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How is the Concept of Resilience Operationalised in Practice with Vulnerable Children?

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CONTENTS

EXECUTIVE SUMMARY

Introduction

Increasing emphasis is being placed on the concept of resilience in policy and practice relating to vulnerable children and their families. However, little is known about how, and to what extent, this concept is actually being employed in child and family services. This report presents the findings from a study in the UK and Australia that examined how the concept of resilience is operationalised in practice with vulnerable, abused or neglected children to answer the following research question:

- When an organisation has the explicit aim of nurturing resilience in vulnerable children:
    - how do practitioners translate that aim into practice and
    - how congruent is the described practice with the principles indicated by the existing literature on resilience?

Method

Data about how practitioners interpret the concept of resilience for practice and ways in which it is operationalised with vulnerable children and their families were collected by means of a survey and a set of case studies. In the UK practitioners working in the services of a large voluntary (non-governmental) organisation across the UK were surveyed; in Australia survey participants worked for a non-governmental organisation in New South Wales. In the UK the case study children received a service from a project in England or one in Scotland. The case families in Australia received a service from a project in two areas of New South Wales. Data from the survey and case studies were considered in the light of the existing literature about resilience and the principles for intervention in order to gauge the extent of congruence between practice as described and the principles indicated by the existing literature.

Findings

The survey findings are based on data from 201 returns (108 in the UK and 93 in Australia). The case study findings are based on data from 32 case studies (18 in the UK – 7 in England, 11 in Scotland; 14 in Australia – 4 NSWa, 10 in NSWb). The UK case studies involved interviews with 12 children, 12 parents/carers, the project workers for all 18 case children and, where there was a parent worker involved in the case, with the parent worker as well, plus 8 other professionals from other organisations who worked with the case children. In Australia 11 parents and carers were interviewed, the project workers for all 14 case families and 3 other professionals.

Most children in the UK were referred to the services by education or Children and Adolescent Mental Health Services (CAMHS); in Australia most referrals came from the Department of Community Service (DOCS) - the child protection response sector or helpline. Reasons for referral differed in the two countries. Most referrals in both services in the UK related to children's behavioural issues. In Australia referrals to the NSWa service were for child protection reasons and those in NSWb were for support which was intended to prevent child protection becoming an issue in the future.

The case children in the UK were aged between 7 and 10; in Australia there was a broader age range - 9 months to 18 years, but a younger average age of 6. Half the case children in Australia were girls and half boys whereas in the UK there was a far higher proportion of males (83%) reflecting the different reasons for referral. In the UK 83% of children were white, in Australia 93% were white.

Understanding of resilience

The survey and case study data suggests that practitioners in the UK and Australia are using definitions of resilience that have been influenced by the literature and are relatively congruent with the current understanding of the concept. They provided relatively sophisticated definitions of resilience and

the focus of many operational definitions was upon processes rather than just outcomes.

Resilience based practice

Resilience based practice was broadly congruent with the principles implied in the literature. Although there were similarities there were also many differences in practice between the UK and Australia and indeed between services in each country. Broadly speaking the Australian services in this study had a less structured approach to resilience based practice than UK services. There were different ecological emphases with the UK focusing more on the child and parents and Australia focusing more on the parents and the wider community.

Measuring resilience and outcomes

The survey findings suggest that outcome measurement is patchy and that many different methods are used. The case study services were using more systematic approaches but different approaches are being used within the same organisation which will make it difficult to collect larger datasets about outcomes.

Strengths and weaknesses of the concept

Many practitioners are enthusiastic about what they consider to be the positive and creative approach to practice that the concept of resilience facilitates. The findings reinforce the concern, however, that 'resilience based practice' can mean different things to different people and confirm the need for more explicit explanation of terms of reference and aims of intervention.

Conclusions and implications for practice, policy and research

The study illustrated the extent to which resilience as a concept has become highly influential in practice with vulnerable children. It is referred to as informing intervention in many different settings and contexts. However, resilience it is not a theory as such. Technically it is a term that describes the product of a combination of coping mechanisms in the context of adversity.

The practitioners in this study used a variety of definitions that coalesced around concepts of 'ability' and 'capacity', but understandings of adversity and the mechanisms by which factors potentially compromise development were less clearly articulated, although, to be fair, we did not enquire in detail on this issue. Precisely because 'resilience' is so often used as shorthand to denote both a developmental trajectory and a set of principles for practice there is potential for the term to denote different things for different people or aspects of an organisation.

One of the important effects of the research on resilience is that is has alerted us to the extent to which each individual has a unique developmental trajectory. Precisely because of this recognition it has not been possible to set out a specific recipe for intervention with vulnerable children – instead a number of principles for practice have been extrapolated.

Understanding of resilience:

Practice

- When an organisation, service or individual practitioner refers to resilience as a guiding principle for practice then it would be helpful for understandings of the concept to be set out explicitly.

Policy

- Policy documents are increasingly referring to the promotion of resilience as an aim – it is important that such documents set out their operational definitions.

Research

- Further research would illuminate the extent to which different organisational, service and individual definitions may directly be associated with different forms of intervention and, in turn, different outcomes for children.

Resilience based practice

Practice

- Practice should aim to target all ecological levels, including the child, siblings, significant adults in the immediate and extended family, including fathers, and the community networks and assets.

- Assessment should set out the exact nature of the adversity that the child is subject to, the potential mechanisms by which it could affect development and the anticipated impact on developmental outcomes.

- Frameworks for assessment and practice are clearly helpful, however, if applied too rigidly may impede practitioner creativity on the face of individual variation of need.

- It may be helpful for organisations to map and audit the range of assessment and practice tools and frameworks in use across services, to gauge their efficacy and to provide opportunities for good practice to be shared across services.

- Whether children receive a group-work or individualised approach or long term or short term support may depend more upon the service model than the particular needs of the children. Organisations need to be clear about the rationale for different service models and consider the relative merits of individual and group-based work, and short and long term provision.

- The principle of user participation was clear in our study and it may be helpful for organisations to articulate the extent to which that nature of engagement can be part of the therapeutic process itself.

- All professionals in the protective network around children, especially teachers, need to be clear about the aims and strategies of intervention.

- The introduction of more focused work on children's attachment relationships would be congruent with a resilience-based approach.

Policy

- Policy should aim to create the conditions that support practice at all ecological levels, especially at the community level.

- Resilience can be a helpful unifying concept for the different professions and disciplines that are involved in protecting and safeguarding children and multi-agency guidelines and forums could build strategic approaches around a common language of resilience.

Research

- Comparative research would help to identify the most effective strategies for nurturing resilience, for example, by comparing approaches that focus on underlying processes with those that focus on behaviour or talents and interests; and comparing the impact of attention to different ecological levels.

- Given the centrality of attachment as a protective factor it would be helpful to research the extent to which a focus on other domains may make up for insecure attachments, or whether such intervention is impoverished.

- More research is needed on how parents and children define adversity and what intervention is regarded as most helpful.

Measuring resilience and outcomes

Messages for practice

- A more rigorous and consistent approach to short term and long term outcome measurement would allow intervention to be evaluated.

- It is important that organisations, services and practitioners clarify both the intended outcomes and the proposed processes by which outcomes will be attained. For example, whether raising self-esteem is a proposed outcome or process or both should be explicit.

Messages for policy

- There is a need for a more deliberate and focused policy drive to ensure that all services incorporate outcomes measures and that there is some consistency in the information collected.

Messages for research

- There is a need for more systematic research into the outcomes associated with intervention strategies aimed at boosting resilience.

Strengths and weaknesses of the concept

Practice

- It is important to disentangle the appeal of the concept of 'resilience' from different models for practice based upon the concept.
- Assessment should incorporate attention to 'apparent' resilience.

Policy

- Policy-makers need to beware of using 'resilience' as a 'buzz' term in an uncritical manner and without attention to the potential pitfalls of individualisation and the lack of an evidence base about outcomes.
- There needs to be careful consideration of the articulation of statutory and non-statutory services with clear agreements about understandings of the concept of early intervention.

