COMPARATIVE REPORT

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Introduction

The experiences that children have whilst growing up put the foundations for their health and wellbeing throughout life. Young children experience their world through their relationships with parents and other caregivers. Promoting safe, stable, nurturing relationships and environments can have a positive impact on a broad range of health problems and on the development of skills that help children reach their full potential. Safety, stability, and nurturing are three critical qualities of relationships and environments that make a difference for children as they grow and develop[1].

So, providing children with the best start in life is a fundamental aspect of European health policy. However, million children in the European Region are estimated to be affected by child maltreatment and will suffer other stressful experiences, such as witnessing domestic violence or living in a household affected by substance misuse or mental illness[2]. Adversities experienced during childhood are often referred to as Adverse Childhood Experiences (ACEs). The term ACEs has been accepted to mean: "intra-familial events or conditions causing chronic stress responses in the child's immediate environment. These include notions of maltreatment and deviation from societal norms"[3]. ACEs may cause high levels of chronic stress (i.e., toxic stress) that rewires the brain's developing architecture (i.e., connections between cognitive, emotional, and social development).

Dr. Anda and Dr. Felitti began the ACEs Study in the late 90s and they found numerous correlations between ACEs and many disorders in adulthood, proving an increased vulnerability of the range subject to adverse experiences. As a result, children who experience ACEs are more likely to engage in risky behaviours in adolescence and have health problems as adults. These problems include alcohol abuse, depression, drug abuse, eating disorders, obesity, sexually transmitted diseases, smoking, suicide, violence towards others, physical inactivity, depression, psychiatric disorders and many chronic diseases.[4] [5]

The following experiences lived within the family context before the age of 18 can be classified as ACEs (Felitti 2013):

- Recurring physical abuse;
- Recurring psychological abuse;

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[1] National Centre for Injury Prevention and Control (CDC) – 2018, Essentials for Childhood Creating Safe, Stable, Nurturing Relationships and Environments for All Children.

[2] Hughes K., Bellis M. A., Sethi D., Andrew R. et al (2019). Adverse childhood experiences, childhood relationships and associated substance use and mental health in young Europeans

[3] Kelly-Irving M, Lepage B, Dedieu D, Bartley M, Blane D, Grosclaude P, et al. Adverse childhood experiences and premature all-cause mortality. European journal of epidemiology. 2013;28(9):721-34. http://link.springer.com/article/10.1007/s10654-013-9832-9

[4] Felitti V, Anda R, Nordenberg D, Williamson D, Spitz A, Edwards V, et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. American Journal of Preventive Medicine; 14(4):245–58.

[5] Hughes K, Bellis MA, Hardcastle KA, Sethi D, Butchart A, Mikton C, et al. (2017). The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. Lancet Public Health; 2: e356-366.

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- Sexual abuse;
- Presence within the family unit of a person addicted to alcohol or drugs;
- Presence within the family of a person charged with a crime;
- A severely depressed family member with overt mental disorders, institutionalized or with suicidal ideation;
- Presence of a mother treated in a violent way;
- Presence of only one parent or no parent;
- Physical neglect;
- Emotional neglect.

One of the merits of this study was certainly that of having underlined the importance of less "visible" traumatic experiences than earthquakes, hurricanes and wars, but no less impacting on the health of society, and unfortunately very widespread.

The exposure to trauma once or twice during childhood generally does not cause long-term physical or psychological damage. But severe and recurring traumatic events activate the child's fight or flight response[6]. The fight or flight response system can become faulty as a result of repeated or prolonged exposure to ACEs resulting in toxic stress which ultimately causes the physical and psychological damages[7]. With repeated or prolonged exposure to traumatic events, the fight or flight system goes from being a constructive function of the body to a destructive function of the body which is essentially health damaging[8].

This comparative report is one of the first steps of the MARTE project that aims to improve quality of support provided by practitioners to minors suffering from Adverse Childhood Experiences (ACEs) through tailored capacity building standardized in new protocols and procedures.

In this context the current report represent the final output of an intense activity of needs assessment to properly define the main aspects related to ACEs and investigate training needs for the professional that will be involved in the next phases of the project in the local area of Sulmona (Italy), Karditsa (GR), Ruse (BG) and Ljubljana (SL).

The report is edited by La Strada and Ares 2.0 with the fundamental contribution of all local partners of the project (The Social Cooperative "Nuovi Orizzonti Sociali", Dinamika Center Association, Women's Center of Karditsa, Zavod Odprta dlan) that collected information about their local context and administered a series of interviews addressed to professionals and children.

In particular, the needs' assessment was run on two levels: the first one addressed the existing literature, official documents, legislations and statistics; the second, more

[6] The fight-or-flight response (also known as the acute stress response), refers to a physiological reaction that occurs when we are in the presence of something that is mentally or physically terrifying. The problem arises when the danger is within a child's home or immediate daily environment, night after night, month after month, year after year-activating their fight or flight response over and over and over again. This is particularly damaging to the brain and cellular development during the child's formative years.

[7] Symonds L. J (2020), Childhood trauma: the cause that needs a cure, tmrjournal, no. 3, vol. 3, July 2020, Life Research.

[8] ibidem.

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important, involved professionals and children in a qualitative data gathering about their perceptions on the ACEs and service system. This was based on participatory research methods and RRA (Rapid Rural Appraisal), using a range of visual methods and semi-structured interviews to enable non- professional researchers to collect data. Each professional category was grouped separately to guarantee higher analytical levels and avoid influences and accusations between different groups.

The main goals of this comparative report are:

- To **highlight deficit in the assessment, treatment and prevention of ACEs** caused by lack of awareness, legislative and local operational procedures especially in light of main provisions of Directive 2012/29/EU, Decision 2001/220/JHA, Child protection Systems, Convention of Istanbul and the European report on preventing child maltreatment (WHO2018)
- To **analyse** the difference among countries and among typology of professionals on their training needs related to ACEs
- To **examine** the information collected by each local partner in order to build a training toolkit able to reach the most urgent and strategic elements in the provision of services to ACEs

In order to realize this comparative report each partner was called to conduct four research activities that were summarized in a national report:

- **Literature Review** on articles and books published in Europe able to produce a theoretical framework the Adverse Childhood Experiences and the legislative approach both in terms of European legislation and in national frameworks of countries involved.
- **Quantitative study** among practitioners to assess their knowledge and support both the analysis and the evaluation and monitoring activities.
- **Qualitative study among practitioners** (Social workers; Doctors and Health Care Professionals; Child educators; Lawyers) organized around semi-structured interviews aimed to assess needs and problems identified by the actors in play. In particular: (a) perceived degree of diffusion of ACEs; (b) perceived definition of the trauma victims' needs; (c) perceived causes and consequences of ACEs (childhood, adolescence and adulthood); (d) presence of specialized structure in the area in which the interviewed work; (e) perceived degree of competences among the practitioners; (f) most relevant and urgent training needs; (g) Lacks of the treatment system.
- **Qualitative among study children** who are victims of trauma residing in family homes and /or communities for minors, based on **interviews and** focus groups at the regional level, to assess their resilience skills, needs and worries with respect to the traumas suffered. Professionals working in family homes and/or communities for minors supported the data collection.

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1. ADVERSE CHILDHOOD EXPERIENCES: AN OVERVIEW

In this chapter, we are going to offer an overview of the literature available on ACEs, starting from a selection of recent articles published in academic journals. We will also focus on resilience in the context of childhood adverse experiences, and will then move onto discussing main studies involving different practitioners (teachers and educators, paediatricians, social workers and family lawyers). As the reader will notice the majority of the publications available present studies and data collected in America, while the data on ACEs in the European Continent is very scarce, and will be presented in the second section of this chapter, together with data about Bulgaria, Slovenia, Greece and Italy. Finally, the qualitative research conducted with children victims of ACEs in the 4 European regions will be discussed.

1.1 General aspects

Public discussion about ACEs has strongly increased both in the scientific realm and in the wider society. The focus of the discussion seems to be on the long-term impact of the exposure to ACEs (on teenagers and adults), and less on the prevalence of ACEs or on different types of ACES and their occurrence trends. Most of the research focuses on aspects related to health, but also on psychopathology, crimes, behaviours, social consequences and romantic relationships later in life (also as death correlation, menopause…), as well as on the economic costs of ACEs for individuals and societies.

Historically, the most important research is the ACEs' study by Felitti et al. (1998), nowadays the main studies are the ones by Finkelhor (2020). In his review of the different types of ACEs, Finkelhor notices how there is currently no formally agreed ACE set, but all the widely used ACE measures include items concerning parental death, absence or incapacitation and children's exposure to violence and maltreatment in the home and the community (Koita et al., 2018). So, if there is a general agreement on the definition of ACEs, it nonetheless appears difficult to agree on how to translate the more abstract definition into specific typologies for professionals to use in their practice. Public health practitioners working on the adoption of ACEs within the criminal justice system are warning about the misuse of ACEs checklists, stemming from an oversimplification of the model, for example using ACE scores or specific single ACEs as the basis for decisions or as intervention thresholds (Bateson et al. 2019).

As per definition, ACEs are considered developmental experiences that are not typical in child development and often overwhelm the normal coping resources of a typical child. They include different forms of violence and threat exposure (physical and sexual abuse, bullying, domestic violence and crime) and various forms of deprivation and loss exposure (parental death, incapacitation, and absence). At the same time, different lists of what could be considered an ACE exist; for instance, according to Public Health Scotland (2020), there are 10 main categories of ACE: physical, emotional, and sexual abuse, physical and emotional neglect, parental abandonment, parental imprisonment,

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mental illness, domestic violence, and substance misuse. Moreover, at times some of the typologies that are included, are considered less "damaging", as in the case of parental divorce that has become less predictive of poor child outcomes, because of a reduced stigma associated with it and because of a more child-sensitive fashion to manage divorces now (Finkelhor, Shattuck, Turner, & Hamby, 2015).

TRENDS IN THE PREVALENCE OF ACES

A comparative study on the generational trends in prevalence of ACEs analysed rates of prevalence in US between 2011 and 2014 (Finkelhor et al., 2015) with a representative sample of 4000 minors suggests that more than one-third of the youth experienced a physical assault in the previous year, one in 10 experienced an assault-related physical injury and one in 20 girls (14 to 17 years old) experienced sexual assault or abuse (5% in the previous year).

Maltreatment occurred to 15.2% of the sample in the previous year. The lifetime rate of child maltreatment for the oldest sub-group (14-17 years) was 38.1%. The rates of physical abuse by a caregiver were 5.0% for the full sample in the previous year and 18.1% for the group 14 to 17 years old in their lifetime. The rates of emotional abuse by a caregiver were 9.3% for the full sample and 23.9% for the group 14 to 17 years old in their lifetime. The rates of neglect were 5.1% in the previous year for the full sample and 18.4% over their lifetime for the group 14 to 17 years old.

More recently (2020) Finkelhor deepened the study about trends in prevalence of ACE types and suggested: a decline in parental illness, sibling death, exposure to domestic violence, childhood poverty, parental divorce, serious childhood illness, physical abuse, sexual abuse, physical and emotional bullying and exposure to community violence versus an increase for parental alcohol and drug abuse.

NEW TRENDS

A new emerging trend is ***bullying***. Findings from the Second National Children's Exposure to Violence Study (Finkelhor, 2020) indicate that a substantial amount of peer perpetrated victimization occurs over the course of one year. It is interesting to observe that even though the focus is not on ACEs within the family, some dynamics seem the same. More specifically, outcomes are worse when: there is a "power imbalance," injury, weapon involvement, Internet involvement and sexual content (Turner et al., 2015) with sexual content having the higher impact on trauma symptomatology.

Gender and age were particularly important characteristics that influenced the prevalence of different forms of peer victimization, with higher rates of physical assault among males and higher rates of verbal, relational, and Internet victimization among girls, types that are more emotional rather than physical in nature. Interestingly, different forms of emotional victimization change in prevalence with age: with verbal aggression most common among elementary school-age children, relational aggression more prevalent in middle school, and Internet victimization greatest in high school. Thus,

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the frequency of emotion-focused peer victimization, in particular, seems to change developmentally.

Lereya and colleagues (2015) contrasted the effects of peer bullying with those of child maltreatment by adults and concluded that being bullied by peers had worse effects than did being maltreated by adults. In their study they found that child maltreatment as a whole category was not associated with adult mental health problems whereas sexual and emotional abuse were associated with mental health problems in adulthood. Other studies about child maltreatment found different results about correlations between maltreatment as a category and mental health (e.g. Kisely et al., 2018; Tailieu et al., 2016; Hughes et al., 2020, Bellis et al., 2019).

A recent ongoing debate revolves around the question 'should we consider **COVID-19** an ACE?' (McManus and Ball, 2020). If on one side the evidence available supports the need to include COVID-19 in the list of ACEs, on the other side evidence stresses the importance of recognising individual differences, risk factors and protective factors even in a pandemic. We know that violence and vulnerability increase for children during periods of school closures associated with health emergencies (Verger, Urbanowicz, Shankland, & McAloney-Kocaman, 2021), and that rates of reported child abuse rise during school closures (Cluveret al., 2020). We also know that a ten days prolonged period of isolation increases the risks of developing post-traumatic stress symptoms (Cluveret al., 2020). However, we cannot assume that the pandemic is a traumatic experience for everyone, as its impact depends on individual resources (resilience), and protective factors (stable attachments, strong relationships with loving extended families and friends and secure accommodation). More in general, it seems advisable to consider the impact of COVID-19 and its consequences on traumatized and at risk children who are already victims of ACEs.

Particularly significant is having been subjected to more than one ACEs (Bellis et al. 2019, Hughes et al. 2020, McGavock, Spratt, 2017), as this increases the chances of trauma and has a more detrimental lifelong impact. McGavock and colleagues (2017) looking at a student population research, suggest that having been victims of domestic violence may be regarded as a proxy indicator for the presence of higher ACE scores than we would expect to find in the general population.

Finkelhor and Tucker (2015) suggest that emphasizing differences in ACEs scores can risk creating rivalries between researchers and child protection lobbies, as funding is always scarce. The psychologists conclude that a turning point could be thinking about ***developmental victimology*** (originally in Finkelhor, 2007), a concept that gathers a broad range of victimizations that children suffer from, into an integrative developmental framework.

Following this idea there has been a growing interest in the concept of **poly-victimization** (e.g. Hamby et al., 2018). Overall, poly-victimization researchers suggest that there is the need to adopt a more holistic child-centred approach without focalizing on differences between contexts, but considering, instead, the total cumulative burden of violence experienced by the minor. A similar approach links to the construct of **poly-**

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strength, and to the importance of considering different qualities as the best possibility to cope with ACEs, also in connection with resilience programmes.

At last but not least, when looking at ACEs **economic considerations** need to be also taken in consideration: a new trend in epidemiology research (Bellis et al., 2019, Hughes et al., 2020) shows that ACEs have a strong economic cost on both individuals and societies in terms of health services, social systems and workforce. Smoking, respiratory disease, cancer, anxiety, depression, drugs and alcohol abuse are significantly correlated with ACEs, and are only examples of the burden of ACEs on public health services. For instance, Bellis and colleagues' (2019) estimated the total annual costs attributable to ACEs were to be $581 billion in Europe and $748 billion in North America. More than 75% of these costs arose in individuals with two or more ACEs (Bellis et al., 2019). Bellis' study suggests that prevention programmes in early childhood should be implemented urgently. Hughes and colleagues (2020) underline the relevance of implementing trauma informed services, strengthening the focus on resilience in order to help individuals to achieve a better quality of life and to reduce the impact of ACEs.

