comunità) e attività di sensibilizzazione all'interno delle scuole e durante iniziative pubbliche (congressi, convegni, manifestazioni, ecc.).

Manuale del Garante per l'infanzia per addestramento volontari con numerosi esempi utili di modulistica.
https://www.garanteinfanzia.org/sites/default/files/compendium-attivita-garanteinfanzia-easo.pdf

Istituto degli Innocenti
https://www.istitutodeglinnocenti.it/content/researcherseducators
L'Istituto degli Innocenti svolge attività di ricerca e monitoraggio su molti dei **fenomeni che riguardano bambini e adolescenti,** affrontandone aspetti della loro vita sui quali spesso manca un'adeguata e approfondita attività di indagine. L'obiettivo è fornire un valido strumento **per la conoscenza su come cambiano le nuove generazioni e i loro bisogni e per la programmazione, a livello nazionale e regionale, degli interventi in ambito sociale, sociosanitario ed educativo.**

Biblioteca Innocenti
https://www.istitutodeglinnocenti.it/content/biblioteca-innocenti-library

La Biblioteca Innocenti Library Alfredo Carlo Moro è specializzata sui diritti dell'infanzia e dell'adolescenza ed è stata istituita nel 2001 come **progetto di cooperazione fra l'Istituto degli Innocenti e l'Innocenti Research Centre dell'UNICEF,** oggi Office of Research, in accordo con il Governo italiano. La Biblioteca, intitolata nel 2009 ad Alfredo Carlo Moro, giudice minorile e ideatore del Centro nazionale di documentazione e analisi per l'infanzia e l'adolescenza, svolge il servizio di reference del Centro nazionale e del Centro regionale di documentazione per l'infanzia e l'adolescenza.

Carta dei servizi sanitari - IRCCS Fondazione Stella Maris - Unipi
https://www.fsm.unipi.it/wp-content/uploads/2019/08/carta-serv-Rev.15-del-28-06-2019.pdf

PARES
https://www.ibambini.it/uploads/formazione/File/progetti/PARESLineeGuida.pdf
Linee guida per l'accoglienza e l'assistenza alle vittime di maltrattamenti, violenza domestica, violenza sessuale, stalking e abuso.

AUSL Bologna Trauma informed care
https://www.ausl.bologna.it/asl-bologna/dipartimenti-territoriali-1/dipartimento-di-cure-primarie/il-faro/centro-doc/centro-di-documentazione/per-i-professionisti/area-psicologica/trauma%20informed%20care.pdf/attachment_download/file

Cismai
Coordinamento italiano servizi contro il maltrattamento e l'abuso all'infanzia
CISMAI documenti / risorse a consultazione e scarico gratuito su protezione minori
https://cismai.it/category/documenti/protocolli/

CISMAI protocollo di Ferrara
https://cismai.it/protocollo-di-ferrara-linee-guida-per-i-rapporti-tra-i-servizi-sociali-e-le-istituzioni-scolastiche-in-presenza-di-minori-che-si-trovano-in-situazione-di-pregiudizio/

CISMAI requisiti per servizi dedicati minori affetti da trauma
http://cismai.it/wp-content/uploads/2015/02/requisiti_minimi_servizi96cb.pdf

CISMAI Requisiti di "qualità" dei centri residenziali che accolgono minori vittime di maltrattamento e abuso
http://cismai.it/wp-content/uploads/2015/02/requisiti_minimi_comunita6efe.pdf

CISMAI
https://cismai.it/i-maltrattamenti-infantili-sono-una-delle-cause-della-devianza-giovanile/

Studio nazionale Università Bocconi/Cismai
http://cismai.it/wp-content/uploads/2015/02/6261_Tagliare_sui_bambini_studioTDH_Bocconi_Cismai.pdf
"Tagliare sui Bambini è davvero un risparmio?"
Spesa pubblica: impatto della mancata prevenzione della violenza sui bambini

Cesvi
https://www.cesvi.org/wp-content/uploads/2019/05/Indice-Cesvi_2019.pdf

Indice regionale sul maltrattamento all'infanzia in Italia

Terre des Hommes Italia
https://terredeshommes.it/chi-siamo/
https://terredeshommes.it/cosa-facciamo/progetti-italia/
nell'ultimo anno ha realizzato 90 progetti in 22 paesi del mondo dedicandosi in particolare ai temi della Child Protection, della sanità di base e del diritto all'educazione

Terre des Hommes Italia
https://terredeshommes.it/dnload/GuidaFARO-2017.pdf

Guida al progetto FARO Salute mentale e supporto psicosociale a minori migranti non accompagnati e a famiglie con bambini in prima accoglienza

Guida Terres des Hommes IV
https://terredeshommes.it/wp-content/uploads/2015/03/GUIDA_MSNA_psicosociale_Terre_des_Hommes.pdf

Organizzazione Mondiale della Salute (OMS)
https://www.cesvi.org/wp-content/uploads/2019/05/Indice-Cesvi_2019.pdf
Indice regionale sul maltrattamento all'infanzia in Italia

OMS Manuale di primo soccorso psicologico
https://apps.who.int/iris/bitstream/handle/10665/44615/9789241548205-ita.pdf?ua=1

Unicef/OMS/Lancet
https://www.unicef.it/doc/9701/rapporto-unicef-oms-lancet-salute-globale-dei-bambini-a-rischio.htm
Rapporto sui rischi alla salute dei bambini nel mondo

Manuali professionali: Panoramica dei disturbi da stress e da trauma
https://www.msdmanuals.com/it/professionale/SearchResults?query=Panoramica+dei+disturbi+da+stress+e+da+trauma&icd9=308.3%3b309.81

2.1 Corona Virus, quarantena e trauma

Fondazione veronesi
https://www.fondazioneveronesi.it/magazine/articoli/lesperto-risponde/coronavirus-consigli-per-gestire-la-quarantena-senza-stress
Lunghi periodi di quarantena possono determinare un aumento dei casi di ansia, paura (del contagio) e disturbo post-traumatico da stress. I consigli per venirne fuori senza conseguenze

Il portale dell'epidemiologia per la sanità pubblica
https://www.epicentro.iss.it/stress/
a cura dell'Istituto superiore di sanità

stress post traumatico Coronavirus, lo psicologo: «Personale sanitario svilupperà disturbi post traumatici. Attivare subito supporto psicologico»

https://www.sanitainformazione.it/lavoro/coronavirus-lo-psicologo-molti-medici-svilupperanno-disturbi-post-traumatici-le-ferite-del-guerriero-si-sentono-finita-la-battaglia/

Coronavirus, parla il primo medico contagiato a Milano: «Ho avuto paura, ma ho vinto la mia battaglia»
https://www.sanitainformazione.it/lavoro/coronavirus-parla-il-primo-medico-contagiato-a-milano-ho-avuto-paura-ma-ho-vinto-la-mia-battaglia/

Programma on line del Governo italiano per risorse a disposizione delle famiglie per gestire l'emergenza Coronavirus.
http://famiglia.governo.it/ci-sto-dentro/

Servizi di supporto psicologico gratuito per emergenza Coronavirus
http://www.salute.gov.it/portale/nuovocoronavirus/dettaglioNotizieNuovoCoronavirus.jsp?lingua=italiano&menu=notizie&p=dalministero&id=4335&fbclid=IwAR3JBR4KXFLNFmK8qmm5KI9Js3ApPEnv1UrEAxb5HlVXQqggn6Tq3K3Sz28

2.2 Orfani a seguito di violenza domestica

- https://www.minori.gov.it/sites/default/files/Orfani_crimini_domestici.pdf
- http://cismai.it/wp-content/uploads/2017/12/Documento-Cismai-Senato.pdf
- https://formiche.net/2019/11/violenza-donne-orfani/
- http://old.iss.it/binary/casa/cont/Manuale_Revamp_2.pdf
- https://www.savethechildren.it/cosa-facciamo/campagne/petizione-bambini-vittime-di-violenza-assistita-e-orfani-di-crimini-domestici
- https://www.poliziadistato.it/statics/28/inserto-2-18.pdf
- http://www.regione.piemonte.it/governo/bollettino/abbonati/2019/12/attach/dgr_08475_1050_01032019.pdf
- https://www.altalex.com/documents/leggi/2017/12/27/orfani-per-crimini-domestici
- http://www.senonoraquando-torino.it/tag/orfani-femminicidio/
- https://www.diritto.it/italia-condannata-dalla-cedu-violenza-domestica-tutela-insufficiente/
- Approfondimento Conoscitivo applicazione Convenzione di Istanbul in Italia https://www.irpps.cnr.it/wp-content/uploads/2018/04/Approfondimento-conoscitivo-Conv-Istanbul.pdf

2.3 Politiche per l'infanzia

- Piattaforma Europea per gli investimenti nell'infanzia
- SOS VIllage - Italy
- Agevolando - L'Associazione dei Care Leavers
- Istituto degli Innocenti | Sei secoli di impegno per i diritti dell'infanzia
- Fondazione Stella Maris - Carta dei servizi sanitari
- Cismai | Coordinamento Italiano Servizi Maltrattamento all'Infanzia
- Terre des hommes; Proteggere i bambini da ogni forma di violenza o abuso, garantire a ogni bambino il diritto alla salute, all'educazione e alla vita

2.4 Diritti dell'infanzia

Il Consiglio d'Europa offre accesso gratuito a una serie di materiali importanti concernenti i minori e i minori leaving care consultabili e scaricabili gratuitamente.

- Consiglio europeo

2.5 Pubbliche amministrazioni ed enti che operano nel settore delle politiche per l'infanzia e l'adolescenza in Italia

- Commissione parlamentare per l'infanzia e l'adolescenza
- Ministero del Lavoro e delle Politiche Sociali
- Ministero dell'interno Minori e disagio giovanile
- Ministero della Giustizia - Minori
- Ministero dell'Istruzione - Ministero dell'Università e della Ricerca
- Ministero per i beni e le attività culturali e per il turismo
- Ministero della salute - Salute dei bambini
- Dipartimento per le politiche della famiglia
- Minori.it - Centro nazionale di documentazione e analisi per l'infanzia e l'adolescenza

2.6 Riferimenti normativi

Convenzione di Lanzarote, ratificata dall'Italia e pubblicata con legge del 1°ottobre 2012, n. 172 in Gazzetta Ufficiale n. 235, 8 ottobre 2012: «*Ratifica ed esecuzione della Convenzione del Consiglio d'Europa per la protezione dei minori contro lo sfruttamento e l'abuso sessuale*

Convenzione ONU sui Diritti dell'Infanzia, 1989, ratificata in Italia con la legge n.176 del 27 maggio 1991, in www.savethechildren.it

Legge n.269/1998, Norme contro lo sfruttamento della prostituzione, della pornografia, del turismo sessuale in danno di minori, quali nuove forme di riduzione in schiavitù

Legge n.328/2000, Legge quadro per la realizzazione del sistema integrato di interventi e servizi sociali in Linea Guida per le strategie nazionali integrate di protezione dei bambini della violenza, approvato dal Consiglio d'Europa in data 18 novembre 2009 (Raccomandazione n.10/2009)

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3. Analisi ricerca e monitoraggio

3.1 Report

- Vite in Bilico: Percorsi di vita dall'infanzia all'età adulta. Formazione, lavoro, relazioni affettive e familiari, salute e violenza
- Banca dati sulle buone pratiche territoriali a favore delle politiche della famiglia (aggiornati al 31 luglio 2018)
- Trauma Informed Care
- Spesa pubblica: impatto della mancata prevenzione della violenza sui bambini
- Indice regionale sul maltrattamento all'infanzia in Italia
- Commenti giuridici - Orfani di crimini domestici

3.2 Manuali e linee guida

- Manuale emergenza infanzia
- Compendio sull'attività svolta dall'autorità garante per l'infanzia
- Linee guida per l'accoglienza l'assistenza alle vittime di maltrattamenti, violenza domestica, violenza sessuale e stalking
- Guida al progetto FARO: Salute mentale e supporto psicosociale a minori migranti non accompagnati e a famiglie con bambini in prima accoglienza
- Guida psicosociale per operatori impegnati nell'accoglienza
- Manuali professionali: Panoramica dei disturbi da stress e da trauma
- Riconoscere, accogliere ed accompagnare le vittime di violenza relazionale
- Questo non è amore - Violenza sulle donne
- Approfondimento conoscitivo sulla Convenzione di Istanbul

3.3 Associazioni

- Rete Nazionale di Psicotraumatologia e Psicologia dell'Emergenza
  - http://www.psicologiaemergenza.it
- Synergia, Studio e Cura del Trauma Psichico
  - http://www.synergiacentrotrauma.it/
- Associazione Italiana, Scientifica e Giuridica, contro gli abusi mentali, fisici e tecnologici
  - http://www.aisjca-mft.org/
- Hansel e Gretel. Centro studi sui problemi dell'età evolutiva
- Violenza contro le donne. Ricevere aiuto, dare aiuto
  - http://web.tiscalinet.it/cadmi/guida/
- Telefono Arcobaleno
  - www.telarcobaleno.com
- C.I.S.M.A.I. Coordinamento Italiano dei Servizi contro il Maltrattamento e l'Abuso all'Infanzia
  - http://www.psychomedia.it/sites/rompsil/prescoord.htm
- Casa delle Donne per non subire violenza
  - Via dei Poeti n. 4, Bologna

Tel. 051/265700

- Associazione gruppo S.O.S. Donna
  Via XXI Aprile n. 1945, Bologna
  - Tel. 051/434345
- Casa di accoglienza delle donne maltrattate
  - Via Piacenza n. 14, Milano
    Tel. 02/55015519
- C.B.M. (Centro per il bambino maltrattato)
  - Via Spadini n¡ 15, Milano
    Tel. 02/6456705 - 02/66201076
- Centro antiviolenza Comune di Venezia
  - Viale Garibaldi n. 155/A, Venezia
    Tel. 041/5349215
- Centro di accoglienza per le donne vittime di violenza
  - Viale di Villa Pamphili n. 86, Roma
    Tel. 06/5811473
- Centro per i diritti delle donne del Comune di Roma
  - Via Tor di Nona n. 43, Roma
    Tel. 06/6832690 - 06/6832820
- Casa di accoglienza delle donne maltrattate o in difficoltà Presso l'U.D.I. (Unione donne italiane)
  - Via XX Settembre n. 57, Palermo
    Tel. 091/327973
- Telefono Azzurro
  - Via dell'Angelo Custode n. 1/3, Bologna
    Consulenza telefonica 24 h su 24 su tutto il territorio nazionale
    Tel. 19696: numero gratuito per i minori di 14 anni
    Tel. 051/481048, al quale possono accedere anche adolescenti e adulti
- Pronto soccorso violenza sessuale
  - Presso l'Ospedale Mangiagalli, Via Commenda n. 12, Milano
    Tel. 02/579955, attivo 24 h su 24
- Centro di Psicotraumatologia
  - Centro Militare di Medicina Legale di Firenze, Dipartimento di Scienze Neurologiche e Psichiatriche Università di Firenze,
    http://www.sipsot.it/emergenza/psicotraumatologia.html

3.4 Articoli

- I care leavers
- Costruire resilienza: analisi e indicazioni per l'accompagnamento educativo in uscita dalle comunità per minori
- Rapporto UNICEF-OMS-Lancet: salute globale dei bambini a rischio

4. Emergenza Coronavirus - Materiali utili

Portale di epidemiologia per Operatori Sanitari

- EpiCentro - Portale di epidemiologia per gli operatori sanitari

4. 1 Cassetta degli attrezzi per la gestione efficace dell'emergenza Corona virus In italiano

Sarà vero? Il fact checking ai tempi del Covid-19
Il Direttore Generale dell'OMS ha dichiarato che rispetto al nuovo Coronavirus "Non stiamo combattendo solo un'epidemia, stiamo combattendo anche un'infodemia".
In questa situazione di sovraffollamento informativo diventa sempre più complicato rintracciare fonti affidabili e credibili ed evitare di inciampare in notizie non sottoposte a verifiche o addirittura in vere e proprie fake news.

Covid-19: un'iniziativa "resiliente" per medici e infermieri
Sono due i progetti messi in campo dalla Fondazione Policlinico Universitario Agostino Gemelli IRCCS per dare supporto psicologico agli operatori sanitari impegnati nella lotta contro il Coronavirus. "Resilienza Covid19" è un progetto ideato da psichiatri e da psicologi del Gemelli per dare supporto a tutti gli operatori sanitari italiani, attraverso una linea telefonica dedicata (attiva 7 giorni su 7 dalle 9 alle 18) o via email. "Non sei solo" è invece il progetto ideato dal Servizio di Psicologia Clinica del Gemelli per supportare il personale sanitario del Policlinico, impegnato nell'emergenza Covid-19. Per il primo progetto è stata attivata una linea telefonica dedicata (+39 342 324.2015), attiva 7 giorni su 7, dalle 9 alle 18, l'email resilienzaCovid19@policlinicogemelli.it e un questionario volto alla misurazione del grado di stress che sta vivendo la popolazione degli operatori sanitari italiani, che può essere compilato cliccando sul link: http://bit.ly/ResilienzaCovid19. Il progetto 'Resilienza Covid-19' prevede la possibilità per gli operatori sanitari di un supporto telefonico immediato, che può essere ripetuto nel tempo, ma anche di percorsi di psicoterapia breve telematica o gruppi di sostegno telematico, per chi avesse bisogno di un intervento più strutturato.

"Non sei solo": un servizio di supporto psicologico dedicato agli operatori sanitari del Policlinico Universitario A. Gemelli IRCCS ha l'obiettivo di supportare psicologicamente le figure sanitarie, cercando anche di prevenire forme di stress post-traumatico. È stato infine stilato un decalogo per potenziare i meccanismi di resilienza per gli operatori sanitari i cui punti salienti sono:

1. Saper chiedere aiuto per poter dare aiuto.
2. Mantenere una vita sana.
3. Combattere l'alienazione.
4. Evitare l'onnipotenza.
5. Non sentirsi in colpa.
6. Rimanere in comunicazione con i colleghi.
7. Gestire le emozioni inaspettate.
8. Informarsi correttamente.
9. Trovare uno spazio personale e del tempo per qualcosa di diverso dall'assistenza.
10. Continuare a pensare ai vostri progetti futuri.

4.1.1 Considerazioni sulla salute mentale e psicosociale durante l'epidemia da COVID-19

L'OMS e le autorità sanitarie pubbliche di tutto il mondo stanno agendo per contenere l'epidemia da COVID-19. Tuttavia, questo momento di crisi sta generando stress in tutta la popolazione. Le considerazioni presentate in questo documento sono state sviluppate dal WHO Department of Mental Health and Substance Use, come una serie di messaggi che

possono essere utilizzati nelle comunicazioni per supportare il benessere mentale e psicosociale in diversi gruppi target durante l'epidemia.