Research

- More research is needed into how practitioners can support children who may have developed coping strategies that may be of benefit in the short term, but may not be helpful in the longer term.

INTRODUCTION

Increasing emphasis is being placed on the concept of resilience in policy and practice relating to vulnerable children and their families. However, little is known about how, and to what extent, this concept is actually being employed in child and family services. This report presents the findings from a study in the UK and Australia that examined how the concept of resilience is operationalised in practice with vulnerable, abused or neglected children to answer the following research question:

- When an organisation has the explicit aim of nurturing resilience in vulnerable children:
  - how do practitioners translate that aim into practice and
  - how congruent is the described practice with the principles indicated by the existing literature on resilience?

BACKGROUND

Resilience is generating intense interest as a concept to guide intervention with children who have experienced adversity or who are identified as vulnerable to poor developmental outcomes. A resilience-led perspective to practice has been described by Gilligan as both 'optimistic and pragmatic'. Luthar's recent review and synthesis of five decades of research on resilience provides a helpful landmark for a shift in emphasis from understanding what resilience is towards grasping the evidence that already exists and exploring whether it can be put into practice for the benefit of abused and neglected children .

Practitioners working with children are already drawing implicitly and explicitly on the concept of resilience, especially in non-statutory and specialist projects . Recent practice guidance, based upon a literature review and studies of effective practice, confirmed the value of the concept for work with fostered children and increasingly 'resilience' is being cited as the underpinning principle for practice in a range of child care and child protection settings. A number of guides to intervention based on resilience are now available . A

11

small pilot study carried out in Scotland drew on a set of 8 case studies to explore the extent to which the concept of resilience can be operationalised for use with neglected children in the context of statutory social work . The study indicated that practitioners were already familiar with the concept, used it to a greater or lesser extent and found it helpful.

However, resilience is defined in different ways and the concept can be criticised precisely because practice guidance has to be extrapolated from a range of research findings and other related theoretical concepts. For example, as an outcome resilience tends to refer to relative mental well-being in the face of adversity and risk and as a process it refers to the adaptive processes that enable a person to make use of internal and external resources to adjust to, and cope with, adversity. These and other aspects of resilience discussed in the literature are examined in more detail in subsequent sections of this report.

Rutter has identified four strategies for the promotion of resilience and Masten five very similar ones (see details later in the report) – however, the strategies are very broad and many different aspects of practice are indicated by them. Given the broad interpretations of resilience, and the differing extent to which it may be used by practitioners who are familiar or unfamiliar with the concept, this study aimed, therefore, to analyse the ways in which 'resilience' as a concept is shaping practice in settings that explicitly espouse a resilience-led framework. The study included a UK-based and an Australian component, to allow for international comparisons and contrasts in the use of resilience as a concept in practice.

METHOD

The study was carried out in partnership with two voluntary (non-governmental) organisations, one in the UK and one in Australia. While both organisations have broad service parameters, they both include services for the care and protection of vulnerable children that explicitly aim to promote resilience in children and their families.

The study was guided by the British Sociological Association's Statement of Ethical Practice (2002) and, in accordance with the University of Stirling ethical approval procedures, the proposal was subject to the approval of a Departmental Research Ethics Committee in the UK and the University of South Australia's Human Research Ethics Committee in Australia. Because of the potential for involvement of health professionals ethical approval was also obtained from NRES in the UK.

Data about how practitioners interpret the concept of resilience for practice and ways in which it is operationalised with vulnerable children and their families were collected in both jurisdictions by a survey and a set of case studies. This data was then considered in the light of the existing literature about resilience and the principles for intervention in order to gauge the extent of congruence between practice as described and the principles indicated by the existing literature.

Survey

The aim of the survey was:

- to obtain practitioners' views about their understanding of the concept of resilience, how they put it into practice and its perceived strengths and weaknesses.

A questionnaire was designed for self-completion (electronically, or in hard-copy) by practitioners working with children and or parents in a service delivery agency; it included open and closed questions and covered:

- definition of the concept of resilience
- the concept's perceived usefulness for practice
- examples of how it is put into practice
- other concepts/theories being drawn on
- details about practice in relation to factors known to be associated with resilience (the full set of questions are shown in appendix 1).

The questionnaire was piloted with staff in two services that would not be targeted in the full survey. Returns were collated into an excel spreadsheet.

Quantitative responses were analysed with descriptive statistics. The qualitative responses were collated by question and then scrutinised in detail for emergent themes and sub-themes.

Survey sampling in the UK

The questionnaire was sent by email to the 9 Regional and National Directors who forwarded it to projects in their area for completion by a practitioner. They were asked to choose a mixed selection of projects including some who explicitly aimed to promote resilience and those who may be using the concept more implicitly. The target for returns was 100. The questionnaire was sent to a total of 125 projects. The name of the project involved was not anonymised, but the person who completed the questionnaire was not asked to provide their name.

Survey sampling in Australia

In Australia, the survey was initially distributed electronically to all practitioners working in the organisation's services for children and families (child protection, early intervention, partnerships and communities for children, and early childhood centres). Due to a limited response rate, hardcopy questionnaires were then provided to team leaders and supervisors within the organisation to be distributed to staff and completed in team meetings or individually. As in the UK, the target for returns was 100 respondents. The questionnaire was distributed to 238 staff. Participants provided anonymous responses to the survey either by entering their responses into the surveymonkey.com website established for the study or by returning hard copy responses in reply-paid envelopes.

Case studies

The aim of the case studies was:

- to produce a detailed description of the work with vulnerable children and their families in a setting where practice is explicitly resilience-led, and to analyse it with reference to the research evidence about factors associated with resilience.

Case study procedures in the UK

Projects providing support for children were asked to provide anonymised information about potential subjects who met the criteria of being girls or boys aged between 7-9 years, from a range of ethnic backgrounds, with similar referral profiles, who had been the subject of a comprehensive assessment and had been receiving services from the agency for at least 2 months. The research team selected cases to represent a spread of characteristics.

Detailed information sheets and consent sheets were provided and project staff described the study to parent/s of potential subjects and went on to obtain informed consent from parents and children if they agreed to take part. Details were then passed to the research team who also obtained written consent from the parents and children interviewed. Each subject was allocated a code number.

For each case:
- the practitioner was interviewed about the theoretical model underpinning the work, the aims and content of their intervention plans and the perceived strengths and limitations of the approach;
- case files were scrutinised for information about explicit and implicit references to resilience, stated aims and descriptions of intervention plans and any information about children's well-being and outcomes;
- other professionals with significant contact with the child and family, were interviewed about their knowledge of the concept of resilience, their perceptions of the focus and efficacy of the work and the extent to which they felt part of an integrated strategy;
- where possible parents and children were interviewed about their perceptions of the aims and efficacy of the intervention (see appendices 2-5 for copies of interview schedules).

The practitioners were encouraged to be as explicit as possible about the longer and shorter term aims of their intervention and to break down the intended stages. For example, if they stated that the overall aim was to

'promote resilience' they were asked about each of the factors they considered to be likely to contribute to that child's resilience and how they intended to nurture each one. All the information about each case was collated onto an excel spreadsheet that set out reasons for referral and initial assessment and information about all interviews and case material. The spreadsheet was designed to capture the practitioners' stated aims of intervention for the child and for the parent – these were set out in a way that allowed the reasons for intervention to be traced through different processes to their intended outcomes. Any information and views about outcomes were also recorded. The data was then scrutinised for key themes.