"There is no higher return on investment than that which protects the happiness and wellbeing of future generations" (Flourish Project, 2020).

1.2 Resilience in the context of ACEs

Psychological resilience is defined as the flexibility in responding to challenges and changing situational demands, and as the ability to bounce back from negative emotional experiences, such as those presented by ACEs. Another less frequently invoked aspect of resilience is that it entails the possibility of a post-traumatic growth, that is, the opportunity not only to survive challenges and return to a given baseline state, but to actually thrive and flourish in the face of adversities (Cyrulnik, 2009).

If a more clinical approach to resilience centres mainly on individual factors, a psychosocial approach identifies three main interconnected variables that influence individual resilience: personality, family and support systems. Resilience comprises a continuum of qualities that can be possessed to varying degrees, and that can be built and enhanced by developing and training. The key insight using this approach is that individual resilience is not only about rigid personality traits, but also includes environmental factors, more open to intervention. Therefore, resilience can be fostered. This understanding opens to a range of policy strategies: beyond limiting risk, and helping those who have succumbed to adversities, promotes environments that foster resilience to those adversities.

As mentioned, resilience implies two components: a) the experience of an adverse situation and (b) a positive development in spite of the context of adversity (Garmezy et al., 1984; Masten, 2001). Resilience research usually distinguishes protective and promotive factors: protective factors act as moderators in the effect of harm (i.e., they

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act to lessen the impact of the risk), whereas promotive factors act as assets or resources (Masten & Barnes, 2018).

The concept of developing resilience in children as a moderator of ACE harms is widely advocated (Center on the Developing Child at Harvard University, 2015; Sciaraffa, Zeanah, 2017). A range of interventions aim to enhance resilience, each working at different levels: through supporting parents; strengthening links with other family members, peers and schools; developing team working, decision-making abilities and confidence; and enhancing academic, athletic and other individual strengths. However, little empirical data is available on the extent to which resilience assets can counteract the impact of ACEs in childhood or which assets are most effective (Bellis et al. 2018).

Hughs and colleagues (2018) in an UK based study, found that personal, relationship and community resilience resources such as social and emotional skills, childhood role models, peer support, connections with school, understanding how to access community support, and a sense that your community is fair to you are strongly linked to reduced risks of mental illness across the life course. Therefore, they advocate public sector support for social and emotional skills development, activities that create connectedness to schools, sign-posting children to available help, opportunities for creating friendship networks, and occasions to engage in cultural traditions, as investments in children's lifelong mental health. Moreover, the researchers point out to the importance of **primary prevention** to avoid ACEs in future generations, as if it is true that resilience factors can provide some protection from mental illnesses, they do not entirely counter the risks associated with exposure to multiple ACEs. So, public health should focus on strengthening early years, parenting and family programmes and the legislative frameworks that support them.

A strong focus on environmental factors, is also encouraged by Bellis and colleagues (2018); in their research they found that *childhood community resilience* assets were independently linked to better outcomes for all childhood health and wellbeing status measures. Having a role model, supportive friends, being culturally engaged or given opportunities were all significantly related to lower levels of all common childhood conditions. ACEs can shape health and life conditions, but **community resilience** can help and should be something to invest on (Bellis et a., 2018).

Yule, Houston and Grych (2019) also agree on the importance of *community factors*. Their meta-analysis involving 101,592 participants, suggested that there are four protective factors (self-regulation, family support, school support, and peer support) which demonstrate significant additive and/or buffering effects in longitudinal studies. The authors noticed how the majority of studies focus on individual or familial level and not on social-cultural factors which are also very important.

The screenshot below is taken from Oral et al. (2016) and reinforces the idea that a holistic approach, in which a number of Institutions look after 'their' children, is the road to follow in order to achieve better results. The table shows primary, secondary and tertiary responses to ACEs, and shows how different goals (prevention, harm reduction and treatment) can be achieved at different stages.

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Table 1. Primary, secondary, and tertiary response to adverse childhood events

Phase	Goal	Examples
Primary prevention	Prevent the occurrence of adverse childhood events so that fewer children experience ACEs	• Programs that prevent child abuse and neglect • Programs that increase family and community stability and resilience • Programs that teach positive and effective parenting skills
Secondary prevention	Reduce the severity and acute consequences of the child adverse experience, thereby reducing the incidence of adverse outcomes associated with ACEs	• Programs that identify and intervene on families experiencing violence and abuse • Trauma informed care to identify and immediately intervene on ACEs • Psychological first aid that reduces psychological impact of trauma
Tertiary prevention	Treat and reduce the long-term consequences of ACEs	• Trauma informed care in health care and service agencies that integrate past traumatic experiences into, for example, care for chronic illnesses • Programs that identify and reduce risky health behaviors associated with ACEs • Social marketing campaigns that build empathy with ACE consequences

To conclude, the literature available shows that we know more about *which* factors *predict* resilience than *how* these factors *promote* resilience, so this should be an area for future investigation.

1.3 Practitioners and Best Practices

For the purpose of this project, the literature review also looked at journal articles that investigate ways in which a range of practitioners working with children affected by ACEs or trauma can be supported in their profession. We searched for studies focusing on teachers and child educators, paediatricians, social workers and lawyers, highlighting strategies worth investing for and examples of best practices. Dealing with students' trauma and toxic stress is challenging, therefore it is paramount for teachers and educators to engage in self-care and to be offered support in finding ways to navigate these difficult experiences, so to avoid the experience of secondary trauma.

EDUCATORS/TEACHERS

Early childhood educators and teachers can assist in increasing physical health and mental wellbeing for children who have encountered ACEs.

Various researchers highlight how early childhood educators are in a unique position in the early identification of ACEs and remark their contribute to the development of protective skills (Sciaraffa et al. 2018).

Current research demonstrates that the most important protective factor for children exposed to adversity is the *availability of a safe, nurturing, dependable relationship with an adult caregiver* (Mortensen and Barnett 2016). When early childhood educators are able to establish such relationships, creating predictable, stimulating, and safe environments, and building the child's personal attributes associated with resiliency (such as self-regulation, social competency, and self-efficacy), they support protective factors that can buffer the effects of adversity.

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In terms of skills that can support building resilience and protective factors for all children, educators should be able to show accurate and sensitive attention to developmental needs (social-emotional development in particular), to establish positive teacher-child relationships, and to provide a safe, predictable, and stimulating environment (Sciaraffa et al. 2018).

The authors identify general basic principles of caring for traumatised children that include: ensuring a physically and emotionally safe environment, developing dependable, consistent, safe "go-to" adults, recognition and prevention of factors that exacerbate symptoms, predictable classroom routines and structure, and developmentally appropriate expectations and stimulation. The authors also provide useful *lists of skills* educators should have depending on the age of the children they work with:

- Infants and toddlers: teachers who are warm, dependable, consistent, and nurturing; who enjoy the child, believe in their ability and who engage in developmentally appropriate, positive interactions, facilitate positive, secure relationships with children and contribute to the child's individual protective factors. The ability to form a secure attachment with one or more teachers is recognised as the most important protective factor for young children, especially in the face of trauma.
- Pre-schoolers: teachers can support children in increasing self-regulation, enhancing problem-solving and social competence, and helping children to develop self-efficacy. For instance, teachers can increase self-regulation in pre-schoolers by modelling, prompting, and reinforcing self-calming strategies.

A study by Blodgett and Lanigan conducted in 2018 with a sample of elementary school children in the USA indicates that educators will benefit from literacy and skills in managing the developmental challenges that can result from ACE exposure. The researchers, still recognising the importance of specialised services, also recommend the adoption of *trauma-informed responses* and *resilience building experiences* within natural systems supporting children (and schools particularly). Two main reasons reinforce their view: first, understanding the protective assets and resilience of the individual child and family are critical mediators of whether adversity results in significant barriers to school success; and second, adopting prevention strategies (typically referred to as trauma-sensitive or trauma-informed school practices) aimed at the school level might yield even greater benefits and reach those children whose ACE exposure is undetermined.

The need for incorporating *trauma-informed approaches in schools* had also been supported by Cavanaugh (2016), who stresses how such practices can both meet the needs of traumatised students, and reduce the stress and vicarious traumatisation of teachers who work with these children (Cavanaugh, 2016). Trauma-informed schools aim to build a positive school climate where students feel physically and emotionally safe so they can focus on learning. Findings from Post and colleagues (2020), evaluating the effectiveness of a training programme aimed at supporting teachers (called "child-teacher relationship training", or CTRT) indicate that CTRT can successfully reduce the teachers' stress. The teachers involved in the training reported that it helped them build stronger

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relationships with vulnerable students, described changes in students' behaviours, and noticed the positive impact of stronger relationships on both the students and themselves.

In her report on "Fostering resilient learners by implementing trauma-informed and socially just practice", Walton-Fisette (2020) addresses Health and Physical Education teachers, and identifies four key aspects they can focus on to foster resilient learners in the work they do: 1) create physically and emotionally safe spaces; 2) formulate positive and healthy relationships with students; 3) develop students' responsibility; 4) guide students towards self-regulation.

HEALTH PROFESSIONALS

Paediatricians

When it comes to health professionals working with children, paediatricians are ideally situated to address both primary and secondary prevention of trauma as well as to identify treatable trauma sequelae and build resilience (Traub and Boynton-Jarrett, 2017).

In order for paediatricians to be successful, significant change at the individual paediatric practice level, as well as in the broader health care policy environment, is required.

Traub and Boynton-Jarrett (2017) offer recommendations for preventive paediatric care aimed at promoting resilience in paediatric patients.

The literature has ample evidence for 5 modifiable resilience factors: a positive appraisal style and good executive function, nurturing parenting, maternal mental health, good self-care skills and consistent household routines, and an understanding of trauma. Moreover, the authors make 10 recommendations for paediatric practitioners (listed below):

1. Train all paediatric clinical staff in the principles of trauma- informed care.
2. Screen paediatric patients for ACEs, resilience, maternal psychopathology and ACEs, family functional capacity, and family violence.
3. Employ non-physicians to conduct psychosocial screening and offer education to families.
4. Create a medical home for children with ACEs, emphasizing strong relationships with families, regular care providers, and individualized care.
5. Integrate behavioural health care into the paediatric office.
6. Offer group-based parenting education and support.
7. Offer peer-based group education and anticipatory guidance to children and families with multiple ACEs about trauma and self-care

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8. Customize paediatric health care to the needs of the family, considering the broad-reaching effects of trauma on physical and mental health as well as social and academic outcomes.
9. Familiarize paediatric staff with resources in the community and make individualized referrals for children and their families.
10. Be cognizant of barriers to engagement facing families of children with ACEs.

Oral and colleagues (2016) also give directions for the future of childhood health care and describe six broad principles for *trauma-informed care* (TIC) advocated by the Substance Abuse and Mental Health Services Administration (SAMHSA) that can increase children's wellbeing:

1. Safety. Ensure that all members and clients of an organisation are physically and emotionally safe.
2. Trustworthiness and transparency in the decision taken by the organisations.
3. Peer support.
4. Collaboration and mutuality.
5. Empowerment, voice, and choice.
6. Culturally sensitive and free of prejudices based on gender biases and stereotypes.

In their 2019 report, Foy, Green and Earls, as members of the American Academy of Paediatrics, update the competencies pertinent to paediatric practice, recognising that the competencies need to take in consideration the impact of ACEs and social determinants on mental health, trauma-informed practice, and team-based care. In the report are included tables that specify how paediatricians can adapt the approach they use in their practice to incorporate Mental Health Treatment for Primary Care, to build a therapeutic alliance (following the HELP model: Hope, Empathy, Language, Loyalty, Permission, Partnership, Plan), and a detailed update of clinical skills that include capacity to incorporate mental health content and tools into health promotion and primary and secondary preventive care, skills in the psychosocial assessment and care of children with mental health conditions, knowledge and skills of evidence-based psychosocial therapy and psychopharmacologic therapy, skills to function as a team member and co-manager with mental health specialists, and commitment to embrace mental health practice as integral to paediatric care.

On a policy level, authors Lopez, Wong and Raphael (2020), advocate for a *whole child approach*, and that, in a systemic and systematic way, offers screening for ACEs combined with evidence-based interventions, to meet the needs of children in their medical homes, schools, communities and within their families. Only with this approach it would be possible to reduce and even prevent adverse experiences in childhood and potentially break the cycle of adversity.

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SOCIAL WORKERS

Similarly to what we found for teachers and paediatricians, also the practice of social work is moving towards a more systemic and trauma-informed approach.

Larkin, Felitti and Anda (2014) suggest social workers to adopt a biopsychosocial perspective (with an emphasis on the interrelation of mind–body coping processes), as there is now enough evidence demonstrating that social work responses to ACEs can contribute to improvement in overall health. According to the researchers, social workers should focus their intervention on one family generation to enhance the protective resources for the next generation, which might *prevent intergenerational ACE transmission*. To achieve this, access to integrated, multidisciplinary family support is paramount. Social workers should also connect policymakers, program directors, professionals, and community members to promote community partnerships for positive parenting, enhance family support, and increase access to effective treatments. Simultaneously, they could use media to increase societal impact.

Levenson (2017, 2020) is another strong advocate for the implementation of *trauma-informed social work practice*. Looking into general principles of trauma-informed care (TIC) Levenson highlights how some should be already part of social workers' approach, for instance the understanding of the frequency and effects of early adversity on psychosocial functioning across the life span. Other trauma-informed principles social workers rely on their knowledge about trauma to respond to clients in ways that convey respect and compassion, honour self-determination, and enable the rebuilding of healthy interpersonal skills and coping strategies.

By viewing clients' needs through the trauma lens, social workers can avoid replicating dismissive or disempowering dynamics in the helping relationship.

More specifically, social workers can engage in TIC by treating everyone with kindness and respect, and listening with curiosity and compassion, and then adhere to the set of TIC following basic principles:

- create safety (relationship, space)
- trustworthiness (conceptualize through the trauma lens, remember that help seeking itself can be traumagenic in itself)
- choice (avoid confrontational approaches, coach de-escalation, self-regulation and relational skills)
- collaboration (ask, don't tell, reframe resistance)
- empowerment (use person-first language, neutralize power struggles and model shared power

According to Levenson TIC should be embedded in all social work settings, from a public or non-profit agency to a private practice. Social workers in clinical, case management, or advocacy roles can all benefit from incorporating TIC principles into their understanding of, and interactions with, clients by conceptualising problematic behaviour as a by-product of posttraumatic stress.

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LAWYERS

The literature available on lawyers or attorneys assisting families and minors is very scarce. We are presenting here main points taken from Jeske and Klas article published in 2016. Again, the recommendations are specifically looking at the American system (Minnesota experience), but we argue these could be effectively translated into the European setting (and into specific regional settings).

The authors state that *family law professionals* have a responsibility to incorporate this critically important ACEs knowledge in what they do, as whenever a family interacts with the court system (whether family court, child protection, juvenile delinquency, domestic violence) the system should endeavour to mitigate the harm already done and do no further harm. This might best be accomplished by ensuring that lawyers, judicial officers, court staff and other stakeholders with whom the family comes in contact understands the effects of ACEs. *So trauma-informed care training* should be required to work more effectively with parties who suffer from the negative impact of ACEs, as well as the availability of meaningful information on the past, present, and future parenting behaviour of those who have influenced the child's environment. Moreover, clients may be more apt to exchange relevant information with lawyers who demonstrate an understanding of the trauma that ACEs may have caused.