4.1.1.1 Messaggi per la popolazione generale:

è probabile che COVID-19 colpisca persone di molti paesi, in molte aree geografiche. Quando si fa riferimento a persone con COVID-19, non associare la malattia a nessuna particolare etnia o nazionalità. Sii empatico con tutti coloro che ne sono colpiti, in e da qualsiasi paese. Le persone colpite da COVID-19 non hanno fatto nulla di male e meritano il nostro sostegno, compassione e gentilezza. 2. Non riferirsi alle persone con la malattia come "casi COVID-19", "vittime" "famiglie COVID-19" o "malati". Sono "persone che hanno COVID-19", "persone che sono in cura per COVID-19" o "persone che si stanno riprendendo da COVID-19", e dopo il recupero da COVID-19 la loro vita andrà avanti con il loro lavoro , famiglie e persone care. È importante separare una persona dall'avere un'identità definita da COVID-19, al fine di ridurre lo stigma. 3. Riduci al minimo la visione, la lettura o l'ascolto di notizie su COVID-19 che ti fanno sentire ansioso o in difficoltà; cercare informazioni solo da fonti attendibili e principalmente in modo da poter prendere misure pratiche per preparare i tuoi piani e proteggere te stesso e i tuoi cari. Cerca aggiornamenti di informazioni in orari specifici durante il giorno, una o due volte. Il flusso improvviso e quasi costante di notizie su un focolaio può far preoccupare chiunque. Prendi i fatti; non voci e disinformazione. Raccogli informazioni a intervalli regolari dal sito Web dell'OMS e dalle piattaforme delle autorità sanitarie locali per aiutarti a distinguere i fatti dalle voci. I fatti possono aiutare a ridurre al minimo le paure. 4. Proteggi te stesso e offri sostegno agli altri. Assistere gli altri nel momento del bisogno può essere di beneficio sia per la persona che riceve supporto sia per l'aiuto. Ad esempio, controlla telefonicamente i vicini o le persone nella tua comunità che potrebbero aver bisogno di ulteriore assistenza. Lavorare insieme come un'unica comunità può aiutare a creare solidarietà nell'affrontare insieme COVID-19. 5. Trova opportunità per amplificare storie positive e di speranza e immagini positive di persone locali che hanno sperimentato COVID-19. Ad esempio, storie di persone che si sono riprese o hanno supportato una persona cara e sono disposte a condividere la loro esperienza. 6. Onora i caregiver e gli operatori sanitari che supportano le persone colpite da COVID-19 nella tua comunità. Riconosci il ruolo che svolgono nel salvare vite e nel proteggere i tuoi cari.

4.1.1.2 Messaggi per gli operatori sanitari

Sentirsi sotto pressione è un'esperienza probabile per te e molti dei tuoi colleghi. È abbastanza normale sentirsi così nella situazione attuale. Lo stress e i sentimenti ad esso associati non riflettono affatto che non puoi fare il tuo lavoro o che sei debole. Gestire la tua salute mentale e il benessere psicosociale durante questo periodo è importante quanto gestire la tua salute fisica. 8. Abbi cura di te in questo momento. Cerca di utilizzare utili strategie di coping come garantire riposo e tregua sufficienti durante il lavoro o tra i turni, mangiare cibo sufficiente e sano, impegnarti in attività fisica e rimanere in contatto con la famiglia e gli amici. Evita di usare strategie di coping inutili come l'uso di tabacco, alcol o altre droghe. A lungo termine, questi possono peggiorare il tuo benessere mentale e fisico. L'epidemia COVID-19 è uno scenario unico e senza precedenti per molti lavoratori, in particolare se non sono stati coinvolti in risposte simili. Anche così, l'utilizzo di strategie che hanno funzionato per te in passato per gestire i periodi di stress può essere di beneficio ora. Sei la persona più propensa a sapere come puoi ridurre lo stress e non dovresti essere riluttante a mantenerti psicologicamente bene. Questo non è uno sprint; è una maratona. 9. Alcuni operatori sanitari

possono purtroppo provare desiderio di evasione dalla propria famiglia o comunità a causa di stigmatizzazione o paura. Ciò può rendere molto più difficile una situazione già impegnativa. Se possibile, rimanere in contatto con i propri cari, anche attraverso metodi digitali, è un modo per mantenere i contatti. Rivolgiti ai tuoi colleghi, al tuo manager o ad altre persone di fiducia per il supporto sociale: i tuoi colleghi potrebbero avere esperienze simili a te. 10. Usare modi comprensibili per condividere messaggi con persone con disabilità intellettive, cognitive e psicosociali. Laddove possibile, includere forme di comunicazione che non si basano esclusivamente su informazioni scritte. 11. Sapere come fornire supporto alle persone colpite da COVID-19 e sapere come collegarle alle risorse disponibili. Ciò è particolarmente importante per coloro che richiedono supporto psicosociale. Lo stigma associato a problemi di salute mentale può causare riluttanza a cercare supporto sia per COVID-19 che per condizioni di salute mentale. La Guida all'intervento umanitario mhGAP include una guida clinica per affrontare le condizioni prioritarie di salute mentale ed è progettata per l'uso da parte di operatori sanitari.

4.1.1.3 Messaggi per team leader o manager in strutture sanitarie

Mantenere tutto il personale protetto dallo stress cronico e da cattive condizioni di salute mentale significa metterli in condizioni di avere una migliore capacità di adempiere ai loro ruoli. Assicurati di tenere presente che la situazione attuale non scomparirà dall'oggi al domani e concentrati sulla capacità occupazionale a più lungo termine piuttosto che sulle ripetute risposte alla crisi a breve termine. 13. Garantire che tutto il personale fornisca comunicazioni di buona qualità e accurati aggiornamenti delle informazioni. Ruota i lavoratori dalle funzioni di maggiore stress a quelle di minor stress. Partner di lavoratori inesperti con i loro colleghi più esperti. Il sistema amico aiuta a fornire supporto, monitorare lo stress e rafforzare le procedure di sicurezza. Garantire che il personale di sensibilizzazione entri nella comunità in coppia. Avviare, incoraggiare e monitorare le pause di lavoro. Implementare programmi flessibili per i lavoratori che sono direttamente interessati o che hanno un membro della famiglia colpito da un evento stressante. Assicurati che i colleghi si supportino reciprocamente. 14. Garantire che il personale sia a conoscenza di dove e come possano accedere ai servizi di assistenza psicosociale e di salute mentale e facilitare l'accesso a tali servizi. I dirigenti e i team leader si trovano ad affrontare simili stress per il proprio personale e possono subire ulteriori pressioni relative alle responsabilità del proprio ruolo. È importante che le disposizioni e le strategie di cui sopra siano in atto sia per i lavoratori che per i dirigenti e che i dirigenti possano essere modelli di ruolo per le strategie di auto-cura per mitigare lo stress. 15. Orientare tutti i soccorritori, inclusi infermieri, conducenti di ambulanze, volontari, identificatori di casi, insegnanti e leader di comunità e lavoratori in siti di quarantena, su come fornire supporto emotivo e pratico di base alle persone colpite utilizzando il pronto soccorso psicologico.16. Gestire urgenti disturbi mentali e neurologici (ad es. Delirio, psicosi, grave ansia o depressione) all'interno di strutture sanitarie di emergenza o generali. Potrebbe essere necessario impiegare personale qualificato e addestrato e in questi luoghi quando il tempo lo consente, e la capacità del personale sanitario generale di fornire assistenza per la salute mentale e psicosociale dovrebbe essere aumentata (vedere la Guida all'intervento umanitario mhGAP). 17. Garantire la disponibilità di farmaci psicotropi essenziali e generici a tutti i livelli di assistenza sanitaria. Le persone che convivono con problemi di salute mentale a lungo termine o convulsioni epilettiche avranno bisogno di un accesso ininterrotto ai loro farmaci e la sospensione improvvisa dovrebbe essere evitata.

4.1.1.4 Messaggi per chi si prende cura dei bambini

Aiuta i bambini a trovare modi positivi per esprimere sentimenti come paura e tristezza. Ogni bambino ha il suo modo di esprimere le emozioni. A volte impegnarsi in un'attività creativa, come giocare o disegnare può facilitare questo processo. I bambini si sentono sollevati se possono esprimere e comunicare i loro sentimenti in un ambiente sicuro e di supporto. 19. Tenere i bambini vicini ai genitori e alla famiglia, se considerati sicuri, ed evitare il più possibile di separare i bambini e la carriera. Se un bambino ha bisogno di essere separato dalla sua badante primaria, assicurati che siano fornite adeguate cure alternative e che un assistente sociale o equivalente seguirà regolarmente il bambino. Inoltre, assicurarsi che durante i periodi di separazione, venga mantenuto un contatto regolare con genitori e tutori, come telefonate o videochiamate programmate due volte al giorno o altre comunicazioni appropriate all'età (ad esempio social media). 20. Mantenere il più possibile le routine familiari nella vita quotidiana o creare nuove routine, soprattutto se i bambini devono rimanere a casa. Fornire attività coinvolgenti adatte all'età per i bambini, comprese attività per il loro apprendimento. Ove possibile, incoraggiare i bambini a continuare a giocare e socializzare con gli altri, anche se solo all'interno della famiglia quando viene consigliato di limitare i contatti sociali. 21. Durante i periodi di stress e crisi, è comune per i bambini cercare più attaccamento ed essere più esigenti con i genitori. Discuti su COVID-19 con i tuoi figli in modo onesto e adatto all'età. Se i tuoi figli hanno delle preoccupazioni, affrontarli insieme può alleviare la loro ansia. I bambini osserveranno i comportamenti e le emozioni degli adulti per suggerimenti su come gestire le proprie emozioni nei momenti difficili.

4.1.1.5 Messaggi per gli anziani, le persone con problemi di salute di base e i loro *caregivers*

Gli anziani, specialmente in isolamento e quelli con declino cognitivo / demenza, possono diventare più ansiosi, arrabbiati, stressati, agitati e ritirati durante l'epidemia o durante la quarantena. Fornire supporto pratico ed emotivo attraverso reti informali (famiglie) e professionisti della salute. 23. Condividi fatti semplici su ciò che sta accadendo e fornisci informazioni chiare su come ridurre il rischio di infezione in parole che le persone anziane con / senza deficit cognitivo possono comprendere. Ripeti le informazioni ogni volta che è necessario. Le istruzioni devono essere comunicate in modo chiaro, conciso, rispettoso e paziente. Può anche essere utile che le informazioni vengano visualizzate per iscritto o in immagini. Coinvolgere i familiari e altre reti di supporto nel fornire informazioni e nell'aiutare le persone a mettere in atto misure di prevenzione (ad esempio il lavaggio delle mani, ecc.). 24. Se hai un problema di salute di base, assicurati di avere accesso a tutti i farmaci che stai attualmente utilizzando. Attiva i tuoi contatti social per fornirti assistenza, se necessario. 25. Essere preparati e sapere in anticipo dove e come ottenere aiuto pratico, se necessario, come chiamare un taxi, ricevere cibo e richiedere assistenza medica. Assicurati di avere fino a due settimane di tutti i medicinali che potresti richiedere. 26. Impara semplici esercizi fisici quotidiani da eseguire a casa, in quarantena o in isolamento, in modo da poter mantenere la mobilità e ridurre la noia. 27. Mantieni le routine e gli orari regolari il più possibile o aiuta a crearne di nuovi in un nuovo ambiente, inclusi esercizi regolari, pulizie, faccende quotidiane, canto, pittura o altre attività. Resta in contatto regolare con i tuoi cari (ad esempio via telefono, e-mail, social media o videoconferenza).

4.1.1.6 Messaggi per le persone isolate

Resta connesso e gestisci i tuoi social network. Cerca di mantenere il più possibile le tue routine quotidiane personali o creare nuove routine se le circostanze cambiano. Se le autorità sanitarie hanno raccomandato di limitare il contatto sociale fisico per contenere l'epidemia, è possibile rimanere in contatto via telefono, e-mail, social media o videoconferenza. 29. Durante i periodi di stress, presta attenzione ai tuoi bisogni e ai tuoi sentimenti. Impegnati in attività salutari che ti piacciono e trovi rilassanti. Esercitati regolarmente, mantieni regolari routine di sonno e mangia cibi sani. Mantenere le cose in prospettiva. Le agenzie di sanità pubblica e gli esperti di tutti i paesi stanno lavorando per garantire la disponibilità delle migliori cure alle persone colpite 30. Un flusso quasi costante di notizie su un focolaio può far sentire ansiosi o angosciati. Cerca aggiornamenti di informazioni e indicazioni pratiche in orari specifici durante il giorno dagli operatori sanitari e dal sito Web dell'OMS ed evita di ascoltare o seguire voci che ti fanno sentire a disagio.

4.1.2 Covid-19: Indagine del Consiglio Nazionale delle Ricerche (CNR) sui mutamenti sociali

Indagine del Consiglio Nazionale delle Ricerche su atteggiamenti e comportamenti della popolazione nell'emergenza Covid-19 in relazione al "distanziamento sociale".
Lo scopo è di analizzare gli atteggiamenti e i comportamenti della popolazione dovuti al "distanziamento sociale", per valutarne le conseguenze e i correttivi nel breve e medio periodo, per arginare l'insorgenza di stati critici a livello psicofisico prodotti dall'assenza di lavoro e socialità. Da un team di studiosi è stato sviluppato un questionario on line.
L'attività è articolata in quattro aree d'indagine. La prima riguarda le informazioni socio-anagrafiche dei rispondenti. La seconda, Interazione e devianza nel distanziamento/avvicinamento sociale, rileva i mutamenti nell'interazione sociale e le conseguenti forme di devianza e disagio dovute sia al distanziamento sia al contatto protratto degli individui conviventi. La terza, Fiducia e opinioni, riguarda la valutazione dell'operato pubblico e i livelli di fiducia relazionale e sistemica. La quarta, Emozioni e disagio, analizza la valutazione del sé, le emozioni primarie e gli stereotipi connessi all'emergenza sanitaria.

4.1.3 La chiave della salute psicofisica per la resilienza alla pandemia

Dichiarazione alla stampa del Dr. Hans Henri P. Kluge, Direttore Regionale per l'Europa dell'OMS, 26-03-2020.
Misure senza precedenti per rallentare e interrompere la trasmissione di COVID-19 ci stanno facendo guadagnare tempo e riducono la pressione sui nostri sistemi sanitari, ma a un costo sociale ed economico significativo. Le misure di distanziamento e isolamento fisico, la chiusura di scuole e luoghi di lavoro, ci mettono particolarmente alla prova, poiché incidono su ciò che amiamo fare, su dove vogliamo essere e con chi vogliamo essere. È assolutamente naturale per ognuno di noi provare stress, ansia, paura e solitudine durante questo periodo. L'OMS ritiene che le conseguenze di COVID-19 sulla nostra salute mentale e sul nostro benessere psicologico siano molto importanti. Mentre la situazione rimane molto grave, stiamo iniziando a vedere alcuni segnali incoraggianti. L'Italia, che ha il maggior numero di casi nella Regione, ha appena registrato un tasso di aumento leggermente inferiore, anche se è ancora troppo presto per dire che la pandemia stia raggiungendo il picco.
In questa situazione, dobbiamo rimanere ottimisti e fisicamente e mentalmente sani, poiché questo sarà fondamentale per la nostra capacità di ripresa psicologica nel superare questa sfida uniti.

Ognuno di noi fa parte di una comunità. È nella natura umana prenderci cura l'uno dell'altro, poiché noi, a nostra volta, cerchiamo il sostegno sociale ed emotivo degli altri. Gli effetti dirompenti di COVID-19 offrono a tutti noi un'opportunità. L'opportunità di controllarci a vicenda, di telefonare e video chattare, di essere consapevoli e sensibili alle esigenze uniche di salute mentale di coloro a cui teniamo. Le nostre ansie e paure dovrebbero essere riconosciute e non ignorate, ma meglio comprese e affrontate da individui, comunità e governi.
È essenziale affrontare, in Europa e oltre, le sfide della salute mentale pubblica nelle prossime settimane e mesi:

- Distribuendo informazioni tempestive, comprensibili e affidabili dai membri più giovani ai membri più anziani della nostra società;
- Fornendo supporto psicologico ai lavoratori in prima linea e alle famiglie in lutto;
- Continuando la cura e il trattamento delle persone con disabilità cognitive, mentali e psicosociali;
- Proteggendo i diritti umani, in particolare di coloro i cui diritti sono spesso trascurati o violati, compresi migranti e rifugiati, prigionieri, residenti in altri contesti chiusi come ospedali psichiatrici o istituti di assistenza sociale e persone con disabilità.

L'OMS e i suoi partner hanno preparato una serie di materiali specifici su COVID per informare e guidare i paesi e il pubblico in relazione a questi livelli di salute mentale e di supporto psicosociale, inclusi briefing e infografiche di accompagnamento sullo stigma sociale nonché sui bisogni della popolazione generale, operatori sanitari, coloro che prestano assistenza a lungo termine e altri. Questi materiali vengono ora tradotti e distribuiti in molti paesi della Regione. Ulteriori materiali in fase di sviluppo da parte dell'OMS e dei suoi partner includono la produzione di un libro di fiabe per bambini dai 4 ai 10 anni e versioni di strumenti dell'OMS come "Psychological First Aid' e 'Problem Management Plus' che possono essere resi disponibili attraverso piattaforme digitali.
Il problema che ognuno di noi deve affrontare è come gestire e reagire alle situazioni stressanti che si evolvono così rapidamente nelle nostre vite e comunità.
Dobbiamo attingere ai nostri poteri di forza, resilienza e cooperazione che fortunatamente noi umani possediamo.
Sono utili, ad esempio, l'apprendimento e la pratica di semplici tecniche di rilassamento (come esercizi di respirazione, rilassamento muscolare, meditazione consapevole) che possono servire per alleviare il disagio fisico e mentale. Quando si verificano pensieri sconvolgenti è utile discuterne con le persone vicine a noi. Probabilmente ne avranno provati anche loro e potremmo essere in grado di trovare soluzioni collettivamente. Bisogna cercare di rimanere positivi mostrando empatia, solidarietà, intelligenza emotiva e parlando a tutti senza lasciare nessuno indietro.
Bisogna agire con gentilezza, agire con amore, ma con un allontanamento fisico.

4.1.4 Cassetta degli strumenti per la sanità pubblica e l'azione comunitaria a contrasto del coronavirus

La pagina riporta collegamenti a strumenti utili tratti da fonti autorevoli — l'Organizzazione Mondiale della Sanità e i Centri statunitensi per il controllo e la prevenzione delle malattie — e the Community Tool Box, utilizzata da quasi 6 milioni di persone in tutto il mondo. The Community Tool Box è un servizio del Center for Community Health and Development, dell' Università del Kansas.