Case study procedures in Australia

In the Australian Case Studies similar methods were used to those described for the UK sample, but with some variations. Initial attempts to recruit only those families with children aged 7-9 years did not prove achievable on the basis of client case files made available to the researchers. Specifically, where families were indicated as suitable for participation by service practitioners, there were typically multiple children involved where only one or two might be within the targeted age range. Infants were also common in the families recruited by the services. Since case workers felt they were unable to discuss cases without due consideration of *all* the children involved (despite some early attempts to focus the questions on just one child), it was determined that 'participation' of all children in the identified families should be seen as evident. Age requirements were therefore abandoned; due to the vast spread of ages involved, however, the interviewing of the children themselves was deemed unfeasible. The focus of the interview procedures thus shifted to obtaining information from parents, service practitioners, and non-service case-affiliated professionals.

Case study sampling in the UK

Cases were drawn from two family service, one in England, one in Scotland, that work with vulnerable children using frameworks explicitly built around the concept of resilience.

The English service works to a model of short term focused intervention. Children are referred from a range of routes including teachers, Special Educational Needs Co-ordinators (SENCOs), educational psychologists, Child and Adolescent Mental Health Services (CAMHS) or GP's. Reasons for referral vary. Some children come from very happy, stable, loving homes but have shown one or two difficulties which professionals are concerned about. Other children live in very chaotic families and present with a number of different barriers to their resilience, for example, violence, lack of friends and inability to bond with family members. The aim of intervention is to improve the emotional resilience of the children. Assessment is undertaken using a framework built around the six domains identified in Daniel and Wassell (2002a,b,c):

- secure base
- education
- friendships
- talents and interests
- positive values
- social competencies.

The intervention plan is structured around the six domains and individual intervention sessions with the parent and the child follow. The sessions are constructed to reflect the intervention plan and may cover all or just some of the domains. Usually, each parent and child receives 4 - 10 interventions depending on need. Intervention is usually limited to 6 months.

The Scottish service undertakes individual support work with children and parents as well as offering group work. In this study we focused on children who were attending the nurture group. This service was originally designed to include a homelink worker specifically to work with parents/family network in order to promote an ecological model. Due to a range of issues they were been unable to maintain a worker in this post, however, staff from other parts of the service provide home support to families where the need is particularly great. These children are mainly referred by teachers who identify young people who need extra support in order to reach their full potential. The

17

children are assessed using the Boxall profile and the nurture group aims to target areas in which the children need extra support and development . This profile covers the 'developmental strands' of organisation of experience and internalisation of controls and a 'diagnostic profile' that covers:

- self-limiting features
    - disengaged
    - self-negating
- undeveloped behaviour
    - makes undifferentiated attachments
    - shows inconsequential behaviour
    - craves attachment, reassurance
- unsupported development
    - avoids/rejects attachment
    - has undeveloped/insecure sense of self
    - shows negativism towards self
    - shows negativism towards others
    - wants, grabs, disregarding others.

The completed profile for each child identifies areas for further attention which were then the focus of intervention in the nurture group. Children can attend the nurture group on a long term basis – and some have received support for several years.

Case study sampling in Australia

Cases were drawn from two different services that operate within New South Wales. NSWa works with families where there has been a substantiated child maltreatment report made to the Department of Community Services (DOCS), the state-run statutory child protection authority, and has the direct goal of ameliorating the 'risk of harm' of child abuse or neglect identified by DOCS. It provides a range of services both home and centre-based, with the stated aim of 'ensuring that children are safe and supported to heal from the impacts of child abuse and neglect'. The service is designed for children aged 0-12 years, although older children are often involved in an entire family's participation. All parents receive some home visitation, with enrolment in other

activities and projects being at the discretion of the case manager and the client. Duration of the case plan is not limited, and in many cases when the practitioner 'closes' the home visiting component of the service, families continue to engage with the extra-curricular and group activities provided.

In contrast, NSWb is an early intervention, rather than child protection, service. It works with local families in the large region to support them in caring for their children. The emphasis of this service is therefore firmly upon parents and the family unit, rather than upon direct case work or intervention with children alone. Referrals come from community agencies, such as hospitals and preschools, as well as from DOCS reports that do not proceed to a substantiated notification and from the DOCS helpline. Only individuals such as GPs or a child or community health worker can refer families to the service. Referrals frequently pertain to a family's social isolation in the region, as well as from concerns surrounding the physical or mental health and well-being of parents and children. Referrals to the service target families where at least one child is aged between 0 - 8 years, though older siblings are often present in participating families. Case work is undertaken in a holistic and individually-tailored way, with all practitioners having extensive experience in areas of case management, child development and child health. Teams also include Indigenous staff members who are available to work with Indigenous families engaged in the program. Participation is currently limited to a maximum of 2 years. This service has been running for approximately 15 months.

Practitioners' approach to assessment was dictated more by service routines than by individual planning. In both services, home visitation plays a central role in the case management, thus first meetings almost always took place in the parents' or carers' homes, with workers just 'having a chat' for an hour or two.

In NSWa, sometimes a Parenting Needs Assessment was urgently required by DOCS, and this would take place prior to any other case planning.

Sometimes, the Family Strengths and Needs questionnaire is utilized. Other than this, initial visits were primarily about talking to the clients in their own space and developing a case plan together. Observations and discussions seemed to largely dictate the modes of intervention or input determined upon:

> *'I do a lot of observations when I first go into a family. I sort of work out what is needed in the family, because every family is different' (worker, NSWa)*

Similarly, in NSWb initial visits would involve the worker visiting the home and talking with the parent at some length. Typically, the Family Strengths and Needs assessment was completed several months after case management had commenced, as most workers emphasized that opening up communication and trust-building is what is really needed by way of 'assessment'. As with NSWa, the importance of a case plan being developed collaboratively and willingly was stressed.

FINDINGS

Survey – UK and Australia

108 completed questionnaires were received in the UK (an 86% return rate for the services approached) and 93 questionnaires in Australia (a 39% response rate for the practitioners approached). In the UK, questionnaires were returned from all nations and regions. The majority of the questionnaires were completed in detail and some responses to open-questions ran to several sentences.

The survey participants worked in a range of different service areas including emotional issues, parenting issues, behavioural issues, relationships, abuse, education, disability, substance misuse, mental health, poverty, sexually problematic behaviour, bereavement, health and offending. Almost three quarters of the Australian respondents addressed parenting concerns in their work with clients and specific to the Australian context, this sample included respondents (3%) whose work focuses on the health and welfare of Indigenous families. In both the UK and Australian samples more than three

quarters of respondents reported that their services worked with parents and carers as well as children and that this work took place in a range of ways with a focus on both individual and group work (see Figure 1).

Figure 1. Types of work carried out by services in the UK and Australia
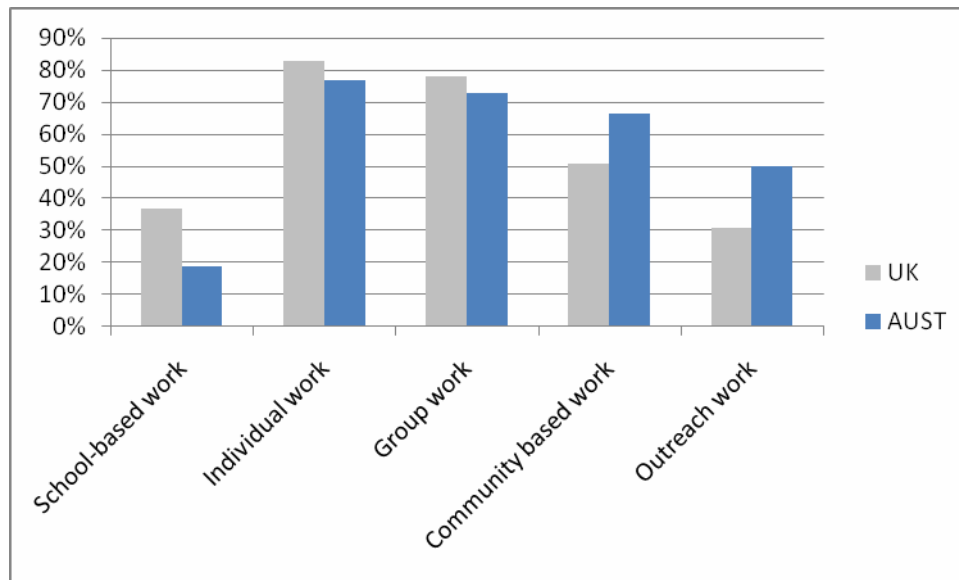
The survey gave us valuable information concerning practitioners' knowledge of and understanding of the concept of resilience as well as other complementary theoretical approaches and practice frameworks. More than three quarters of respondents in the UK and Australia (87%) had heard of the concept of resilience and the vast majority of these (82% in the UK and 83% in Australia) did not agree that it was a difficult concept to put into practice, irrespective of their particular field of work. In fact, the majority felt that the concept of resilience played some role in their work: just under two thirds (63% in the UK and 60% in Australia) felt that the concept of resilience was explicit in their work; 86% of respondents in the UK and 73% in Australia believed it to be implicit. This was borne out by the fact that large proportions of respondents stated that their service addressed many of the issues which are known to be related to the promotion of resilience (see Figure 2). All services addressed some of these issues. Services who work with parenting issues, emotional issues or behavioural issues were most likely to say they addressed all of these ten issues.