2.EUROPEAN FRAMEWORK

After having presented a general overview of the phenomenon of ACEs, mainly based on American data, we now move onto a brief consideration of the scarce European data available, followed by a comparison of the current situation in the four European Countries involved in the MARTE project, Italy, Slovenia, Greece and Bulgaria.

As we could imagine, it's particularly difficult to find comparative data on ACE's phenomenon in Europe. Organizations, including the CDC (Centers for Disease Control and Prevention) and WHO, have strongly promoted research into ACEs internationally and have developed standard ACE tools to support measurement of their prevalence and impact on population health. ACE studies have been conducted in many countries around the world, including several in Eastern Europe in collaborations involving health ministries and WHO. Nevertheless the sources and methodologies to study and understand the ACE are very uneven in the rest of Europe: we have many qualitative studies and various surveys conducted in different years in the European countries, but there is no production - for now - of official statistics on this topic.

However, the available data, even if limited, allow us to describe the main characteristics of this phenomenon in Europe.

In the WHO European Region there are about 190 million children age under 18. The WHO in its last publication "Violence, health and sustainable development" (2020) shows

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a prevalence rate of 9.6% for sexual abuse (13.4% in girls and 5.7% in boys), 22.9% for physical and 29.1% for mental, with no real gender differences. Few studies have been done on neglect, but analyses of worldwide research shows that prevalence is also high – 16.3% for physical neglect and 18.4% for emotional. Applying these figures to the population of children in Europe suggests that:

- 18 MILLION children suffer from sexual abuse
- 44 MILLION children suffer from physical abuse
- 55 MILLION children suffer from emotional abuse
- 90% of all abuse goes undetected.[9]

2.1 The ACEs in the local/national context

From the comparison of the current state of the art in Italy, Slovenia, Greece and Bulgaria, we note how the fact that the categorisation of ACEs has changed and broaden over the years, makes it difficult to create a common framework, not simply in terms of policies, but also in terms of how to practically adopt such framework.

It is interesting to highlight how each countries focuses on different types of ACEs and on their consequences, and it would be wise to investigate further if this has to do with different rates of prevalence in different countries or else.

Data from Bulgaria, Greece and Slovenia report an increase of ACEs and a serious lack in country policies and legislation; in Bulgaria worrying cultural changes are at place (political parties and Orthodox Church are acting as "traditional" forces in favour of "traditional" corporal punishments). The situation is slightly different in Italy, where country policies appear better organised.

With their unique specificities, Bulgaria, Slovenia, Greece and Italy all face similar challenges: the lack of systematically collected data specifically on ACEs types and their prevalence; the lack of a structure that connects the various stakeholders supporting children in the country (and in the regions of the country); the lack of a specific focus on early years detection and intervention, and more in general on primary prevention of ACEs; the impact of COVID-19 on children already experiencing ACEs, and the need to address possible related trauma.

ITALY

"In the course of pandemic and economic crises, the concerns of the present risk distracting us from the future represented by our children who must be loved, cared for and kept safe. Child abuse, largely submerged and increasingly overshadowed by other emergencies, remains a particularly serious and pervasive problem in our society: every

[9] Unfortunately the European report on preventing child maltreatment (WHO) have data on 2013, but the analyses of community surveys from Europe and around the world have confirmed the extent of abuse.

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year almost 100,000 children, 9.5 minors per 1000 residents are followed by the social services of the municipalities while for each case known by the social services there are at least 9 others submerged that will never be intercepted or treated". These are the data reported by the *Regional Index on Child Abuse in Ita*ly, 2020 edition, entitled *Restituire il Futuro* (Give Back the Future), conducted and published by CESVI.

Each year, the regional index on child abuse in Italy assesses how the socio-economic context and the services present in the various regions can affect, positively or negatively, the well-being of children or, vice versa, their vulnerability to abuse phenomena. The comparison between the context index and that relating to policies and services shows the ability and sensitivity of local administrations to prevent and combat this problem through policies and services, offering policy indications that are essential to highlight the strengths and weakness of the various territories.

The territorial services and policies for the prevention and treatment of child abuse in the family are in this study analyzed and indexed according to a correspondence both with the capacities and with the possible risk factors identified for adults and minors. But the lack of specific indicators with respect to the age groups, recipients and targets of families potentially most vulnerable to abuse only returns a general context data, useful however for highlighting the different political and administrative cultures of the territories. Most of the indicators refer to the activities of the social services of the Municipalities, administrations most responsible for the prevention and treatment of abuse: almost all the indicators relating to services come from the Istat survey on interventions and social services of individual or associated municipalities updated in 2016. The index proposes a decreasing ranking among regions starting from those that present both lower risks of family abuse for children and a system of territorial policies and services adequate to face and prevent the problem. The regional index of prevention and treatment that returns the synthesis between risk factors and services, sees twelve regions above the national average (there were thirteen in 2019), among which we find all eight regions of Northern Italy, three of the Central Italy (Tuscany, Umbria and Marche) and one in the South (Sardinia). At the bottom of the ranking Abruzzo (15th place) and Sicily gain one position, while Basilicata and Calabria drop by one.

In 2015 the *National Survey on the Mal-Treatment of Children and Adolescents in Italy* was published[10]: first national qualitative-quantitative survey on child maltreatment, which provided a framework on the data of the phenomenon in Italy collected through the cases of load to the Social Services. From this survey it emerges that:

- the collection of data and the monitoring of the phenomenon of child maltreatment are an indispensable tool for the knowledge of the phenomenon, the adoption of effective policies of contrast and prevention, the measurement of the results of these policies;

[10] It was carried out by the Guarantor Authority for Childhood and Adolescence, the Terre des Hommes Association (international organization for the protection of children) and the CISMAI (Italian network of public and private centers and services against maltreatment and abuse to children), with contributions from ANCI and ISTAT

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- the lack of long-term systematic investment in the prevention of maltreatment produces greater social and health costs for the State in the short and medium term. Investing more and in a better way in the prevention of violence against children would therefore mean producing a decisive structural change in spending policy with evident economic benefits for the state budget, in addition to the creation of a more effective protection of children's rights;
- an efficient monitoring system on violence against children, which monitors the data in a timely and periodic manner, is not yet active.

The survey carried out provided a partial answer (231 Municipalities, 2.4 million as an effective basin of the minor population resident in Italy covered by the survey) but an important one, photographing the reality of the country (data are referred to 2013). In Italy 47.7 minors out of 100 are followed by the Social Services; the children and young people who are in a state of need and for whom an intervention by the Social Services has been activated are therefore equal to 457,453 (63.1% north, 44.5% center, south 30.5%), 45.3% are girls, 50.2% are boys. In Italy, out of 100 minors taken into care by social services, 19.5% are abused, 9.5 of the total child population. The reasons for taking charge and the type of maltreatment are distributed as follows: material and/ or emotional neglect (47.1%), witnessed violence (19.4%), psychological abuse (13.7%), pathology of treatment (discuria/hypercure) (8.4%), physical abuse (6.9%), sexual abuse (4.2%), prevailing form of violence not defined (1.2%). The main types of protection, care and protection measures implemented by the Social Services in favor of minors taken into care for mistreatment were also analyzed: 27.9% receive financial assistance to the family unit; 19.3% of abused children are removed from their family of origin and hospitalized in the Community; 17.9% continue to be followed in the family of origin with home educational assistance interventions; 14.4% is protected through family fostering; 10.2% is supported in a semi-residential day center; 38.4% are assisted with other types of intervention (eg. direct support from the professional Social Service); 7.6% do not receive any type of intervention. On average, every abused minor receives at least two types of protection and guardianship service. This data highlights the ability of the Social Services to respond in a complex way to a specific and individual need. The distribution of minors assisted by Social Services is not uniform, as it decreases in the Center (44.5 per thousand minors compared to 63.1 in the North) and in the South (30.5 per thousand resident minors). If, on the one hand, this phenomenon can be linked to a more efficient functioning and capacity of interception of services, on the other it amazes and worries, given the more widespread level of socio-economic discomfort that is recorded in Southern Italy. Similar results emerged in the specific analysis of those taken in charge for maltreatment: 9.5 children per thousand out of the total child population, with significant geographical differences: 9.8 in the North, 11.6 in the Center and 8.4 in the South. Finally, maltreatment is more widespread in metropolitan areas. These data therefore oblige a serious reflection on the effective guarantee for all minors residing in Italy to enjoy equal rights to protection and care from maltreatment.

If these differences between Northern, Central and Southern Italy were due to the lesser ability to intercept juvenile distress or to a greater undeclared amount of data due to

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socio-cultural reasons, it would be necessary to implement adequate strategies for the emergence of the phenomenon, so as to be able to protect and take care of all minors. There is also an evident increase in the ability to intercept maltreatment with the increasing age of the children assisted. This denotes a strong response from the ex post Social Service, but also a lack of preventive intervention and early taking in charge. It follows that precisely in the most delicate age group, that of the first years of life, children are less protected.

The 11th update report on the monitoring of the convention on the rights of the child and adolescence in italy was published in 2020. In chapter 4 - *Violence Against People of Younger Age* - he states that "violence against children and young people, in its various forms, appears to be a reality that is still too underestimated and minimized in our country, in particular in the cognitive dimension of the entity of the phenomenon and in the awareness of the consequences that derive from it for subjects in developmental age. Twenty years after the first Supplementary Report drawn up by the CRC Group, alongside the undeniable steps forward in the direction of a greater protection of children's rights, there are still some critical issues that have not yet been solved". And what struggles to take off is precisely an exhaustive and periodic analysis in order to structure homogeneous and coordinated contrast strategies.

SLOVENIA

In Slovenia, there are very few empirical researches that would address the exposure of children and adolescents to domestic violence, which was also pointed out in Resolution on the National Program for the Prevention of Domestic Violence 2009-2014[9]. One of the studies is 'Mladina 98'[10], in which 20.8% of young people report experiencing physical violence (beatings) by their parents. However, as violence also means indirect exposure, it is important to note that in the same survey, 16.8% of young people answered that violence in their families is a very big problem.

A 2012 survey Exposure to psychological violence in the family and the willingness to act among students of Slovenian secondary schools[11] shows that 40% of high school students were exposed to at least low, if not high, levels of domestic violence. Only 3% of these cases were also reported to the relevant institution, but (due to relatively poor information) students first turned to friends or relatives. Compared to pre-school and primary school children, high school students are no less exposed to domestic violence, but they report it less often because they find it difficult to recognize psychological violence or feel guilt and fear that they would not be believed or that those responsible would not be interested.

The only study of adverse childhood experiences and their prevalence conducted in Slovenia was carried out in 2019 by Faculty of Social Sciences of the University of Ljubljana and the National Institute of Public Health. The main purpose of the research was to examine the prevalence of ACE and connection of ACE to functioning in adulthood in Slovenian sample. The study measured 10 categories of ACE: psychological, physical, sexual violence (or abuse), mental and physical neglect, violence between adult

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members of the household, addiction or mental illness or disorder, criminal act, parental divorce or termination of contact between the child and the parents due to the death of the parent, abandonment. The survey found that the majority (76%) of respondents had at least one stressful experience out of ten in childhood, with as many as 27% of survey participants reporting four or more stressful experiences. Most participants reported emotional (56%) and physical violence (43%) of adult household members (at least one member) against them, slightly less than a third reported the death of a biological parent, parental separation, parental abandonment, and about a quarter reported emotional and physical neglect, a good fifth report addiction by at least one adult member of the household. A good eighth report violence among adults in the household, and just under a fifth report a mental disorder in a household member. The lowest percentages are of reported sexual abuse and criminal activity by a household member.

Adverse childhood experiences is a relatively new concept in Slovenia, but the country has already in place some structures and organisations for child protection, prevention and trauma recovery; these already existing structures would certainly benefit from a training on ACEs and on trauma-informed care.

GREECE

In Greece there is not a sufficient number of surveys for children victims of ACE. Researchers will draw indirect conclusions mainly based on data on domestic violence, statistics on child abuse-neglect published by NGOs, Helplines or Public Services and excerpts from doctoral dissertations and conference presentations. Dimitra Pitta and Konstantinos Stavrou in their presentation entitled "Depression of children and adolescents as a result of abuse and neglect by the parental environment"[11] based on international literature, they typically report: "Child and adolescent abuse and neglect have been closely associated with an increased risk of developing depression in both childhood and adolescence and adulthood. (Petersen et al, 2013). Here, the fact added is that sexually abused children are even more likely to develop the disease. (Swanston et al, 1997). It follows that child abuse and neglect can lead to a 3-fold increased risk of major depressive disorder in adolescence (Brown et al, 1999). Finally, it is worth noting that children and adolescents who have experienced abuse and neglect from their environment are more likely to develop depression in later adulthood (Heneghan et al, 2013)". Eleni P. Serafetinidou,[12] in her doctoral dissertation, studies prognostic factors that can cause depression in late adulthood in citizens of European countries. Among the factors she explores the importance of childhood conditions, including health, adverse experiences and socioeconomic factors. In her analysis she uses recent and

[11]Pitta, D. Stavrou K. (2016). Depression of children & adolescents as a result of abuse & neglect by the parent environment. 5th Panhellenic Conference on Education Sciences, 2015, conference proceedings at https://eproceedings.epublishing.ekt.gr/index.php/edusc/article/view/365

[12] Eleni P. Serafetinidou, PhD Thesis «Assessment of the factors that determine the levels and patterns of morbidity in vulnerable populations in Greece and other European countries with emphasis on mental health», Department of Statistics and Insurance Science, University of Piraeus, 2020. Details here:http://dione.lib.unipi.gr/xmlui/bitstream/handle/unipi/12745/Serafetinidou_syd1401.pdf?sequence=1&isAllowed=y

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retrospective data from the European Health, Aging and Retirement Survey (SHARE). In Greece, 16,8% of people suffers from depression. Regarding the unfavorable experiences of people in childhood, only 8,4% of them stated that their parents drank a lot, while regarding the profession of their parents, only 7,5% of them claimed that their parents were engaged in manual occupations. Finally, she points out that: "The importance of childhood events in all aspects of mental health as it develops in late adulthood highlights the need for policy interventions between social welfare systems that should focus on vulnerable groups, such as socio-economically disadvantaged children".[13]

In 2003, the Center for Equality Research conducted a survey on domestic violence against women and a majority of 28.4% of women surveyed stated: "that the children of the family were often or sometimes present in the violent outbursts of the husband/partner"[14]. The Institute of Child Health emphasizes that there are not national statistics on the adverse experiences of the child such as abuse or neglect in a dysfunctional family or not, because in Greece there is no official and systematic collection of data, as it is not mandatory to report and record cases of child abuse and neglect[15]. As already mentioned, researchers will find statistical references in the annual data published by NGOs, Helplines or Public Services. The sub-categorization is absent from the statistical data, e.g. under the umbrella of children at risk, problems of physical, sexual, psychological abuse, behavioral problems, etc. are incorporated. The Institute of Child Health refers to the identification of specific high-risk characteristics for abuse-neglect, which distinguish the Greek population. There are virtually no reliable primary data for estimating the extent of the phenomenon in our country.