Le risorse sono organizzate in:

- Strumenti per l'azione della sanità pubblica (Comunicare la minaccia e la risposta, Protezione e cura di te e della tua famiglia, Guida per gli operatori sanitari, Guida per scuole, luoghi di lavoro e luoghi comunitari)
- Strumenti per l'azione comunitaria.

L'area comunità è articolata per fasi operative: coinvolgimento/partecipazione (engagement), analisi dei bisogni (assessment), programmazione/pianificazione (planning), azione/attività, valutazione.
In particolare, si segnalano:

- le indicazioni concrete e operative inerenti azioni di protezione e "cura" per ii cittadini e i loro familiari (fonte: CDC)
- le indicazioni di gestione per il sistema scuola e luoghi di lavoro (fonte: CDC)
- la sezione per gli operatori sanitari (comprensiva di un corso on line su aspetti clinici: prevenzione e controllo delle infezioni) – fonte WHO

4.1.5 Salute mentale: Fact sheet dell'Organizzazione Mondiale della Sanità (2019)

La salute mentale dovrebbe essere vista come una preziosa fonte di capitale umano o di benessere nella società. Abbiamo tutti bisogno di una buona salute mentale per progredire, prenderci cura di noi stessi e interagire con gli altri, quindi è vitale non solo rispondere ai bisogni delle persone con disturbi mentali definiti, ma anche proteggere e promuovere la salute mentale di tutte le persone e riconoscerne l'intrinseco valore.
Dopo aver fornito una definizione del valore della salute mentale, vengono citate le influenze esercitate su di essa (caratteristiche individuali, circostanze sociali e ambiente in cui si vive). Vengono poi analizzati i legami tra i disturbi mentali e le principali malattie non trasmissibili (NCD). I disturbi mentali influenzano e, a loro volta, sono influenzati dai maggiori NCD: possono essere un precursore o una conseguenza di condizioni croniche come malattie cardiovascolari, diabete o cancro. I fattori di rischio per queste malattie, come il comportamento sedentario e l'uso dannoso di alcol, sono anche fattori di rischio per disturbi mentali e legano fortemente i due. Nella pratica clinica, tuttavia, tali interazioni e comorbilità sono abitualmente trascurate. La mortalità prematura e la disabilità potrebbero essere ridotte se ci si concentrasse maggiormente sulla lotta alla comorbilità. Le persone con disturbi mentali muoiono mediamente vent'anni anni prima della popolazione generale. La grande maggioranza di questi decessi non è dovuta a una causa specifica (come il suicidio) ma piuttosto ad altre cause, in particolare le malattie non trasmissibili che non sono state adeguatamente identificate e gestite.
I disturbi mentali sono una delle sfide più significative per la salute pubblica nella Regione europea dell'OMS, in quanto sono la principale causa di disabilità e la terza causa principale del carico complessivo della malattia (misurato come anni di vita adattati per disabilità), dopo le malattie cardiovascolari e i tumori. Nella Regione Europea si calcola che 44.3 milioni di persone soffrano di depressione e 37.3 di problemi d'ansia.
La promozione e la protezione della salute fisica e mentale richiedono una risposta multisettoriale, che a sua volta richiede un approccio dell'intero governo. che vada oltre il settore sanitario, e che comprenda l'assistenza sociale, l'educazione e l'ambiente. Vi è un'ampia variazione tra il numero degli operatori del settore fra uno stato e l'altro così come

vi è un'enorme differenza sugli investimenti che ogni paese fa per il settore della salute mentale e sui servizi ad esso dedicati.
Gli obiettivi del piano d'azione europeo per la salute mentale 2013-2020 sono stati e sono: migliorare il benessere mentale della popolazione e ridurre il carico di disturbi mentali, con particolare attenzione ai gruppi vulnerabili, ai fattori che determinano l'esposizione e al comportamento a rischio; rispetto dei diritti delle persone con problemi di salute mentale e pari opportunità per raggiungere la massima qualità della vita e affrontare lo stigma e la discriminazione; istituzione di servizi accessibili, sicuri ed efficaci in grado di soddisfare le esigenze mentali, fisiche e sociali delle persone e le aspettative delle persone con problemi di salute mentale e delle loro famiglie.

4.1.6 Un intervento psicologico raccomandato durante la pandemia da Coronavirus

L'articolo descrive un intervento di sanità pubblica specificamente ideato per fronteggiare la crisi causata dall'epidemia di coronavirus in Cina: si tratta di un MODELLO di intervento psicologico sperimentato all'interno del West China Hospital, che fa uso delle moderne tecnologie (piattaforma internet e smartphone), prevede un'équipe multi professionale (medici, psichiatri, psicologi, operatori sociali), e viene RACCOMANDATO in forza dei significativi risultati ottenuti.
Ecco le caratteristiche di un intervento di supporto psicologico in situazioni di epidemie come quella che stiamo vivendo: dinamicità e tempestività, e sviluppo per "fasi" (durante e dopo). La risposta di tipo psicologico deve prevedere due linee di attività simultanee - oltre che tempestive:

a) contrasto della paura della malattia (realizzata da medici e psicologi)
b) rinforzo per chi ha difficoltà di adattamento (a cura di operatori sociali)

Gli psichiatri entrano in gioco nel caso in cui vengono intercettate situazioni gravi (rischio suicidario, violenza intrafamiliare, ecc.)
Tutte le figure professionali coinvolte devono comunque avere una formazione di tipo psicologico, ed essere seguiti in maniera costante con delle supervisioni.
L'assistenza e il supporto psicologico si realizzano attraverso una linea telefonica e delle consulenze on line (Wechat platform), che in prima battuta identificano le persone "a rischio" e il tipo di risposta/aiuto da fornire.
L'intervento viene rappresentato graficamente come una sorta di piramide: alla base c'è la comunità/popolazione, e man mano che si sale alla sommità si incontrano le varie équipe operative (Psychological Rescue Team: individua soluzioni informatiche e sviluppa i programmi formativi; équipe operativa) fino ad arrivare al gruppo supervisori.

Le fasi:

- assessment iniziale (uso di questionari per la rilevazione dello stato di salute mentale della popolazione in generale, con particolare attenzione alle situazioni maggiormente a rischio, tra cui gli operatori sanitari.)
- sulla base dei risultati dell'assessment: intervento ad hoc
- follow up

Per quanto riguarda "il dopo emergenza, necessaria un'attenzione particolare alle persone che sono state sottoposte a quarantena e sul personale medico/infermieristico che si è occupato di loro, in termini di specifici interventi di supporto psicosociale.
A partire dall'intervento appena descritto, sperimentato con successo in Cina, il West China Hospital ha standardizzato il metodo, chiamandolo "APD" - Anticipated, Plan and Deter Responder Risk and Resilience Model, rivolgendolo in maniera specifica al personale sanitario. La finalità principale è lo sviluppo delle competenze di resilienza per gestire lo stress, ed è articolato in due fasi: primo intervento e riabilitazione post-intervento.

4.1.7 Come gestire la paura e lo stress durante la quarantena da Covid-19

Vademecum dell'Ordine nazionale degli psicologi, indirizzato alla popolazione, con l'obiettivo di dare indicazioni per gestire la paura e lo stress conseguenti alla quarantena da Coronavirus.
https://www.psy.it/vademecum-psicologico-coronavirus-per-i-cittadini-perche-le-paure-possono-diventare-panico-e-come-proteggersi-con-comportamenti-adeguati-con-pensieri-corretti-e-emozioni-fondate

4.1.8 Violenza assistita: dossier sui bambini di Save the Children

In Italia 427 mila bambini, in soli 5 anni, testimoni diretti o indiretti dei maltrattamenti in casa nei confronti delle loro mamme, quasi sempre per mano dell'uomo.
Dal dossier emerge che tra le donne che in Italia hanno subito violenza nella loro vita – oltre 6,7 milioni secondo l'Istat -, più di 1 su 10 ha avuto paura che la propria vita o quella dei propri figli fosse in pericolo. In quasi la metà dei casi di violenza domestica (48,5%), inoltre, i figli hanno assistito direttamente ai maltrattamenti, una percentuale che supera la soglia del 50% al nord-ovest, al nord-est e al sud, mentre in più di 1 caso su 10 (12,7%) le donne dichiarano che i propri bambini sono stati a loro volta vittime dirette dei soprusi per mano dei loro padri.
Per quanto riguarda gli autori delle violenze, i dati sulle condanne con sentenza irrevocabile per maltrattamento in famiglia – più che raddoppiate negli ultimi 15 anni, passando dalle 1.320 nel 2000 alle 2.923 nel 2016 - evidenziano che nella quasi totalità dei casi (94%) i condannati sono uomini e che la fascia di età maggiormente interessata è quella tra i 25 e i 54 anni, l'arco temporale nel quale solitamente si diventa padri o lo si è già. (Fonte: Save the Children).

4.1.9 Apertura dei centri antiviolenza D.i.Re durante l'emergenza da Coronavirus

I Centri Antiviolenza della rete D.i.Re si sono organizzati per rispondere all'emergenza COVID-19 e alle disposizioni emanate dal governo con l'istituzione della zona rossa a livello nazionale, in modo da non lasciare sole le donne che hanno subito violenza.

4.1.10 Emergenza coronavirus: il servizio di aiuto di psicologi e psicoanalisti

Per aiutare la popolazione a reagire il Consiglio nazionale dell'ordine degli psicologi (Cnop) ha promosso l'iniziativa #psicologionline: i cittadini tramite un apposito motore di ricerca (accessibile dal sito Cnop) possono trovare lo psicologo o psicoterapeuta più vicino e prenotare un teleconsulto gratuito (via telefono o piattaforma di videochiamata). In caso di

necessità verranno programmati interventi a distanza più strutturati. Oltre 4mila professionisti dislocati in tutta Italia hanno già aderito al progetto.
Anche la Società psicanalitica italiana (Spi) ha messo a disposizione un servizio di ascolto e consulenza di psicologia psicoanalitica (da 1 a 4 teleconsulti gratuiti) per problematiche connesse all'emergenza coronavirus. I Centri psicoanalitici associati alla Spi, presenti su tutto il territorio nazionale (Roma, Milano, Bologna, Genova, Torino, Firenze, Pavia, Padova, Napoli, Palermo) forniranno per il progetto i nominativi dei professionisti disponibili per l'ascolto tramite telefono o piattaforma di videochiamata. (Fonte: Ministero Salute)

4.1.11 La necessità di interventi di salute mentale durante la pandemia da Coronavirus

In situazioni di epidemie virali a livello mondiale, come quella che stiamo vivendo adesso a seguito della massiccia diffusione del 2019-nCoV (nuovo coronavirus), i disturbi mentali gravi e i problemi comuni di salute mentale sono presenti in maniera massiccia e affliggono soprattutto le persone contagiate (o con sospetto di contagio) e gli operatori sanitari che lavorano all'interno di ospedali/reparti dedicati. È pertanto necessario sviluppare e fornire urgentemente e tempestivamente strumenti e servizi specifici per supportare queste persone.
A seguito degli studi effettuati durante situazioni analoghe (ad esempio l'epidemia di SARS del 2003), alcuni metodi si sono rivelati utili a tale scopo:

- istituire a livello nazionale e regionale équipe multidisciplinari che includano psichiatri, infermieri psichiatrici, psicologi clinici e altre categorie di professionisti della salute mentale
- comunicare in maniera chiara dati aggiornati e accurati sull'epidemia, per contenere il senso di incertezza e paura; le informazioni devono riguardare in particolare il piano di trattamento, il resoconto del monitoraggio sull'andamento dello stato di salute, e devono essere destinati ai pazienti e ai loro familiari
- incoraggiare canali comunicativi "sicuri" tra pazienti e familiari, ad esempio chat via smartphone, per ridurre l'isolamento
- fare screening regolari - per individuare segni di depressione, ansia, tendenze suicidarie - su persone con sospetto di contagio o con contagio conclamato e sugli operatori sanitari che lavorano negli ospedali e reparti infettivi. Qualora si rilevassero problemi di salute mentale, prevedere un tempestivo intervento di tipo psicoterapeutico (lo "stress-adaption model" è uno dei più usati) o psichiatrico, con eventuale ausilio farmacologico ma "base".

Paura, incertezza, stigma sono comuni in situazioni di disastro biologico/epidemie e pandemie causate da virus, e possono ostacolare gli interventi medico-clinici, compresi quelli inerenti la salute mentale. A partire dall'esperienza dell'ultima epidemia e dell'impatto psicosociale, è cruciale sviluppare e implementare strumenti di *assessment*, supporto, trattamento e servizi dedicati a proteggere le persone e la loro salute mentale.

Xiang YT, Yang Y, Li W, Zhang L, Zhang Q, Cheung T, Ng CH. Timely mental health care for the 2019 novel coronavirus outbreak is urgently needed. Lancet Psychiatry. 2020 Mar;7(3):228-229.

4.1.12 Coronavirus SARS-CoV-2 - Materiali di comunicazione

In questa sezione segnaliamo i materiali di comunicazione realizzati da alcuni Enti nazionali e internazionali di riferimento, utili alla diffusione delle informazioni relative al Coronavirus SARS-CoV-2 e alle tematiche ad esso correlate.
Sul sito del Ministero della Salute sono disponibili i materiali di comunicazione diffusi attraverso i social network Facebook e Instagram. Una sezione specifica è dedicata agli spot e video.
Sul sito dell'Istituto Superiore di Sanità sono disponibili numerose infografiche che illustrano i dati aggiornati di diffusione del Coronavirus in Italia, forniscono indicazioni sulle regole da seguire, sui comportamenti da tenere durante la permanenza a casa e molte altre informazioni correlate all'emergenza sanitaria in atto. Molti dei materiali informativi sono stati tradotti in diverse lingue per consentire agli stranieri l'accesso alle medesime informazioni.
Sul sito di Epicentro - L'Epidemiologia per la sanità pubblica è disponibile la traduzione in italiano delle raccomandazioni dell'Organizzazione Mondiale della Sanità relative alle modalità per "Far fronte allo stress durante l'epidemia di COVID-19".
Dal sito dell'Organizzazione Mondiale della Sanità è possibile accedere a materiali di comunicazione sui falsi miti relativi al coronavirus, in lingua inglese.

4.1.13 coronavirus – link utili

Governo

- http://www.governo.it/it/approfondimento/nuovo-coronavirus-che-cos/13970
- http://www.governo.it/it/approfondimento/coronavirus-la-normativa/14252
- http://www.governo.it/sites/new.governo.it/files/protocollo_condiviso_20200314.pdf
- https://www.gazzettaufficiale.it/dettaglioArea/12

Ministero degli Affari Esteri

- https://www.esteri.it/mae/it/ministero/normativaonline/normativa-altre-amministrazioni.html
- https://www.esteri.it/mae/it/ministero/normativaonline/normativa-altre-amministrazioni.html
- http://www.viaggiaresicuri.it/

Minestero della Salute

- http://www.salute.gov.it/portale/nuovocoronavirus/dettaglioContenutiNuovoCoronavirus.jsp?lingua=italiano&id=5351&area=nuovoCoronavirus&menu=vuoto
- http://www.salute.gov.it/portale/nuovocoronavirus/archivioMaterialiNuovoCoronavirus.jsp
- http://www.salute.gov.it/imgs/C_17_opuscoliPoster_444_1_alleg.pdf
- http://www.salute.gov.it/portale/nuovocoronavirus/dettaglioOpuscoliNuovoCoronavirus.jsp?lingua=italiano&id=444
- http://www.salute.gov.it/portale/nuovocoronavirus/dettaglioOpuscoliNuovoCoronavirus.jsp?lingua=italiano&id=444
- http://www.salute.gov.it/portale/nuovocoronavirus/dettaglioNotizieNuovoCoronavirus.jsp?lingua=italiano&menu=notizie&p=dalministero&id=4229

Ministero dell'Interno

- https://www.interno.gov.it/it/speciali/coronavirus

- https://www.interno.gov.it/it/notizie/nuovo-modello-autodichiarazioni

Istituto Superiore di Sanità
- https://www.epicentro.iss.it/coronavirus/aggiornamenti

INMP
- https://www.inmp.it/ita/CoViD-19-cose-da-sapere

Protezioen Civile
- http://www.protezionecivile.gov.it/

AGI
- www.garanteinfanzia.org
- https://www.garanteinfanzia.org/sites/default/files/agia-decalogo-covid19.pdf
- https://tutelavolontaria.garanteinfanzia.org/10-consigli-i-tutori-volontari

Regione Lombardia
- https://www.en.regione.lombardia.it/wps/portal/site/en-regione-lombardia/health/covid-19

Regione Emilia Romagna
- https://sociale.regione.emilia-romagna.it/intercultura-magazine/notizie/covid-19-cosa-ce-da-sapere-in-diverse-lingue

Regione Valle D'Aosta
- http://immigrazione.regione.vda.it/www/2020/03/12/i-contatti-per-lemergenza-coronavirus-e-autocertificazione-per-spostamenti-in-diverse-lingue/

Comune di Milano
- https://www.comune.milano.it/home/coronavirus-informazioni-e-link

Comune di Ravenna
- http://www.comune.ra.it/Aree-Tematiche/Anagrafe-e-immigrazione/Politiche-per-l-Immigrazione/Emergenza-Coronavirus-tutto-cio-che-devi-sapere

Comune di Nonantola
- http://www.comune.nonantola.mo.it/

Comune di Cesena
- http://www.comune.cesena.fc.it/flex/cm/pages/ServeBLOB.php/L/IT/IDPagina/44222

Comune di Reggio Emilia
- https://www.comune.re.it/retecivica/urp/retecivi.nsf/DocumentID/06D78B589470D3D3C1258519003BAAC9?Opendocument

Comune di Scandiano
- https://www.comune.scandiano.re.it/2020/03/coronavirus-comportamenti-da-tenere-in-6-lingue/

AUSL Modena

- http://www.ausl.mo.it/coronavirus

AUSL Reggio Emilia

- www.ausl.re.it/comunicazione/news/nuovo-coronavirus-tutto-quello-che-c%C3%A8-da-sapere

ATS Bergamo

- https://www.ats-bg.it/servizi/gestionedocumentale/ricerca_fase03.aspx?ID=30866

UNICEF

- https://www.unicef.it/doc/9757/come-parlare-nostri-figli-coronavirus-covid-19.htm
- https://www.facebook.com/watch/?v=287513862214812
- https://www.unicef.it/doc/9658/coronavirus-e-rischi-per-infanzia-cose-da-sapere.htm
- https://www.facebook.com/UreportOnTheMove/photos/pcb.939079309823691/939079243157031/?type=3&theater

IOM

- https://italy.iom.int/
- https://italy.iom.int/sites/default/files/news-documents/LeafletIOMCovid19.pdf

