MIRACLE FOUNDATION -INDIA-

FAMILY STRENGTHENING AND FAMILY-BASED ALTERNATIVE CARE

Resource Handbook for Master Trainers

REFERENCE DOCUMENT

Chapter 4

Assessment of Children & Families

1. Handout: JJA Form 43 Child Case History JJA Form 43
2. Handout Multi-Disciplinary Teams (MDT)

1. Handout 1: JJA Form 43 Child Case History JJA Form 43

FORM 43

[Rule 69 (H) (3)]

CASE HISTORY OF THE CHILD

(FOR CHILD CARE INSTITUTION)

Affix a latest photograph here

Case/Profile No……

Date & Time……

A. PERSONAL DATA

1. Name……

2. Male / Female (tick the appropriate category) ……..

3. Age at the time of admission……..

4. Present age……

5. Category (tick as applicable):

(i) Separated from family

(ii) Abandoned/deserted

(iii) Victim of exploitation and violence (give detail)

(iv) Run-away

(v) Any other

6. Religion

(i) Hindu (OC/BC/SC/ST)

(ii) Muslim/Christian/Other (pl. specify)

7. Native District & State:

8. Description of the Housing:

(i) Concrete building/ Kuchha

(ii) Three bedroom/ two bedroom/ one bedroom/ no separate bedroom

(iii) Owned / rental

9. By whom the child was brought before the Child Welfare Committee/Juvenile Justice Board (tick as applicable):

i. Police-Local Police/Special Juvenile Police Unit/ designated Child Welfare Police Officer / Railway Police/ Women Police

ii. Probation Officers

iii. Social Welfare Organization

iv. Social Worker

v. Parent(s)/Guardian (s) (please specify the relationship)

vi. Any public servant

vii. Any public spirited citizen

viii. Child himself/herself

10. Reasons for leaving the family

i. Abuse by parent(s)/guardian(s)/step parents(s)

ii. In search of employment

iii. Peer group influence

iv. Incapacitation of Parents

v. Criminal behavior of Parents

vi. Separation of Parents

vii. Demise of Parents

viii. Poverty

ix. Others (please specify)

11. Types of abuse met by the child

i. Verbal abuse – parents/siblings/ employers/others (pl. specify)

ii. Physical abuse

iii. Sexual abuse parents/siblings/ Employers/others (Pl. Specify)

iv. Others – parents/siblings/ employers/others (Pl. Specify)

12. Types of ill-treatment met by the child.

i) Denial of food –parents/siblings employers/other (pl. specify)

ii) Beaten mercilessly-parents/ Siblings/employers/other (pl. specify)

iii) Causing injury – parents/ siblings/employers/other (pl. specify)

iv) Detention - parents/ siblings/employers/other (pl. specify)

v) Other (please Specify)

13. Exploitation faced by the child

i) Extracted work without payment

ii) Little (low) wages with longer duration of work

iii) Others (pl. specify)

14. Health status of the child before admission.

i) Respiratory disorders- present / not known / absent

ii) Hearing impairment- present / not known / absent

iii) Eye diseases- present / not known / absent

iv) Dental disease- present / not known / absent

v) Cardiac diseases- present / not known / absent

vi) Skin disease- present / not known / absent

vii) Sexually transmitted diseases- present / not known / absent

viii) Neurological disorders- present / not known / absent

ix) Mental handicap- present / not known / absent

x) Physical handicap- present / not known / absent

xi) Urinary tract infections- present / not known / absent

xii) Others (pl. specify)- present / not known / absent

15. With whom the child was staying prior to admission

i. Parent(s) – Mother / Father / Both

ii. Siblings / Blood relative

iii. Guardian(s) – Relationship

iv. Friends

v. On the street

vi. Night shelter

vii. Orphanages / Hostels/ Similar Homes

viii. Other (pl. specify)

16. Visit of the parents to meet the child

Prior to institutionalization- Frequently / Occasionally / Rarely / Never

After institutionalization - Frequently / Occasionally / Rarely / Never

17. Visit of the Child to his parents

Prior to institutionalization - Frequently / Occasionally / Rarely /During festival times / During summer holidays / Whenever fallen sick / Never

After institutionalization-- Frequently / Occasionally / Rarely /During festival times / During summer holidays / Whenever fallen sick / Never

18. Correspondence with parents -

Prior to institutionalization – Frequently / Occasionally / Rarely /During festival times / During summer holidays / Whenever fallen sick / Never

After institutionalization – Frequently / Occasionally / Rarely /During festival times / During summer holidays / Whenever fallen sick / Never

19. Details of disability

20 Type Family: Family / joint family/ broken family / single parent

21. Relationship among the family members:

i) Father & mother- Cordial/ Non-cordial/ Not known

ii) Father & child- Cordial/ Non-cordial/ Not known

iii) Mother & child- Cordial/ Non-cordial/ Not known

iv) Father & siblings- Cordial/ Non-cordial/ Not known

v) Mother & siblings- Cordial/ Non-cordial/ Not known

vi) Child & siblings- Cordial/ Non-cordial/ Not known

vii) Child & relative- Cordial/ Non-cordial/ Not known

22. History of crime committed by family members, if any:

S. No.	Relationship	Nature of Crime	Legal Status of the Case	Arrest if any made	Period of confinement	Punishment Awarded
1.	Father					
2.	Step Father					
3.	Mother					
4.	Step Mother					
5.	Brother (a) (b)					

	(c)					
6.	Sister (a) (b) (c)					
7.	Child					
8.	Others (Uncle/aunty/ Grandparents)					

23. Properties owned by the family:

    i. Landed properties (pl. specify the area)

    ii. Household articles- Cows/ Cattle/ Bull

    iii. Vehicles- two wheeler/ three wheeler/ four wheeler (lorry/ bus/ car/ tractor/ jeep)

    iv. Others (please specify)