According to the annual report for the year 2019 of the Greek Ombudsman[16] (the report for the year 2020 has not been made public yet): "The 2019, was characterized as a whole by the increase of reports in relation to violations of the rights of the child, but also by the increase in the requests for intervention of the children themselves". The same image is captured by The Smile of the Child, an NGO that operates the national line SOS 1056 for children and adults[17].

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[13] Same as above

[14]Equality Research Center, (KETHI). (2003): Domestic violence *against women*, First nationwide epidemiological research. KETHI Publications, Athens, Scientific Officers: V. Artinopoulou, Iak. Farsedakis

[15] Impact Study of KAPA-P based on recorded cases Results report, BECAN program, Institute of Child Health, Athens, 2013

[16] Available online here: https://online.fliphtml5.com/hmpf/wbfk/#p=8

[17] Detailed SOS 1056 line call statistics here: https://www.hamogelo.gr/gr/el/paidia-thimata-vias:sos-1056/

Comparing call statistics in the field Children at Risk, in 2020[17], 13,780 calls were made, a percentage of 38.2% of the total number of calls, while in 2019, 12,203 calls were made, a percentage of 34.1% of the total number of calls. The number of calls for hosting requests for children was 3.609 in 2020 percentage 10%, a little lower than in 2019 which was 3.947 percentages 11%. For the period 1-1-2020 until 31-12-2020, a total of 1,123 complaints of serious abuse were recorded, 92.5% were anonymous. The calls concerned a total of 2.009 children, of whom 46,3% were boys, 39,7% girls and for 14% the gender or age was not known, with the majority group in the age category 0-6, 39%. The complaints concerned psychological, emotional abuse was 5%, 40% of them concerned physical abuse, while the largest percentage 51% related to Child Neglect/Abandonment. For the period 1-1-2019 until 31-12-2019, a total

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The Greek Ombudsman – Assistant Ombudsman for the Rights of the Child has repeatedly proposed, by providing detailed recommendations, the established reinforcement and delimitation of the role of the recognition system, through the introduction of the "Protocol of Investigation, Diagnosis and Management of the abuse and neglect"[18] of the Child Health Institute, in all services that come into contact with children, as well as the mandatory training of police, prosecutors - judges, teachers and social workers in social services in relation to the methodology and approach that should be followed in cases of abuse, as appropriate. It has also suggested strengthening services that are crucial to preventing abuse and retroactive intervention, which is a valuable tool to prevent further victimization of the child within the also closed walls of an institution.

According to Ms Theoni Koufonikolakou, Assistant Ombudsman for the Rights of the Child, "Children's abuse undermines social cohesion in total. Therefore, the preparation of a National Action Plan for the Children's Rights, is an opportunity to be also designed a delineated and well -structured management system of the problem, including measurable indicators and realistic goals - which does not currently exist - in order to link services and interdisciplinary groups, based on common protocols, in order to protect children from the violence itself and the traumatic interventions of our currently unarmed system"[19] and ending "Without bold decisions and interventions for the overall reform of the child protection system, the goal of combating domestic violence, protecting children and respecting their rights will seem remote".

BULGARIA

The issue of child protection and of raising children is a quite a sensitive topic for the Bulgarian society. From one side the majority of people are considering raising a child and domestic violence in general as a family issue. On the other side there is really a low level of respect for the institutions. For the first time since the original issue of *Report Card: What Is the Average Government Score for Childcare* (annual monitoring done by National Network for Children) back in 2011, the year 2019 not only failed to register

of 825 complaints of serious incidents of abuse were recorded, 99% of which were anonymous. The calls concerned a total of 1.622 children, of whom 50,5% were boys, 42% girls and for 7,5% the gender or age was not known, with the majority group being in the age category 0-6, 40%. Complaints concerning psychological and emotional abuse were 4,5%, while the largest percentage of 48% concerned the Child Neglect/Abandonment. The same NGO, The Smile of the Child, also operates the 116111 European Child Support Line. According to statistics17for the year 2020, 4.798 people addressed the line, without giving additional information. Of these, 22,66% asked for counseling support for family relationships, 19,47% for Behavioral Problems and 1,96% for Problems of Physical-Psychological Abuse of Minors, without any further clarification. For the year 2019, 5.048 people addressed the line, without giving additional information. Of these, 18,5% asked for counseling support for family relationships, 20,3% for Behavioral Problems and 2,2% for Problems of Physical-Psychological Abuse of Minors, without further clarification. It is not easy to draw safe conclusions from the call statistics of the two lines, for the recording of children witnessing violence.

[18] http://www.ichhsw.gr/sites/default/files/%CE%A0%CF%81%CF%89%CF%84%CF%8C%CE%BA%CE%BF%CE%BB%CE%BB%CE%BF%20%CE%94%CE%B9%CE%B1%CF%87%CE%B5%CE%AF%CF%81%CE%B9%CF%83%CE%B7%CF%82%20%CE%9A%CE%B1%CE%A0%CE%B1-%CE%A0_0.pdf

[19] As above

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any progress in the implementation of child and family policies in the country, but also reported a significant decline in the government's policy for the child, which was particularly evident in a number of sectors. On 2020, the National Network for Children together with 70 civil society organizations in Bulgaria sent an alarm signal to 13 European and international institutions regarding the attack on children's rights in the proposals of IMRO (Internal Macedonian Revolutionary Organization – party, part of the government) for amendments to the Child Protection Act. The violation of children's rights and the opposition of some parents against other parents violate a number of international acts, as well as Bulgarian law. There are already a number of negative opinions on the proposed bill from the Ombudsman of the Republic of Bulgaria, the Supreme Court of Cassation, the Ministry of Justice, UNICEF, the Supreme Bar Council, the State Agency for Child Protection and others[20].

ACEs are directly connected with the situation with violence against children (VAC) and VAC continues to be a serious problem in Bulgaria. At the time of this evaluation, there were no reliable national population-based prevalence studies on VAC in Bulgaria. Despite the lack of VAC prevalence studies, a 2012 study of the National Centre for Public Opinion Research found that 68 % of adults surveyed reported using 'minimal force' corporal punishment methods for educational purposes, and 83% of adults were against methods of corporal punishment that degrade children's dignity. In addition, a 2013 study found that 39% of parents would use corporal punishment in rearing their child, and 72% of parents approved of corporal punishment in cases where the child exposes his/her life to threat. Furthermore, a 2014 Health Behavior among School-aged Children Survey found that at least 20 % of students were punished with a slap on the face, nearly 17% were punished with a slap on the body, 15 % were punished by standing upright by the wall, and 11% were punished by pinching of the hands, legs and/or body. In addition, 9% of students were punished by kicks and hair pulling, 8 % were beaten by more than one hit, 7% were deprived of food or had been beaten to bruises or scrapes, and 6% were punished by being locked in the dark.

More recently, a survey published in 2021, conducted for UNICEF by the international research company Coram International, (data collection by the ESTAT agency).

The first comprehensive study of its kind in Bulgaria, as it includes data collection on all forms of violence against children in different types of environment, as well as a thorough

[20] "*The lack of a National Strategy for the Child is contrary to the Child Protection Act and hinders the implementation of state policies in the field of children's health, education, justice and child protection. This year we will have a Strategy for the child at European level, but such is lacking in Bulgaria, which puts our children at a disadvantage compared to children throughout the European Union",* said Georgi Bogdanov – Executive Director of the National Network for Children. The European Commission praised the contribution of civil society to the protection of children's rights. The Vice-President of the European Commission for Democracy and Demography Dubravka Suica sent a letter on behalf of the European Commission. "*While the European Commission, as a matter of policy, does not comment on draft laws, I would like to emphasize that EU action on the rights of the child is guided by the EU Charter of Fundamental Rights, which is applicable to EU institutions, and to Member States in the implementation of EU law. All EU policies that have an impact on children should be designed in line with the best interests of the child. EU action in this area is also guided by international human rights standards, such as the UN Convention on the Rights of the Child that all EU Member States have ratified*", wrote in response Mrs. Dubravka Suica.

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assessment of the capacity of the relevant services to prevent and counteract this phenomenon.

It was conducted in the period 2019-2020 and includes a nationally representative sample of households, covering 1,174 children aged 13-17 years, 837 young people aged 18-25 years and 1,411 adults, as well as a survey among 887 specialists - teachers, social workers, prosecutors and magistrates, health professionals and police officers.

The data gathered show how violence against children is widespread in Romania, and how it is also happening (and at times 'justified' in Institutions where children should be safe (as in school).

- Every second child (47%) has experienced some form of violence by the age of 18.
- Emotional violence is the most common type (45.9%), followed by physical (31.2%), sexual violence (15.6%) and neglect (10.5%).
- Violence is most common among children at school (38.3%), followed by community (37.6%) and home (30.9%).
- Every third child (34.8%) states that they feel in danger at home, at school or in the community.

Children and young people who have experienced violence or neglect, and those who feel in danger, have a much lower level of well-being than other children.

In terms of attitude, a lack of awareness has been registered, especially within families, teachers and health professionals, showing a real need for training and for a coordination between different Institutions.

These data are in line with the National Network for Children that in 2018 found that 50% of parents used corporal punishment at least once and 25 % systematically use corporal punishment. This study also found that 71 % of children who experienced corporal punishment stated they felt fear and sadness. Among families of school-age children, 41 % of children reported experiencing verbal violence, 22% experienced corporal punishment, and 14 % experienced emotional violence (such as being ignored and/or isolated). It was also found that only 58 % of adults maintained they would report incidents of child violence to 112; this is down from 80 % in 2013. In addition, only 30 % of all parents sought information about problems with children. These studies demonstrate that corporal punishment is widely used in Bulgaria, particularly in the home and family setting, and is widely accepted as a means to discipline and control children. In fact, a recent study revealed 68 % of parents/caregivers accept the use of 'reasonable violence' as a means of discipline. Given the social norms supportive of corporal punishment, there is reluctance among state authorities to interfere in private family matters, and VAC is generally perceived as a private family matter; as a result, most incidents of VAC go unreported and undocumented. So, despite a lack of data, data that exists reveals VAC is a major problem in Bulgaria, and that there is tolerance for the use of corporal punishment on children in society. In addition, professionals have limited knowledge and ability to recognize the signs and symptoms of VAC; thus, registered incidents of VAC are mostly severe forms of VAC. As a result, most incidents of VAC go

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unreported and undocumented in Bulgaria; resulting in very low prosecution and conviction rates for perpetrators of VAC.

In the last decade, lawmakers amended national legislation to broadly align with international standards and the main principles and provisions of the CRC. One of the main areas of reform has been to close down state-run residential institutions for children and to deinstitutionalize children and reintegrate them back to their families. The transition away from the state model of residential institutions for children has led to the development of a foster care system and family type homes to support community integration of children without parental care. In 2019, the Analysis of the Child Protection System in Bulgaria found that despite increasing formal alignment with international standards in legislation and policy, the fragmented nature of Bulgaria's child protection system has resulted in a lack of clarity as to the multi-sectoral nature of the child protection system and its main components, functions and approaches. This has contributed to a lack of clarity among public authorities as to responsibilities for coordination of policies and child protection, and provision of care and services to children and their families. The Government has struggled in some areas to translate legal provisions into practice. For instance, as it relates to realizing the best interests of the child, there are no standard operating procedures on how to listen to children or to take their opinions into account and to assess their best interest.

Policy coordination takes place via the National Council of Child Protection (NCCP) in keeping with Article 18 of the CPA; yet, the NCCP lacks sufficient representation of municipalities, despite their growing role. Unlike many other policy councils, the NCCP is not chaired by a Deputy Prime Minister, which reduces the political commitment of its decisions. The State Agency for Child Protection (SACP) is the body responsible for ensuring child protection and provision of quality social services, yet the Agency for Social Assistance (ASA) has oversight and control functions over the ASA's CPD and social services providers. Recently, a new Social Services Act was passed which will weaken the mandate of SACP, and hand over licensing of social services functions to the Agency for Quality of Social Services (AQSS) and municipalities; however, the launch of the new Social Services Act has been postponed until 1 June 2020. The limitation is that oversight and control efforts are not coordinated across the various institutions with oversight and control functions, and a relatively small number of social service providers are subjected to inspections. Moreover, inspections of CPDs and social services providers does not focus on the outcomes of child protection cases, but rather on alignment with administrative procedures.

In the child protection system, the bottleneck is that case management practices do not translate from existing implementation guidelines, procedures and/or protocols. At local levels, coordination mechanisms on VAC involves social workers who are the point of entry into the CPD and responsible for coordinating multiple actors, including social service providers, medical doctors, educators, police, judges and municipal representatives. Annual monitoring reports show that after an initial good start of coordination mechanisms, over the past two years, there has been a decrease in the quality of coordination and interaction among multi-sectorial teams. Social workers' focus

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is often placed on administrative tasks and multiplication of forms is a burden, as well as a lack of clarity as to how case files trigger action or decisions at higher levels. Although operational cooperation exists at the municipal level, there is not enough coordination and cooperation to demonstrate outcomes in cases of child protection. In addition, not all alert channels work properly and there is low reporting from health and education institutions. There is also a lack of prevention and specialized services for child victims of violence. The main challenges facing the social work workforce include: lack qualifications and training; lack of supervision of social workers; recruitment and staff retention; workload and supervision and performance monitoring. In certain regions of the country, attracting social work university graduates to the ASA (Agency for Social Assistance) is challenging.

Lack of social services and frontline service providers and justice officials with specialized training on VAC and working with child victims and witnesses of violence and crimes, as well as lack of integrated, multi-sectoral approaches and responses to VAC serves as a bottleneck to ending VAC in Bulgaria. Services that do exist are largely private initiatives that are not recognized by public authorities. In addition, a scarcity of resources directed to child protection is a major challenge.

As it relates to financing the child protection system, there is limited information about the financial and material resources invested at national and municipal levels, and there is no understanding of the financial and material resources that nongovernmental organizations (NGOs) invest. There are reasonable indications that investments are low and only cover basic social services for children. In addition, it is also difficult to ascertain to what extent EU funding of innovative social services practices have been sustainable and led to their subsequent adoption. In recent years, national policy and coordination mechanisms for responding to VAC have improved; yet, a very small number of VAC cases are reported and handled by interdisciplinary teams. Quality coordinated, multi-sectoral responses are not systematically available across the country and the effectiveness of interventions has yet to be documented.

In 2016, the UN Committee for the Rights of the Child expressed in its Concluding Observations to Bulgaria concerns with prevailing social norms that domestic violence is a private matter and that there are insufficient services for children who have experienced violence. In recent years, prevailing social norms in Bulgaria have challenged the advancement of reforms related to women and children's rights. This has led to non-ratification of the Council of Europe's Convention on Preventing and Combatting Violence Against Women and Domestic Violence (Istanbul Convention) and blocking of the draft National Strategy for the Child 2019- 2030. The Bulgarian Constitutional Court ruled that the Istanbul Convention was inconsistent with Bulgaria's Constitution. More specifically, the Constitutional Court ruled the term "gender", as used in the Istanbul Convention, is misleading and introduces a concept that is incompatible with the constitution's understanding of "sex" as a binary conception with two rigidly fixed options of male or female. More than 30 prominent NGOs and individuals working in the field of human rights, children's rights, women's rights and lesbian, gay, bisexual, transgendered and intersex (LGBTI) rights condemned the decision by the Bulgarian

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Constitutional Court. Eventually, the Bulgarian Orthodox Church intervened with an official statement in which it maintained that parents have the right to use corporal punishment to discipline their children. The Church also took a public stance against abortion, contraception and sex education in the schools, which the Church maintained should be replaced with abstinence. After negative public reactions, the Holy Synod of the Church announced that this was not their official opinion and came up with a softer and more diplomatic stance.