21

Figure 2. Resilience-related issues addressed by services
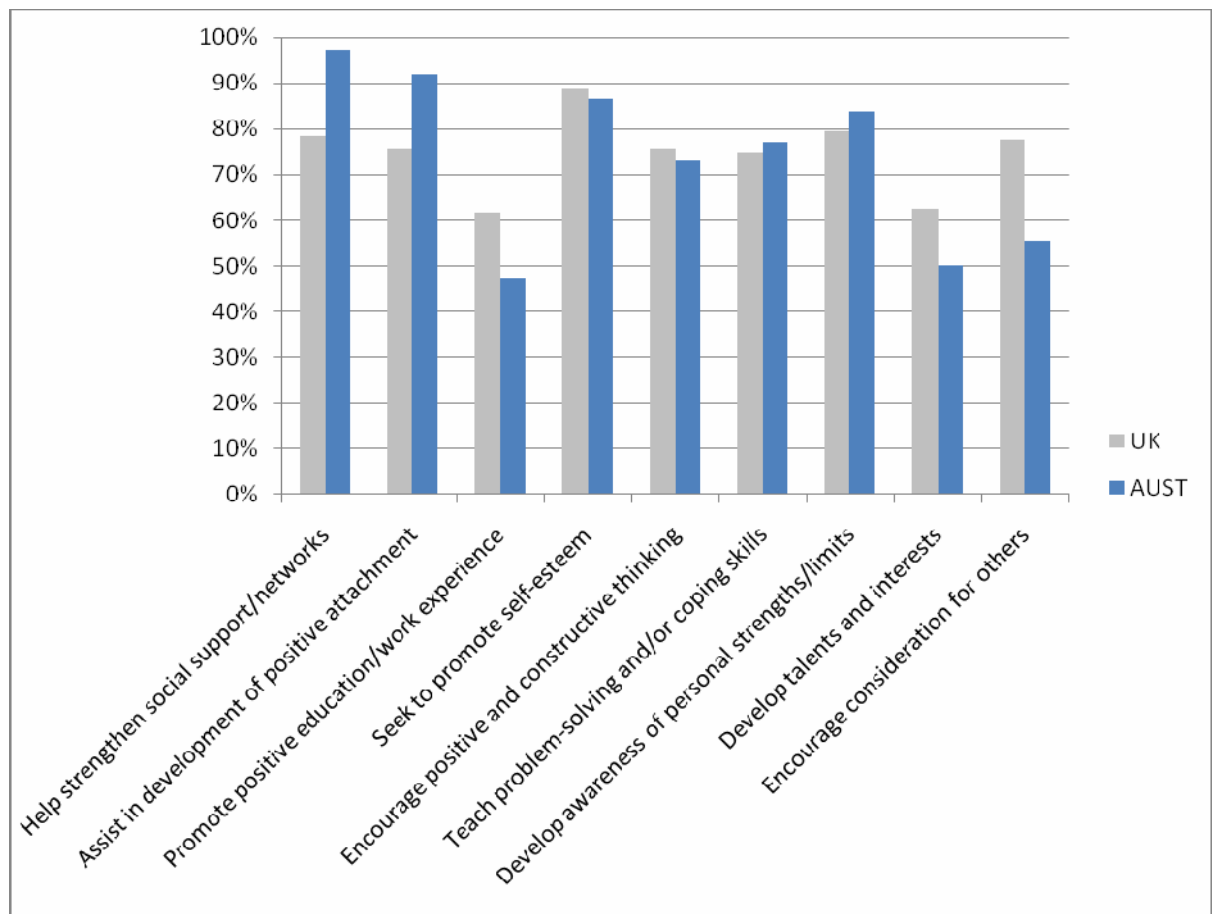
In the UK sample, just over a half (54%) said their service provided access to a written framework, materials or guidance on how theoretical approaches, including resilience, should be put into practice. This was much higher in the Australian sample, with 79% of respondents reporting access to such materials. The vast majority (85% in the UK and 92% in Australia) of those who had access to a written framework or guidance found it useful.

More than half of UK participants and over two thirds of the Australian sample had attended training on theoretical approaches within the last year and 13% in the UK and 11% in Australia had never received training (see Figure 3).

Figure 3. Last time attended training on theoretical approaches
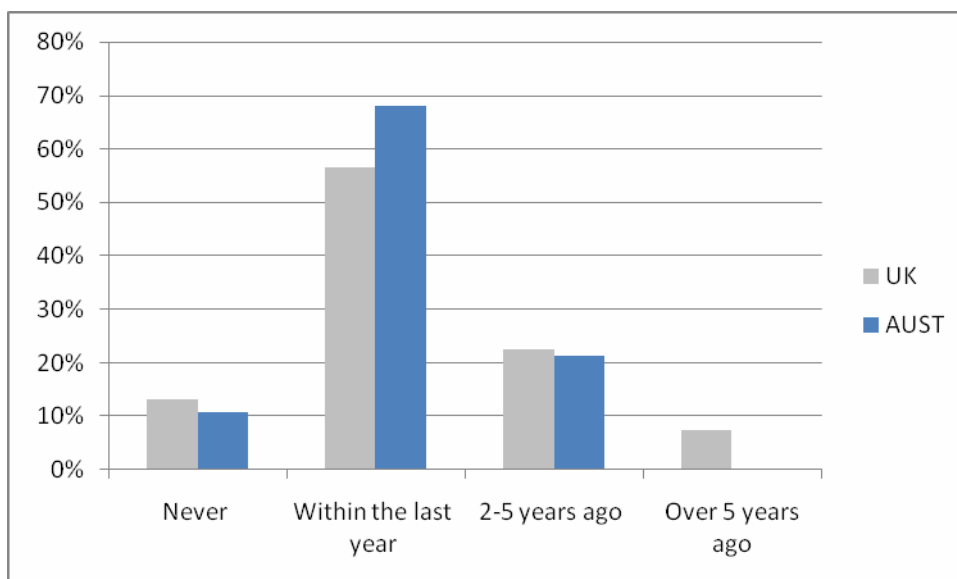
Case studies UK

Number of participants

Twenty-five families were approached by their key worker or by the Children's Service Manager who explained the aims of the study and the involvement required. Generally, consent forms were distributed two weeks prior to the date that the researchers had allocated for conducting face-to-face interviews, and the completed forms were returned to the Service Managers prior to the visit by the researchers. Seven out of 10 families in England, and 11 out of 12 families in Scotland agreed to take part in the research making 18 case studies in total. The target had been for 20 cases, however, in the event there were only 18 where the referral criteria was met and where consent was granted. We had decided to stretch the age upwards to 10 to increase the numbers, but we did not lower it because of the significant developmental changes at the younger ages.