24. Marriage details of family members:

    i) Parents- Arranged/ Special Marriage

    ii) Brothers- Arranged/ Special Marriage

    iii) Sisters- Arranged/ Special Marriage

25. Social activities of family members:

    i. Participate in social and religious functions

    ii. Participate in cultural activities

iii. Does not participate in social and religious functions

iv. Not known

26. Parental care towards child before admission:

i. Over protection

ii. Affectionate

iii. Attentive

iv. Not affectionate

v. Not attentive

vi. Rejection

ADOLESCENCE HISTORY (Between 12 and 18 years)

27. At what age did the child attain puberty?

28. Details of delinquent behavior if any

i. Stealing

ii. Pick pocketing

iii. Arrack selling

iv. Drug peddling

v. Petty offences

vi. Violent crime

vii. Rape

viii. None of the above

ix. Others (please specify)

29. Reason for delinquent behavior

i. Parental neglect

ii. Parental overprotection

iii. Parents criminal behavior

iv. Parents influence (negative)

v. Peer group influence - To buy drugs/alcohol

vi. Others (pl. specify)

30. Habits

A	B
i) Smoking	i) Watching TV/movies
ii) Alcohol consumption	ii) Playing indoor/outdoor games
iii) Drug use (specify)	iii) Reading books
iv) Gambling	iv) Religious activities
v) Begging	v) Drawing/painting/acting/singing
vi) Any other	vi) Any other

EMPLOYMENT DETAILS

31. Employment details of the child prior to entry into the Home:

S. No.	Details of Employment	Timing and Duration	Wages Earned
1	Coolie		
2	Rag Picking		
3	Mechanic		
4	Hotel Work		
5	Tea Shop Work		

6	Shoe Polish		
7	Household Works		
8	Other: (Pls Specify)		

32. Details of income utilization:

Sent to family to meet family need

i. For dress materials

ii. For gambling

iii. For prostitution

iv. For alcohol

v. For drug

vi. For smoking

vii. Savings

33. Details of savings

i. With employers

ii. With friends

iii. Bank/Post Office

iv. Others (pl. specify)

34. Duration of working hours

i. Less than six hours

ii. Between six and eight hours

iii. More than eight hours

EDUCATIONAL DETAILS

35. The details of education of the child prior to the admission to Children's Home

i. Illiterate

ii. Studied up to V Standard

iii. Studied above V Std but below VIII Standard

iv. Studied above VIII Std but below X Standard

v. Studied above X Standard

36. The reason for leaving the School

a. Failure in the class last studied

b. Lack of interest in the school activities

c. Indifferent attitude of the teachers

d. Peer group influence

e. To earn and support the family

f. Sudden demise of parents

g. Rigid school atmosphere

h. Absenteeism followed by running away from school

i. There is no age appropriate school nearby

j. Others (pl. specify)

37. The details of the school in which studied last:

i. Corporation/Municipal/Panchayat

ii. Government/SC Welfare School/BC Welfare School

iii. Private management/ Convents

38. Medium instruction: Hindi/English/Urdu/Tamil/Malayalam/Kannada/Telugu/Marathi/ Gujarati/ Bengali / Other language (please specify)

39. After admission to Children's Home, the educational attainment from the date of admission till date;

No. of years Class studied Promoted /detained

40. Vocational training undergone form the date of admission into Children's Home till date.

No. of years

Name of Vocational Trade

Proficiency Attained

Details of certification?

41. Extra-curricular activities developed form the date of admission into the Children's Home till date

i) Scout

ii) Sports (please specify)

iii) Athletics (please specify)

iv) Drawing

v) Painting

vi) Others (pl. specify)

MEDICAL HISTORY

42. Height and weight at the time of admission:

43. Physical condition:

44. Medical history of child (gist):

45. Medical history of parent/guardian (gist):

46. Present health status of the child:

Sl. No.	Annual Observation	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
	Date of Review				
	Height				

	Weight				
	Nutritious diet given				
	Stress				
	Dental				
	ENT				
	Eye				

47. Height and Weight Chart

Date, Month and Year	Height	Admissible Weight	Actual Weight

SOCIAL HISTORY

48. Details of friendship prior to admission into Children's Home:

i. Co-workers

ii. School/Classmate

iii. Neighbours

iv. Others (pl. specify)

49. Majority of the friends are

i. Educated

ii. Illiterate

iii. The same age group

iv. Older in age

v. Younger in age

vi. Same sex

vii. Opposite sex

50. Details of membership in group (please specify details)

i. Associated with cine fans association

ii. Association with religious group

iii. Associated with arts and sports club

iv. Associated with gangs

v. Associated with voluntary social service league

vi. Others (please specify)

51. The position of the child in the groups/league

i. Leader

ii. Second level leader

iii. Middle level functionary

iv. Ordinary member

52. Purpose of taking membership in the group:

i. For social service activities

ii. For leisure time spending

iii. For pleasure seeking activities

iv. For deviant activities

v. Others (please specify)

53. Attitude of the group / league

i. Respect the social norms and follow the rules

ii. Interested in violating the norms

iii. Impulsive in violating the rules

54. The location/meeting point of the groups

i. Usually at fixed place

ii. Places are changed frequently

iii. No specific places

iv. Meeting point is fixed conveniently

55. The reaction of the society when the child first came out of the family

i. Supportive

ii. Rejection

iii. Abuse

iv. Ill-treatment

v. Exploitation

56. The reaction of the police towards children

i. Compassionate

ii. Harsh

iii. Aggressive and abusive

iv. Exploitative

v. Ill-treated

57. The response of the general public towards the child …….

HISTORY OF THE CHILD (Brief)

(i) Education

(ii) Health

(iii) Vocational training

(iv) Extra-curricular activities

(v) Others

Suggestion of Child Welfare Officer/ Probation Officer after orientation to child and the response towards orientation.