Another aspect is the situation with the foster care. According to a recent research of National Foster Care Association shows that most of the parents requested of state wage for taken care of a child. Just 10% don't put any requirements for taking a child. 63% of Bulgarians won't accept a child at risk at any circumstances. 51% of people think that each 4th child at a foster care is a victim of violence[21]. Services that should be looking after children's health and wellbeing such as foster care services (according to National Foster Care Association) and mental health services are currently in an unsatisfactory situation and there is a pressing need for reform, especially with all the new concern related to how COVID-19 can affect children already victim of ACEs.

2.2 European and local legislation on children protection

Legislation is a – without any doubt – a key component of any strategy to prevent and address all forms of violence against children. It sends a clear message to society about acceptable behaviour towards children and it legitimizes actions required to safeguard children's safety and protection at all times. It is an important reference for capacity-building initiatives for professionals working with and for children, and supports public information, social mobilization and behavioural change22. It should be noted as a preliminary point that minors are not only subjects to be protected, but also holders of rights, so broad that they cannot be treated here, but what is interesting to highlight is that there are corresponding obligations at all levels of society, whatever the role assigned (parents, educators, state bodies, etc.). On the other hand, we could not review the picture of adverse experiences limiting ourselves to considering only the infantile age in the strict sense (which should have a natural end between eleven and fifteen years. Actually, there are no specific adverse experiences attributable to particular ages, the same can affect the minor throughout the developmental age and be such as to jeopardize a harmonious development. From this point of view, we must take into consideration the age in which the subject is most fragile and therefore most vulnerable, which embraces a rather large time interval. Violence against minors, represents a complex phenomenon that has multiple manifestations that often overlap with each

[21] According to a data for ASA 1738 children have been hosted at 1947 foster families. Near 10% of them are with disabilities. Main part are children at school age (6-14 yrs.) – 647 and toddlers and children below 3 are 548. 80% of the children are in foster care services because at their biological families they have been victims of violence or abuse. More than a half of these children afterwards have been adopted. 70% of the children stay at foster families average an year and bigger – up to 5 years.

[22] Unicef (2013), Toward a world free from violence. Global survey on violence against children.

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other as an expression of a single disadvantaged relational situation. Furthermore, other phenomena have emerged in recent decades to such an extent that they require particular attention, such as, for example, slavery, prostitution, involvement in pornography or marginalization resulting from illegal immigration, due to their meaning of "violent experiences", such as to deeply affect the development of the minor.

So, violence rises to a public health problem and, therefore, requires state interventions of prevention, protection and treatment, which represent acts due to satisfy the fundamental right to health, sanctioned by International Conventions. Being more specific, with regard to childhood, the World Health Organization states that "*by child abuse and maltreatment must be understood all forms of ill and / or emotional health, sexual abuse, neglect or neglect or exploitation commercial or other that involve a real or potential prejudice to the child's health, survival, development or dignity in a relationship characterized by responsibility, trust or power*". The United Nations and the Council of Europe have taken a number of measures in a bid to safeguard the rights of children and more specifically protect them from violence. The Convention on the Rights of the Child is of fundamental importance in this connection. Under Article 19 thereof, children are entitled to protection from all forms of violence or brutality, abandonment or neglect, mistreatment or exploitation, including sexual violence. In any case, the provisions contained in the Council of Europe Convention for the protection of minors against sexual exploitation and abuse, stipulated in Lanzarote on 25 October 2007, were the basis for important changes to our penal code, aiming at a complete adaptation of internal regulations. While child protection systems are principally the responsibility of the Member States, the EU also plays an important role, given its obligation to promote initiatives to protect the rights of the child. Its actions in this area have a direct impact on the relevant laws and policies introduced by the Member States. Member States have a duty under the United Nations Convention on the Rights of the Child to enact and enforce legislation to protect children from violence.

Nevertheless, legislative protection remains fragmentary, and few children benefit from legal protection from all forms of violence in all settings. Furthermore, where legislation is in place, there is a pressing need for periodic reviews to address any emerging concerns and ensure its effective enforcement. A comprehensive legal ban on violence against children must be complemented by detailed legislation addressing distinct manifestations of violence that occur in specific contexts. Without such a two-tiered legal framework, there is a serious risk that certain instances of violence against children will not be addressed. For example, domestic violence may still be seen as a 'private' issue, for example, or corporal punishment in schools as a valid form of discipline. Countries are nevertheless encouraged to extend legislation to ban corporal punishment in all settings, as the current situation leaves settings such as home and day care with a lack of legislative clarity in four out of 10 countries. Inevitably, the impact of any legislation will be limited by the extent of its enforcement; improvement is required in this area[23].

[23] (EPRS) European Parliamentary Research Service (2014), Violence towards children in the EU.

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ITALY

The protection of minors is a particularly important issue in all Western countries, and in this context, a legislation of particular rigor has also been developed in Italy. It must be emphasized that the Italian penal code, although it is on the threshold of the century in force, has had, since its emanation, reference standards for the protection of minors. These protections examined both the profile of the "abuse of the means of correction or discipline" and the profile of the "mistreatment in the family or towards children" (this was the original text of the column), respectively contemplated by articles 571 and 572 of the criminal code. The aforementioned norms have been a point of reference for generations of jurists and on which an extensive jurisprudential elaboration has been built in order to bring back the most varied cases that could be offered over the decades. Basically, maltreatment in its most recent meaning is realized in "the acts and deficiencies that seriously disturb boys and girls, attack their bodily integrity, their physical, emotional, intellectual and moral development, the manifestations of which are the negligence and / or physical and / or psychological and / or sexual injuries by a family member or third parties" (IV criminological seminar - Council of Europe, Strasbourg 1978). Furthermore, the mistreatment can take the form of active conduct (beatings, injuries, sexual acts, hypercuria) or omissive conduct (negligence, carelessness, abandonment). Physical abuse occurs when a child's parents or legally responsible persons perform or allow physical injuries to occur, or let children risk physical injury. While psychological abuse and/or emotional abuse come to materialize when emotional relationships are characterized by repeated and continuous psychological pressures, emotional blackmail, indifference, rejection, denigration and devaluations that damage or inhibit the development of fundamental cognitive-emotional skills such as intelligence, perception, memory. Among the very recurring cases there is witnessed violence, which takes shape with the involvement of the minor in acts of violence carried out on reference figures that are emotionally significant for him, resulting in psychological damage equal to those deriving from the mistreatment directly suffered (Lombardy region guidelines).

The Civil Code provides for the duty of parents to maintain, educate and educate their offspring taking into account the abilities, natural inclinations and aspirations of the children (art. 147 - 261 of the Civil Code). In line, art. 30 of the Constitution establishes the principle according to which parents have the right and duty to educate their children, even if born out of wedlock. However, the autonomy of the child's educational choices finds legal limitations in the provision of art. 330 et seq. of the civil code up to the pronouncement of the forfeiture of the parental power by the judge, when the parent violates or neglects the duties inherent to it or abuses the relative powers with serious prejudice to the child, coming to provide for the removal of the child, even in the face of the irrelevance of the elements of malice and fault on the part of the parents. Limitations of authority for any prejudicial conduct are provided for by art. 333 of the civil code. The services, in particular the professional social service and, subsequently, the territorial psychological service, constitute the primary source of knowledge of the situations at present or potential risk in which minors find themselves: they report the

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situations of prejudice or moral and material abandonment in which the minor finds himself to the Public Prosecutor's Office at the Juvenile Court, an organ of procedural impulse. The services, at the request of the Tutelary Judge, collaborate to acquire information regarding the living conditions of the minor under tutelage or guardianship. For the division of competences with regard to proceedings involving minors, the Ordinary Court / the Tutelary Judge / the Juvenile Judicial Authority are involved in civil matters.

SLOVENIA

In the Slovenian legal system, the rights of children are regulated very partially, within the framework of individual laws that regulate more or less substantively rounded areas. The rights and children protections are built into the system of family relations, health care and health insurance, education, social security, citizenship, the media, and criminal regulations.

The first comprehensive international legal instrument on the rights of the child, adopted by Slovenia (initially as a republic of former SFRY) is Convention on the Rights of the Child. The document contains the rights that all children should enjoy and sets basic standards for a child's development at different ages and in different areas of his or her life. The Convention sets out these rights in 54 articles and three optional protocols. It defines the basic human rights of children around the world: the right to survival, to the development of all potentials, to protection from any exploitation, and to participation and participation.[4]

The fundamental national legal source regulating the field of human rights is the Constitution of the Republic of Slovenia. The articles concerning the issue of children's rights and protection are mainly:

Article 14: contains a provision on equality before the law, regardless of nationality, race, sex, language, religion, political opinion, financial status, birth, education, social status or any other circumstances.

Article 41: regulating freedom of conscience

Article 53: marriage and family relations

Article 54: rights and duties of parents

Article 56: children's rights

Article 57: education and schooling

The most important provision is Article 56, which explicitly regulates the rights of the child: ‘’Children enjoy special care and attention. Human rights and fundamental freedoms are enjoyed by children in accordance with their age and maturity. Children are provided with special protection against economic, social, physical, mental or other exploitation and abuse. Such protection is regulated by law. Children and minors who are not cared for by their parents or do not have parents or adequate family care, enjoy special state protection. Their position is governed by law.”[5]

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Special attention to the best interests of the child is also paid by the Family Code, which came into force on 15 April 2019 and replaces the previously valid Marriage and Family Relations Act. The Family Code raises the legal standard of the best interests of the child to the level of a principle. The Family Code entrusted the primary role in caring for the child and the child's benefit to the parents, and all others involved in any relationship with the child are obliged to protect the interests of the child in all activities and procedures. When parents perform their parental duty inadequately, it is the duty of the state to intervene in family relationships and protect the child and their best interests.[6]

The Government of the Republic of Slovenia has recently adopted a number of decisions and ensured the implementation of activities aimed at improving the situation and life of children, including the already mentioned Family Code, the basic principle of which is to assert the fundamental benefits of the child, The Ombudsman Act, which guarantees every child the right to a lawyer who provides professional assistance to the child, Resolution on Family Policy 2018 - 2028, which provides guidelines and measures for the realization of children's rights in key areas, and Program for children 2020-2025 with main goal to set fundamental goals and measures in the field of children's rights and the well-being and quality of life of children.

Although Slovenia has very well-regulated legislation in the field of domestic violence, violence against women and children violence, the Human Rights Ombudsman in its 2019 annual report[7], draws attention to the findings that citizens do not receive the same quality of service from institutions across the country, even though they should. Their warning and call for highly qualified staff in various institutions in all regions is more than necessary. According to the project of the Social protection Institute of the Republic of Slovenia[8], with the aim of creating a data and analytical tool with which it is possible to compare the well-being of children on the basis of a uniform and clear methodology, the results show significant regional differences on the level of child well-being.

GREECE

On the legislative level, Greece has incorporated into its legislation international conventions and regulations for the protection of children's rights. The Greek Parliament, with the increased standard law 2101/92 (FEK A' 192, 2-12-1992) has ratified the International Convention on the Rights of the Child. The Article 19 provides that:

1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

2. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for

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identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.

In order to be implemented the above commitments and for the handling of the children's abuse problem and their possible protection, firstly we have to recognize the problem. Most of the time, violence against children happens in families. In Greece the legislation gives a wide definition of the family. According to the law 3500/2006 (FEK 322/A/24-10-2006 «to tackle domestic violence and other provisions») Article 1 Definitions, paragraph 2.a & 2.b. "family or community consisting of spouses, or persons associated with a civil partnership, or parents and relatives of the first and second degree of blood or relatives in law and their children of adoption. The family includes, if they live together, blood relatives or relatives up to the fourth degree and persons whose commissioner, bailiff or foster parent has been designated as a family member, as well as any minor who resides in the family". Also, in the same article, paragraph 2.c. "the provisions on domestic violence apply to permanent partners and children, common or one of them, to former spouses, to the parties to a dissolved cohabitation agreement, as well as to former permanent partners".

The drafters of the Istanbul Convention had in mind the children's protection when they negotiated the Convention. There are several provisions that address both children as direct victims of physical, sexual or psychological violence, and children who witness such violence between their parents. The Greek Parliament has ratified the Istanbul Convention24 with the law 4531/2018 (FEK 62/A/5-4-2018). According to the Article 26 Protection and support for child witnesses:

1. Parties shall take the necessary legislative or other measures to ensure that in the provision of protection and support services to victims, due account is taken of the rights and needs of child witnesses of all forms of violence covered by the scope of this Convention.

2. Measures taken pursuant to this article shall include age-appropriate psychosocial counselling for child witnesses of all forms of violence covered by the scope of this Convention and shall give due regard to the best interests of the child.

The Article 13 paragraph 1, calls to conduct or promote awareness-raising campaigns on the different forms of violence it covers, including domestic violence and specifically that such campaigns should show or emphasize the consequences on children (in the area of preventive measures).

In Greece, most of the relevant international conventions, directives and regulations have been incorporated. Important provisions for the protection of children and their best interests in all proceedings concerning them are included in the Civil Code (on the legal capacity of minors, custody and parental issues, etc.), in the Penal Code (for the criminal treatment of minors), in the Code of Civil Procedure and in the Code of Criminal Procedure (for the examination of children - witnesses, etc.) After all, the protections of

[24] Full text of Istanbul Convention https://www.coe.int/en/web/conventions/full-list/-/conventions/rms/090000168008482e

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childhood, as well as the protection of the family, are constitutionally guaranteed principles. However, despite significant efforts to modernize, it is a serious flaw that the legal framework for child protection in Greece is fragmented. In other words, relevant provisions are found in different laws that in many cases have introduced fragmentary interventions that are not based on a strategically coordinated action plan. The fragmentation of the regulations in combination with the absence of governance mechanisms has been repeatedly pointed out as a key gap that makes any child protection state efforts in Greece negligible. Both the UN Committee on the Rights of the Child in its concluding remarks on Greece in 2012 and the European Commission in its reports on the fight against child poverty in Greece (see, for example, the relevant report "Investing in Children - Breaking the Circle Disadvantage - National Policy Study - Greece[25]") have highlighted the fragmentary nature of child protection interventions, which have shrunk during the economic crisis.[26]

Despite the importance of the problem, however, accurate estimates of its extent and characteristics in the general population are difficult to obtain due to two key interrelated problems: reporting and recording child exposure to ACEs, such as domestic violence, child abuse / neglect, cohabitation with dependent family members, in a single platform, to which the services and professionals involved will have access. Services that welcome children who have been exposed to unwanted childhood experiences use different data entry forms, are not required to register the case somewhere, and privacy regulations do not allow the free flow of information between services. This makes it difficult to detect and address the issue of the effects of ACEs on children. The prevention of undesirable childhood experiences must be seen in the broader context of tackling social inequalities. Prevention and early intervention are the measures that society should take to address the problem of adverse childhood experiences (ACEs). And while, at the international level, for a decade now, many steps have been taken in this direction, Greece does not follow the same tactics, maximizing the risk for its citizens.