The researchers spent three consecutive days at each project to conduct face-to-face interviews. Children's Service Managers and Project Workers assisted the researchers in scheduling convenient times to meet with parents and children. By being flexible with their time, researchers were able to meet with some parents and the majority of children face-to-face.

In total, four parents and 12 children were interviewed face-to-face and eight parents were interviewed by telephone. Where possible and where permission was given, face-to-face interviews were recorded and transcribed. In Scotland, children were interviewed within the Nurture Group setting, therefore general background noise restricted use of recording equipment. In addition, one parent and three children declined recording. Where parents failed to agree a time to meet with researchers or missed appointments, researchers made every effort to reschedule (carrying out at least three follow-up calls in each case). In most cases, these efforts resulted in telephone interviews at a later date (one parent in England and seven parents in Scotland), but in seven cases, researchers were unable to interview parents because they could not be contacted (three), could not agree a time to be interviewed (two), did not wish to be interviewed by telephone or declined to be interviewed (two).

In many of the cases, researchers also interviewed relevant external professionals, who were recommended by the practitioners. In England, three professionals were interviewed, including a substance misuse worker, a clinical psychologist and a Special Educational Needs Co-ordinator (SENCO). For the remaining English cases, it was impossible to interview any external professionals, mainly due to time constraints. In Scotland, where the case studies were drawn from nurture groups in three schools, the main external professionals involved were teachers: a total of five from two of the schools were interviewed for the research. In the third school, the teachers were unavailable for interview at the time of the researchers' visit. In addition, two educational psychologists were interviewed in Scotland, who provided an overview of their work and feedback on the Scottish service. They were not, however, interviewed in relation to specific cases.

Profile of case children

Table 1 shows the details of all the children in the UK sample and what interviews were undertaken. The gender imbalance is representative of the fact that both projects receive far more referrals of boys than girls. As the

table shows, the children in England came from a range of ethnic backgrounds whilst the children in Scotland were all of white Scottish origin.

Reasons for referral

Most of the children in the project in England had been referred by the Child and Adolescent Mental Health Service (CAMHS); a small number were referred by social care. Most of the children in the project in Scotland had been referred by education. The children were referred for a range of reasons, with the majority referred because of concerns about aggressive behaviour directed towards parents, siblings, peers or in all settings. The described manifestations of aggression ranged from violent outbursts, through 'mischievousness' to a tendency to grab and have difficulty with sharing and behaving pro-socially. Another factor associated with referral was 'disengagement' – a sense that the child tended to remain outside of activities and learning processes. For a couple of the Scottish children there was a description of them having an undeveloped 'sense of self', incorporating a lack of confidence and low self-esteem (reflecting the Boxall profile). Three children appeared to have been referred as a result of a specific feature in their lives rather than their behaviour – bereavement, disability and the experience of domestic violence.

Some of the parents and children graphically described the behaviour that led to referral:

> *'...he would just lash out at the slightest thing'* (mother E)[1].

> *…'playing up at school, and playing up at home as well'* (mother E).

> *'Because I had bad behaviour …Naughty, I used to fight'* (child E).

> *'...a hyperactive child, always on the go. He can be wicked, he's a typical boy'* (mother S).

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[1]   E denotes a case from the English service and S denotes a case from the Scottish service

'...out of hand' (mother S).

'He didn't know how to deal with his emotions...he was angry…He'd cry if he couldn't do something, heartfelt crying, not silly kind of crying' (mother S).

'He flew off the handle' (mother S).

'..a nightmare' (mother S).

'...really bad, angry, just really bad' (mother S).

Table 1. Showing details of all case studies (E = England, S= Scotland)

Code	Gender	Age at time of study	Ethnicity	Service status	Referred by	Interviews
E1	M	10	White /British	Closed (work completed)	CAMHS	Child Parent 2 project workers
E2	F	10	White Irish	Closed (work completed)	CAMHS	Parent Project worker
E3	M	9	White British	Closed (work completed)	CAMHS	Project worker
E4	M	7	White British	Open (Sept 07)	CAMHS	Child Parent 2 project workers
E5	F	10	Asian/British - Indian	Closed (work completed)	Social Care & Health	2 project workers Worker from alcohol service
E6	M	8	Asian British / Indian	Closed (work completed)	School	Parent Project worker SENCO
E7	M	7	Mixed White / Asian	Closed (work completed)	Social Care & Health	Child Project worker Clinical psychologist
S1	M	8	White / Scottish	Open (Dec 03 -)	Information not available (likely Education)	Child 2 project workers Teacher
S2	M	8	White / Scottish	Open (2006 -)	Education	Child Parent 2 project workers Teacher
S3	M	7	White/ Scottish	Open (Nov 2003 -)	Education	Child Parent 2 project workers Teacher
S4	M	8	White / Scottish	Open (March 2007 -)	Education	Parent 2 project workers
S5	M	9	White / Scottish	Open (Feb 2006 -)	Education	Child Parent 2 project workers Teacher
S6	F	10	White / Scottish	Open (2007 -)	Education	Child Grandparent (carer) 2 project workers
S7	M	7	White / Scottish	Open (nursery group from 2002, nurture group since 2006)	Education / Nursery	Child Parent 2 project workers Teacher
S8	M	7	White / Scottish	Open (Nov 2003 -)	Education	Child Project worker
S9	M	9	White / Scottish	Open (2006 -)	Mother	Child Parent Project worker
S10	M	9	White / Scottish	Open (sep 2003 -)	Health Visitor	Child Project worker
S11	M	7	White / Scottish	Open (2005 -)	Education	Parent Project worker

Case Studies – Australia

Number of participants

Twenty families were approached by their case workers across both services, and the purposes of the study explained. Consent forms and information sheets were distributed several weeks prior to the proposed time of data collection. The planned mode of data collection was through face-to-face interviews only, however after the first round of interviews were completed with participants engaged with the NSWa service, it became apparent that phone interviews would impose less of a burden on participating practitioners and parents (the latter of whom especially were affected by considerations of child minding and physical access to the household). Data collection in NSWb was also likely to be impacted by the vast geographic region involved, thus phone interviews were proposed to workers and parents from the outset of their invitation to participate.

Four out of the six families approached by NSWa caseworkers, and 10 out of the 14 families approached by NSWb case workers participated in the research. It should be noted that all families signified their consent to participate; however difficulties in making contact with families (for a number of reasons, which prevented gaining written consent) precluded their ultimate involvement.

One researcher spent 4 consecutive days at the NSWa service conducting the face-to-face interviews. As may be seen in Table 2, which sets out all details of participating families, four parents/carers were interviewed, all of whom were sole carers for their children. Three service caseworkers (one had two clients involved), and two non-service professionals were interviewed also. One of these non-service professionals was a therapist from the DOCS-affiliated child protection counseling service and currently treating a 14 year old boy from one of the participating families, and the other was from an organization known as Big Brothers Big Sisters who organize companions or confidants for children who can take on a mentoring role. The worker

interviewed was a regional manager who was responsible for overseeing the matches set with children – in this case, with a 12 year old girl from one of the participating families.

In NSWb five service caseworkers were interviewed, and one non-service professional, covering the case study of all 10 participating families. The non-service professional in this case oversees a supportive playgroup that one of the mothers in the sample was involved in. Not all 10 parents/carers undertook their own phone interview, with 3 out of the ten not completing due to illness in one case, and multiple difficulties in scheduling and/or keeping appointments with the other two parents.

Profile of families

Table 2 shows a number of pertinent details about the sample of 14 families. All families but one were Caucasian or white Anglo-Australian, the majority of cases were open or ongoing, and several parents/guardians were sole carers. Physical or mental health concerns were also prominent amongst the participants, and were a cause for concern within, or prompted, the referrals made in all such cases.

In terms of the *children* represented by these participating families, these 14 cases related to a total of 28 children, ranging in age from 9 months to 18 years. Five children (all from NSWb) were under 12 months of age, with the remaining 13 children being aged between 18 months and 18 years. There were 14 girls and 14 boys in the sample of families.