Follow up by Child Welfare Officer/ Probation Officer/ Case Worker/ Social Worker

Quarterly Review of Case History by Management Committee

PERSON IN CHARGE/ SUPERINTENDENT/ CHILD WELFARE OFFICER/ PROBATION OFFICER

2. Handout 2 Multi-Disciplinary Team (MDT) Meeting – Purpose/Guideline Document

Important Recommendation: As far as possible, the concerned team should try to leverage any existing committee to carry out the function of MDT, for example – Home Management Committee in case of a CCI or VCPC/WCPC committee or any closed group relevant committee in case of community. The below functions and roles will apply to the existing committee when it carries out the function of MDT.

In case no such existing committee is there (which will only be a rare scenario), MDT should be formed and carry out the functions as suggested in this guideline.

The Purpose: Collaboration within a multidisciplinary team is crucial for optimal outcomes for children and families in Child Care Institutions (CCI) or at risk of separation. The MDT aims to coordinate efforts across various disciplines to identify, treat, and plan for children and families in the care system.

The Participants' Profile and Structure: The MDT should include:

In case of prevention: Case Worker/case worker, Representative from the concerned CSO that's involved in the interventions with the child and the family (Someone involved in decision making), Govt. authorities including DCPO, CWC representatives, representatives from the community like PRI members and other influential persons from the community. Mental Health Resource Person or any barefoot counselor as available should also be included.

In case of transition: case worker/case workers, core team of FS-FBAC project, In-charge, Mental Health Resource Person (MHRP), Chief Functionary (CFO) and other experts on need-basis (e.g. those working in health, education, mental health, substance abuse or domestic violence services). It will be also useful to involve District Child Protection Officials (DCPOs) or caseworkers from government agencies who are directly involved in working with the child/family.

Note: that the child and family will not participate in these meetings. However, their opinions and thoughts, fears and challenges will be taken into account beforehand, by the Case Worker/case worker and Outreach team members. And the same will be brought to discussion during these meetings.

Note that the presence of Case Worker and/or CCI-SW & Chairperson (whoever will chair these meetings) will be vital during the meetings and meetings can carry on if they are the only ones in attendance. The meetings can also take place remotely via conference call if in-person meetings are not possible.

The ***Facilitator*** of these meetings will be the Case Worker or case worker, or in cases where there is none of above, In-charge or SW.

The In-charge Or CFO can ***Chair*** these meetings. In case of prevention, any stakeholder from the community or govt. officials (ideally DCPO) can also chair these meetings.

Here are Few Key Functions for MDT Meetings:

1. The MDT team meets Bi-monthly (Once in every 2 months) to discuss about the case management plan, key updates, key issues faced, & forward planning for case which can include but not limited to:
    a. ALL children from the community who are at the risk of separation from their families
    b. ALL Children in Planning Stage & Implementation Stage
    c. ALL Children placed outside within 6 months
    d. ALL Critical cases which need prompt intervention: these can be children in assessment phase, those in placement more than 6 Months or any New Admissions
    e. Families who are identified to require who need Immediate Attention/ support under 5 wellbeing domains
    f. Case with HIGH/CRITICAL Risks or red flags
    g. Case which requires discussion before presenting to CWC

2. The MDT Meeting minutes will be recorded in register or soft copy in the prescribed format (Below) immediately after the meeting no later than (2 days)
3. The facilitator presents the case identifying:
    a. Crisp Background History
    b. Have documents (Assessment/case notes) handy regarding the case if required
    c. Discuss what has been done so far
    d. Key issues
    e. The MDT discusses the next action steps

4. The MDT Meeting can also include discussion on ways to further improve the service delivery system, for e.g. If there is a need to increase the no. of follow-ups per case, or means to better engagement from the care-givers/parents.

5. Subject matter experts on the topics such as health, education, mental health, substance abuse or domestic violence services, Childline, DCPOs, etc. can be involved on need basis : this can be in form of sharing their thoughts in writing (emails/any reports) or can be in-person/remotely (via phone/WhatsApp call) to discuss any key issue which impacts child's placement if required. The experts should have access to minutes of meetings if required.

Some ground rules:

1. The meeting should NOT be scheduled for more than 2 hours (Maximum time). The chairperson will also be responsible for timekeeping.
2. Case discussion time for 1 case capped at 20 minutes, which includes: *Background and discussion of supporting documents: 5 min, Discussion of key issues and what has been done so far: 5 min, Next Action Steps: 10 min.*
3. At least 1 meeting every quarter to apprise, update and share; (may be virtual – via conference call/ WhatsApp Call) but face to face is suggested.
4. if an MDT member is unable to attend the meeting in person, his/her presence can be ensured remotely via Video WhatsApp, Skype, Zoom or conference call if agreeable by the Chairperson (the session can also be recorded ONLY for the members who miss the meeting for any unavoidable reasons.
5. The facilitator will share the agenda of the meeting in prescribed format (Annexure 1) with the participants at least 2 days before the meeting.
6. The minutes of the meeting to maintained by the facilitator in prescribed format (Annexure 2)
7. Effective multidisciplinary working relationships are reinforced by Chairperson:
    a. Common goals and shared understanding the needs of the child, the desired outcomes and the route to achieving those outcomes
    b. Responsibility for the well-being of children and their families
    c. Clarity over the roles of agencies, understanding of each other's responsibilities, and clear role boundaries
    d. Commitment, including a willingness to work together
    e. Trust and mutual respect
    f. Understanding each other's 'uniqueness' – an awareness and appreciation of what other agencies can contribute, understanding the range of perspectives
    g. Effective and regular communication
    h. Information exchange - Sharing information

8. Encourage diverse opinions for best solution to the process
9. It will be the facilitator's role to ensure that all the participants are sent written and telephonic reminders at least 7 days prior to the meeting.
10. The venue of the MDT meetings will be a community facility (prevention) or CCI facility (transition).

11. The member should intimate 7 days in advance from the meeting date if they are unable to attend the next meeting or at least 24 hours in case of emergency and can share their discussion pointers to the moderator via email, text or over the phone.
12. Date of the next MDT meeting will be decided immediately after the end of each session.
13. To ensure confidentiality, all documents related to MDT should remain ONLY within the members of MDT.