The problematic implications of childhood adverse experiences (ACEs) in the various areas of child development and functionality necessitate the development of effective coping practices, both on the part of experts and the state. The state is required to take measures at multiple levels, legislative, criminal, therapeutic, counseling, as well as at the level of social welfare. On the part of the experts, constant information and training on incident handling is required. However, emphasis needs to be placed on prevention as well, as it has proven to be more cost-effective than dealing with the consequences and this can be done either through strategic prevention programs.

"In responding to reports of abuse, we need to strike a balance between safety and legal protection, and support and treatment as part of a health and social care approach. Unprotected assistance endangers the well-being of the child and violates the Convention on the Rights of the Child. Also, protection and focus on the law, with

[25] https://ec.europa.eu/social/BlobServlet?docId=11641&langId=en

[26] "Domestic violence during the economic crisis: The perspective of professionals and proposals for improving the implemented policies " Action Aid, Athens, 2018 https://www.actionaid.gr/enhmerwsou/ereunes-dimosieyseis/noemvrios-2018/

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insufficient monitoring, treatment and care can lead to serious and long-term damage to the health and development of the child. It is therefore important that there is close cooperation between different areas of intervention and a simultaneous approach to the investigation of the case and the treatment of the child, the family, but also the perpetrator. The health system, social and legal actors play an important role in this process. Services providing support to children and families should exchange information about the case. Although privacy and confidentiality regulations may make this difficult, the free flow of information between services could be important to protect a child. Cooperation can be improved by developing a local service, whose representatives will provide support to families and children"[27].

BULGARIA

Bulgaria has ratified core international human rights conventions, including the Universal Declaration of Human Rights (UDHR), Convention on the Rights of the Child (CRC), Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the International Covenant of Economic, Social and Cultural Rights (ICESC), as well as the Millennium Declaration and the 2030 Agenda for Sustainable Development. As a signatory, the Government of Bulgaria has prioritized improving access to and quality of child protection and social services for children and families in need.

Since ratifying the CRC in 1991, Bulgaria has made significant progress in ensuring compliance of its legal and policy frameworks to protect children from violence and abuse. After the adoption of the Child Protection Act in 2000, Bulgaria developed a national child protection system in keeping with international standards and practices. Corporal punishment is prohibited under the Child Protection Act, the Family Code (2009) and the Pre-school and School Education Act (2015). In 2017, the Council of Ministers adopted a National Programme on Prevention of Violence Against and Abuse of Children.

Children's issues have remained high on the national policy agenda and significant progress has been achieved in key areas with support from UNICEF and other partners. In particular, progress has made in early childhood development and education, and education in general, child protection and access to justice for children, including improvements to the juvenile justice system, and deinstitutionalization of children from state-run residential institutions. In recent years, Bulgaria has increasingly provided technical assistance to other countries in the region for advancing child rights, by sharing knowledge and experiences through horizontal cooperation. Still, however, negative trends in child and adolescent health, well-being and behaviours exist, including early pregnancies and abortions, adolescent mental health problems, and engagement in risky behaviours which undermines the realization of a healthy transition into adulthood. As it relates to child protection, Bulgaria has achieved progress in moving away from the inherited system of placing vulnerable children in state-run residential institutions to

[27] Child Abuse Prevention: action and documentation guide, Hellenic Society for the Study and Prevention of Sexual Abuse - World Health Organization, in detail here: https://blogs.sch.gr/kyriakou/files/2011/01/Prolipsi_paidikis_kakopoiisis_egxeiridio.pdf

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developing a system of foster care and family type homes of children in need of alternative care. Bulgaria has been a leader to other countries in the region for their work to deinstitutionalize children. Still, however, Bulgaria struggles with coordination of multi-sectorial responses to children in need of protection and building the capacities of professionals at local and regional levels to assess and respond to the needs of vulnerable children and their families. In addition, weak enforcement and implementation of otherwise good child protection policies, and inadequate budgeting and monitoring of multi-sectoral programmes have served as a barrier in Bulgaria. There is also a lack of disaggregated administrative data on vulnerable children and child victims of violence, abuse and exploitation. At the societal level, Bulgaria does have a weak child rights culture, and discriminatory social norms, attitudes and practices contribute to the disparities and social exclusion that impact children nationwide. This contributes to Bulgaria having among the lowest social indicators for children in the EU.

3.THE ROLE OF PROFESSIONALS

In this part of report, the main results of field activities - quantitative and qualitative interviews with professionals - are described. The professionals involved are: educators, social workers, lawyers and health professionals. Practitioners were asked to answer questions about the ACE phenomenon: prevalence of ACE, victims, common type, competence, procedure, etc.

3.1 The results of quantitative interview

Starting from the quantitative interviews, we can observe that we have an equal distribution among the professional figure, with a slight prevalence of child educators (31,2%); lawyers are the professionals less present (17,6%). Regarding countries involved, the professionals interviewed are mainly from Bulgaria (31,2%), followed by Greece (28,2%), Italy (21,8%), Slovenia (18,8 %).

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Table 2. Professionals interviewed and nationality

Profession	*a.v.*	*%*
Child educator	53	31,2
Doctor/Health Care professionals	42	24,7
Lawyer	30	17,6
Social worker	45	26,5
Total	**170**	**100,0**
Professionals by nationality		
Bulgaria	53	31,2
Greece	48	28,2
Italy	37	21,8
Slovenia	32	18,8
Total	**170**	**100,0**

The first theme addressed with interviewees is on the prevalence of ACEs in Europe and more specifically about the perception of diffusion of phenomenon. The major part of professionals interviewed, thinks that in Europe there are 35 million of children victims of ACEs (35,4%) (34% of practitioner thinks they are 55 million (34%)) and the 44,8% of respondents say that in their country there are between 10,000 and 100,000 children who are victims of ACEs; there are non-relevant differences among the countries. This first empirical evidence, confirm a clear underestimation of the problem also among our professionals involved in the survey.

If we observe the most common type of ACEs, the average across the countries shows that the most common types are witnessing domestic violence (72,6%), with most prevalence in Italy (88,6%) and less in Bulgaria (62,5%). It is followed by emotional abuse (66,5%). Physical abuse and parental divorce are both about 54% in the countries average, but in these cases, there are relevant differences among countries. In fact, only 27% of Slovenian and 40% of Italians professionals believe that physical abuse is a common case of ACEs. Parental divorce is one of the most common type of ACEs according to Bulgarian practitioners (64,6) compared to the country average of 54%.

Less common are the prevalence of parental substance abuse (31%), sexual abuse (25%) and parental mental illness (11,6%). The presence of incarcerated relative appears to be a residual phenomenon (3,2%).

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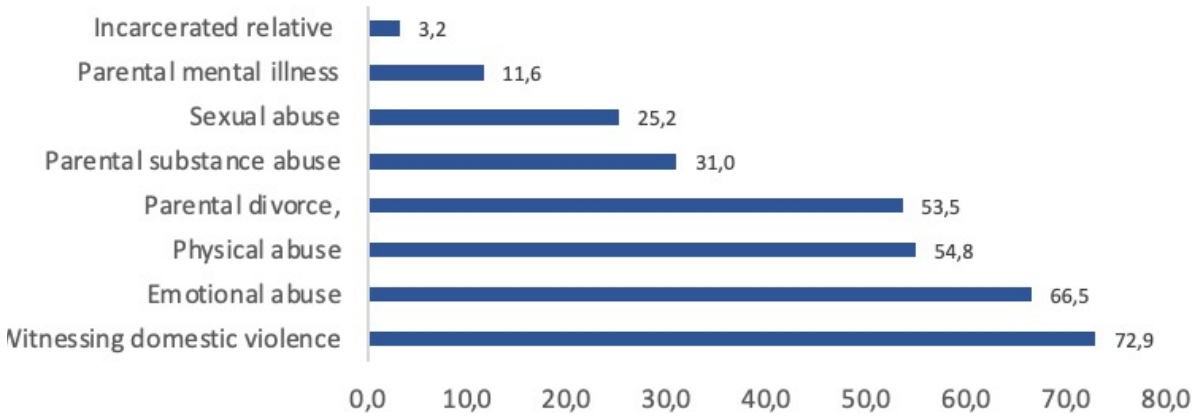
Figure 1. Most common types of ACEs – average answers from professionals from the four countries



Furthermore ACEs appear to have, according to the practitioners, a long-term impact especially on an individual level (37,5%) - with higher level for the practitioner of Bulgaria (60,9%) - and on the social care system of a country (29,6%) - with higher level among the professional of Italy (47,1%) and Greece (44,2%).

Talking about the competences of professionals and their main skills, the analysis shows that they believe to have solid skills in their field, but it's clear that there is still a need of training in new ones. In fact, for all the statements related to the skills of professionals (1. I feel confident in my ability to recognize cases of ACEs and intervene appropriately; 2. I am capable of taking decisions with regard to cases of ACEs; 3. I am able to deal with cases of ACEs; 4. I feel able to meet the challenge of preventing ACEs in my area; 5. Practitioners in my field know what to do when they identify a victim of ACEs; 6. Practitioners in my field are usually able to give an accurate estimate of the prevalence of ACEs), they have positioned themselves mostly always in the middle (about 30% says that the sentences asked are "somewhat true") of the Likert scale that has a score from 1(not all true) to 7 (very true). And it's interesting that a consistent part of them doesn't know how to answer to the questions.

Going into detail, we could see some differences among the countries; in particular: the 20% of Bulgarian practitioners have great confidence in their ability to recognize cases of ACEs and intervene appropriately. Greek and Italian professionals are more confident in a capacity of taking decisions with regard to cases of ACEs (29% and 24% respectively). Finally, the 32% of Italian professionals believe they are very able to deal with cases of ACEs.

Interesting elements emerge on the actions that should be avoided in case of suspected child maltreatment. In fact, professionals think that it's very important avoid to "asking question to the child (interrogation style)"(63,4%) (in Italy arrives to 74,3%), "dismissing the child' claim" (61,4%) and "never talk about it again with the child" (37,9%). There are not relevant differences among countries, except for the action "Listening to the child with empathy", here in fact about 60% of Greek professionals think it's an action to avoid against an average of 24%.

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Table 3. Procedure: Actions should be avoided in case of suspected child maltreatment -countries average

Talking directly to the parents/caregives	281,1
Sharing your concerns in your team	7,2
Dismissing the child's claims	61,4
Asking questions to the child (interrogation style)	63,4
Listening to the child with empathy	24,2
Never talk about it again with the child	37,9

Now we describe the main results emerged from the survey on the various professionals involved. Due to the low number of cases, here we describe the results of survey keeping the 4 countries together, and we'll highlight the particularities among the professionals within the countries, in the qualitative analysis.

SOCIAL WORKERS

Starting with the social workers, firstly, we asked them where - in their opinion - the signs of ACE are most likely to be identified. Most of them, think that it's possible identify signs of ACEs specially among educational psychologists (55,6%), professional who works with children (38,9%) and health care professionals (33,3%). In case of suspected child maltreatment, most of social workers manage the case on the basis of the evidence gathered from a range of different sources (75%), only 22% manages the case only on the basis of child disclosure. Residual is the percentage of social workers who base the management of case on a referral from a paediatrician (2,2%).

LAWYERS

Talking about lawyers, we asked them the opinion about the procedures for making and taking a referral. The 86,2% of lawyers thinks that legal aspects are still in need to be fully integrated in the process, only 10,3% thinks that legal aspect should be addressed separately; at last, the 3,4% says that the legal aspects are already well integrated in the process.

As regards the current legislation available for safeguarding children's rights in judicial experiences, according to the opinion of the 79,9% of the lawyer interviewed, is it not enough.

CHILD EDUCATORS

To child educators we asked questions about aggressive behaviour and trauma. Regarding the aggressive behaviour, it seems to be more widespread among children who were exposed to domestic violence (70,2%), much less common among children with ADHD (10,6%).

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The main cause of trauma can be identified, according to child educators, in feeling vulnerable (51,1%), followed by physical pain (27,7%). Scents, sounds, tastes play a residual role (2,1%).

HEALTH CARE PROFESSIONALS/DOCTOR

Most health care professionals came across case of PTSD (Post-traumatic stress disorder) throughout their careers (57,1%). The symptoms of PTSD in children are the persistent avoidance of trauma reminders and emotional numbing (34,2%), persistent symptoms of hyperarousal and re-enacting the traumatic event again and again through their play (both 26,3%).

3.2 The results of qualitative interviews

In this part of report, we present the result of field's analysis about qualitative interviews among the four countries involved in the MARTE project. The qualitative research will aim to assess needs and problems identified by the actors in play. In particular: perceived degree of diffusion of ACEs; perceived definition of the trauma victims' needs; perceived causes and consequences of ACEs (childhood, adolescence and adulthood); presence of specialized structure in the area in which the interviewed work; perceived degree of competences among the practitioners; most relevant and urgent training needs; lacks of the treatment system.

Indeed, the purpose of the interviews was to explore some of the areas that have already been examined in quantitative research, with a more specialized focus on professional experience (direct and indirect experience) regarding cases of unwanted/traumatic childhood experiences. So here we can find easily the main particularity of professionals in each country.

ITALY

About the practitioners interviewed in Italy, the first element that we can observe is on the **perception** of the diffusion of the phenomenon. It, as well as the information about it, varies according to the professionals and their relevant work environment. The answer that results more frequently about diffusion was "quite high", only some professionals (those who work in contact with social services in the area of minors) have given more detailed answers.

In the area of **training** we find important disparities of levels: in particular psychologists and social workers assert that there are training and refresher courses, often organized by the reference bodies, of a transversal type (violence in families, mistreatment, trauma ...), but nothing specific about the approach to the recognition and treatment of ACE. Again, training is relegated to personal interest and initiative. And personal initiative emerges strongly among lawyers, especially among those dealing with family

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relationships and minors. Lawyers who mainly deal with families express the need to be trained in the "recognition" of signs of malaise that they could intercept during the first interviews they carry out with families to be then supported by specific professionals on the internet, in order to make this way of working a praxis and not a practice entrusted exclusively to personal sensitivity and initiative.

There is a demand for training on legal aspects and bureaucratic procedures to be followed among childhood educators and teachers (their knowledge stops at the internal procedures of the school to report situations that they consider anomalous and / or that needs attention to the headmaster), on addictions and mental illnesses, from which the family members of minors often suffer, and therefore on the behavioural dynamics to which these addictions and / or pathologies lead, as well as a more general training aimed at recognizing signs in younger children.

As far as the **common signs** of ACE are concerned, in fact, teachers, put neglect in children first (poor hygiene, inappropriate clothing for the season, disorder in the teaching material ...) and they recognize a sudden drop in learning and the difficulty in staying focused as a wake-up call for "something wrong". However, these signs must be contextualized and analysed with a comparison with an expert psychologist able to produce a differential diagnosis that allows us to identify what really lies behind the symptom.

Also on the possible **consequences** of ACE cases we find a different understanding of the phenomenon, even within the same category of professionals, between those who work / have worked with the services that have followed these cases, and those who instead know the phenomenon in a superficial way; a difference that we also find in the recognition of risk factors in the development of PTSD from ACE. We find greater uniformity instead in the identification of **protective factors**: resilience as an individual character trait, presence of adults with whom to establish a healthy and trusting relationship, whether they belong to the family network or services.