Reasons for referral

As Table 2 indicates, children were mostly referred by DOCS (child protection response sector or the helpline), for a range of specific concerns that boiled down to a general need for child protection initiatives at NSWa, and early intervention for the family to prevent child protection becoming an issue at NSWb.

Table 2. Showing details of the case studies for N = 14 participating families

Case ID	Interviewee	Service Status	Referred By	Partner or Spouse in Home	Number of Children	Ethnicity	(P) Physical or (M) Mental or (B) Blend Health Concerns***
NSWa1	Father	Open	DOCS	No	2	Caucasian	P: 2 Children (vision loss) B: Father (D&A)
NSWa2	Mother	Closing	DOCS	No	4	Hispanic	M: Mother (D)
NSWa3	Uncle/Carer	Open	DOCS	No	3	Caucasian	P/B: Child (MD + ADHD)
NSWa4	Father	Closing	DOCS	No	1	Caucasian	-
NSWb1	Mother	Open	Hospital	Yes	2	Caucasian	P: Mother (HRP)
NSWb2	N/A	Open	DOCS Helpline	Yes	2	Caucasian	P: Mother (CP) B: Father (D&A)
NSWb3	N/A	Open	DOCS	No	1	Caucasian	M: Mother (DD)
NSWb4	Father	Open	DOCS	No	1	Caucasian	M: Child (AUT)
NSWb5	Mother	Open	DOCS	No	1	Caucasian	M: Mother (D)
NSWb6	Mother	Open	Hospital	Yes	2	Caucasian	P: Child (Deafness)
NSWb7	Mother	Open	Ch. & Com. Health*	Yes	1	Caucasian	M: Mother (PND)
NSWb8	Mother	Open	Early Links**	No	2	Caucasian	P: Child (AUT. + GDD) B: Child (ADHD + ODD) B: Mother (ADHD)
NSWb9	N/A	Open	DOCS Helpline	Yes	4	Caucasian	-
NSWb10	Mother	Open	Preschool	No	2	Caucasian	-

*Child and Community Health, Nursing service

 **Early Links is an early intervention service run by Child and Community Health

***Health Concern Abbreviations: D&A drug and alcohol; D depression; MD muscular dystrophy; ADHD attention deficit hyperactivity disorder; HRP high risk pregnancy; CP cerebral palsy; DD developmentally delayed; AUT autism; PND post-natal depression; GDD global developmental delay; ODD oppositional defiant disorder.

Specific concerns often related to capacity to parent effectively in the face of physical or mental health concerns (child or parent/carer); to ability to cope in the absence of any social support networks; or to parenting ability and needs for 'first-time' carers, relating to situations where children had either moved into the full-time custody of an alternate parent/carer or had just been born to a mother already facing other stressors like mental ill-health or social isolation.

Practitioners and parents alike commented on the many risk factors to the family's well-being or functioning at the time of the referral, with concerns surrounding substance misuse, mental health, physical health or disability, single parenting, and a lack of social support common across all the referrals to varying degrees:

> *'…she needed help caring for her baby. She was very apprehensive, very anxious, no confidence… and her family situation was quite horrendous… she was kicked out of home…' (worker, NSWb).*

> *' …things were out of control, I was a mess… between dealing with TAFE, [daughter's] behaviour, [son's] diagnosis [of autism]… it was just trying to get on top of it, but other people around me… they could see I wasn't coping' (mother, NSWb).*

> *'…there's no time to recover from all the stresses in my life… I'm just emotionally exhausted' (mother, NSWb).*

As a result of the strains and stressors impacting on the daily lives of these parents, children were also often highlighted as evincing worrying behaviours or emotional patterns at the time of referral:

> *'…he was very aggressive and destructive and just did as he pleased…' (mother, NSWb).*

> *'… she seemed to go through periods where her behaviour just seems to escalate' (mother, NSWb).*

> *'…he would just scream and scream and scream… for hours…' (father, NSWb; of autistic child).*

Both parents and practitioners seemed to have an equal understanding of the issues and behaviours causing concern around the children, with significant

congruence between their comments. Parents and carers were well aware of the impact their health and well-being was likely to have on their children's health and well-being:

> '…I need help in moving forward with my life… if I'm not happy, the kids aren't happy' (mother, NSWb).

The position children took in the therapeutic alliance varied across the two services, however. Specifically, the NSWa concentrated upon the family *unit*, with children well at the fore. In this setting, group outings provided a major focus of the child protection-led intervention to build family cohesion and engagement, thereby promoting child safety. The one-to-one parenting support provided through home visitation, and the parenting groups were also seen as critical in supporting parents to keep their children safe and well. These services were highly regarded by practitioners and parents.

In contrast, NSWb practitioners were a lot more likely to view addressing concerns surrounding the parents as more of a focus than directly addressing concerns around the children. This was evidenced by their practice of home visitation to meet with parents (which often occurred when children were at school or preschool), and is in line with their focus on supporting parents to make changes in their lives that allow them to care properly for their children – something that parents also recognized.

International comparison of findings: UK vs. Australia

There was a far higher response rate to the survey in the UK than in Australia despite similar attempts to maximise response. Without further information it is difficult to gauge the reason for this.

There were some key differences in the case studies. Reasons for referral were demonstrably different in the UK and Australia. A notable difference is that the two UK services primarily work with referred children out of their home environment, while both Australian services operate on a home

visitation premise in the first instance, with any other activities being at the discretion of workers and parents involved.

The services in the UK and Australia also differed in terms of the underlying issues and concerns driving the referral. Specifically, while both the Scottish and English referrals related in the majority of cases to significant concerns about children's behaviour, with a clear need for behavioural intervention identified, Australian referrals varied as to whether it was a case of child protection or early intervention, and were primarily precipitated by concerns surrounding the parents' ability to cope with the situation and/or parent effectively.

There was also a difference in terms of the gender of the children in the two countries. In the UK most of the case children were male which is representative of the case load of the two services and may reflect the fact that boys are more likely to be referred for behavioural support. In contrast in Australia there were an equal number of males and females which reflects the different reasons for referral.

These differences provide a useful juxtaposition of the many ways in which an organization may seek to promote the resilience of children and families in concerted and explicit ways. It is hoped that these variations will in the course of this report serve to better elucidate the ways in which the concept of resilience may be harnessed in work with vulnerable children across qualitatively different contexts and settings.

ANALYSIS OF FINDINGS

Four overarching themes were used to analyse the data from surveys and case studies:
- understanding of resilience
- resilience-based practice
- measuring outcomes
- strengths and weaknesses of the concept.

The key points in each of these sections are presented and considered in the light of the existing resilience literature.

Understanding of resilience

Resilience is not an easy concept to pin down and the literature varies in the extent to which it focuses on

- absence of symptoms of psychological distress despite adversity
- good outcomes in the face of adversity
- mechanisms or processes that lead to the outcome.

From the literature a range of definitions and ways of describing resilience can be found, including:

- 'normal development under difficult circumstances'
- 'qualities which cushion a vulnerable child from the worst effects of adversity in whatever form it takes and which may help a child or young person to cope, survive and even thrive in the face of great hurt and disadvantage'
- 'resilient children are better equipped to resist stress and adversity, cope with change and uncertainty, and to recover faster and more completely from traumatic events or episodes'
- 'manifested competence in the context of significant challenges to adaptation or development'
- 'everyday magic of ordinary, normative human resources in the minds, brains and bodies of children, in their families and relationships, and in their communities' .

A number of people have highlighted the extent to which resilience, as a concept, has been misunderstood, especially with the notion that there is an all-or-nothing aspect to being 'resilient' and that it is a fixed trait, when the evidence, in fact, suggests that is a more relative phenomenon . Rutter has summarised the current evidence thus:

'…children's resistance to stress is relative, rather than absolute; the origins of stress resistance are both environmental and constitutional; and the degree of resistance is not a fixed individual characteristic. Rather resistance varies over time and according to circumstances' p. 651).