Medicine du Monde

- https://www.facebook.com/MdMmissioneItalia/

Medu

- https://mediciperidirittiumani.org/coronavirus-informazioni-importanti-per-cittadini-italiani-e-stranieri/
- https://mediciperidirittiumani.org/coronavirus-medu-attiva-intervento-per-homeless-ed-insediamenti-precari/

Save the Children

- https://www.savethechildren.it/blog-notizie/coronavirus-come-spiegarlo-ai-bambini-video-info-utili-anche-per-adulti
- https://www.savethechildren.it/blog-notizie/coronavirus-non-solo-italiano-i-nostri-suggerimenti-diverse-lingue

Emergency

- www.facebook.com/ComunediCastelVolturno/videos/216661866368339/UzpfSTEwMDAwMTI5MTYyMzE5ODpWSzo5Njc4MjYxNDAyODY0OTI/
- https://www.emergency.it/progetti/emergenza-sanitaria-in-italia-per-covid-19-ecco-cosa-stiamo-facendo/
- https://www.emergency.it/progetti/emergenza-sanitaria-in-italia-per-covid-19-ecco-cosa-stiamo-facendo/

Arci

- https://www.arci.it/nuovo-coronavirus-le-10-regole-da-seguire-in-tante-lingue/

- https://www.jumamap.com/notizie/81/coronavirus-le-regole-per-gli-spostamenti.html
- https://www.facebook.com/natalizia.fanciullo/videos/2490985924488088/

ASGI
- https://www.asgi.it/coronavirus/

CIR
- http://www.cir-onlus.org/

ASGI
- https://www.asgi.it/coronavirus/

CIR
- http://www.cir-onlus.org/

A Buon Diritto
- https://www.abuondiritto.it/notizie/2019/notizia/emergenza-sanitaria-coronavirus-informazioni-utili

Il Grande Colibrì
- https://www.ilgrandecolibri.com/coronavirus-spiegato-migranti-asilanti/
- https://www.youtube.com/user/ilgrandecolibri/videos

Naga
- https://naga.it/2020/03/13/traduzioni-decalogo-del-ministero-per-il-coronavirus/

Cooperativa Sociale K-Pax Onlus
- https://www.facebook.com/cooperativakpax/

Ilpost.it
- https://www.ilpost.it/2020/03/10/coronavirus-traduzione-italia/

Radio Onda D'Urto
- https://www.radiondadurto.org/2020/03/11/coronavirus-traduzioni-multilingue-sulle-disposizioni-anti-contagio/

Associazione Diritti di Brescia
- https://dirittipertutti.gnumerica.org/

Alterego – Fabbrica dei Diritti
- https://www.asgi.it/wp-content/uploads/2020/03/divieto-di-uscire.pdf

Associazione Camera a Sud Lecce
- https://www.youtube.com/watch?v=RcrKUaX4T3A&feature=youtu.be

Gruppo CRC

- http://gruppocrc.net/emergenza-covid-19-limpegno-delle-associazioni-del-gruppo-crc/

Gus Italia
- https://www.gus-italia.org/it/tutela-dei-diritti-ed-integrazione/decreto-coronavirus-le-traduzioni-varie-lingue

Centro Astalli – Samifo
- https://centroastalli.it/servizi/progetto-samifo/

Ciac Onlus – Parma
- https://www.facebook.com/ciaconlus/videos/589824695208693/UzpfSTE0NzIwNTE2Nzg6MTAyMjMyMTAwNTIwMjc1ODk/?comment_id=10223210091108566&notif_id=1584360489664981&notif_t=comment_mention
- https://coronavirus.ciaconlus.org/?fbclid=IwAR0USgQ-kX4Uu07ya1c68NFztcfMR0PHDSVOaVoB4T7P4fGR9lEEKnOYvlE

Arca di Noe' – Bologna
- https://www.arcacoop.com/stopcovid19-campagna-multilingue/

Consorzio Comunita' Brianza
- http://comunitamonzabrianza.it/news/videoperstranieri_coronavirus/

Glovo Italia
- https://glovers.glovoapp.com/it/stopcovid19

Sanità di Frontiera
- https://www.sanitadifrontiera.org/sanimapp/index.html?l=it

Universita' di Trento- Biodiritto
- https://www.biodiritto.org/Dossier/Dossier-Coronavirus-Italia-In-costante-aggiornamento

Oasi 2
- http://www.oasi2.it/covid-19-oasi2-sottoscrive-il-documento-per-i-diritti-dei-migranti/
- https://www.facebook.com/comunitaoasi2/

Pensare Migrante
- https://www.facebook.com/pensaremigrante/

Cambalache
- https://www.cambalache.it/nonseisolo/

Consorzio il Nodo
- https://www.youtube.com/playlist?list=PLPRQCZvEr-aKHFGvd7HgNvFwqb3UUDQzd

Mosaico

- https://play.google.com/store/apps/details?id=it.oasi_mosaico&fbclid=IwAR0LOJVsPpHKlkieKP8XhJFYt2Nl0PVvhnJfKirFF15TmvX2HuBAklLv8YQ

Etnopsicologia Analitica

- www.etnopsicologianalitica.com

TOOL KIT LEAVING CARE

Version française

Résumé

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Préface

La présente boîte à outils s'inscrit dans le cadre du projet Care Path ("Empowering public authorities and professionals towards trauma-informed leaving care support - CarePath", projet no. 785698, présenté dans le cadre de l'appel à propositions REC-AG-2017 (REC-RCHI-PROF-AG-2017)), qui est financé par le Programme « Droits, égalité et citoyenneté » de l'Union européenne (2014-2020). Le contenu des documents qu'elle contient est disponible gratuitement sur internet. A l'instar de tous les contenus du Mooc de CarePath, ils reflètent exclusivement l'avis de leurs auteurs et relèvent de leur unique responsabilité. La Commission européenne ne peut être tenue responsable d'une quelconque utilisation des informations qu'ils présentent.

La boîte à outils CarePath pour les professionnels travaillant avec des enfants victimes de traumatismes s'adresse aux professionnel.les certifié.es CarePath pour qu'ils.elles soient en position d'offrir aux enfants des services d'accompagnement et de suivi uniques et sensibles aux traumatismes. La boîte à outils a pour propos d'aider ces professionnel.les à suivre une démarche intégrée et

pluridimensionnelle d'accompagnement des enfants victimes de traumatismes, notamment des services de logement et de soutien à domicile, des soins de santé, des services de formation et d'orientation professionnelles, d'inclusion sociale et des services psychothérapeutiques. Elle guidera également les professionnel.les vers une plus grande participation des enfants dans la planification du suivi et, si nécessaire, vers une participation d'autres professionnels, tels que les psychothérapeutes, les travailleurs sociaux, les formateurs, les responsables politiques, les juristes.
Les informations figurant dans la présente boîte à outils sont disponibles sur internet pour toute personne intéressée par les thématiques couvertes. Les arguments, informations et théories scientifiques repris dans toutes les composantes et tous les documents de la boîte à outils Care Path sont structurés de manière à aider tout qui, venant d'horizons professionnels différents et oeuvrant en diverses qualités, offre des services et une aide aux enfants ayant subi un traumatisme.
Les connaissances scientifiques que contiennent les documents du projet CarePath, et plus précisément que propose la présente boîte à outils, sont accessibles gratuitement dans de nombreuses publications scientifiques du monde entier. La manière d'appliquer ces notions et ces connaissances au niveau national dépend des législations des pays concernés, de leurs règlementations respectives et d'éventuels codes éthiques des différentes guildes professionnelles et associations professionnelles ou bénévoles, qui diffèrent souvent d'un pays à l'autre.
Tous les contenus de la présente boîte à outils sont offerts dans le strict respect de l'ensemble des lois et règlementations en vigueur dans ce domaine. Aucune composante de la présente boîte à outils ou du Mooc Care Path ne peut être utilisée ou envisagée pour d'autres fins que celles soulignées ci-dessus. Il reste obligatoire et impératif pour chaque professionnel.le de toujours travailler dans le respect de la science et de sa conscience. Il s'agit notamment de respecter scrupuleusement les règlementations en vigueur dans son pays, les compétences spécifiques d'autres professionnels, d'être conscient.e de ses limites et de ses connaissances, ainsi que de respecter la frontière entre leur profession et leur rôle et compétence professionnels et para-professionnels. Chaque professionnel.le doit également se plier aux règles internes de l'organisation dans laquelle il.elle travaille.
La présente boîte à outils est le fruit d'une procédure scientifique standard, notamment de recherches dans des bases de données (MEDLINE, Embase, and PsycINFO), de consultations d'autres professionnel.les compétent.es actifs.ves dans les différentes disciplines et activités reprises dans la boîte à outils et dans le projet Care Path. Il s'agit notamment de différent.es professionnel.les susceptibles d'offrir des services aux enfants victimes de traumatismes, dont les gestionnaires de services ou de structures publiques ou privées qui participent, comme législateurs, administrateurs, professionnels, para-professionnels ou bénévoles, à la protection et à la promotion des droits, au rétablissement, à la protection et à la promotion de la santé et du bien-être des enfants traumatisés ou à la prévention des traumatismes. En outre, la boîte à outils contient une série de documents destinés aux victimes de traumatismes et à leurs familles, ainsi que des témoignages d'aidant.es, à propos de leurs besoins en formation, de la promotion et de la protection de la santé sur le lieu de travail, de la prévention et de la gestion du stress, de l'épuisement (burn- out) et de la prévention et de la gestion du stress indirect.
La présente boîte à outils remet au centre de l'échiquier une série d'aspects primordiaux, tels que les soins sensibles aux traumatismes, les approches centrées sur les enfants et sur les personnes, la planification axée sur les personnes, le rétablissement centré sur la personne, les meilleures pratiques, les dénominateurs communs, les exemples d'études de cas, les formations intersectorielles du personnel, la formation continue, les politiques organisationnelles, le développement et la gestion organisationnels, etc.
Nous avons voulu, dans la structure de la boîte à outils, éviter une simple énumération mécanique de ressources, pour proposer un aperçu de ressources disponibles qui serait transparent et respectueux des préceptes de la Sociologie de la Connaissance (Berger et Luckmann 1966), sachant que chaque thérapeutique et chaque démarche d'accompagnement reposent sur une vision spécifique de la nature

humaine et sur des valeurs qui lui sont propres. Celles-ci définissent la politique de la relation d'aide et influencent les résultats atteints.
Chaque vision de la nature humaine reposant sur une série de valeurs, les relations d'aide sont, en réalité, un acte politique. Le patient ou la patiente doit développer une nouvelle manière d'interpréter son expérience et d'adopter des comportements – en d'autres termes, il.elle doit intégrer le récit de la relation d'aide. Michael Polanyi (1958) qualifie cela « d'apprentissages interpersonnels implicites et inconscients, échangés en permanence ».
Ainsi, les relations d'aide se caractérisent par un déséquilibre marqué de pouvoir entre le.la professionnel.le et le.la patient.e ou client.e (Proctor, 2002, 2004, 2005, 2006; Sanders & Tudor, 2001; Sommerbeck, 2003; Sanders 2006). Ce déséquilibre de pouvoir se déploie plus ou moins selon les différentes démarches d'accompagnement : il est plus important lorsque le.la thérapeute joue le rôle d'un.e expert.e censé.e diagnostiquer, soigner et exiger le respect de ses consignes. Dans le cadre d'approches sensibles aux traumatismes, centrées sur la personne, le suivi, le genre et où la relation repose sur le respect et la confiance de l'aidant.e envers le.la client.e et ses capacités innées de résilience et de changement, le déséquilibre de pouvoir a tendance à fortement diminuer. Dans ce cas, le rôle de l'aidant.e ne consiste pas à diagnostiquer et soigner, mais à accompagner la tendance formative innée du patient ou de la patiente et à adopter une attitude phénoménologique de respect et de confiance envers la compréhension qu'a le.la patient.e de son expérience. **«** *C'est le client qui sait ce qui est douloureux et qui connaît la direction à suivre, les problèmes essentiels, et les expériences profondément enfouies »* (Rogers, 1961, pp. 11-12).
Si, à son époque, la vision de Rogers est profondément révolutionnaire, malheureusement, elle reste aujourd'hui pertinente et nécessaire dans les psychothérapies et dans les pratiques d'aide. Envisageons les soins de santé et les relations d'aide aujourd'hui, nous nous apercevons que les problématiques et préoccupations sont assez proches de celles abordées par Rogers et ses collègues dans les années 1940 et 1950 : de nos jours, la gestion des soins, la théorisation de la psychothérapie, la politique et les valeurs de la recherche psychothérapeutique, la réglementation, la psychothérapie et l'aide professionnelle, perçues comme autant de formes potentielles de contrôle social plutôt que de promotion et de protection des droits humains.
Aujourd'hui, en notre qualité d'aidant.es professionnel.les, nous pouvons apporter une contribution importante au discours et aux politiques professionnelles dans le domaine des relations d'aide. Pour le faire de manière efficace, nous devons suivre les pas de Rogers et des autres membres fondateurs et fondatrices de la psychologie humaniste, tels qu'Abraham Maslow, Gordon Allport, Charlotte Butler, Bugental, et exposer la problématique des valeurs et de l'utilisation du pouvoir dans les professions d'aide à autrui. Nous devons mettre au point des pratiques démocratiques et socialement responsables, tandis que sur les plans politique et scientifique, nous devrions aborder les questions de rétablissement, de résilience, d'émancipation et de responsabilisation.
La présente boîte à outils offre également un large éventail de recherches, d'études de cas, d'exemples de bonnes pratiques du monde entier sur la promotion et la protection des droits des enfants et la manière dont un accompagnement centré sur l'enfant et sensible aux traumatismes peut être au cœur de la planification et de la gestion des approches centrées sur les personnes et sensibles aux traumatismes et des démarches de rétablissement dans toutes les facettes de la construction sociale de la réalité : une législation sensible aux traumatismes, l'affectation des fonds, l'organisation des communautés, la planification et la gestion scolaires, les institutions pour enfants, la planification et l'offre de services aux enfants. Qui veut tenir compte des implications bio-psycho-sociales et traiter les victimes de traumatismes de manière efficace doit également prévenir les traumatismes, les nouveaux traumatismes, l'épuisement (burn-out) du personnel et les traumatismes indirects. C'est la seule manière de prendre conscience qu'on fait partie de la solution et non pas du problème.
Au moment de mettre la touche finale à la présente boîte à outils, la pandémie du coronavirus frappait le monde entier, avec un effet traumatique sur tou.tes les citoyen.nes, et principalement sur les enfants, les

enfants victimes de traumatismes, leurs familles et tous les aidant.es. Cette nouvelle source d'énormes traumatismes s'ajoute à une liste déjà longue.
La boîte à outils s'enrichit donc d'une longue liste d'informations, de ressources et de manuels sur la manière de traiter efficacement les problématiques liées à la Covid 19, ainsi que de liens gratuits vers les meilleures institutions scientifiques, telles que l'Organisation Mondiale de la Santé (OMS).
Soulignons que l'une des nombreuses caractéristiques de la boîte à outils est l'absence de risque de violation du droit de propriété intellectuelle, puisqu'elle contient des documents accessibles gratuitement via les liens internet ou sur YouTube et mentionnés par les différentes organisations et professionnels du monde entier. Si, dans la plupart des cas, les documents proposés sont rédigés dans les langues officielles du projet Care Path : anglais, italien, français, hongrois et grec, il peut arriver qu'ils le soient dans d'autres langues, quand ils proviennent de l'Organisation Mondiale de la Santé ou d'autres institutions scientifiques internationales.
En outre, les liens internet peuvent donner un accès gratuit, non pas seulement à un document isolé, mais à des banques de données et des ressources d'institutions. En conséquence, via les liens vers les sites des institutions, la boîte à outils offre un accès gratuit à des documents régulièrement mis à jour, à des résultats de recherche, et à des exemples de bonnes pratiques. Enfin, non seulement la boîte à outils facilite-t-elle l'accès à de précieux documents et à des formations, mais elle contribue également à notre mise en réseau avec des institutions et des collègues du monde entier.
Autre précision : nous avons trouvé plusieurs boîtes à outils disponibles gratuitement sur les sites internet d'institutions scientifiques réputées, qui présentent une gamme complète de documents et d'outils scientifiques validés ; donc, plutôt que de proposer un simple recueil des documents, nous avons préféré rendre les documents disponibles directement pour les professionnel.les intéressé.es. En effet, il s'agit non seulement d'une boîte à outils, mais également d'un répertoire électronique et d'une banque de données en accès libre. Ainsi, la présente boîte à outils offre un large éventail d'outils scientifiques validés et classés, qui sont le fruit du travail de milliers de professionnel.les, d'un nombre incalculable de recherches scientifiques et de bonnes pratiques bien établies. Ajoutons que les manuels disponibles dans la présente boîte à outils sont souvent à la pointe dans l'ensemble des domaines, pour toutes leurs diverses applications dans des contextes et pour des besoins différents.
Voir, par exemple, ce qui suit :
Boites à outils sur les soins sensibles aux traumatismes

Principes des soins sensibles aux traumatismes :

- Comprendre le traumatisme et son impact
- Promouvoir la sécurité
- Garantir la compétence culturelle
- Soutenir le contrôle, le choix et l'autonomie des consommateurs
- Partager le pouvoir et la gouvernance
- Intégrer les soins
- La guérison se fait dans les relations
- Le rétablissement est possible

Le Centre national sur le sans-abrisme familial. p 17-18
Consulter la présentation PowerPoint sur les soins sensibles aux traumatismes sur SAMHSA/HRSA.

1. Lignes directrices

« The Last Frontier » Practice Guidelines for Treatment of Complex Trauma & Trauma Informed Care & Service Delivery - Adults Surviving Child Abuse (ASCA)/Australia. (2012).
National Center for Trauma-Informed Care - SAMHSA.
Tips for Staff and Advocates Working with Children Polyvictimization. « The Safe Start Center, Office of Juvenile Justice and Delinquency Prevention », Office of Justice Programs, U.S. Department of Justice. (ca 2011-2012).

VETO: Violence Educational Tools Online - VetoViolence a été développé par les « Centers for Disease Control and Prevention (CDC) » pour permettre aux bénéficiaires de subventions et aux partenaires d'accéder à des formations et à des outils axés sur la prévention primaire de la violence. Le portail propose une formation gratuite, des ressources sur la planification de programmes et une application en ligne pour partager des exemples de réussite. Il existe des modules et des outils sur la prévention de la maltraitance des enfants, la prévention du suicide, la prévention de la violence sexuelle, la prévention de la violence des jeunes et la prévention de la violence entre partenaires intimes. Le portail continuera à évoluer à mesure que des ressources supplémentaires y seront ajoutées.