Regarding the questions relating to personal experience, we note that all those that in their work have encountered a case of ACE, have found themselves having to **manage** critical issues related to the lack of uniformity of procedures and / or the impossibility of sharing and comparing within an operational team (not all local authorities have them and most of the time decisions fall on the individual professional) on the process to be followed in order to better "help" the minor and his family.

The importance of discussion and networking emerges strongly: no professional believes that such cases can be managed except in a collegial manner, but a structured and integrated system does not seem to exist yet. It is up to the individual ability of the single social worker (generally the one who presides over the social service of the small municipality to which the reports arrive) to activate a network and often does so through knowledge and personal relationships that have been established during the years of work.

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SLOVENIA

Majority of practitioners based on the interviews believe ACEs are quite common, they think that almost everyone has experienced some kind of trauma as a child and they assume that we do not differ in frequency from the rest of European countries. Interviewees also expressed a lack of knowledge of ACEs in their field of profession. They do not have mandatory **training** within their profession about ACEs, except in the case of social workers and teachers who in the process of formal education within the faculty had some training in recognition and procedures of child maltreatment. Child educator in particular pointed out that they do have seminars and trainings at their disposal, where they choose from the topics offered, but there is not much seminars offered on ACEs. Child educators and social workers also expressed a lack of practical training in particular. While information on the theoretical framework is sufficiently available, they lack practical advice and guidance, ie how to react to and communicate to the victim, how to approach the victim, how to prevent secondary victimization.

General knowledge on ACEs is the lowest among lawyers, they had most difficulties with providing examples of **common signs** and possible consequences of ACEs. Health care professionals are mostly focused on physical signs as indicators of ACEs, while teachers and social workers have identified the most signs, of which the most frequently mentioned were social exclusion, anxiety, aggression, sudden changes in behaviour, poor self-esteem, decline in school success, physical change.

Among the possible **consequences** later in life and in adulthood the most frequently mentioned were mental disorders, alcohol abuse, isolation from society and aggression. A child to develop PTSD as a consequence of ACEs is more likely in an unhealthy family environment, lack of psychological and social support. On the other hand interviewees believe that a sense of security and support for the family would reduce the impact of ACEs on mental and physical wellbeing.

All participants **came across cases** of ACE. In the case of lawyers the ACE cases were already in the process of institutional care, in case of social workers, the cases were assigned to them as a result of report to the social work centre. Both child educators and health professionals in the case of suspicion of child maltreatment or if the child told them about the trauma, handed the case over to their superiors. The first step was therefore reporting the case within the institution in which they are employed and their superiors initiated further proceedings. Health care professionals and lawyers usually didn't follow-up on the child's progress, social workers and child educators are more likely to monitor the proceedings of the case and find out what happened to the child.

Most of the practitioners are mainly concerned that there is much more domestic violence and ACEs than official statistics show. Despite awareness-raising campaigns, they believe there is still too little awareness of this in general public and that most violence remains behind four walls, inside the home. Many of them highlighted psychological violence, which is still unnoticed in many cases and not sanctioned by the state institutions. They also point out that child maltreatment is not recognized early enough, that action is not taken early enough, they notice the lack of practical knowledge and slow way of institutional addressing and dealing with child abuse cases.

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GREECE

The majority of the professionals interviewed believe that the **ACEs are very common** Greece. Some said that the increase phenomenon of these cases may be due to the economic crisis that our country is experiencing and has consequences on the living standards of people as well as the increase of the immigrant-refugee population in our country.

The majority of professionals in the **adverse experiences of childhood** included all forms of child abuse, i.e. neglect, domestic violence, parental divorce, couple's bad relationships, parent's psychopathology, financial misery, while there were also references to school bullying, war and refugees. Lawyers are those professionals who do not know enough about adverse childhood experiences (ACEs) and have not reported any form of ACEs.

The majority of professionals, even the most experienced, state that they do not have sufficient **training** in how to distinguish and handle forms of ACEs. The knowledge acquired - mainly for social workers and teachers - is either empirical from handling children's affairs, or from personal interest and participation in conferences, or workshops. The social workers who work in the social structures of the Municipalities have the opportunity to participate in training programs organized by the National Centre for Public Administration, mainly in matters of child abuse and neglect.

Regarding the **common signs of ACEs**, the majority of professionals report mainly changes in behaviour, personality, emotional world of a child, signs such as aggression, poor school performance, antisocial behaviour, introversion, isolation, panic attacks, phobias, anxiety disorders, anxiety decision making, isolation, lack of trust. Most of the signs were mentioned by the team of teachers and social workers. The medical team pointed out mainly the physical signs and secondarily the behavioural ones (with the exception of the paediatrician), mainly because of the insufficient time they see the children.

As **possible effects** of childhood adverse experiences, professionals cite: -behavioural problems such as aggression, social isolation, delinquency; -emotional effects such as anxiety, melancholy, anger, fear; -mental health problems such as depression, anxiety, phobias, psychosomatic problems, anxiety disorders. The majority of professionals cited the potential risk factors for developing post-traumatic stress disorder: the child's repeated exposure to difficult situations and experiences within the family, at school and in the wider social environment, combined with the lack of support and effective management for both child and their environment. They note that the "trauma" may not heal, in the future, if the gets to a direct or indirect exposure to a traumatic event, that will reactivate the experience.

For all professionals, the family and the school can act as **protective factors** for the child. This means support for the creation of a healthy family and school environment, support and empathy for parents and teachers in the presence of expert scientists. Managing and treating ACEs requires the presence of trained professionals, such as a

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child psychologist, psychologist, and social worker, who could significantly help children with unwanted / traumatic childhood experiences.

About 35% of professionals answered that they have not been directly or indirectly involved in any case of unwanted/traumatic childhood experiences. However, social workers and educators, specialties working with children, said they **had encountered cases of ACEs**. The common denominator of the cases is the abusive family environment: a violent father, addiction problems, sexual abuse within the family, domestic violence, a difficult divorce.

Regarding the handling of the incident, the professionals followed the **management protocols** defined by their specialty in their workplace. The professional who undertakes the investigation studies the family environment, sees the child and can refer to another professional in charge of the subject (child psychologist), or order the removal of the child from his / her problematic family environment. All the professionals state that they would not change anything in the way they handle the incidents. Almost all professionals express their concerns about the social services of the Municipalities, as understaffed and with too many responsibilities. Of all the professionals, only the social workers of the social services of the Municipalities keep in touch with the incident for some time.

Almost all professionals reported that they **needed more practical information** regarding ACE case support. Most of them would get any type of information from specialized bodies on child issues, from some social structure or social welfare service, they would consult a child psychologist or psychologist, they would get information from the bibliography and from the internet.

The biggest concern of almost everyone is the untimely detection and recognition that a child is a victim of unwanted / traumatic childhood experience, in order to help him immediately and effectively. Some expressed concern that even if the incident is detected early, there will be difficulty in the cooperation of the parents or even their refusal to deal with it, so that the child will remain without medical intervention. The team of Lawyers expressed its concern regarding the re-victimization of the child during their legal defence.
Regarding the proposals for the improvement of the way the ACEs cases are supported, the professionals point out the need for:
-existence of more social structures, staffed with specialized staff on this issue
-training of professionals who come in direct contact with children, especially teachers
-staffing of educational units of all levels with a social worker and a psychologist
-awareness / Trauma Child Awareness and Awareness Campaigns (ACEs)
-better coordination and cooperation between professionals and organizations
-need for a single reference framework with common terminology

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BULGARIA

Most of the Bulgarian experts think that **diffusion of ACEs** is widespread, but not recognized by specialists and it's hardly observed by the society. This is the opinion mainly of the experts working directly with children (social workers and teachers). Others lack capacity in recognizing the signs and definitely need training in that. Most of the experts easily recognize signs of physical abuse as they are visible and can't be hide.

About the **common signs of ACEs f**or health specialists there are especially physical problems and exploring deeper they come to problems of mental and behavioural problems. Usually the first signs appear at school – problems with the performance and social contacts. Experts should be very sensitive towards the reasons for the change – it can be just a transitional problem as moving from kindergarten to school and them to adolescence. Change of behaviour is usually pointed as a red signal that may be something is wrong.

Regarding the perception of the consequences for the child, most experts report different forms of depression, aggression and addictions (especially alcohol and drugs), an impact on social relationships and future parenting skills. The lack of parenting skills is reflected in the next generations. A problem with the child is always a reflection of the parental deficits, especially in the communicative aspect. "*We should care a lot of untreated injuries and its impact because these children are future parents – in many cases they transfer their ambition to the children - more neurotic children. Very few families took advantage of family therapies and psychology support".* Unfortunately, in Bulgaria mental health is not an issue of public dispute and no much attention has been paid on that. So many of the experts support the conclusion and that in many cases the untreated traumas are reasons for many other even societal issues as aggression and school, high rate of suicides and different of forms of violence.

Experts recognize different **protective factors**: mainly family, teachers and friends, social workers. Some of them also point sport or other extracurricular activities. Unluckily, in our society we miss the figure of a stable community centre (f.e as the catholic church and its role in the community) that can help in process of resilience.

There are not many cases of ACE detected by experts, but some may be reported: for example, a 5-year-old boy with signs of direct physical violence whose grandmother long denies that there is a problem; a boy with an autism spectrum problem who was the victim of a school assault and whose parents refused a long time that there was a problem, a boy who despite all the efforts of the experts commits suicide as it did a long time ago when he was not strong the presence of the institutions.

About the **management of the cases**, lawyers usually look for expert advice or support because they work indirectly with children victims. It's good that the people met are fully aware of the fact that this treatment is a long process and in most of the cases they have just a limited contact with that particular child. Many of them directed the case to the CPD and other responsible institutions or NGO with a special expertise. There is need for combined treatment among child, his family and people from the close environment.

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Regards **training**, unfortunately this issue is the less explored. Many experts point the need of trainings, but they hardly remember participation of such courses. It's emerged a Need for trainings on main signs of ACEs and how to recognize them, how to react and the legislation.

4. GIVING VOICE TO CHILDREN AFFECTED BY ACES

In this section of the report, the qualitative data collection involving children and related comparative results are described.

4.1. Methodology

When it comes to collecting data from young children who are victims of ACE extreme care must be placed in the definition of the methodology (Morgan et al., 2002). For the purpose of the present study we initially planned to use the *focus group* methodology for three main reasons: 1) small focus groups are one of the best ways to replicate a natural and more familiar form of communication in which children talk together with peers, 2) focus groups are acknowledged as a privileged methodology to investigate sensitive topics with minors, and 3) during focus groups it is also possible to gather non-verbal communication cues (Gibson, 2012).

Initially, each partner had to organise 3 focus groups involving a total 30 minors victims of trauma (aged 8 - 12) and who were living in residential child-care/therapeutic communities for children. However, as a consequence of a series of lockdowns starting at different times in the different regions involved in the project, it became nearly impossible to gain access to children's residential communities and to run focus groups with lockdown restrictions in place. So, the team had to come up with alternative solutions. Adopting the online alternative (online focus group) was considered too challenging by the partners, as it would have required specialist training to the group moderators beforehand. Therefore, the team decided to make use of semi-structured interviews, face-to-face when possible, online otherwise.

As working in therapeutic communities kept proving very difficult, the team also decided to broaden the selection criteria of the participants including minors who had undergone Adverse Childhood Experiences and still lived with a protective parent. Eventually, two different interview schedules were used (see Toolkit), one to be used with children living in communities, and one to be used with children living with a protective parent/guardian.

Even with the use of the online option, the data collection has not been totally homogeneous, due to organisational and contextual reasons, and therefore this represents a limitation of the present study.

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The interview schedule was developed taking into consideration what was the best way to involve children in sharing their view and experience of adversities. To safeguard the children taking part in the research and avoid the risk of secondary traumatization, a number of ethical measures have been observed (as seen in the Toolkit: information sheet for interviewers, information sheet for children, informed consents for children and guardians, handbook for the interview with minors for the interviewers), including the use of semi-projective tools: children were not asked direct questions about their personal history, but were instead asked to help telling the story of a child who went through adversities. Together with the *mutual storytelling activity* (adapted by Gardner, 1970), other tools were used: *emotions flashcards,* with a visual and textual representations of a range of emotions, employed to facilitate the investigation of emotional resilience; *paper figures,* to which interviewees could attribute roles and names at different points of the story, used to support the investigation of children's practical resilience skills. These tools were introduced flexibly during the interview with the aim to support the younger participants of the study.

4.2 Results from the qualitative study with children

In the following sections, data about the samples in each country, main types of ACEs, and overarching results will be discussed.

GREECE (KARDITSA)

15 face-to-face interviews were conducted with children aged 8 to 12 years, 11 boys and 4 girls. Data on age and gender of the sample is reported in the table below:

GREECE	AGE					
GENDER	8yo	9yo	10yo	11yo	12yo	Tot.
M	3	/	2	3	2	10
F	/	1	2	1	1	5
Tot.	3	1	4	4	3	15

The most common types of ACEs were:

- parental divorce (5)
- loss, death of a parent (4)
- abusive behaviour by father to mother (1)
- abusive behaviour by the mother (1)
- imprisoned parent (father) (1)

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- cohabitation with addiction problems in the family (alcoholic father) (1)
- stressful situations from family environment, (sick family member, child acquired out of wedlock) (5)
- stressful situations from living together in the family with a sibling on the autism spectrum (1).

Most participants were subjected to more than one ACE.

Lockdown and a general resistance made it impossible to gain access to children living in therapeutic communities; the sample of children interviewed in Karditsa were living with a protective parent (usually their mother) and were in a therapeutic relationship with a psychologist. Other practitioners were also supporting the family.

BULGARIA (RUSE)

Data collection in Bulgaria was also impacted by restrictions due to the pandemic. Data were gathered in a number of ways and consisted of 23 individual interviews (both face to face and online), and of two focus groups with 7 children in total. The children involved were aged 8 to 12 years.

Data on age and gender of the sample is reported in the table below:

BULGARIA	AGE					
GENDER	8yo	9yo	10yo	11yo	12yo	Tot.
M	3	4	6	2	2	17
F	5	1	/	3	4	13
Tot.	8	5	6	5	6	30

The most common types of ACEs were:

- witness of DV (11)
- abandonment (8)
- object of DV (4)
- witness and object of DV (3)
- neglect (3)
- loss, death in the family (1)
- cohabitation with addiction problems in the family (alcoholic father) (1)
- separated from the mother (1)

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SLOVENIA (LJUBLJANA)

Data collection in Slovenia consisted of 16 interviews conducted with children aged between 8 and 12 years, 2 with girls and 14 with boys. Specific data on age are still being elaborated.

SLOVENIA	AGE					
GENDER	8yo	9yo	10yo	11yo	12yo	Tot.
M	2	1	5	/	6	14
F	1	/	/	1	/	2
Tot.	3	1	5	1	6	16

The most common types of ACEs were:

- domestic violence (16)
- violence between adult members of the household and parental divorce (15)
- psychological and physical abuse by the father (8)

Most of the children interviewed live with their mothers (12), 2 with their grandparents, 1 is in a foster home and 1 is still at home with both parents.

ITALY (SULMONA)

Data collection in Italy has been heavily impacted by COVID-19, and therefore, only 2 girls living in a therapeutic community for minors have been interviewed online. The types of ACEs experienced by the two girls were: physical and emotional neglect, DV and addiction problems in the family.