Handout: Agenda Template:

Cases for Discussion: 5 (Discuss Maximum up to 5 cases)

1. Case 1 (20 min): Insert Name_____

    a. Crisp Background of the case (5 min):

        i. Brief History of the case [Can include background about the child & family, admitted since (year) and other important details to share]

    b. Other Supporting Documents refer child case file:

        i. JJA Form 43 ☐

        ii. Most Recent SIR ☐

        iii. ICP Part A&B☐

        iv. ICP Part C&D (If applicable)☐

        v. Thrive Scale Assessment (For children in Planning/Implementation/follow-up stage)☐

        vi. Other Reports if require discussion: e.g. Health/Education etc report: _____

    c. Current situation (5 min): [Discuss what has been done so far, any change in circumstances, key challenges, what is working well, identified needs of child and family]

    d. Reason for discussion: ☐ Risk of Separation, ☐ Placement change, ☐Support required in 5 wellbeing domains (Mention which one) _____, any other

    e. Next Action Steps (10 min)

Other Points for Discussion (e.g. improving service delivery system): 10 – 15 minutes

Handout : Minute Recording Format/Template for the MDT Meetings: (Can be recorded in Local Language)

- Date of the Meeting
- Name & Signature of Participants
- Name & Signature of Facilitator
- Name & Signature of Chairperson

Agenda points/Case for discussions - To be shared by the facilitator minimum 2 days in advance	Brief on important discussion points	Next plan of action	Person Responsible	Timeline

Minutes recorded by (Date and Sign) :

Date of Next Meeting :

Hand out - Home visit observation record sheet

HOME VISIT / OBSERVATION RECORD SHEET		
This form has been developed to help workers maximise the use of home visits by providing a framework for gathering information and to reflect on the information obtained through the home visit and how this might impact on child wellbeing / protection. *NOTE – Where parents are mentioned, this refers to whoever normally cares for the child on a regular basis – including grandparents*		
DATE / TIME:	**FAMILY NAME:**	**WORKER:**

Who is present:				
	No concern	Some concern	Many concerns	Comments / Notes
Physical Environment				
Is the home suitable? For example, is there sufficient space? Is there running water / toilets? Is it warm enough?				
Is the home clean and tidy? Are there any indications that there may be risks to the child's health?				
Does the child have an appropriate place to sleep?				
Are there any obvious physical dangers? For example, glass, knives and sharp objects lying around, or home is near to a busy road?				
Are there any age-appropriate toys available for the child?				
Child Observation & Behaviour				
Is the child dressed appropriately?				
Is the child clean?				
Given the child's age, do they seem to be meeting normal developmental milestones?				
Is the child's interaction with you appropriate, given their age?				
Is the child's speech and language appropriate for their age?				
Does the child play / occupy him/herself appropriately?				

Does the child follow instructions / request?				
Are there any signs of abuse, such as bruises or unexplained injuries?				
Is there any behaviour which is a cause for concern or does not seem 'normal'?				
Parent – Child Interaction				
Is there any loving / physical interaction between parent and child?				
Does the parent make positive comments about the child in the child's presence?				
Is the parent child directive (controlling) or do they give the child choices?				
Is there eye contact between the parent and the child?				
Does there appear to be a warm and natural relationship between the parent / child (or does the child seem frightened / cautious)				
Does the child appear happy?				
Does it appear that there is an obvious difference in the attitude or behaviour towards different children in the family?				
If there are other children in the house, does the relationship between the children seem appropriate? Is one child dominating or bullying the others?				
Parent's / Adult Presentation				

Does the parent express unrealistic expectations about the child / their behaviour?				
Does the parent speak in negative terms about the child / appear highly critical?				
Does the parent seem in full control of their behaviour, or do they seem under the influence of drugs / alcohol etc.?				
Is there any indication of domestic violence within the household?				
Is there any indication or mention of difficult or strained relationships between the adults in the home?				
Does the parent express any child care ideas that are a cause for concern? For example corporal punishment.				
Is there anything 'strange' or worrying about the parents' behaviour that would indicate there may be underlying problems, such as mental health issues?				
Was the parent aggressive / defensive during the visit?				

AFTER THE VISIT
What were the dynamics during the visit?
Did you have the opportunity to speak with the child individually? If so, have you any concerns?
Are there any issues / concerns that need to be followed up?
Thinking about the home visit, are you concerned about the welfare / safety of the child? Do you think they are at risk? If so, please say why

Chapter 5

Planning & Implementation

Preparation of Children & Families towards Family Strengthening

1. Handout 1: Supporting Child Specific Needs

Helping Children Develop Self-Esteem

- Help children learn to do new things. Show and help them first, then let them do what they can, even if they make mistakes. Be sure the child has many opportunities to learn, try, and feel proud – it increases their feelings of competence and confidence, and builds their problem solving skills.
- Give children choices. To build confidence in the world, kids have to take chances, make choices and take responsibility for them. Giving choices – within a reasonable set of options offered by you – makes them feel empowered. Choices may be simple when young, but they will prepare the child for more difficult choices as they get older.
- Let children know that no one is perfect. And explain that no one expects the child to be. The way you react to the child's mistakes and disappointments impact how the child will react.
- Offer sincere praise. Praise the child often, but be specific in your compliments, Praise their effort.
- Ban harsh criticism. The messages kids hear about themselves from others easily translate into how they feel about themselves. Harsh words ("You're so lazy!") are harmful, not motivating. When kids absorb negative messages about themselves, they feel bad about themselves, and act accordingly.
- Focus on strengths. Pay attention to what the child does well and enjoys. Make sure the child has opportunities to develop these strengths. Nurturing strengths is better than focusing on weaknesses if you want to help kids feel good about themselves and succeed.
- Teach the child to make positive self-statements. Self-talk is very important in everything we do. Therefore, it is important to teach children to be positive about how they "talk to themselves." Some examples of useful self-talk are: "I can get this problem, if I just keep trying." "It's OK if our team lost today. We all tried our best and you can't win them all." "It makes me feel good to help others even if the person doesn't notice or thank me."