2. Communauté sensibilisée aux traumatismes

Toolkit for Starting a Link Coalition in Your Community - Cette boîte à outils décrit comment les communautés peuvent former des coalitions entre responsables des services de protection de l'enfance, de protection des animaux, de lutte contre la violence domestique et de protection des adultes, afin d'identifier et de répondre aux cas de maltraitance d'animaux et de violence interpersonnelle. Il détaille comment mettre en place une coalition, et contient une série d'études de cas visant à encourager les communautés à agir et à inciter les parties prenantes à collaborer et à œuvrer en faveur d'une approche multidisciplinaire dans la lutte contre la cruauté animale et la violence humaine (2013). Plus d'informations sur « The Link » ici.

3. Bâtir des collaborations / des communautés

Building Collaborations - Resources from the Office of Adolescent Health, U.S. Dept. of Health & Human Services.
Community Conversations About Mental Health Discussion Guide - Cette boîte à outils de 20 pages sur les « conversations communautaires à propos de la santé mentale » est conçue pour aider les personnes et les organisations désireuses d'organiser des conversations communautaires. SAMHSA, (2013).
Community Conversations About Mental Health: Information Brief - La fiche d'informations a été conçue pour être utilisée parallèlement aux autres éléments de la « boîte à outils sur les conversations communautaires à propos de la santé mentale » et fournit des données et des informations censées aider les participants aux conversations communautaires à aborder des questions clés importantes pour leurs communautés. SAMHSA. (2013).
Essentials for Childhood - Steps to Create Safe, Stable, and Nurturing Relationships - Ce document suggère des stratégies à envisager pour les communautés. Il est destiné à toute personne qui s'engage en faveur du développement positif des enfants et des familles, et plus particulièrement de la prévention de toutes les formes de maltraitance des enfants (CM). Plus de ressources : CDC. (2013).

4. Services d'aide et de protection de l'enfance

Child Welfare Trauma Training Toolkit: Comprehensive Guide - National Child Traumatic Stress Network (NCTSN). (2008). 2nd Edition (2013).
Learning Center for Child & Adolescent Trauma - National Child Traumatic Stress Network (NCTSN).
A Social Worker's Tool Kit for Working With Immigrant Families: Healing the Damage: Trauma and Immigrant Families in the Child Welfare System - American Humane Assn. (Sept. 2010).
Supporting Infants, Toddlers and Families Impacted by Caregiver Mental Health Problems, Substance Abuse, and Trauma - SAMHSA. (2012).
Soins sensibles aux traumatismes : perspectives et ressources ; « The National Technical Assistance Center for Children's Mental Health » auprès de l'Université de Georgetown et JBS International ont créé cet outil en ligne pour aider les responsables et les décideurs à tout niveau (national, étatique, tribal, territorial et local) dans toutes les étapes de leur parcours.
L'outil contient des notes de synthèse, des entretiens vidéo et des listes de ressources. Il raconte l'histoire de la mise en œuvre de services d'aide aux victimes de traumatismes et offre des conseils et des ressources pour vous aider dans votre démarche. Les vidéos présentent des entretiens avec des responsables nationaux, étatiques, tribaux et locaux de nombreux services à l'enfance, avec les concepteurs de traitements et de pratiques fondés sur des données probantes, avec des médecins, des chercheurs, des administrateurs d'organisations de prestataires, des cliniciens, des jeunes et des jeunes adultes, avec les familles et sympathisants, qui partagent les enseignements tirés et identifient les lacunes restantes. Les jeunes et leurs familles apportent leur point de vue d'usagers sur la nécessité de pratiques sensibles aux traumatismes et sur l'impact qu'un accompagnement sensible aux traumatismes a eu sur leur vie. Des parties prenantes, choisies dans une sélection d'États, partagent les enseignements d'une année d'efforts intensifs qui leur ont permis de mieux se sensibiliser aux traumatismes. Les notes de synthèse donnent une introduction et une vue d'ensemble de chacun des huit modules de l'outil.

5. Liste exhaustive de ressources aidant les utilisateurs à comprendre comment mettre en place des systèmes et des organisations tenant compte des traumatismes.

Trauma-Informed Care resources - Office of Adolescent Health, U.S. Dept. of Health & Human Services.
Trauma-Informed Child Welfare Practice Toolkit - Téléchargeable sur le site du projet « Chadwick Trauma-Informed Systems ». (2013).
Trauma & Resilience: An Adolescent Provider Toolkit - Cette boîte à outils est conçue pour tous les niveaux de prestataires de services destinés aux jeunes/jeunes adultes, depuis le personnel de première ligne jusqu'aux cliniciens, en passant par les administrateurs. Nous espérons qu'elle vous aidera, vous et vos agences et programmes respectifs, à vous sensibiliser aux traumatismes. St. Andrews. (2013). San Francisco, CA: Adolescent Health Working Group.
Tips for Child Welfare Staff - Un dossier du Centre Safe Start, Bureau de la justice des mineurs et de la prévention de la délinquance, Programmes de l'Office de la justice, Département de la Justice des Etats-Unis d'Amérique. (2011).
A Behavioral Health Toolkit for Providers working with Children of the Incarcerated and their Families - Afin d'aider les praticiens des services sociaux, la « Division of Behavioral Health and Recovery » (DBHR) du Département des services sociaux et de santé (DSHS) de l'État de Washington, Health and Recovery Services Administration, s'est associée à « l'Office of Planning, Performance and Accountability » du DSHS pour créer une boîte à outils en ligne, qui comprend des outils destinés aux professionnels, des informations pour les jeunes et les soignants, et des recherches sur les interventions. Cette boîte à outils de formation en ligne fournit aux praticiens les compétences nécessaires pour répondre aux besoins des enfants de parents qui sont en prison ou qui ont des antécédents

d'incarcération. Washington State Dept. of Health & Human Services. (2009). Vous trouverez d'autres ressources à l'adresse FindYouthInfo.gov.

Little Children Big Challenges: Incarceration - Cette boîte à outils fournit des outils multimédias bilingues (anglais / espagnol) très nécessaires aux familles ayant de jeunes enfants (3-8 ans) dont un parent est incarcéré. Ces ressources GRATUITES comprennent une série d'outils et guide pour les parents et les aidants, un livre d'histoires pour enfants et une nouvelle vidéo de Sesame street, une fiche de conseils pour parents incarcérés et l'application "Sesame Street: Incarceration" pour téléphones intelligents et tablettes. (2013).

Children in Foster Care with Parents in Federal Prison: A Toolkit for Child Welfare Agencies, Federal Prisons, and Residential Reentry Centers - L'objectif de cette boîte à outils est de faciliter la communication et la coopération entre les agences de protection de l'enfance et les prisons fédérales afin que les parents puissent rester impliqués dans la vie de leurs enfants. (2013).

6. Justice pénale / Maintien de l'ordre public

The National Prevention Toolkit on Officer Involved Domestic Violence - Un projet du « Law Enforcement Families Partnership » (LEFP) à l'Institut d'Etude sur les Violences familiales auprès du Collège de Sciences sociales de l'Université de l'Etat de Floride. La boîte à outils s'inscrit dans une large initiative visant à prévenir la violence dans les foyers des familles relevant de la justice pénale et à soutenir les familles, les organismes et les communautés en bonne santé. Veuillez noter que cette boîte à outils n'est pas un programme d'intervention auprès des agresseurs et ne doit pas être utilisée lorsque la violence a déjà eu lieu. Université de l'Etat de Floride. (2013).

7. Violence domestique

Closing the Gap: Integrating Services for Survivors of Domestic Violence Experiencing Homelessness-A Toolkit for Transitional Housing Programs - Le Centre national de sans-abrisme de familles. (2013).

The National Prevention Toolkit on Officer Involved Domestic Violence - Un projet du « Law Enforcement Families Partnership » (LEFP) à l'Institut d'Etude sur les Violences familiales auprès du Collège de Sciences sociales de l'Université de l'Etat de Floride. (2013).

Real Tools: Responding to Multi-Abuse Trauma - Alaska Network on Domestic Violence and Sexual Assault. (2011).

8. Education

Child Trauma Toolkits for Educators - En anglais et en espagnol (avec un financement de CMHS, SAMHSA, HHS).

Creating Trauma-Sensitive Schools to Improve Learning: A Response to Intervention Model - Le département de l'instruction publique du Wisconsin propose une série de ressources pour aider les écoles à devenir plus sensibles aux traumatismes. Le site explique le modèle « Response to Intervention » (RtI) pour accompagner les étudiants présentant un large éventail de problèmes comportementaux et émotionnels.

« How Schools Can Help Students Recover from Traumatic Experiences » (pdf) - Une boite à outils élaborée par la Rand Corporation. De nombreux changements dans les performances et le comportement des élèves surviennent, par exemple, après qu'ils aient été témoins de violences, qu'ils aient subi des agressions ou des mauvais traitements, qu'ils aient vécu des catastrophes naturelles ou qu'ils aient été victimes d'actes de terrorisme. La boîte à outils décrit comment pareils changements peuvent apparaître dans le milieu scolaire et fournit un recueil des programmes destinés aux écoles souhaitant soutenir le rétablissement à long terme des élèves victimes de traumatismes. Elle explique comment sélectionner les étudiants pour ces programmes et comment les financer. Elle compare les programmes entre eux en fonction des types de traumatismes traités, des problèmes ciblés, des exigences en matière de formation et de mise en œuvre, et des preuves de leur efficacité. Enfin, elle donne une fiche d'informations d'une page sur chaque programme sélectionné, résumant l'objectif, la population visée et le format et fournissant des détails sur sa mise en œuvre, la formation du personnel et le matériel, ainsi que les coordonnées des personnes à contacter. Site web décrivant le livre « Cognitive Behavioral Intervention for Trauma in Schools » (CBITS), sur le site du projet Rand Health.

Trauma-Informed Resources for Educators - (NCTSN).
**Helping Traumatized Children Learn* -- Vol. 1 (Purple Book) and Vol. 2 (Teal Book) How to integrate trauma-informed practices and policies into your school and school district from the people at the Trauma and Learning Policy Initiative.

9. Foyer d'accueil / Adoption

Trauma Informed Assessment and Preparation Toolkit - Un centre de ressources de l'Ohio Trauma Consortium, une initiative locale de travailleurs sociaux, thérapeutes et formateurs qui fournissent une préparation et un accompagnement sensibles aux traumatismes aux familles adoptives et d'accueil. Pour plus de ressources, allez sur le site de « Trauma Consortium » (2013).

Children in Foster Care with Parents in Federal Prison: A Toolkit for Child Welfare Agencies, Federal Prisons, and Residential Reentry Centers - L'objectif de cette boîte à outils est de faciliter la communication et la coopération entre les agences de protection de l'enfance et les prisons fédérales afin que les parents puissent rester impliqués dans la vie de leurs enfants. (2013). Vous trouverez d'autres ressources sur FindYouthInfo.gov.

10. Soins de santé

Health Care Toolbox for Providers - ABC and now DEF (Distress, Emotions, Family) - Center for Pediatric Traumatic Stress (CPTS).
Handbook on Sensitive Practice for Health Care Practitioners: Lessons from Adult Survivors of Childhood Sexual Abuse -
Ce manuel présente une série d'informations susceptibles d'aider les professionnels de la santé à exercer leur profession en tenant compte des besoins des adultes ayant survécu à des abus sexuels durant leur enfance et à d'autres formes de violence interpersonnelle. Il est destiné aux praticiens et aux étudiants de toutes les disciplines de la santé qui n'ont pas de formation spécialisée en santé mentale, en psychiatrie ou en psychothérapie et qui ont une expérience limitée du travail avec des adultes ayant survécu à des abus sexuels durant leur enfance (2009).

11. Sans-abrisme

Closing the Gap: Integrating Services for Survivors of Domestic Violence Experiencing Homelessness - A Toolkit for Transitional Housing Programs - The National Center on Family Homelessness. (2013).
Trauma-Informed Care for Women Veterans Experiencing Homelessness: A Guide for Service Providers - US Dept. of Labor. (2011).

12. Familles de militaires

Resources for military families facing PTSD/TBI - « Post Deployment Health and Distress Responses: Overview for Practitioners » ; « The Invisible Injuries of War: Impact on Military Families and Children, for Providers » et « The Impact of Invisible Injuries: Helping Your Family and Children, for Service Members and families », disponibles pour téléchargement auprès du « Center for the Study of Traumatic Stress » (CSTS). (2013).
Working with Military-Connected Youth - Guide de l'éducateur contenant une série de ressources susceptibles d'aider les jeunes issus de familles de militaires. Beyond the Yellow Ribbon (Jul. 2013).

13. Services aux réfugiés / aux immigrants

A Social Worker's Tool Kit for Working With Immigrant Families: Healing the Damage: Trauma and Immigrant Families in the Child Welfare System - American Humane Assn. (Sept. 2010).
Transcending Violence: Emerging Models for Trauma Healing in Refugee Communities - SAMHSA's National Center for Trauma-Informed Care (NCTIC). (2008). *Warning Signs of Exposure to Violence, Immigrant Families* - (Office of Juvenile Justice & Delinquency Prevention).

14. Services pour la jeunesse

**Adolescent Health Working Group* (San Francisco, CA) *Trauma & Resilience Adolescent Provider Toolkit.* (avec un explicatif de la boite à outils) La boîte à outils comprend plus de 50 fiches sur des thèmes variés : spectre des traumatismes et de la résilience, inégalités en matière de traumatismes, expériences négatives dans l'enfance (Adverse Childhood Experiences - ACE), développement cérébral chez les adolescents, troubles traumatiques du développement, déclencheurs de traumatismes, croissance post-traumatique, résilience, atouts de développement, compétences en matière de développement, l'autogestion des soins par les prestataires, pleine conscience, soins sensibles aux traumatismes, conséquences sensibles aux traumatismes, approches des soins adaptées à la culture, pratiques réparatrices, action sociale; ainsi qu'une liste complète des meilleures pratiques et des approches prometteuses en matière de soins sensibles aux traumatismes.
Son contenu - textes, tableaux, graphiques - peut être intégré dans les actions de sensibilisation, l'élaboration de politiques, les pratiques cliniques, le développement et la formation du personnel, les protocoles de cours et les programmes de pairs.
Le droit d''utilisation de cette boîte à outils et du MOOC Care Path, et du projet Care Path en général, peut être partagé avec les collègues, les organisations et les institutions qui s'occupent de ces questions, pour autant que son origine soit mentionnée, et diffusé, mais pas commercialisé. Aucun des contenus ne peut être vendu ni commercialisé.

Si vous diffusez cette boîte à outils ou le MOOC Care Path, il est obligatoire de mentionner qu'elle fait partie du projet Care Path financé par le programme « Droits, égalité et citoyenneté de l'Union européenne » (2014-2020).
Les informations contenues dans cette boîte à outils sont disponibles sur le web pour toute personne intéressée par les sujets traités. Les arguments, informations et théories scientifiques contenus dans toutes les parties et éléments constitutifs de la boîte à outils Care Path ont été organisés dans l'intention d'être utiles à toutes les personnes qui, à divers titres et avec des parcours professionnels différents, offrent une aide et des services aux enfants souffrant de traumatismes.
Les connaissances scientifiques contenues dans tous les documents du projet Care Path et en particulier celles qui figurent dans cette boîte à outils sont librement accessibles dans de nombreuses publications scientifiques à travers le monde. Les applications de ces notions et connaissances sont réglementées de différentes manières dans les différents pays par les lois, règlements et codes de déontologie respectifs des diverses corporations professionnelles et associations professionnelles ou bénévoles, qui varient souvent d'un pays à l'autre.
Le contenu de la présente boite à outils est proposé dans le respect précis de toutes les lois et réglementations en vigueur et aucune de ses parties ni aucun élément du Mooc Care Path ne peut être utilisée ou comprise à des fins différentes de ce qui vient d'être souligné. Il demeure un devoir et un impératif pour tout.e professionnel.le de travailler toujours dans le respect de la science et de sa conscience dans le meilleur intérêt de ses clients, ce qui implique le respect total des réglementations en vigueur dans son pays, le respect des compétences spécifiques des autres professions, la conscience de ses propres limites et connaissances et le respect des frontières qui délimitent sa profession, son rôle et sa compétence professionnelle ou paraprofessionnelle, ainsi que le respect nécessaire des règles internes de l'organisation dans laquelle il.elle travaille.

TOOL KIT LEAVING CARE

Ελληνική έκδοση

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Πρόλογος

Αυτός ο οδηγός εργαλείων αποτελεί μέρος του έργου Care Path «Empowering public authorities and professionals towards trauma-informed leaving care support». Το έργο CarePath αριθ. 785698 υποβλήθηκε στα πλαίσια του REC-AG-2017 (REC-RCHI-PROF- AG-2017) και χρηματοδοτείται από το Πρόγραμμα Δικαιωμάτων, Ισότητας και Ιθαγένειας της Ευρωπαϊκής Ένωσης (2014-2020). Το περιεχόμενο του οδηγού είναι ελεύθερα διαθέσιμο στο διαδίκτυο και όπως ισχύει σε όλα τα περιεχόμενα του CarePath Mooc αντιπροσωπεύει αποκλειστικά την άποψη των συγγραφέων και είναι αποκλειστική ευθύνη τους. Η Ευρωπαϊκή Επιτροπή δεν μπορεί να θεωρηθεί υπεύθυνη για οποιαδήποτε χρήση των πληροφοριών που περιέχονται σε αυτόν.