General results and considerations:

All the interviews and focus groups were conducted by clinical psychologists and/or psychotherapists. Overall, children reacted well to the storytelling task. Children who (together with their family) had been looked after and supported by specialists for more than one year and who were at a good stage of their trauma elaboration, showed more interest and participation in the storytelling; while children who were at the beginning of the therapeutic process, offered less feedback and contribution.

The children experienced a number of ACEs, and Domestic Violence is the most common type of ACE in our sample. The majority of children experienced of more than 1 ACE. We know from the literature, how having suffered more than 1 ACEs brings even higher risk factors for long term health and wellbeing. It is relevant to note how the types of ACEs reported by different countries varies; it would be important to further investigate if this variety reflects an inconsistent use of 'labels' and a general difficulty when it comes

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to identify the type of adverse experience, or if the variety reflects a real difference in the prevalence of ACEs that is region-dependant.

In terms of ***emotions***, especially at the beginning of the story ('the past') the most common emotions mentioned by the children were *sadness* and *grief*. *Fear* (embodied as hyper-arousal "afraid of loud noise and of the dark") *anxiety (*and the more specific death anxiety: *"afraid of sleeping as they might not wake up")*, *anger* (a very common emotions that children victims of ACEs can easily act out when triggered) and *loneliness* were also mentioned. Children who were ashamed to talk about their fathers also mentioned *shame*.

At the beginning of the storytelling, it looked like children did not know where to turn to ask for help, seemingly because in their real experience they did not have enough information at the time; they expressed a passive approach, probably linked to a deeper feeling of helplessness, and would wait for someone to ask them about their wellbeing and what was wrong. This shows the importance of receiving support from the Institutions and services children usually attend (schools, GP practices for instance), and how practitioners working with children at different levels need to be trained and be able to detect possible adverse situations.

Different emotions started to be mentioned by the children in the second part of the story, after the introduction of the characters of the teacher and/or psychologist. A supportive environment then dominates in the descriptions where children express emotions such as *joy, confidence, calm* and *relief*, because someone aware of their situation and not judgemental was there with them, and they could discuss their feelings and their daily life with, *e.g. "my psychologist helps me to feel calm and able to talk with to about my concerns", "I talk with him (psychologist) about my feelings"* (Greek sample).

In terms of ***resilience skills*** (both emotional and practical), children gave good examples of strategies the main character of the story could adopt, when they were feeling sad, scared or angry. **Finding someone they could trust**, was the most common resource, with many children mentioning protective members of their family "*mother"*, "*father"*, "*grandparents", "siblings*", or other adults they were in a safe relationship with such as the *"psychologist", "teacher"*, someone they could *"shares things that scare or worry her", "seek support from an adult in case of a need"* (Bulgarian sample).

Finding a safe place was also mentioned as a strategy to cope with negative emotions *"finding a quiet room", "close their eyes and imagine", "going for a walk with friends", "playing with their dolls in their bedroom"; "he would try to think about something beautiful", "she would try not to listen to them and to keep doing what she was doing"; "she would say to the teacher that she was too unwell and sad, angry, because her parents didn't listen to her and she had to go upstairs to her room and play with her favourite toys"* (Italian sample). Other avoidance coping strategies were eating (a strategy that could easily turn into emotional overeating), and sarcasm, using humour

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and turning everything into a joke. It would be interesting to further investigate if these were intentional coping strategies or examples of PTS dissociation.

In terms of ***needs***, children expressed their need for *attention, emotional warmth* and *care* (from specialists, from their parents, from their peers).

As collected in the Slovenian sample, most children showed a great need to take care of their parents' feelings (particularly for their mother's feelings). They felt responsible to improve the emotional state of their mother with their good behaviour, a clear example of *role reversal*: common in cases of domestic violence, consists of a reversal of responsibilities between parent and children, with the children taking 'charge' of care and households chores that are not appropriate for their age.

Other children expressed how now some of their needs had been met, as we can read in the extract below, taken from the Greek sample:

"I'm happy that my dad is better and my parents talk to each other without shouting, now that they do not live together. I hope they continue like this in the future and that my dad and mom are calm". (Interesting to note how unfortunately, many times this is not the case, as separation is not that common in cases on domestic violence).

Another extract, taken from the Italian sample, shows how the girl has now found a safe place in the residential community *"She found new friends, grown ups that love her, and friends that love her".*

In terms of ***concerns, worries and fears*** about the future, explored in the last part of the story, we can identify the following commonalities in the sample:

1. Children worry about themselves, about re-experiencing sadness, loneliness, fear and anxiety as their main feelings in the future. Some are worried about being left alone, or that 'bad things' could still happen to them in the future; some wonder if they will still be supported and if they will have the resources to ask for help if needed *"Will things be better in the future? Will I feel better?", "Will bad things still happen? Will I be able to talk to someone about what is happening to me?"* (Greek sample).
2. Children worry about their parents and what will happen to them, both because they feel responsible for them, are concerned for their happiness, their health, and wonder if they will be spending time with them, if they will have changed and could be trusted (*"I'm worried about my dad; will he have become a better person? Will he have his own house so I can see him?"* Greek sample), but oppositely, some children worry about their parents because they are afraid of re-experiencing violence from them *"Fears the father will be released soon and will harass their family again"* (Bulgarian sample).

When asked about the future (usually a challenging task for children who have suffered trauma), two main types of answers were offered: one, in which children expressed their worries about their parents and voiced their desire of being with them in the future, but as a functional family:

"He will live with perfect parents who are always there with him" (Bulgarian sample)

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The other, in which children anticipate a life without their parents, a life in which they would be independent, happy and in some cases surrounded by other loving and caring adults.

"Daniela will learn many new things, she will start a job, and no more bad things will happen to her, she will be really happy and she won't be angry anymore, and her parents won't be there anymore, because her parents had never paid any attention to her" (Italian sample).

"In her story, she decided that her parents would perish, and she and all the other children would be adopted, and later she would get more brothers and sisters" (taken from the Bulgarian report)

These types of prefiguration, though very different from each other, represent 'happy endings' for different children at different stage of their grief and trauma elaboration. Some are more realistic while other appear more like escaping into fantasy to hide from painful experiences, signs that therapeutic work is still needed.

From the data described in this paragraph it appears that the Greece, Bulgaria, Slovenia and Italy should invest in an approach focused on training practitioners and professionals that have close contacts with children (teachers in the school environment, doctors and paediatricians, for instance) on ACEs, on its effects and on how to adopt a trauma-informed type of care into the work they do. Children need to have basic information on what to do and where to ask for support in case of need, so together with easily accessible media campaigns on this matter, workshops in schools on ACEs, clarifying where children can get help should be also organised.

Children who have already started a healing path need to be reassured that the structures and services that are looking after them now will be able to support them even in the future. These children would benefit from specific resilience trainings to improve their self-regulation, social competency and self-efficacy, to support those protective factors that can counterbalance the adversities they have experienced, in order to effectively break the intergenerational cycle of ACEs. In order to achieve this, a systemic approach in which different Institution, Organisations and stakeholders, both private and public, collaborate and take a whole-child approach is needed. As seen from the comparison of the legislation of the 4 countries involved in the study, their specific regional situations and the field data collected, we are far from having a homogenous approach to the phenomenon of ACEs. This reinforces the need for shared European Programmes aimed at giving European countries a shared basic knowledge onto which implement shared best practices.

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References:

Bateson, K., McManus, M., & Johnson, G. (2020). Understanding the use, and misuse, of Adverse Childhood Experiences (ACEs) in trauma-informed policing. *The Police Journal, 93*(2), 131-145.

Bellis, M. A., Hughes, K., Ford, K., Hardcastle, K. A., Sharp, C. A., Wood, S., ... & Davies, A. (2018). Adverse childhood experiences and sources of childhood resilience: a retrospective study of their combined relationships with child health and educational attendance. *BMC public health*, *18*(1), 1-12.

Bellis, M. A., Hughes, K., Ford, K., Rodriguez, G. R., Sethi, D., & Passmore, J. (2019). Life course health consequences and associated annual costs of adverse childhood experiences across Europe and North America: a systematic review and meta-analysis. *The Lancet Public Health*, *4*(10), e517-e528.

Blodgett, C., & Lanigan, J. D. (2018). The association between adverse childhood experience (ACE) and school success in elementary school children. *School Psychology Quarterly*, *33*(1), 137–146.

Cavanaugh, B. (2016). Trauma-informed classrooms and schools. Beyond Behavior, 25(2), 41-46.

Center on the Developing Child at Harvard University (2015). Supportive relationships and active skill-building strengthen the foundations of resilience: Working Paper No. 13. https://developingchild.harvard.edu/resources/supportive-relationships-and-active-skill-building-strengthen-thefoundations-of-resilience/. Accessed 8 Apr 2021.

Cluver, L., Lachman, J. M., Sherr, L., Wessels, I., Krug, E., Rakotomalala, S., ... & McDonald, K. (2020). Parenting in a time of COVID-19. *Lancet*, *395*(10231).

Cyrulnik, B. (2009). *Resilience: How your inner strength can set you free from the past*. Penguin UK.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American journal of preventive medicine*, *14*(4), 245-258.

Finklehor, D. (2007). Developmental victimology: The comprehensive study of childhood victimizations. *Victim of Crime*, *3*, 9-34

Finkelhor, D., Turner, H. A., Shattuck, A., & Hamby, S. L. (2015). Prevalence of childhood exposure to violence, crime, and abuse: Results from the national survey of children's exposure to violence. *JAMA pediatrics*, *169*(8), 746-754.

Finkelhor, David. "Developmental victimology: The comprehensive study of childhood victimization". Victims of crime (4th Ed). Robert C. Davis, Arthur J Lurigio, & Susan Herman, (Eds.) Thousand Oaks: CA: Sage, 2013. pp 75-106. Print.

Finkelhor, D. (2020). Trends in adverse childhood experiences (ACEs) in the United States. *Child Abuse & Neglect*, *108*, 104641.

This report, was funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020)

Foy, J.M., Green, C. M., & Earls, M. F. (2019). Mental health competencies for pediatric practice. *Pediatrics*, *144*(5). https://doi.org/10.1542/peds.2019-2757

Gardner, R. A. (1970). The mutual storytelling technique: Use in the treatment of a child with post-traumatic neurosis. *American Journal of Psychotherapy*, *24*(3), 419-439.

Garmezy, N., Masten, A. S., & Tellegen, A. (1984). The study of stress and competence in children: A building block for developmental psychopathology. *Child development*, 97-111.

Hamby, S., Taylor, E., Jones, L., Mitchell, K. J., Turner, H. A., & Newlin, C. (2018). From poly-victimization to poly-strengths: Understanding the web of violence can transform research on youth violence and illuminate the path to prevention and resilience. *Journal of interpersonal violence*, *33*(5), 719-739.

Hughes, K., Ford, K., Kadel, R., Sharp, C. A., & Bellis, M. A. (2020). Health and financial burden of adverse childhood experiences in England and Wales: a combined primary data study of five surveys. *BMJ open*, *10*(6), e036374.

Jeske, J., & Klas, M. L. (2016). Adverse childhood experiences: Implications for family law practice and the family court system. *Family Law Quarterly*, *50*(1), 123-137.

Kisely, S., Abajobir, A. A., Mills, R., Strathearn, L., Clavarino, A., & Najman, J. M. (2018). Child maltreatment and mental health problems in adulthood: birth cohort study. *The British Journal of Psychiatry*, *213*(6), 698-703.

Koita, K., Long, D., Hessler, D., Benson, M., Daley, K., Bucci, M., & Harris, N. B. (2018). Development and implementation of a pediatric adverse childhood experiences (ACEs) and other determinants of health questionnaire in the pediatric medical home: A pilot study. PloS One, 13(12), Article e0208088. https://doi.org/10.1371/ journal.pone.0208088.

Larkin, H., Felitti, V. J., & Anda, R. F. (2014). Social work and adverse childhood experiences research: Implications for practice and health policy. *Social work in public health*, *29*(1), 1-16.

Lereya, S. T., Copeland, W. E., Costello, E. J., & Wolke, D. (2015). Adult mental health consequences of peer bullying and maltreatment in childhood: two cohorts in two countries. *The Lancet Psychiatry*, *2*(6), 524-531.

Levenson, J. (2017). Trauma-informed social work practice. *Social Work*, *62*(2), 105–113.

Levenson, J. (2020). Translating Trauma-Informed Principles into Social Work Practice. *Social Work*, *65*(3), 288–298. https://doi.org/10.1093/sw/swaa020

Lopez, M. A., Wong, S. L., & Raphael, J. L. (2020). Health policies to address adverse childhood experiences: taking a whole child approach. *Pediatric research*, *88*(1), 8-10.

Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American psychologist*, *56*(3), 227.

This report, was funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020)

Masten, A. S., & Barnes, A. J. (2018). Resilience in children: Developmental perspectives. *Children*, *5*(7), 98.

McGavock, L., & Spratt, T. (2017). Children exposed to domestic violence: Using adverse childhood experience scores to inform service response. *British Journal of Social Work*, *47*(4), 1128–1146. https://doi.org/10.1093/bjsw/bcw073

McManus, M. A., & Ball, E. (2020). COVID-19 should be considered an Adverse Childhood Experience (ACE). *Journal of Community Safety and Well-Being*, *5*(4), 164-167.

Oral, R., Ramirez, M., Coohey, C., Nakada, S., Walz, A., Kuntz, A., ... & Peek-Asa, C. (2016). Adverse childhood experiences and trauma informed care: the future of health care. *Pediatric research*, *79*(1), 227-233.

Post, P. B., Grybush, A. L., Elmadani, A., & Lockhart, C. E. (2020). Fostering resilience in classrooms through child–teacher relationship training. *International Journal of Play Therapy, 29*(1), 9–19.

Sciaraffa MA, Zeanah PD, Zeanah CH. Understanding and promoting resilience in the context of adverse childhood experiences. Early Child EducJ. 2017; https://doi.org/10.1007/s10643-017-0869-3.

Sciaraffa, M. A., Zeanah, P. D., & Zeanah, C. H. (2018). Understanding and promoting resilience in the context of adverse childhood experiences. *Early childhood education journal*, *46*(3), 343-353.

Taillieu, T. L., Brownridge, D. A., Sareen, J., & Afifi, T. O. (2016). Childhood emotional maltreatment and mental disorders: Results from a nationally representative adult sample from the United States. *Child abuse & neglect*, *59*, 1-12.

Traub, F., & Boynton-Jarrett, R. (2017). Modifiable resilience factors to childhood adversity for clinical pediatric practice. *Pediatrics*, *139*(5).

Turner, H. A., Finkelhor, D., Shattuck, A., Hamby, S., & Mitchell, K. (2015). Beyond bullying: Aggravating elements of peer victimization episodes. *School psychology quarterly*, *30*(3), 366.

Verger, N. B., Urbanowicz, A., Shankland, R., & McAloney-Kocaman, K. (2021). Coping in isolation: predictors of individual and household risks and resilience against the COVID-19 pandemic. *Social Sciences & Humanities Open*, *3*(1), 100123.

Walton-Fisette, J. L. (2020). Fostering resilient learners by implementing trauma-informed and socially just practices. *Journal of Physical Education, Recreation & Dance*, *91*(9), 8-15.

Yule, K., Houston, J., & Grych, J. (2019). Resilience in children exposed to violence: a meta-analysis of protective factors across ecological contexts. *Clinical child and family psychology review*, *22*(3), 406-431.

This report, was funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020)