Strategies to Address Bedwetting

- Be sure to look for any "hidden causes" of bedwetting: what is the child experiencing emotionally that might be contributing to the issue? Give the child the opportunity to talk about their stressors.
- Supporting the Child:

- Teach the child to imagine themselves waking up dry before they go to sleep. Practice this positive imagery with them during the day so they are prepared for the evening.
- Help the child build his/her self-esteem by focusing on their strengths and positive traits.
- Work with the child to plan for how they can respond effectively to teasing, if needed.
- Create a quiet time at bedtime to ease any feelings of anxiety or stress. Read a book together, massage the child, go through a visualization, etc.
- Invite the child to draw or write about how they feel about their bedwetting issues.

- Behavior Modification:
  - Train the bladder during the day – have the child hold urine for increasing longer times throughout the day, and get rewarded to do so
  - Introduce a reward system not necessarily for dry nights, but just for following the bedwetting treatment plan.
  - Guide the child to drink less before bed Eliminate bladder irritants at night, start by eliminating caffeine (such as chocolate milk, etc.) and cutting citrus juices at night.
  - Set an alarm for around 1-2am to get the child to awaken and use the toilet. Give the child a flashlight – sometimes children are afraid to get up at night to use the toilet when it is dark.

Strategies to support child with learning difficulty/ disability:

- Remember, success leads to success. It is important to set kids up for success – not failure – as much as possible. Teachers, counselors, and parents should set small achievable goals that children can work towards meeting. When a child sees proof that they are making progress, they will be more motivated to continue putting in that extra effort.
- Find their special talent. That is possibly the most important thing you can do for a child who has a learning disability. Find something that the child feels good about doing, and that gives them a sense of accomplishment, and give them time to practice it. As their talent grows, so will their confidence, self-esteem, and overall happiness.

Self-care Techniques:

- Accept support - this may be from your family, a friend or by using online forums. Knowing that there are other parents in the same situation can be a great encouragement.
- Do not overlook success - If you have coped well with something difficult, be proud of what you've achieved. Celebrate your children's successes too.
- Make time for yourself - This may involve doing things like exercising or listening to music. It can be as simple as watching a film or going for a walk.
- Be as prepared as possible. Parenting can of course be stressful at certain times, so consider ways of dealing with this in advance.

2. *Handout 2: Child and family preparation checklist for reintegration/F-BAC options*

After finalizing the most suitable care option (reintegration with the family or FBAC), it is important to prepare both the child and the family to smoothly adjust to their new environment and living arrangements.

Below is a checklist of steps to follow while preparing a child and family for living together.

Family & Child Preparation Checklist for Transition

Name of the Case Worker:
Case ID:
Supervisor (if any)

Action (Family)	Done (✔)	Missed (×)	Remark/Comment (if any)
Talk to all the members of the household to understand their feelings around placement			
Address any questions or concerns any family member might have regarding the child moving in.			
Reassess safety and success of critical family strengthening interventions			
Have the family prepare a plan for the child's reintroduction into the family and his/her day to day care, with your support			
Discuss with the family, a care plan for critical care needs of the child and how they will be addressed at home (ex. Schooling, health needs, relationship with other family members, etc.)			
Plan initial short stays for the child in the family			
Pre and post short stay take feedback from the family on the experience and understand their plan to manage these stays			
Discuss with family the process to reach out for support in case they need it when the child			

moves with them			
Conduct SIR/ICP/TS as per the schedule			
Action (Child)	**Done (✔)**	**Missed (×)**	**Remark/Comment (if any)**
Explain to the child, in detail, the plan for their moving in with the family (How, when, all the steps involved)			
Take a note of the child's feelings about the move regularly			
Address any hesitation the child might have regarding the placement			
Discuss with the child their plan for organizing their days after the move and understand how they are imagining the move to look like			
Manage expectations and provide clear information about the plans you are supporting the family to make as well			
Pre and post short stay take feedback from the child on their experience and understand their plan to manage these stays			
Discuss with child the process to reach out for support in case they need it after the move			
Do a few frequent follow up visits post the move to ensure the child's needs are being met adequately			

Note: Once criteria set in the checklist are met, the case-manager recommends and sought order of CWC/ relevant authority and & plan transition. Post reintegration, continue follow-up and continue activities to enhance family bond

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Child and Family Preparation - For Prevention

As a critical step to ensure sustainability of family placement, it is important to prepare both the child and the family to enable them to build on their strengths and address their challenges in

order to be able to provide their children with a safe and nurturing environment thus preventing risk of separation.

Below is a checklist of steps to follow while preparing a child and family

Family & Child Preparation Checklist

Name of the Case Worker:
Case ID:
Supervisor (if any):

Action (Family)	Done (✔)	Missed (×)	Remark/Comment (if any)
Talk to all the members of the household to understand their feelings about the current situation & support offered			
Address any questions or concerns any family member might have regarding the child specific needs			
Reassess safety and success of critical family strengthening interventions			
Discuss with the family, a care plan for critical care needs of the child and how they will be addressed at home (ex. Schooling, health needs, relationship with other family members, etc.)			
Planned Home visitation to strengthen parenting skills, improve child-parent relationship and connect parent/caregiver to sources of support (focus on community-based support)			
Discuss with family the process to reach out for support in case they need it (in case of crisis)			
Conduct SIR/ICP/TS as per the schedule			
Action (Child)	**Done (✔)**	**Missed (×)**	**Remark/Comment (if any)**
Take a note of the child's feelings regularly			

Address any hesitation the child might have			
Manage expectations and provide clear information about the plans you are supporting the family to make as well			
Child is guided on strategies to control over strong emotions			
Discuss with child the process to reach out for support in case they need it			
Do a few frequent follow up visits to ensure the child's needs are being met adequately . this includes individual discussion with child			

3: Handout 3 Attachment:

Attachment occurs when the child's physical, psychological and emotional needs are met. Attachment is the word for a strong kind of love that is predictable and consistent. People who are well loved as a child can love others.
This attachment is extremely influential on:
*How the child views him/herself
*How the child relates to others

Securely attached people are confident in their relationships, and not overly dependent on others. This kind of love is the goal of every parent/caregiver. It allows children to grow up to be loving parents, husbands, and wives themselves.