Ο Οδηγός εργαλείων CarePath για τους επαγγελματίες που εργάζονται με παιδιά που έχουν βιώσει τραύμα έχει αναπτυχθεί ώστε οι πιστοποιημένοι επαγγελματίες του CarePath να είναι σε θέση να παρέχουν άμεση και ενημερωμένη πάνω στο ψυχικό τραύμα υποστήριξη σε παιδιά. Ο Οδηγός θα βοηθήσει τους επαγγελματίες να ακολουθήσουν μια πολυδιάστατη και ολοκληρωμένη προσέγγιση για την υποστήριξη τραυματισμένων παιδιών, σε θέματα διαβίωσης και στέγασης, υγειονομικής περίθαλψης, καθοδήγησης και επαγγελματικής κατάρτισης, κοινωνικής ένταξης και ψυχοθεραπευτικές υπηρεσίες. Παράλληλα θα βοηθήσει τους επαγγελματίες στο να επιτύχουν τη συμμετοχή των ίδιων των παιδιών στον προγραμματισμό της φροντίδας, καθώς και τη συμμετοχή άλλων επαγγελματιών (όπου

απαιτείται), όπως ψυχοθεραπευτών, κοινωνικών λειτουργών εκπαιδευτών, υπεύθυνων χάραξης πολιτικής, δικηγόρων.
Όλες οι πληροφορίες που συμπεριλαμβάνονται στον οδηγό βρίσκονται επίσης στο διαδίκτυο και είναι διαθέσιμα για οποιοδήποτε ενδιαφέρεται πάνω στα θέματα που καλύπτει ο οδηγός. Τα επιχειρήματα, οι πληροφορίες και οι επιστημονικές πληροφορίες που συμπεριλαμβάνονται σε αυτόν τον οδηγό έχουν οργανωθεί με τέτοιο τρόπο, ώστε να είναι χρήσιμα για όλους τους ανθρώπους -ανεξαρτήτως το μορφωτικό ή επαγγελματικός τους υπόβαθρο- που με κάποιο τρόπο παρέχουν βοήθεια ή κάποια υποστήριξη σε παιδιά που έχουν βιώσει ψυχικό τραύμα.
Οι επιστημονικές γνώσεις που περιέχονται σε όλα παραδοτέα του Care Path και συγκεκριμένα σε αυτά που περιλαμβάνονται σε αυτόν τον οδηγό είναι ελεύθερα προσβάσιμα μέσα από πολλές επιστημονικές δημοσιεύσεις σε όλο τον κόσμο. Οι εφαρμογές αυτών των εννοιών και γνώσεων ρυθμίζονται με διαφορετικούς τρόπους στις διάφορες χώρες από τους αντίστοιχους νόμους, κανονισμούς και κώδικες δεοντολογίας των διαφόρων επαγγελματικών συντεχνιών και επαγγελματικών ή εθελοντικών ενώσεων, οι οποίοι συχνά διαφέρουν από χώρα σε χώρα
Όλα τα περιεχόμενα αυτού του οδηγού παρέχονται μέσα στα πλαίσια σεβασμού όλων των νόμων και κανονισμών που ισχύουν για τα θέματα που διαπραγματεύονται και κανένα μέρος αυτού του οδηγού ή του Care Path Mooc δεν μπορεί να χρησιμοποιηθεί ή να κατανοηθεί για διαφορετικούς σκοπούς πέρα από αυτόν που έχει ήδη αναφερθεί. Παραμένει καθήκον και επιτακτική ανάγκη για κάθε επαγγελματία να εργάζεται πάντα με γνώμονα την επιστήμη και τη συνείδησή του και αυτό περιλαμβάνει την πλήρη συμμόρφωση με τους κανονισμούς που ισχύουν στη χώρα του, τον σεβασμό για τις ικανότητες άλλων επαγγελμάτων, την επίγνωση και σεβασμό των επαγγελματικών του ορίων, καθώς και την απαιτούμενη συμμόρφωση με τους εσωτερικούς κανόνες του οργανισμού στον οποίο λειτουργεί.
Ο οδηγός είναι το αποτέλεσμα μιας τυποποιημένης επιστημονικής διαδικασίας που περιλαμβάνει ορισμένες αναζητήσεις σε συγκεκριμένες τράπεζες δεδομένων (MEDLINE, Embase και PsycINFO), και διαβουλεύσεις με διάφορους επαγγελματίες που δραστηριοποιούνται στους διάφορους κλάδους και δραστηριότητες που καλύπτονται τόσο από τον οδηγό όσο και από το Έργο CarePath γενικά. Πρόκειται για διάφορους επαγγελματίες που προσφέρουν υπηρεσίες σε παιδιά θύματα τραύματος, συμπεριλαμβανομένων διευθυντών υπηρεσιών/δομών στον ιδιωτικό ή δημόσιο τομέα που ασχολούνται με την προστασία και προώθηση των δικαιωμάτων, την ανάκαμψη, την προστασία και την προώθηση της υγείας και της ευημερίας παιδιών που έχουν πληγεί από τραύμα ή πρόληψη τραύματος σε νομοθετικό, επαγγελματικό διευθυντικό, μετα-επαγγελματικό και εθελοντικό επίπεδο. Επίσης συμπεριλήφθηκε υλικό που αφορά τα θύματα του τραύματος και τις οικογένειές τους, καθώς και τους φροντιστές και τις σχετικές πτυχές των εκπαιδευτικών τους αναγκών και την προστασία και προαγωγή της υγείας τους στο χώρο εργασίας (ιδίως για την πρόληψη και τη διαχείριση του άγχους, την αποφυγή της συναισθηματικής υπερκόπωσης και τη πρόληψη και διαχείριση του τοξικού άγχους).
Αυτός ο οδηγός έχει αναπτυχθεί έτσι ώστε να έχει άμεση συσχέτιση με την φροντίδα πάνω στο τραύμα, τις παιδοκεντρικές προσεγγίσεις, τις ανθρωποκεντρικές προσεγγίσεις πάνω στον σχεδιασμό και την ανάρρωση, τις καλές πρακτικές, τις μελέτες περίπτωσης, τις δια τομεακές προσεγγίσεις για την κατάρτιση προσωπικού, της συνεχιζόμενη εκπαίδευση, τις πολιτικές οργάνωσης, ανάπτυξης και διαχείρισης οργανώσεων κ.α.
Έχουμε δημιουργήσει αυτόν τον οδηγό αποφεύγοντας τη δημιουργία μιας μηχανιστικής καταχώρησης πηγών, Αντιθέτως προσπαθήσαμε να δημιουργήσουμε έναν οδηγό - πανόραμα διαθέσιμων πόρων που είναι προσιτές και σε συμφωνία με τις αρχές της κοινωνιολογίας της γνώσης (Berger και Luckmann 1966) αλλά και με την άποψη ότι κάθε θεραπευτική ή βοηθητική προσέγγιση βασίζεται σε ένα συγκεκριμένο όραμα της ανθρώπινης φύσης που, με τη σειρά του, βασίζεται σε αξίες. Αυτές οι αξίες καθορίζουν την πολιτική της υποστηρικτικής σχέσης και επηρεάζουν τα αποτελέσματα:
Δεδομένου ότι οποιαδήποτε άποψη της ανθρώπινης φύσης βασίζεται σε ένα σύνολο αξιών, οποιαδήποτε πράξη βοήθειας είναι, στην πραγματικότητα, μια πολιτική πράξη. Ο πελάτης πρέπει να αναπτύξει έναν νέο τρόπο για να ερμηνεύσει την εμπειρία και να δημιουργήσει τη συμπεριφορά του - με άλλα λόγια,

για να εσωτερικεύσει την αφήγηση της πράξης βοήθειας. Ο Μάικλ Πολάνι (1958) έχει αναφερθεί σε αυτήν την πτυχή ως τις εσωτερικές και μη συνειδητές διαπροσωπικές γνώσεις που ανταλλάσσουμε συνεχώς

Για τους λόγους αυτούς, οι υποστηρικτικές σχέσεις χαρακτηρίζονται από έντονη διαφορά ισχύος μεταξύ του επαγγελματία και του ασθενούς ή του πελάτη (Proctor, 2002, 2004, 2005, 2006; Sanders & Tudor, 2001; Sommerbeck, 2003; Sanders 2006). Αυτή η διαφορά ισχύος είναι μεγαλύτερη ή μικρότερη σε διαφορετικές υποστηρικτικές προσεγγίσεις: είναι μεγαλύτερη όταν ο ρόλος του θεραπευτή είναι του ειδικού που υποτίθεται ότι πρέπει να διαγνώσει, να θεραπεύσει και να απαιτήσει συμμόρφωση. Στις προσωπο-κεντρικές, ενημερωμένες στο τραύμα, με στόχο την ανάρρωση και ευαίσθητες στο φύλο και την κουλτούρα προσεγγίσεις, όπου η σχέση βασίζεται στον σεβασμό και την εμπιστοσύνη του βοηθού προς στον πελάτη και στις έμφυτες δυνατότητές του για ανθεκτικότητα στην ανάπτυξη και αλλαγή, η διαφορά ισχύος είναι πολύ μικρότερη. Εδώ ο ρόλος του βοηθού δεν είναι να διαγνώσει και να θεραπεύσει, αλλά να υποστηρίξει την έμφυτη διαμορφωτική τάση του πελάτη, να υιοθετήσει μια φαινομενολογική θέση που σέβεται και εμπιστεύεται την κατανόηση της εμπειρίας του πελάτη. «Είναι ο πελάτης που ξέρει τι πονάει, ποιες κατευθύνσεις να πάει, ποια προβλήματα είναι ζωτικής σημασίας, ποιες εμπειρίες έχουν βαθιά θαφτεί» (Rogers, 1961, pp. 11-12).

Η άποψη του Rogers ήταν επαναστατική για την εποχή της, αλλά δυστυχώς είναι εξίσου σχετική και αναγκαία για τη σημερινή ψυχοθεραπεία και τις πρακτικές εξάσκησης βοήθειας. Μερικά από τα τρέχοντα ζητήματα και ανησυχίες στην υγειονομική περίθαλψη και τις σχέσεις βοήθειας δεν διαφέρουν τόσο πολύ από αυτά που ο Rogers και οι συνάδελφοί του αντιμετώπισαν στις δεκαετίες του 1940 και του 1950: σήμερα η περίθαλψη, η ψυχοθεραπεία, η πολιτική και οι αξίες της ερευνητικής ψυχοθεραπείας, χρησιμοποιούνται ως πιθανές μορφές κοινωνικού ελέγχου αντί για την προστασία και προώθηση των ανθρωπίνων δικαιωμάτων.

Εμείς, ως επαγγελματίες βοηθοί, μπορούμε να συνεισφέρουμε σήμερα σημαντικά στο διάλογο και την επαγγελματική πολιτική στον τομέα της ψυχολογικής υποστήριξης. Προκειμένου να το κάνουμε αποτελεσματικά, πρέπει να συνεχίσουμε στα βήματα των Rogers και των άλλων ιδρυτικών μελών της ανθρωπιστικής ψυχολογίας όπως ο Abraham Maslow, ο Gordon Allport, ο Charlotte Butler, ο Bugental για να αντιμετωπίσουμε και να καταστήσουμε σαφή τα ζητήματα των αξιών και της χρήσης εξουσίας στα επαγγέλματα ψυχολογικής υποστήριξης. Πρέπει να ασχοληθούμε ενεργά με τις προσπάθειες για την ανάπτυξη κοινωνικά συνειδητών και δημοκρατικών πρακτικών, και πρέπει, σε επιστημονικό και πολιτικό επίπεδο, να ασχοληθούμε με τα θέματα της ανάκαμψης, της ανθεκτικότητας, της χειραφέτησης και της ενδυνάμωσης.

Αυτός ο οδηγός περιλαμβάνει επίσης μια μεγάλη συλλογή ερευνών, μελέτες περιπτώσεων, παραδείγματα βέλτιστων πρακτικών για το πώς σε διάφορα μέρη του κόσμου προστατεύονται και προωθούνται τα δικαιώματα των παιδιών, πώς η παιδο-κεντρική και ενήμερη στο ψυχικό τραύμα φροντίδα μπορεί να είναι το επίκεντρο του σχεδιασμού και της διαχείρισης των πρόσωπο-κεντρικών προσεγγίσεων με και των προσεγγίσεων για την ανάρρωση σε όλες τις μορφές της κοινωνικής πραγματικότητας: η ενήμερη στο ψυχικό τράυμα νομοθεσία, οι κατανομές κεφαλαίων, η οργάνωση της κοινότητας, ο σχεδιασμός και η διαχείριση σχολείων, τα παιδικά ιδρύματα, ο προσανατολισμένος στα παιδιά σχεδιασμός υπηρεσιών. Εάν θέλουν να γνωρίζουν τις ψυχο-κοινωνικές συνέπειες, δεν πρέπει μόνο να μπορούν να θεραπεύσουν αποτελεσματικά τα θύματα του τραύματος, αλλά πρέπει να αποτρέψουν το τραύμα, τον αναδρομικό τραυματισμό, την εξάντληση του προσωπικού και τα αντίστοιχα τραύματα. Με αυτόν τον τρόπο θα εργάζονται συνειδητά για να είναι μέρος της λύσης και όχι για του προβλήματος.

Όταν ολοκληρώθηκε αυτός ο οδηγός, η πανδημία Covid 19 επηρέασε ολόκληρο τον κόσμο και δημιούργησε έναν τραυματικό αντίκτυπο σε όλους τους πολίτες και ιδιαίτερα στα παιδιά, στα παιδιά με ψυχικό τραύμα, στις οικογένειές τους και σε όλους τους φροντιστές. Αυτή η νέα πηγή τεράστιας τραυματικής επίδρασης προστέθηκε στον ήδη πλούσιο κατάλογο θεμάτων και πόρων.

Προσθέσαμε μια μεγάλη λίστα πληροφοριών, πόρων, εργαλείων για το πώς να αντιμετωπίσουμε αποτελεσματικά τα ζητήματα που έφερε το Covid 19 προσφέροντας δωρεάν σύνδεση με τα καλύτερα επιστημονικά ιδρύματα, όπως ο Παγκόσμιος Οργανισμός Υγείας (ΠΟΥ).
Αυτός ο οδηγός είναι το αποτέλεσμα μιας τυποποιημένης επιστημονικής διαδικασίας που περιλαμβάνει ορισμένες αναζητήσεις από τράπεζες δεδομένων, διαβουλεύσεις με διαφορετικούς επαγγελματίες που είναι αρμόδιοι και δραστηριοποιούνται στους διάφορους κλάδους και δραστηριότητες του του έργου CarePath. Αυτό περιελάμβανε και όλους τους επαγγελματίες που προσφέρουν υπηρεσίες σε παιδιά θύματα τραύματος, συμπεριλαμβανομένων διευθυντών υπηρεσιών ή δομών στον ιδιωτικό ή δημόσιο τομέα που ασχολούνται με την προστασία και προώθηση των δικαιωμάτων, την ανάκαμψη, την προστασία και την προώθηση της υγείας και της ευημερίας παιδιών που έχουν πληγεί από τραύμα ή πρόληψη τραύματος σε νομοθετικό, επαγγελματικό διευθυντικό, παρα-επαγγελματικό και εθελοντικό επίπεδο. Επίσης συμπεριλήφθηκε υλικό που προσφέρει πρόσβαση στις φωνές και τις μαρτυρίες των θυμάτων τραύματος και των οικογενειών τους, καθώς και τις φωνές των φροντιστών και των εκπαιδευτικών αναγκών τους, της προστασίας και προαγωγής της υγείας τους στο χώρο εργασίας και ιδίως στη πρόληψη και διαχείριση του άγχους και την αποφυγή της συναισθηματικής εξάντλησης.
Ένα από τα πολλά χαρακτηριστικά του οδηγού που αξίζει να αναφερθεί είναι η απουσία κινδύνων παραβίασης πνευματικών δικαιωμάτων για τη χρήση του υλικού που είναι προσβάσιμο μέσω συνδέσμων ιστού ή συνδέσμων YouTube που διατίθενται ελεύθερα στον ιστό και δημοσιεύονται από διάφορους οργανισμούς και επαγγελματίες από πολλά διαφορετικά μέρη του κόσμου. Στις περισσότερες περιπτώσεις, το υλικό που προσφέρεται είναι στις επίσημες γλώσσες του Care Path Project. Αγγλικά, Ιταλικά, Γαλλικά, Ουγγρικά και Ελληνικά. Σε ορισμένες περιπτώσεις το διαθέσιμο υλικό είναι σε πολλές διαφορετικές γλώσσες δεδομένου ότι διατίθενται από τον Παγκόσμιο Οργανισμό Υγείας ή άλλα διεθνή επιστημονικά ιδρύματα.
Μια άλλη πτυχή που αξίζει να αναφερθεί είναι το γεγονός ότι σε πολλές περιπτώσεις οι διαδικτυακοί σύνδεσμοι παρέχουν πρόσβαση σε δωρεάν τράπεζες δεδομένων και πόρους ιδρυμάτων, όχι μόνο σε μεμονωμένα έγγραφα, οπότε για συνδέσμους ιστότοπων με ιδρύματα ο οδηγός προσφέρει δωρεάν πρόσβαση σε συνεχώς ενημερωμένο υλικό, ερευνητικά αποτελέσματα , νομοθετικό σώμα και βέλτιστες πρακτικές που δεν έχουν ακόμη πραγματοποιηθεί. Τέλος, ο οδηγός προσφέρει μια διευκόλυνση όχι μόνο για την πρόσβαση σε πολύτιμα υλικά και σε σχηματισμούς, αλλά και για τη δημιουργία ενός πολύτιμου διεθνούς δικτύου με ιδρύματα και συναδέλφους σε όλο τον κόσμο.
Ένα άλλο χαρακτηριστικό του οδηγού είναι ότι μπορέσαμε να εντοπίσουμε διάφορα εργαλεία που διατίθενται δωρεάν στους ιστότοπους γνωστών επιστημονικών ιδρυμάτων που προσφέρουν μια ολόκληρη σειρά επιστημονικών επικυρωμένων υλικών και εργαλείων, οπότε αντί να γράφουμε μια απλή σύνοψη των υλικών, παρέχουμε υλικό άμεσα διαθέσιμο στους ενδιαφερόμενους επαγγελματίες παρέχοντάς τους όχι μόνο μια εργαλειοθήκη αλλά και μια ηλεκτρονική αποθήκη και τράπεζα δεδομένων ελεύθερα διαθέσιμη σε οποιονδήποτε ενδιαφέρεται. Με αυτόν τον τρόπο ο οδηγός προσφέρει μια αρκετά μεγάλη γκάμα εργαλείων που είναι επιστημονικά επικυρωμένα και ήδη καλά οργανωμένα και είναι τα αποτελέσματα χιλιάδων επαγγελματιών, αμέτρητων επιστημονικών ερευνών και καθιερωμένων ορθών πρακτικών. Σε πολλές περιπτώσεις, οι διαθέσιμα εργαλεία είναι της ανώτερης στάθμης της τεχνολογίας ολόκληρου του πεδίου και των διαφορετικών εφαρμογών του.
Για παράδειγμα:
Εργαλεία ενημερωμένα στο ψυχικό τραύμα
Αρχές που διέπουν την ενημερωμένη στο τράυμα φροντίδα (TIC):

- Κατανόηση του τραύματος και των επιπτώσεών του
- Προώθηση της ασφάλειας
- Διασφάλιση πολιτιστικής ικανότητας
- Υποστήριξη ελέγχου καταναλωτών, επιλογών και αυτονομίας
- Κοινή χρήση δύναμης και διακυβέρνησης

- Προώθηση της φροντίδας
- Η επούλωση συμβαίνει στις σχέσεις
- Η ανάρρωση είναι δυνατή

The National Center on Family Homelessness. p 17-18
Δείτε την παρουσίαση σε powerpoint πάνω στην TIC από SAMHSA/HRSA:

1. Οδηγίες

'The Last Frontier' Practice Guidelines for Treatment of Complex Trauma & Trauma Informed Care & Service Delivery - Adults Surviving Child Abuse (ASCA)/Australia. (2012).
National Center for Trauma-Informed Care - SAMHSA.
Tips for Staff and Advocates Working with Children Polyvictimization." The Safe Start Center, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. (ca 2011-2012).