These aspects are summed up in Luthar's definition :

'a phenomenon or process reflecting relatively positive adaptation despite experiences of adversity or trauma' (p6)

In summary, as an outcome resilience refers to relative mental well-being in the face of adversity and risk of poor mental well-being and as a process it refers to the adaptive processes that enable a person to make use of internal and external resources to adjust to, and cope with, adversity. In order to be considered resilient in the context of adversity a child needs to have access to internal and external resources and have the adaptive capacity to make use of those resources so that they buffer the effects of adversity.

The research into the factors associated with resilience is now very extensive and the number of factors that have been identified as contributing to resilience are also numerous. There is considerable agreement now that resilience is associated with the presence of protective factors in three categories of:

- psychological/dispositional attributes
- family support and cohesion
- external support systems .

Werner's substantial longitudinal study identified a range of factors associated with resilience at each of these levels . Her findings and subsequent research coalesces around some key factors including three fundamental factors of security of attachment, self-esteem and self-efficacy as well as others such as female gender, intelligence, internal locus of control, capacity to regulate negative emotions, empathy, good peer relationships, social competence, positive school experiences and good community connections. Key personal strengths associated with resilience have been identified by Benard as social

competence, problem solving, autonomy and a sense of purpose . Similarly, Rutter, emphasises the importance of 'planful competence' which entails a combination of dependability, productivity, self-esteem and ability to interact with others .

The starting point of different definitions may lead to differences in focus of intervention. Some practitioners may focus on producing the *outcome* of better than expected emotional well-being, and draw upon a range of approaches to reach that outcome. Other practitioners could focus on enhancing the *processes* of adaptation and self-efficacy with the aim of boosting mechanisms associated with resilience.

Survey UK

Almost two thirds of the survey participants who offered a definition of resilience referred to it as being about the processes that enable a person to cope with and adapt to adversity. For example:

> *'The qualities that enable you to deal with the ups and downs of life'.*

> *'My understanding of the concept of resilience is that of an individual having the ability to cope and make positive adaptation in difficult circumstances whether this be personal, familial or environmental… This is something that is a process rather than a character trait, which children may or may not be lucky enough to have'.*

They variously described resilience as:

- an ability (36 respondents),
- a capacity (13 respondents),
- a strength (11 respondents),
- a set of protective factors (11 respondents),
- a personal quality or trait (8 respondents),
- a mechanism (7),
- a concept or approach (7),
- a resource (5),
- a strategy (5) or

- a process (4).

Twenty two people suggested that resilience was, at least in part, an innate or internal quality, but 10 people felt that it was, at least in part, influenced by external or environmental factors. Six people stated that internal resources could be built upon to develop resilience and another four stated that qualities associated with resilience could be learned. One person explained that

> *'.. .people may inherently have this characteristic, which can be built on, whilst others have to have help in forming a positive foundation i.e. children from the same family facing the same adversity cope very differently.'*

Participants used various terms to describe the way in which resilience enables people to deal with adversity. Forty three people referred to *coping*, eleven to *managing*, nine talked about *overcoming a difficulty* and another nine talked about *recovering*. Eight people talked about *moving on*, *moving forward* or *continuing*, seven talked about *adapting*, six about being able to *bounce back* and a further six to being able to *deal with a problem or difficulty*.

Forty eight people talked about resilience as being a positive response to some sort of difficult experience or set of experiences or a challenging or stressful event and 37 people referred specifically to adversity or adverse conditions.

A small number of participants defined resilience purely as an outcome. Those that did explained that resilient children develop in a normal or positive way, and/or have relatively positive outcomes despite having experienced adversity. They tended to see resilience as a way of explaining why some children do better than might be expected, considering the high level of adversity they have experienced, or better than other children who have had comparable experiences.

> *'Resilient children can present as not having been affected by circumstances that may damage or cause other children distress.'*

A quarter of participants defined resilience as both a process and an outcome. They talked about it being a process which enabled individuals to cope with difficulties but linked this process to the achievement of positive outcomes.

> *'The ability for individuals to be able to cope with the trials and tribulations of every day life. To be able to deal with and face difficult situations so they don't have a negative effect on their emotional well being and everyday life skills'.*

Survey Australia

Consistent with the resilience literature and the findings in the UK, respondents to the Australian component of the survey most frequently described resilience as being a capacity or ability to deal with, adapt to or remain unaffected by adversity. Less often, respondents described the internal and external protective factors that contributed to this process. Participants' responses are explored in more detail below.

> *'Resilience is about the capacity of individuals, families, groups and communities to overcome adversity. It is the thing that allows us to manage difficult situations and not fall apart. It usually means we have a number of strengths and resources to draw on. These strengths and resources can include a support network, emotional intelligence, problem solving skills, positive approach to life etc'.*

> *'The concept of resilience underlies the capacity for children and families to deal with and manage challenges and/or crises which occur during the lifespan. Resilient people are those who are able to draw upon supports when needed, deal with challenges, and move forward'.*

Resilience was largely described as a process which included various responses to adversity. Such responses included:

- Recovering, rebounding, bouncing back or returning to normal,
- withstanding, enduring, persevering, getting through, and not giving up,

- managing, coping, surviving and dealing with,
- adapting to, overcoming, accommodating changes and moving forward; and/or
- becoming stronger and thriving.

'A person's ability to weather the storms in life and bounce back. Ability to have internal resources to call upon in times of need'.

'The ability to survive at least, if not thrive in an environment which is adverse or normally regarded as potentially harmful'.

Adversity itself was variously described in terms of situations that were beyond the control of, or not initiated by an individual such as:
- past or current challenges, stress, hardships, disadvantages, obstacles, life situations and problems,
- significant trauma, crisis situations, child abuse and neglect, and pain,
- risk; and/or
- future challenges.

'Resilience is the way a person bounces back and gets on with life after a disadvantaged beginning or traumatic start to life'.

'Being able to 'bounce back', achieve developmental milestones and wellbeing in spite of abuse, neglect, hardship'.

'The ability to bounce back from life's adversity's and adopt and develop coping strategies in dealing with life's ups and downs'.

Also consistent with the results from the UK component of the study, respondents referred to the internal characteristics and skills that promote resilience as well as to contextual factors that were seen to promote wellbeing

and serve a protective function in the presence of significant challenges. Such factors included:

- inner/innate strength, coping mechanisms, skills and tools, self worth and self esteem, emotional intelligence, problem-solving skills, and empathy,
- connectedness to community and support networks,
- family characteristics; and/or
- supportive and structured services for individuals.

'Resilience is the process of setting up structures and support around a child/ person to enable them to find their own strengths and achieve their best. It also allows people to feel a sense of care or community. It also can pull people/ families/ children out of social isolation by connecting them with community'.

'Resilience is a capacity to bounce-back from adversity. It requires an internal capacity that is influenced by personal and external factors'.

Less often, resilience was described in terms of the outcomes arising from the processes described above. Some of these outcomes were also described as the protective factors contributing to resilience, reflecting the dynamic nature of the process of resilience. Such outcomes included:

- happiness, positivity, mental health and wellbeing including self esteem,
- normative development,
- connectedness to community including participation and engagement in community activities; and /or
- safety.

'Good self esteem resulting in good self concept and knowing your limits, being able to participate and develop in today's society, good internal coping mechanisms, being educated no matter what

intellectual capacity and building skills that enhance mental health and well being.'

'Normal development under difficult conditions. It is focusing on reducing vulnerabilities of children and families whilst increasing the protective factors.'