Trauma can harm the brain, but the right kind of nurturing can help heal the brain. Children from troubled pasts have lost their voice and we need to help them restore that voice. The way we communicate with the child can stimulate certain areas of the brain that help them regulate emotion, attention, and how they understand themselves and others. Relationships are brain food. How we interact can change the way the brain processes. What they should have learned from their parents, they must now learn from you.

Signs of Poor Attachment

- Resisting cuddling and physical contact
- Lack of eye contact
- Never developing a sense of honesty
- Always wanting to be alone
- Not feeling remorse for hurting others, or not recognizing the need to stop because their behavior hurts others
- Not able to understand how their behavior will affect the future (because there was no consistency in associating things like hunger and eating)

- Will not ask for help or care, even when they need it
- They will try to control their feelings, and do not show clearly what they feel
- They will try to resolve problems on their own much too early in development
- They will have problems remembering and talking about sad or difficult events such as separation and loss
- They will often appear to be cynical, stressed, emotionally disconnected and say things like “Who cares?” “You can’t trust adults”
- They often appear to be lonely and sad, but refuse to talk about it.
- Everything that did not happen for the child in their early years needs to happen for them now.

If a child has experienced deprivation and random changes in early caregiver relations, everything is “delayed.” Child development slowed down, especially social, emotional and brain development.
So, you may see a child behaving as a much younger child. What to do?

- Divide the child’s age in half– what kind of contact is good for a child that age? How much does the child understand instructions? How long can a child that age concentrate? *Offer explanations and activities that are appropriate for younger children – plan very short and scheduled activities during the day
- Be very patient
- Use eye contact, kind touch, and lots of conversation
- Attachment behavior in adults includes responding sensitively, appropriately, and consistently to the child’s needs.
- Look children in the eyes when they are talking to you, even if it means you need to stop what you are doing for a minute.
- Bend down to their level if necessary
- Show smiling eyes, calm voice
- Give hugs and kind touch
- Listen with full attention and show that you are listening with phrases such as “Hmm-mm” or “Oh…
- Get excited for a child’s achievements and encourage them with “You can do it!
- Give their feelings a name
- Help them identify how they are feeling
- Accept their feelings - even if you do not think they should feel sad or scared in a particular situation, the truth is, they are sad or scared, so let them know you understand. Accepting their feelings does not mean accepting their behavior.
- Teach them “Give me words because I am listening. I am here for you.” (eg, When the child is angry and acting out, ask them to stop shouting and tell you about their anger.) Then, you must listen. How do you let them know they are safe and you are here for them?
- Take whatever time the child needs. It may take some children longer to develop trust and feel comfortable building a relationship with you. Do not give up.
- Treat the child with respect. Treat them as you would like to be treated. Model the desired behavior.

- Nurture the child even when the child seems unlikable. Separate the child from the behavior. You can love the child even if you do not like their behavior… let them know this.
- Tell the children something special about themselves every day!

So how do you fit these attachment behaviors into your busy days? Incorporate attachment behaviors while completing your tasks. Examples: while handing out snacks, lean down to talk to the child, listen carefully, smile, touch the child's shoulder, etc.

This is necessary for making the child feel secure and for promoting attachment.
Attachment behaviors from the caregiver are just as important to teens as to young children.
It is easy to fall into a pattern of negative interactions or questioning (why didn't you finish that work yet? when did you plan on telling me about that?) rather than positive (thank you for helping me…you have the best smile).

Adolescents still need to hear, feel, and know that we love them and enjoy being with them. When speaking with teens, strive for a tone of respect, dignity, humanity, and care.

- Listen for the deeper meaning behind their words and behavior and respond to that first.
- Act as a loving sounding board without rushing into the mode of problem solver
- It is wise, with teens, to keep advice that is not requested to a minimum, and if it must be given, do it gently, perhaps first asking if they are open to receive it. This communicates that we believe in their ability to handle their own problems, and we are here to help them when they need us.
- It is important that we continue to show physical affection with teens. It can be something as simple as a playful tousle of his/her hair, or a hand on the shoulder, but it communicates your love and connection.
- Do not take teens' negative behavior personally. Mean behavior is about their tangled-up feelings and immature ability to understand and express their emotions. When mean behavior is taken personally, we tend to close off or lash out, which only makes the situation worse. Instead, set limits with a calm, empowered mind.
- While all of this sometimes feels like a burden of responsibility, it is also a gift. When you succeed, you have given the child a secure base – a positive foundation for life. This is why your role is so incredibly important.

Case Management intervention in Mental Health

Right from the time of the first referral when the intake process begins, is where we have to include the mental health component along with the rest of the dimensions for assessment. The following figure gives us an overview of the mental health component in the process.