VETO: Violence Educational Tools ONLINE - Το VetoViolence αναπτύχθηκε από τα Κέντρα Ελέγχου και Πρόληψης Νοσημάτων (CDC) για να παρέχει στους δικαιούχους και τους συνεργάτες πρόσβαση σε εκπαίδευση και εργαλεία που εστιάζουν στην πρωτογενή πρόληψη της βίας. Το εργαλείο αυτό περιλαμβάνει δωρεάν εκπαίδευση, πηγές προγραμμάτων και μια διαδικτυακή εφαρμογή για τη δημιουργία ιστοριών επιτυχίας. Υπάρχουν ενότητες / εργαλεία για την πρόληψη κακοποίησης παιδιών, την πρόληψη αυτοκτονίας, την πρόληψη της σεξουαλικής βίας, την πρόληψη της βίας των νέων και την πρόληψη της βίας από στενούς συντρόφους. Η πύλη θα συνεχίσει να εξελίσσεται καθώς προστίθενται επιπλέον πηγές.

2. Κοινότητα ενημερωμένη στο τραύμα

Οδηγός για την δημιουργία ενός συνασπισμού στην κοινότητά σας – Αυτός ο οδηγός περιγράφει τον τρόπο με τον οποίο οι κοινότητες μπορούν να σχηματίσουν συνασπισμούς συνδέοντας τους επαγγελματίες οργανισμών για την καλή διαβίωση των παιδιών, την καλή μεταχείριση των ζώων, την αντιμετώπιση ενδοοικογενειακής βίας και τις υπηρεσίες προστασίας ενηλίκων για τον εντοπισμό και την αντιμετώπιση περιστατικών κακοποίησης ζώων και διαπροσωπικής βίας. Περιλαμβάνει λεπτομέρειες σχετικά με το πώς να ξεκινήσει η συνεργασία που θα ενθαρρύνει τις κοινότητες να αναλάβουν δράση και να παροτρύνουν τους ενδιαφερόμενους να συνεργαστούν και να εργαστούν για μια διεπιστημονική προσέγγιση για την αντιμετώπιση της σκληρότητας των ζώων και της ανθρώπινης βίας. (2013). Περισσότερες πληροφορίες για το Link εδώ.

3. Δημιουργώντας σχέσεις συνεργασίας/ κοινότητες

Building Collaborations - Resources from the Office of Adolescent Health, U.S. Dept. of Health & Human Services.
Community Conversations About Mental Health Discussion Guide - αυτός ο οδηγός των 20 σελίδων με τίτλο ¨Community Conversations About Mental Health¨ στόχο έχει να βοηθήσει ανθρώπους και οργανισμούς στην προώθηση διαβουλεύσεων σε επίπεδο κοινότητας SAMHSA, (2013).
Community Conversations About Mental Health: Information Brief – το εργαλείο αυτό έχει σχεδιαστεί ώστε να χρησιμοποιείται μαζί με άλλα εργαλεία του οδηγού ¨Community Conversations About Mental Health¨ και παρέχει πληροφορίες και στοιχεία που μπορούν να βοηθήσουν στα πλαίσια των

διαβουλεύσεων σε επίπεδο κοινότητας στο να εστιάσει ο εκάστοτε ομιλητής στα σημεία ζωτικής σημασίας για την κοινότητα. SAMHSA. (2013).
Essentials for Childhood - Steps to Create Safe, Stable, and Nurturing Relationships - Αυτό το έγγραφο προτείνει στρατηγικές που πρέπει να λάβουν υπόψη οι κοινότητες. Προορίζεται για όσους έχουν δεσμευτεί για τη θετική ανάπτυξη παιδιών και οικογενειών, και ειδικά για την πρόληψη κάθε μορφής παιδικής κακοποίησης (CM). Για περισσότερα . CDC. (2013).

4. Υπηρεσίες πρόνοιας / προστασίας παιδιών

Child Welfare Trauma Training Toolkit: Comprehensive Guide - National Child Traumatic Stress Network (NCTSN). (2008). 2nd Edition (2013).
Learning Center for Child & Adolescent Trauma - National Child Traumatic Stress Network (NCTSN).
A Social Worker's Tool Kit for Working With Immigrant Families: Healing the Damage: Trauma and Immigrant Families in the Child Welfare System - American Humane Assn. (Sept. 2010).
Supporting Infants, Toddlers and Families Impacted by Caregiver Mental Health Problems, Substance Abuse, and Trauma - SAMHSA. (2012).

Trauma-Informed Care: Perspectives and Resources: To National Technical Assistance Center for Children's Mental Health at Georgetown University and JBS International δημιούργησε αυτό το on line εργαλείο για να υποστηρίξει αρχηγούς και διαχειριστές σε κάθε επίπεδο (εθνικό, κρατικό, φυλετικό, εδαφικό και τοπικό) ως προς την χάραξη πορείας και αποφάσεων.
Αυτό το εργαλείο περιλαμβάνει συντομεύσεις ζητημάτων, συνεντεύξεις, βίντεο και λίστες με πηγές για την υλοποίησης υπηρεσιών ενημερωμένες στο τραύμα και προσφέρει καθοδήγηση και πόρους για να σας βοηθήσουν στο ταξίδι υλοποίησης της δικής σας στρατηγικής. Οι τηλεοπτικές συνεντεύξεις αφορούν εθνικούς, πολιτειακούς, φυλετικούς και τοπικούς ηγετες/ υπευθύνους πολλών και διαφόρων οργανισμών υποστήριξης παιδιών, προγραμματιστές θεραπευτικών μοντέλων που στηρίζονται σε τεκμήρια, γιατρούς, ερευνητές διαχειριστών οργανώσεων παροχής φροντίδας, νέων, ενηλίκων και οικογενειών που μοιράζονται μαθήματα που αντλήθηκαν μέσα από προσωπικές εμπειρίες και εντοπίζουν τα κενά που υπάρχουν. Οι νέοι και οι οικογένειές τους παρέχουν σημαντικές πληροφορίες από την οπτική του πελάτη σχετικά με την ανάγκη πρακτικών ενημερωμένων στο τραύμα και τον αντίκτυπο της TIC φροντίδας. Εκπρόσωποι σε επιλεγμένες πολιτείες μοιράζονται μαθήματα που έχουν αντληθεί σε μια περίοδο εντατικής προσπάθειας 1 έτους για να ενημερώνονται περισσότερο για τα τραύματα. Οι συνόψεις παρέχουν μια εισαγωγή και μια επισκόπηση για καθεμία από τις οκτώ ενότητες του εργαλείου.

5. Περιεκτικές λίστες πηγών που υποστηρίζουν τους χρήστες στην κατανόηση του τρόπου δημιουργίας συστημάτων και οργανισμών ενημερωμένων στο ψυχικό τραύμα

Trauma-Informed Care resources - Office of Adolescent Health, U.S. Dept. of Health & Human Services.
Trauma-Informed Child Welfare Practice Toolkit - Downloadable from the Chadwick Trauma-Informed Systems Project. (2013).
Trauma & Resilience: An Adolescent Provider Toolkit – Αυτός ο οδηγός έχει σχεδιαστεί για όλα τα επίπεδα των φορέων παροχής υπηρεσιών για νέους / εφήβους, από το προσωπικό της πρώτης γραμμής, τους κλινικούς, έως τους διαχειριστές. Ελπίζουμε ότι θα βοηθήσει τόσο εσάς όσο και τους αντίστοιχους οργανισμούς και προγράμματα στο ταξίδι σας να ενημερωθείτε για τα τραύμα. St. Andrews. (2013). San Francisco, CA: Adolescent Health Working Group.

Tips for Child Welfare Staff - A brief from The Safe Start Center, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. (2011).
A Behavioral Health Toolkit for Providers working with Children of the Incarcerated and their Families – Προκειμένου να προωθήσει την αμοιβαία κατανόηση μεταξύ επαγγελματιών των κοινωνικών υπηρεσιών, το τμήμα Division of Behavioral Health and Recovery (DBHR) του State of Washington Department of Social and Health Services (DSHS), Health and Recovery Services Administration, συνεργάστηκε με το DSHS' Office of Planning, Performance and Accountability για την δημιουργία ενός ηλεκτρονικού οδηγού, που περιλαμβάνει εργαλεία για επαγγελματίες, πληροφορίες για νέους και φροντιστές και έρευνες πάνω σε παρεμβάσεις. Αυτός ο ηλεκτρονικός οδηγός κατάρτισης παρέχει στους επαγγελματίες τις δεξιότητες που απαιτούνται για να ανταποκριθούν στις ανάγκες των παιδιών που οι γονείς τους βρίσκονται στη φυλακή ή έχουν ιστορικό φυλάκισης.. Washington State Dept. of Health & Human Services. (2009). More resources at FindYouthInfo.gov.
Little Children Big Challenges: Incarceration – Αυτός ο οδηγός παρέχει δίγλωσσο (Αγγλικά/ Ισπανικά) οπτικό ακουστικά εργαλεία για οικογένειες με παιδιά (ηλικίας 3-8) που οι γονείς έχουν ιστορικό φυλάκισης. Αυτές οι ελεύθερες στη πρόσβαση πηγές περιλαμβάνουν τα: A Guide for Parents and Caregivers, a Children's Storybook, και ένα νέο Sesame Street βίντεο; an Incarcerated Parent Tip Sheet; and the Sesame Street: Εφαρμογή για κινητά τηλέφωνα και tablet. (2013).
Children in Foster Care with Parents in Federal Prison: A Toolkit for Child Welfare Agencies, Federal Prisons, and Residential Reentry Centers - Ο σκοπός αυτού του οδηγού είναι να βοηθήσει στη διευκόλυνση της επικοινωνίας και της συνεργασίας μεταξύ των υπηρεσιών κοινωνικής πρόνοιας των παιδιών και των ομοσπονδιακών φυλακών, έτσι ώστε οι γονείς να μπορούν να παραμείνουν ενεργοί στη ζωή των παιδιών τους . (2013).

6. Ποινική δικαιοσύνη / Επιβολή του νόμου

The National Prevention Toolkit on Officer Involved Domestic Violence – Ένα έργο του οργανισμού Law Enforcement Families Partnership (LEFP) at the Institute for Family Violence Studies within Florida State University's College of Social Work. Ο οδηγός αυτός είναι μέρος μιας ευρείας προσπάθειας για την πρόληψη της βίας στα σπίτια των οικογενειών που αντιμετωπίζουν θέματα ποινικής δικαιοσύνης και για την υποστήριξη υγιών οικογενειών, οργανισμών και κοινοτήτων. Ο οδηγός αυτός δεν αποτελεί πρόγραμμα παρέμβασης κακοποιών και δεν χρησιμοποιείται όταν έχει ήδη συμβεί βία. Florida State University. (2013).

7. Ενδοοικογενειακή Βία

Closing the Gap: Integrating Services for Survivors of Domestic Violence Experiencing Homelessness- A Toolkit for Transitional Housing Programs - The National Center on Family Homelessness. (2013).
The National Prevention Toolkit on Officer Involved Domestic Violence – ένα έργο του οργανισμούς Law Enforcement Families Partnership (LEFP) στο Institute for Family Violence Studies within Florida State University's College of Social Work. Ο οδηγός αυτός είναι μέρος μιας ευρείας προσπάθειας για την πρόληψη της βίας στα σπίτια των οικογενειών που αντιμετωπίζουν θέματα ποινικής δικαιοσύνης και για την υποστήριξη υγιών οικογενειών, οργανισμών και κοινοτήτων. Ο οδηγός αυτός δεν αποτελεί πρόγραμμα παρέμβασης κακοποιών και δεν χρησιμοποιείται όταν έχει ήδη συμβεί βία. Florida State University. (2013).
Real Tools: Responding to Multi-Abuse Trauma - Alaska Network on Domestic Violence and Sexual Assault. (2011).

8. Εκπαίδευση

Child Trauma Toolkits for Educators - Στα Αγγλικά και τα Ισπανικά (με χρηματοδότηση από CMHS, SAMHSA, HHS).
Creating Trauma-Sensitive Schools to Improve Learning: A Response to Intervention Model – Το Wisconsin Department of Public Instruction παρέχει πηγές και υλικό προκειμένου τα σχολεία να είναι πιο ενήμερα πάνω στο ψυχικό τραύμα. Ο συγκεκριμένος ιστότοπος παρέχει πληροφορίες για το μοντέλο Response to Intervention (RtI) για την αποτελεσματική υποστήριξη μαθητών που καλύπτουν ένα μεγάλο εύρος συμπεριφορικών και συναισθηματικών θεμάτων.
How Schools Can Help Students Recover from Traumatic Experiences (pdf) –
Ένα κιτ εργαλείων σε συνεργασία με την Rand Corporation. Πολλές αλλαγές στην απόδοση και τη συμπεριφορά των μαθητών προέρχονται από την εμπειρία τους, για παράδειγμα όταν έχουν υπάρξει μάρτυρες βίας, επίθεσης ή κακοποίησης, διαβίωσης από φυσικές καταστροφές ή έχουν βιώσει τρομοκρατικές ενέργειες. Αυτό το κιτ εργαλείων περιγράφει τον τρόπο εμφάνισης τέτοιων αλλαγών στο σχολικό περιβάλλον και παρέχει μια συλλογή προγραμμάτων που είναι διαθέσιμα σε σχολεία που βοηθούν στην υποστήριξη της μακροπρόθεσμης αποκατάστασης μαθητών με τράυμα. Το κιτ εργαλείων περιγράφει τον τρόπο επιλογής μαθητών για τέτοια προγράμματα και πιθανούς τρόπους χρηματοδότησης αυτών των προγραμμάτων. Συγκρίνει τα προγράμματα το ένα με το άλλο ανάλογα με τους τύπους τραύματος που αντιμετωπίζουν, τα προβλήματα που στοχεύουν, τις απαιτήσεις για εκπαίδευση και υλοποίηση και τα αποδεικτικά στοιχεία για την αποτελεσματικότητα ενός προγράμματος. Τέλος, παρέχει πληροφορίες για κάθε επιλεγμένο πρόγραμμα, συνοψίζοντας τον στόχο, τον προβλεπόμενο πληθυσμό και τη μορφή του προγράμματος και παρέχοντας λεπτομέρειες σχετικά με την εφαρμογή, την εκπαίδευση προσωπικού και το υλικό, καθώς και πληροφορίες επικοινωνίας. Ιστοσελίδα που περιγράφει το βιβλίο. Cognitive Behavioral Intervention for Trauma in Schools (CBITS) από την Rand Health Project.
Trauma-Informed Resources for Educators - (NCTSN).
**Helping Traumatized Children Learn* -- Vol. 1 (Purple Book) and Vol. 2 (Teal Book) How to integrate trauma-informed practices and policies into your school and school district from the people at the Trauma and Learning Policy Initiative.

9. Ανάδοχη φροντίδα /Υιοθεσία

Trauma Informed Assessment and Preparation Toolkit -Ένα κέντρο πηγών από το Ohio Trauma Consortium, μια προσπάθεια κοινωνικών λειτουργών, θεραπευτών και εκπαιδευτών που παρέχουν πληροφόρηση σχετικά με την προετοιμασία και την υποστήριξη που είναι ενημερωμένη για το τραύμα για παιδιά προς υιοθεσία και τις θετές οικογένειες. Δείτε περισσότερα στον ιστότοπο Trauma Consortium Resources (2013).
Children in Foster Care with Parents in Federal Prison: A Toolkit for Child Welfare Agencies, Federal Prisons, and Residential Reentry Centers - Ο σκοπός αυτού του οδηγού είναι να βοηθήσει στη διευκόλυνση της επικοινωνίας και της συνεργασίας μεταξύ των υπηρεσιών κοινωνικής πρόνοιας των παιδιών και των ομοσπονδιακών φυλακών, έτσι ώστε οι γονείς να μπορούν να παραμείνουν ενεργοί στη ζωή των παιδιών τους (2013). Για περισσότερες πληροφορίες στο FindYouthInfo.gov.

10. Φροντίδα Υγείας

Health Care Toolbox for Providers - ABC and now DEF (Distress, Emotions, Family) - Center for Pediatric Traumatic Stress (CPTS).
Handbook on Sensitive Practice for Health Care Practitioners: Lessons from Adult Survivors of Childhood Sexual Abuse -
Αυτό το εγχειρίδιο παρουσιάζει πληροφορίες που θα βοηθήσουν τους επαγγελματίες της υγειονομικής περίθαλψης να δράσουν με τρόπο ευαίσθητο στις ανάγκες των ενήλικων επιζώντων σεξουαλικής κακοποίησης κατά παιδικής ηλικίας και άλλων τύπων διαπροσωπικής βίας. Προορίζεται για επαγγελματίες υγείας και μαθητές όλων των κλάδων υγείας που δεν έχουν εξειδικευμένη εκπαίδευση στην ψυχική υγεία, την ψυχιατρική ή την ψυχοθεραπεία και έχουν περιορισμένη εμπειρία στη συνεργασία με ενήλικες επιζώντες παιδικής σεξουαλικής κακοποίησης (2009).

11. Άστεγοι

Closing the Gap: Integrating Services for Survivors of Domestic Violence Experiencing Homelessness - A Toolkit for Transitional Housing Programs - The National Center on Family Homelessness. (2013).
Trauma-Informed Care for Women Veterans Experiencing Homelessness: A Guide for Service Providers - US Dept. of Labor. (2011).

12. Οικογένειες στρατιωτικών

Resources for military families facing PTSD/TBI - "Post Deployment Health and Distress Responses: Overview for Practitioners;" "The Invisible Injuries of War: Impact on Military Families and Children, for Providers," and; "The Impact of Invisible Injuries: Helping Your Family and Children, for Service Members and families," τα παραπάνω εγχειρίδια είναι διαθέσιμα στο διαδίκτυο. Center for the Study of Traumatic Stress (CSTS). (2013).
Working with Military-Connected Youth - Οδηγός εκπαιδευτικού με πηγές για τη βοήθεια των νέων από στρατιωτικές οικογένειες. Beyond the Yellow Ribbon. (Jul. 2013).

13. Υπηρεσίες προσφύγων / μεταναστών

A Social Worker's Tool Kit for Working With Immigrant Families: Healing the Damage: Trauma and Immigrant Families in the Child Welfare System - American Humane Assn. (Sept. 2010).
Transcending Violence: Emerging Models for Trauma Healing in Refugee Communities - SAMHSA's National Center for Trauma-Informed Care (NCTIC). (2008). Warning Signs of Exposure to Violence, Immigrant Families - (Office of Juvenile Justice & Delinquency Prevention).