Figure 5.1

MHPSS interventions will be the final assessment after analysing the interplay of the following 4 dimensions:

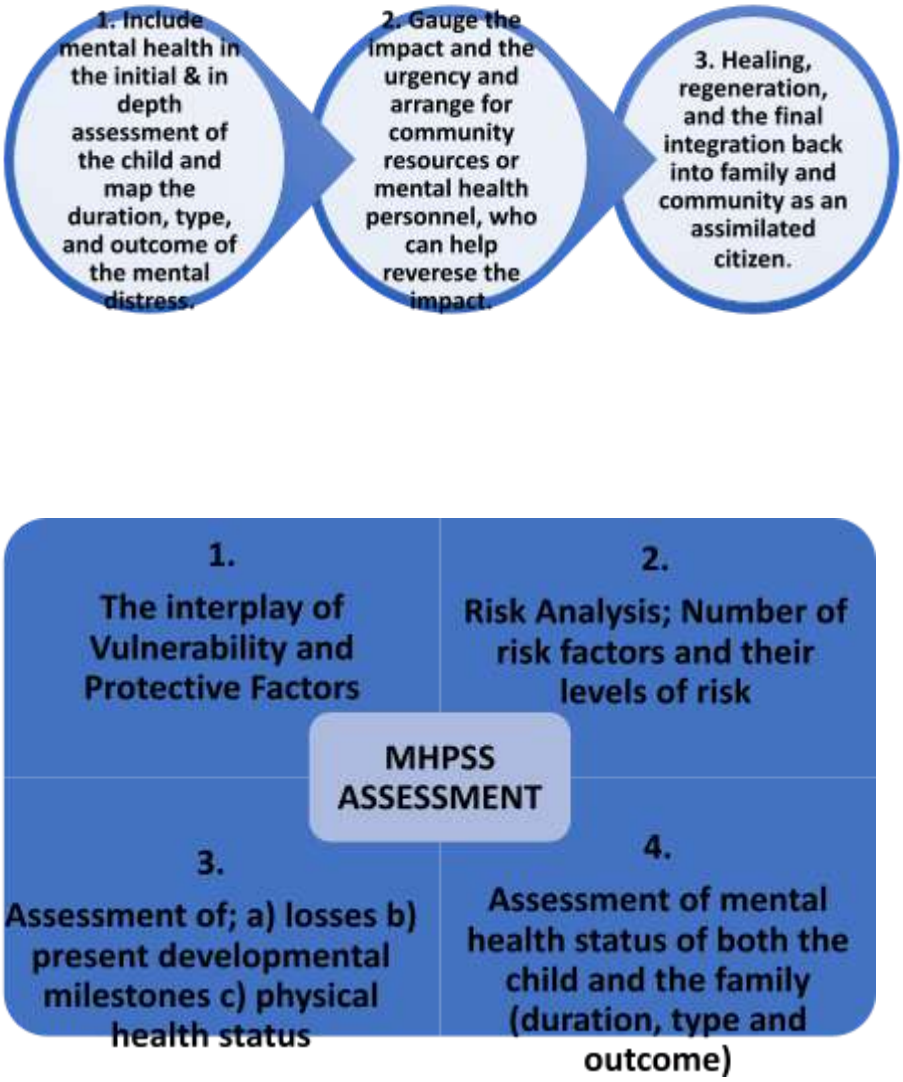

Figure 5.2

The analysis should guide the case workers/counsellors who are handling the case regarding the level of psychological distress of the child and family (the child and family may be at different levels), and the corresponding layers of psycho-social support that can be made available to both the child and the family.

A broad overview of possible MHPSS interventions are described here. Note that this is a listing of possibilities and not written to correspond to the levels of MHPSS services or the broad psychological states given in diagram 1. Choosing the right interventions will depend on the MHPSS assessment as shown in figure 5.2

MHPSS INTERVENTION	
COUNSELLING SERVICES AND RELATED SERVICES	**PARENTS, CAREGIVERS AND COMMUNITY SERVICES**
These will address the different mental health needs of the child and the caregivers: to help develop positive attitude and coping methods, resilience building, resolve conflicts, deal with trauma, personality strengthening, relationships strengthening, self-esteem and confidence building, helping children to understand their emotions and find ways to express themselves. - Psychological first aid for children undergoing trauma - Structured and/or unstructured activities to relieve stress, ventilate feelings and emotions, share details of adverse events etc.: Art and craft, sports, games, drama and music, storytelling, reading, etc. - Various methods of counselling: Art and play therapies, Behaviour modification, CBT, TF-CBT, Family therapy, Talk therapy, Supportive therapy, Expressive therapy etc. - Group activities/sessions: peer support groups, group activities/therapy sessions for children who share similar mental health issues, group sessions with caregivers.	A child's problems do not form or exist in vacuums. The family, caregivers, teachers play a major role in control or remission of the problems. We work on their informed active participation and their empowerment to be supportive of children. Hence outreach with them is to help them gain knowledge and skills to help a child in distress. - Depending on specific problems and needs, several of the therapies mentioned in the counselling section will be used with families and caregivers too. - Help parents, caregivers to understand the child's problems and learn skills to support and be part of the child's healing through; training families and caretakers about the child's mental issues and how to deal with it, their own behaviour modification, supportive outreach, inclusion and relationship strengthening. - Communities: Training of communities for: child protection, understanding -child distress, disabilities, and their capacities to support children and their wellbeing. Community campaigns too will help- Stigma reducing campaigns, children's psycho-social needs, education regarding child marriages, gender discrimination, child labour and trafficking etc. Besides, information gathering and sharing regarding education, skills

- Alternate therapies- music, dance and movement therapies, and mindfulness therapy. - Not the least but under medical advice; medication for certain types of mental health issues. - Education, skills building and Vocational help and counselling.	building and vocational possibilities and trying to arrange for the same. To coordinate with- community leaders, women's groups, local NGO's, DCPU's, gram panchayats, government concerned agencies etc. to improve basic infrastructure which are necessary for child protection.

Chapter 6

Monitoring, & Followup

Handout 1: Importance of followup mechanism for children in families

Followup is an important step in Case management Process which focuses to ensure that the child and their family are receiving appropriate support to meet their needs and revise the care plan if the situation has changed or the plan is no longer fit for purpose. A structured Followup mechanism for children in families can support in:

- Regularly monitor the child's situation, including their safety, the risk of harm and their wellbeing - Ensuring there is absence of any Red flag and child & family are thriving in 5 well being domains.
- Check if there has been progress, i.e.:
  - If the child's needs are being addressed
  - If the care plan is working

  Progress can be identified by comparing the child & family's current situation - at the time of follow up – with the assessment and care plan.

- Check if the care plan needs to be adapted/changed, i.e.:
  - The child's needs are not being addressed in time
  - Little progress is occurring
- Check if there are significant changes in a child's situation
- Family members can access family support services, if required linking the child & family to any other services to address any 'new need' - while also ensuring the family has supportive relationships with extended family, community members and society at large.
- Child & Family can maintain or strengthen the relationship (adjustment.)
- To ensure the child & family can express their views and concerns about the placement freely.

Overall **goal of the Follow-up** is ensuring the family achieves self-sufficiency & permanency for children in families.

It will be important to understand how to effectively conduct these follow-ups. The follow-ups with children and families can take place multiple was: through in-person visit Or remotely through phone calls/ video calls.

- **Home visits:** Home visits can be important when following-up on the situation in the home. This is especially important when the home environment changes quickly or when levels of care are low. Home visits give the opportunity to not only gather information by meeting with the child and/or their family, but also learn more about the child's situation through observation. These visits can be scheduled in advance (planned with family) or done unannounced (mostly when there is high risk Child

Protection Risk). Caseworkers should ensure that the child and their family are not exposed to harm, e.g. drawing the attention of neighbors or the community.

If a home visit might cause further harm to a child and/or their family, caseworkers should consider meeting with the child and/or their family/trusted adult in another location.

- **Phone Follow-ups**: Phone calls can be very useful for quick check-in with the child and family, or to share any information. It also gives the opportunity to the child and their family to ask for support.

- Contacting others who are involved in supporting Child & family:
  - These can include members of extended family, community, and society at large (e.g. community heroes, supportive-neighbour, school, community leaders etc)
  - Service Providers whose services are accessed by the family (e.g. Counseling support, skill development etc)
  - Contacting a service provider to which the child was referred
- A caseworker can also follow up with the service providers to which a child has been referred. This can be also done by email, by phone call – whatever is appropriate.

Key points case-worker take note of of when planning/conducting follow-ups:

- *Rapport and trusting relationship:* It is vital that a caseworker has built a relationship of trust with the child, parent, caregiver, and/or trusted adult which enables open and honest communication about the placement by child & family and allows the caseworker to provide quality support. 'ALWAYS share that you and family are on the same team of ensuring best-outcomes for the child'.
- *Discuss follow-up Schedule:* Provide a written schedule to the family ahead of the time and check with family on their availability before visiting except in situations where child protection is a pressing issue.
- Ask Open-ended Questions: Referring to key skills of case managers learnt in the previous session on communication & building relationship (session 3). Ask questions which provide an opportunity for the child & family to elaborate on their circumstances & their feelings (e.g. questions begin with how, what, why to explore more information).
- *Empathy*: Empathy is an important skill for the caseworker during follow-up interaction with the family, as the families are still vulnerable especially at initial stages where they are implementing the learnt skills like positive parenting or are in process of adjustment (incase of transition cases).
- Listening: Listening not just the words but the feelings behind the words said is very important.
- *Ensure everyone has a voice:* Talk to child and family to understand their views and thoughts including concerns about the placement is very important. Caseworker should try to speak to the child individually when possible.
- *Maintain Confidentiality:* Caseworkers should not share any private/confidential information shared by family except situations when child safety/wellbeing is at risk. Caseworkers should ensure that the child and their family are not exposed to harm, e.g. drawing the attention of neighbors or the community to avoid discrimination.

- *Observe & Analyze:* It is very important for caseworkers to not just ask questions but also observe the family interactions: hence planning visits during meal-times or family time will be important.
- *Offer guidance and support when needed:* Visits and followup interactions provide a great opportunity for caseworkers to offer support and guidance to the family when needed, e.g. teaching positive parenting skills.
- *Ensure Child's SAFETY!:* Main focus however should be the Child's SAFTEY at all times. If the child expresses he/she is in danger - the caseworker should take prompt steps to address the concerns.

Another important factor while planning follow-ups is the frequency of the follow-ups. Based on the guidelines shared by JJ Act regarding the duration of follow-up, Miracle foundation has come-up with a follow-up schedule for children at risk of separation & Reintegrated children.

- Prevention of Separation cases:
  - Need-based follow-up till 1 Year after family strengthening
  - In-person Visits - Complete Thrive scale quarterly to understand progress on the interventions planned.
  - Phone follow-up – as required
  - Frequency of follow-up increases in high risk (RED FLAG) cases (plan weekly/fortnightly or monthly follow-up if required)

- Transition/ Reintegrated children
  - 18 months – 2 years post placement
  - 1st visit in 7 days of placement (complete ICP)
  - In-person Visit- Complete Thrive scale quarterly
  - Phone follow-up: 15 days till 6 months, then monthly
  - In-person Visits - Complete Thrive scale quarterly
  - Frequency of follow-up increases in high risk (RED FLAG) cases

Given that every child and situation is different, the caseworker needs to remain flexible and adapt the follow-up schedule when required. There are changes that might impact the child's needs, their well-being, safety and the risk to which they are exposed. When changes like this happen, the caRe plan might no longer be fully relevant and review is required. Following are some signs of more frequent follow-up/evaluation required with the child & family:

- Planned intervention is not working or is not effective
- RED FLAGS: New signs of violence, abuse, neglect and/or exploitation
- Significant increase in the level of risk the child is facing
- The wellbeing of the child is deteriorating
- Life Changing event with child & family
- Changes in the care arrangement of the child

Chapter 8

Record Keeping & Reporting

1. Handout - Family Visit Observation report

(To be filled by the case worker, as a record keeping for their level)

Name of the Child:
Age:
Stage of case management:
Number of visits:
District (block):
Date of visit:
Submitted by

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1. Major observations made during the family visit (specific, those not captured in assessment tools)
2. Community structures/groups identified during the visit
3. Major concerns observed
4. List out suggestions/ recommendations shared during visit
5. Next steps

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