14. Υπηρεσίες Νέων

**Adolescent Health Working Group (San Francisco, CA) Trauma & Resilience Adolescent Provider Toolkit. (There's also a Toolkit Tour).* Η εργαλειοθήκη περιλαμβάνει περισσότερα από 50 φυλλάδια σχετικά με: Φάσματα τραύματος και ανθεκτικότητας, ανισότητες τραύματος, Ανεπιθύμητες εμπειρίες παιδικής ηλικίας (ACEs), ανάπτυξη εγκεφάλου εφήβων, αναπτυξιακή διαταραχή τραύματος, ενεργοποιήσεις τραυμάτων, μετατραυματική ανάπτυξη, ανθεκτικότητα, αναπτυξιακά στοιχεία, αναπτυξιακές ικανότητες, φροντίδα ενημερωμένη στο τραύμα, συνέπειες βάσει τραυμάτων, πολιτισμικά ευαίσθητες προσεγγίσεις στη φροντίδα, πρακτικές αποκατάστασης, κοινωνική δράση και μια

ολοκληρωμένη λίστα βέλτιστων πρακτικών βάσει τεκμηριωμένων τεκμηρίων και υποσχόμενων προσεγγίσεων

Το περιεχόμενό του - κείμενο, πίνακες, γραφήματα - μπορεί να ενσωματωθεί σε προσπάθειες υπεράσπισης, σε δράσεις ανάπτυξης πολιτικής, σε κλινικές πρακτικές, στην ανάπτυξη και κατάρτιση προσωπικού και σε εκπαιδευτικές διαδικασίες.

Η χρήση αυτού του πακέτου εργαλείων και το Care Path MOOC και το Care Path Project γενικά μπορούν να προωθηθούν σε συναδέλφους, σε οργανισμούς και ιδρύματα που ασχολούνται με αυτά τα ζητήματα εφόσον έχει γίνει αναφορά της προέλευσής τους. Κανένα από τα περιεχόμενα δεν μπορεί να πωληθεί ή να αποτελέσει προϊόν εμπορικής εκμετάλλευσης.

Στη περίπτωση που προωθήσετε αυτόν τον οδηγό ή το Care Path Mooc είναι υποχρεωτικό να αναφέρεται πως αποτελούν μέρος του έργου Care Path Project που χρηματοδοτείται από το πρόγραμμα της Ευρωπαϊκής Ένωσης για τα Δικαιώματα, την Ισότητα και την Ιθαγένεια (2014-2020).

Οι πληροφορίες που περιέχονται σε αυτόν τον οδηγό είναι διαθέσιμες στο διαδίκτυο για όσους ενδιαφέρονται. Τα επιχειρήματα, οι πληροφορίες και οι επιστημονικές θεωρίες που περιέχονται σε όλα τα μέρη και το υλικό του Care Path Toolkit έχουν οργανωθεί με σκοπό να είναι χρήσιμα σε όλους τους ανθρώπους που, με διάφορες ικανότητες και με διαφορετικό επαγγελματικό υπόβαθρο, προσφέρουν βοήθεια και υπηρεσίες σε παιδιά που έχουν βιώσει τραύμα.

Οι επιστημονικές γνώσεις που περιέχονται σε όλα τα υλικά του Care Path Project και ιδίως σε αυτά που περιλαμβάνονται σε αυτό το Toolkit είναι ελεύθερα προσβάσιμα σε πολλές επιστημονικές δημοσιεύσεις σε όλο τον κόσμο. Οι εφαρμογές αυτών των εννοιών και γνώσεων ρυθμίζονται με διαφορετικούς τρόπους στις διάφορες χώρες από τους αντίστοιχους νόμους, κανονισμούς και κώδικες δεοντολογίας των διαφόρων επαγγελματικών συντεχνιών και επαγγελματικών ή εθελοντικών ενώσεων, οι οποίοι συχνά διαφέρουν από χώρα σε χώρα.

Όλα τα περιεχόμενα αυτού του οδηγού προσφέρονται με την ακριβή πρόθεση του σεβασμού όλων των νόμων και κανονισμών που ισχύουν για τα θέματα και κανένα μέρος αυτού του οδηγού ή του Care Path Mooc δεν μπορεί να χρησιμοποιηθεί ή να κατανοηθεί για διαφορετικούς σκοπούς από ό, τι μόλις είχε αναφερθεί. Παραμένει καθήκον και επιτακτική ανάγκη για κάθε επαγγελματία να εργάζεται πάντα μέσα σε επιστημονικά πλαίσια και συνειδητά με τις καλύτερες προοπτικές των πελατών τους και αυτό περιλαμβάνει την πλήρη συμμόρφωση με τους κανονισμούς που ισχύουν στη χώρα τους, τον σεβασμό των ειδικών ικανοτήτων άλλων επαγγελμάτων, την επίγνωση των τα δικά τους όριων που περιγράφουν το επάγγελμά τους, ο επαγγελματικός τους ρόλος και ικανότητά τους, καθώς και την απαιτούμενη συμμόρφωση με τους εσωτερικούς κανόνες του οργανισμού στον οποίο εργάζονται.

TOOL KIT LEAVING CARE

Magyar változat

Előszó

Ez az eszközkészlet az Európai Unió REC-AG-2017 (REC-RCHI-PROF- AG-2017)) az Európai Unió Jogi, Esélyegyenlőségi és Állampolgársági Programja (2014-2020) által finanszírozott Care Path projekt részét képezi („A hatóságok és szakemberek felkészítése a trauma-tudatos gondozás támogatására - CarePath", projekt 785698). Az eszkökészlet anyagainak tartalma szabadon elérhető az interneten. A Care Path online (MOOC) képzés teljes tartalma, csakúgy, mint a szerzők nézetei, kizárólag az ő felelősségük. Az Európai Bizottság nem tehető felelőssé az azokban foglalt információk bármilyen felhasználásáért.

A traumatizált gyermekekkel foglalkozó szakemberek számára készített CarePath eszközkészletet a tanúsított CarePath szakemberek számára fejlesztettük ki, hogy egyablakos, traumára alapozott utókezelési támogatási szolgáltatásokat nyújthassanak a gyermekek számára. Az eszközkészlet segíti a szakembereket abban, hogy többdimenziós és integrált megközelítést kövessenek a traumatizált gyermekek támogatásában, ideértve az életvezetést és a lakhatást, az egészségügyet, a szakképzési tanácsadást, a társadalmi befogadást és a pszichoterápiás szolgáltatásokat. Ezenkívül útmutatást nyújt a szakemberek számára a gyermekek részvételéről az utógondozás tervezésében, valamint más kiegészítő szakemberek bevonásáról, például pszichoterapeuták, szociális munkások, oktatók, politikai döntéshozók, ha szükséges, ügyvédek.

Az ebben az Eszköztárban található információk az interneten elérhetők azok számára, akik érdeklődnek a téma iránt. A Care Path Toolkit minden részében és anyagában szereplő érvek, információ és tudományos elméletek azzal a szándékkal szerveződtek, hogy hasznosak legyenek minden olyan ember számára, akik különböző minőségekben és különböző szakmai háttérrel nyújtanak segítséget és szolgáltatást a traumát elszenvedett gyermekek számára.

A Care Path Project összes anyagában található tudományos ismeret, különös tekintettel az ebben az eszközkészletben található információkra, a világ számos különféle tudományos publikációjában szabadon hozzáférhető. Ezeknek a fogalmaknak és ismereteknek az alkalmazását a különböző országokban különböző módon szabályozzák a különféle szakmai szervezetek és szakmai vagy önkéntes egyesületek rendeletei és etikai kódexei.

Ennek az Eszköztárnak a tartalmát pontosan azzal a szándékkal kínáljuk fel, hogy tiszteletben tartsa a témákkal kapcsolatos összes törvényt és rendeletet, és ennek az Eszköztárnak vagy a Care Path Mooc tanfolyamnak egyetlen része sem használható fel és értelmezhető a fentiektől eltérő célokra. Minden szakember kötelessége és elengedhetetlen feladata, hogy mindig a tudományosság és a lelkiismeretesség területén dolgozzon, ez magában foglalja az országukban hatályos előírások maradéktalan betartását, más szakmák sajátos kompetenciáinak, a korlátok és ismeretek, valamint saját szakmai haráraik, hivatásbeli szerepük, kompetenciájuk, valamint a szervezet belső szabályainak tiszteletben tartását.

Ez az eszközkészlet egy szabványos és tudományosan megalapozott eljárás eredményeként állt össze, amely tartalmazott néhány adatbázis keresést (MEDLINE, Embase és PsycINFO), konzultációt folytatott különböző, az Eszköztár és a CarePath projekt által érintett tudományterületeken és tevékenységekben aktív és kompetens szakemberekkel. Ez magában foglalta azokat a szakembereket, akik szolgáltatásokat kínálnak a trauma gyermekek áldozatai számára, ideértve a magán- vagy az állami szektor szolgáltatásainak vagy struktúrájának munkatársait, akik részt vesznek a jogvédelmében, a gyógyulásban, az egészség és jólét előmozdításában vezetőkként, hivatásos vagy önkéntes szakemberekként. A traumák áldozatainak és családjaiknak hozzáférést biztosító anyagokat, valamint a gondozók hangját, képzési igényeik, valamint a munkahelyi egészségvédelem és promóció releváns

szempontjait is figyelembe vettük, különös tekintettel a stressz megelőzése és kezelése, a kiégés, valamint a másodlagos stressz megelőzése és kezelése területén.
Az eszköztárat úgy állítottuk össze, hogy maximálisan releváns legyen a traumalapú ellátás, a gyermekközpontú megközelítések, a személyközpontú megközelítés, a személyközpontú tervezés, a személyközpontú ellátási-helyreállítási megközelítések, a legjobb gyakorlatok, a közös nevezők, az esettanulmányok illusztrációi, az ágazatok közötti megközelítések és a személyes képzés és továbbképzés, a szervezeti politikák, szervezetfejlesztés és irányítás stb szempontjából.
Arra törekedtünk, hogy elkerüljük az erőforrások mechanikus felsorolását, azzal a szándékkal kíséreltük meg felépíteni az eszköztárat, hogy a rendelkezésre álló erőforrások teljes körét bemutassuk, amely átlátható és megfelel a tudásszociológia tételeinek (Berger & Luckmann, 1966), és figyelembe veszi, hogy minden terápiás vagy segítő megközelítés egy az emberi természetből következik, amely viszont értékeken alapul, és ezek az értékek meghatározzák a segítő kapcsolat természetét és befolyásolják az eredményeket.
Tekintettel arra, hogy az emberi természet bármilyen nézete értékrenden alapul, minden segítő kapcsolat valójában „politikai" cselekedet. Az ügyfélnek új módszert kell találnia a tapasztalatok értelmezéséhez és viselkedésének kialakításához - más szavakkal, a segítő kapcsolat narratívájának internalizálásához. Polányi Mihály (1958) ezzel a kérdéssel foglalkozott az implicit és nem tudatos interperszonális tanulásokkal kapcsolatban, amelyeket folyamatosan végzünk.
A segítő kapcsolatokat ezen okokból a szakember és a beteg vagy az ügyfél közötti hatalmi különbség jellemzi (Proctor, 2002, 2004, 2005, 2006; Sanders & Tudor, 2001; Sommerbeck, 2003; Sanders 2006). Ez a hatalmi különbség nagyobb vagy kisebb a különböző segítő megközelítésekben: akkor nagyobb, ha a terapeuta feladata a szakértőé, akinek diagnosztizálnia, gyógyítania és követelnie kell az együttműködő megfelelést. Traumára alapozott, személyközpontú, gyógyulás-orientált, nemek és kultúrára érzékeny megközelítések esetében, ahol a kapcsolat a segítő ügyfél iránti tiszteletén és bizalmán, valamint a kliens növekedési rugalmasságának és változásának veleszületett lehetőségein alapul, a hatalmi különbséget sokkal kisebbnek szánják. Itt a segítő szerepe nem a diagnózis felállítása és a gyógyítás, hanem az ügyfél veleszületett formatív hajlamának támogatása, egy olyan fenomenológiai álláspont kialakítása, amely tiszteletben tartja és bízik abban, hogy az ügyfél megértette tapasztalatait. „A kliens tudja, mi bánt, milyen irányba kell haladni, milyen problémák döntőek, milyen tapasztalatok mélyen eltemetettek" (Rogers, 1961, 11–12.).
Rogers véleménye a maga idejében forradalmi volt, de sajnos ugyanolyan releváns és szükséges a pszichoterápiához és a segítő gyakorlatokhoz ma is. Az egészségügy és a segítő kapcsolatok jelenlegi kérdései és aggályai nem különböznek annyira azoktól, amelyekkel Rogers és munkatársai az 1940-es és 1950-es években küzdöttek: ma az irányított ellátás, a pszichoterápia „kézivezérlése", a pszichoterápiás kutatás politikája és értékei, szakmai szabályozás és a pszichoterápia, valamint társadalmi kontrollként történő segítségnyújtás a meghatározó az emberi jogok védelme és előmozdítása helyett.
Mi, mint szakmai segítők, ma jelentősen hozzájárulhatunk a párbeszédhez és a szakmai politikához a segítő kapcsolatok terén. Ahhoz, hogy ezt hatékonyan tudjuk megvalósítani, Rogers és a humanisztikus pszichológia többi alapító tagja, például Abraham Maslow, Gordon Allport, Charlotte Butler, Bugental nyomában kell folytatnunk az értékek és a hatalmi kapcsolatok megjelenését a segítő szakmákban. Aktívan részt kell vennünk a társadalmilag tudatos és demokratikus gyakorlatok kifejlesztésére irányuló erőfeszítésekben, és tudományos és politikai szinten is foglalkoznunk kell a gyógyulás, az ellenálló képesség, az emancipáció és a megerősítés témakörével.
Ez az eszközkészlet széles körű kutatásokat, esettanulmányokat, bevált gyakorlati példákat is tartalmaz arra vonatkozóan, hogy a világ különböző részein hogyan védik és támogatják a gyermekek jogait, hogyan lehetnek a gyermekközpontú és traumára alapozott gondozás személyközpontú és traumára alapozott ellátási formái és gyógyulás megközelítései a tervezés és az irányítás központi szempontjai a valóság társadalmi felépítésének minden aspektusában: traumára alapozott jogszabályok, pénzügyi források elosztása, a közösségi szervezetek, iskolák tervezése és irányítása, gyermekintézmények,

gyermekorientált szolgáltatástervezés és szolgáltatáskínálat. Ha tisztában akarunk lenni a bi-pszicho-szociális következményekkel, nemcsak a trauma áldozatait lehet hatékonyan kezelni, hanem meg kell akadályozniuk a traumát, meg kell akadályozniuk a retraumatizációt, meg kell akadályozniuk a személyzet kiégését és a másodlagos traumát. Így tudatosan dolgozhatunk azon, hogy a megoldás és ne a probléma részesei legyünk.
Mire az eszközkészlet elkészült a Covid 19 járvány az egész világot elérte, és traumatikus hatást váltott ki annak összes lakójára, különösen a gyermekekre, a gyermekek traumájának áldozataira, családjukra és az összes gondozóra. Ez a hatalmas traumatizáló hatás is felkerült a témák és források amúgy is gazdag listájára.
Sok információt, forrásokat adtunk az eszköztárhoz a Covid 19 által felvetett kérdések hatékony kezelésének módjáról, amely kapcsolattartási lehetőséget kínál a legfontosabb tudományos intézményekhez, például az Egészségügyi Világszervezethez (WHO).
Ez az eszközkészlet összeállt, és egy szabványos tudományos eljárás eredménye, amely magában foglal néhány adatbank keresést, konzultációt különböző szakemberekkel, akik kompetensek és aktívak az eszköztárban és a Care Path projektben érintett különféle tudományterületeken és tevékenységekben. Ez magában foglalta mindazokat a szakembereket, akik szolgáltatásokat kínálnak a traumában elszenvedő gyermekek számára, beleértve a magán- vagy közszféra szolgáltatásainak vagy struktúrájának igazgatóit, akik részt a jogok védelmében és előmozdításában működnek közre, a gyógyulás a traumák vagy traumák megelőzése által érintett gyermekek egészségének és jólétének védelme és előmozdítása törvényhozói, vezetői szakmai, paraprofesszionális és önkéntes szinten. Ugyancsak szerepelnek olyan anyagok, amelyek hozzáférést kínálnak a traumák áldozatainak és családtagjaik, valamint a gondozók tapasztalataihoz és ajánlásaihoz, képzési szükségleteikhez, valamint a munkahelyi egészségvédelemhez és szakmai fejlődéshez, különös tekintettel a megelőzésre. valamint a stressz, a kiégés, valamint a másodlagos stressz megelőzésére és kezelésére.
Az Eszköztár anyagai, a szerzői jogok megsértése nélkül, szabadon elérhetők az internetes linkeken vagy a YouTube-on és különböző szervezetek szakemberei által publikált anyagok megtekintéséhez. Az esetek többségében az elérhető anyagok a Care Path projekt hivatalos nyelvein találhatók. Angol, olasz, francia, magyar és görög, egyes esetekben más nyelveken állnak rendelkezésre, mivel az Egészségügyi Világszervezet vagy más nemzetközi tudományos intézmények bocsátották rendelkezésre.
Egy másik említésre méltó szempont az a tény, hogy a webes linkek több esetben hozzáférést biztosítanak az ingyenes adatbázisokhoz és az intézmények erőforrásaihoz, nem csak egyes dokumentumokhoz, így az intézményekkel való kapcsolatokhoz az Eszköztár ingyenes hozzáférést kínál a folyamatosan frissülő anyagokhoz, kutatási eredményekhez, bevált gyakorlatokhoz és a jogi környezet várható változásairól szóló információkhoz. Végül, de nem utolsósorban az eszköztár nemcsak a értékes anyagokhoz nyújt hozzáférést, de segítséget nyújt nemzetközi kapcsolatokat kialakítani intézményekkel és kollégákkal a világ minden tájáról.
Az eszközkészlet másik jellemzője, hogy számos, online elérhető ingyen rendelkezésre álló eszközkészletet kutattunk fel jól ismert tudományos intézmények weboldalain, amelyek validált, tudományos anyagok és eszközök egész sorát kínálják, így ahelyett, hogy a kiválasztott anyagokból egyszerű összefoglalót írnánk, ingyenes, közvetlen elérést biztosítunk online forrásokhoz, adatbázisokhoz az érdeklődő szakemberek számára. Az eszközkészlet tudományosan validált és már bevált, jól használható eszközök széles skáláját kínálja több ezer szakember munkájának, számtalan tudományos kutatásnak és bevált jó gyakorlatnak az eredményeként. Számos esetben az ebben az eszközkészletben rendelkezésre álló anyagok a szakterületen elérhető legkorszerűbb információk, amelyek a legkülönbözőbb igényekre adnak gyakorlati válaszokat.