Case studies - UK

Project workers defined resilience in similar, but briefer terms to some survey respondents - their understanding of resilience tended to emerge more fully later from the descriptions of practice. They also tended to use less 'academic' language than some of the survey respondents. Project workers' definitions included the element of innate characteristics and 'bouncing back' and 'coping' were also important themes:

'Being able to bounce back from things….natural coping strategies in order to do that'

'being able to cope with whatever life throws at you'

'being able to cope in adverse circumstances, if they've got….negative things going on in their lives that they're given coping strategies…connections'

'the ability to bounce back and to cope with whatever comes along'

'It's about looking [at] the positives around you and taking from them and getting through it'

One teacher used very similar terminology:

'the ability to bounce back from the kind of whatever knocks you might get in life…and having the self confidence, I think, to be able to accept the challenges and not have an emotional outburst or anything like that.'

41

While another used a more concrete definition:

'facing facts and problems'

Case studies – Australia

The eight case workers and three non-service affiliated professionals interviewed all provided quite detailed definitions as to what the concept of resilience meant to them, utilizing fairly academic language as they outlined the understanding they had of this concept.

When attempting to define resilience, most practitioners did not rely upon aligning the concept to its practical utility or impact to outline its meaning, instead being able to provide clear conceptual propositions. Most definitions did, however, gain a degree of salience or clarity when interviewees *did* proceed to outline its relevance to their approach to practice – which, importantly, was not always seen as 'resilience-led' per se. This latter aspect of practical utility will be explored in a later section.

In terms of the length and depth of the definitions provided, the 11 responses fell quite neatly into two groups: the first were shorter definitions of 2-3 lines maximum (N = 5); the second were longer and more detailed, typically a full paragraph when transcribed (N = 6).

More interestingly, these two groupings displayed two key trends in content. Within the shorter definitions, themes of 'coping' and 'bouncing back', and 'innate' or 'inner' qualities or strengths were abundant, with definitions very much focused on the individual:

'The ability to bounce back from adversity… resilience is about your success in dealing with your own issues… a personal quality that people bring to situations rather than something that's imposed from the outside' (non-service practitioner, NSWb)

'The feature of coping well with life adversities, and recovering quicker from a stressful event… more about the individual, and their resources' (worker, NSWb)

'…it's in the strengths of the person and the way they're able to cope in challenging times' (worker, NSWb)

In the more lengthy definitions provided, however, there was a much greater consideration of resilience as a *process*, as something that might be taught or fostered in the individual, as well as of the broader familial and ecological factors that might drive resilience. An acknowledgment of intra-personal qualities was still present:

'They are inherent strengths that people can possess, that can also be fostered through establishing supportive networks. Inherent strengths… when people are in difficult stages, that help them to get through. Resilient people are able to move forward or move beyond critical traumas in their lives and even just everyday challenges… with correct nurturing and attachment, people can become more resilient… it's about learning that the world is a safe place in their first critical early years of life' (worker, NSWb)

'Resilience to me is something that I think is inherent in most people. And some families can continue that on from their childhood to their adult life and manage life's ups and downs – especially the downs – by having that innate ability to bounce back and be resourceful…. It's something that can be taught well in childhood by parents, in terms of not always overcompensating and rescuing children, allowing them to stand on their own two feet, and go through challenges… with good support, they can take those steps forward' (worker, NSWb)

'I would define resilience as the capability to, in any capacity, to cope with daily life, really. It's about a capacity to manage, it's about support

43

to make changes and improve. It's a process, it's an ongoing process in life, and I guess some people are naturally more resilient than other people; but you can learn to be more resilient! And that's why I mean it's a process for all of us really… people can become more resilient over time' (worker, NSWa)

In all, the responses obtained indicated what amounts to two distinct levels of understanding of the concept of resilience: the individual level, where personal strengths and qualities are seen as driving or underpinning one's capacity to cope; and the ecological level, where individual considerations play a role, but where family and environmental influences are seen as equally important, and where there is also scope for resilience to be nurtured and increased as a function of the multi-faceted and fluid nature of the construct.

International comparison of findings: UK vs. Australia

There was a high degree of consistency in the definitions of resilience provided by the survey respondents in the UK and Australia. Consistent with the literature respondents in both countries most frequently described resilience as being a capacity or ability to deal with, adapt to or remain unaffected by adversity.

There are some similarities and some differences between the definitions provided in the UK and Australian case studies. Specifically, the set of shorter definitions from the Australian data resonated with the themes of coping and 'bouncing back' seen in the UK explanations; the UK case study data did not, however, seem to extend to an understanding of broader ecological influences on children's resilience nor upon the capacity for children to 'learn' or increase their resiliency. This might perhaps be seen as directly reflective of the fact that the UK practitioners for these case studies were focusing mainly on improving the children's behaviours and enabling them to cope better with anger, frustrations, and challenges, while Australian practitioners were predominantly concerned with the family unit and the needs of parents, and were therefore more likely to consider the influence of the environment

upon a family's well-being as well as parent's capacity to nurture and protect their children – in effect, 'increasing' their children's ability to be resilient.

Congruence with the literature

The practitioners in this study provided relatively sophisticated definitions of resilience and the focus of many operational definitions was upon processes rather than just outcomes. There were differences of emphasis on the extent to which resilience could be viewed as an innate characteristic, although, the general tenor of definition implied that resilience could be nurtured – perhaps not a surprising response from those whose professional role is to promote children's well-being.

Defining resilience in terms of an 'ability' or 'capacity' perhaps has the danger of being a little misleading or oversimplified. If resilience is better understood as an emergent property from a combination of adversity and a range of coping mechanisms then it may be better to confine the term 'ability' to some of the contributing factors to resilience rather than to resilience itself.

Another potential shortcoming in the operational definitions lies in the lack of specificity about the concept of 'adversity'. Clearly, for practitioners working with children defined as 'vulnerable' there is an assumption of adversity. However, there can be a danger in making assumptions about the nature of risk factors. This has been a problem for those researching resilience, as has been highlighted by Rutter:

> 'Resilience cannot be studied satisfactorily in the absence of the prior demonstration that the individuals concerned have actually experienced substantial risk' p.654.

Rutter, is of course, pinpointing potential pitfalls in the empirical study of resilience, but there are implications for practice if the exact nature of the pre-supposed risk is not carefully analysed before intervention is planned.

Overall, however, the data suggests that practitioners are using definitions of resilience that have been influenced by the literature and are relatively congruent with the current understanding of the concept.

Resilience based practice

Precisely because a resilience led approach depends on a very detailed, individual and specific plan for intervention for each child every plan will necessarily be different. However, the research into factors associated with resilience has led to the development of a number of similar guiding frameworks for intervention via a range of protective factors. Rutter's framework suggests that practice should:

- alter or reduce child's exposure to risk
- reduce the negative chain reaction of risk exposure
- establish and maintain self-esteem and self-efficacy
- create opportunities .

Masten's framework suggests that practitioners should aim to:

- reduce vulnerability and risk
- reduce the number of stressors and pile-up
- increase the available resources
- foster resilience strings
- alter or reduce the child's exposure to risk .

And Benard suggests the need for the child to experience:

- caring relationships
- high expectations
- opportunities to participate and contribute .

It is also important, as Luthar (2005) points out, to focus on factors that are 'modifiable modifiers', that is, they can be changed rather than being relatively fixed, as is, for example, gender.

Masten and Coatsworth provide an overall framework for intervention by suggesting that prevention and intervention design can be:

a) risk-focused, for example, public-health programmes such as those aimed at preventing low birth weight and projects aimed at reducing the stressors associated with transition between primary and secondary education;

b) resource-focused, for example, adding extra assets for children or improving access to resources, especially when risks are intractable and

c) process-focused, for example, improving attachment, self-efficacy and self-regulation .

Yates and Masten suggest that the most effective intervention programmes involve all three:

> 'These multi-faceted paradigms attempt to reduce modifiable risk, strengthen meaningful assets, and recruit core developmental systems to enhance positive adaptational processes within the child, the family and the broader community…' p. 10

In one of the few previous studies that explored ways in which resilience is operationalised Barnardo's sent a postal questionnaire to 140 education, health and social work professionals in child and family support services in Scotland and received 71 returns . In response to a question that asked which of the four approaches identified by Rutter were being used 39 projects identified - 'reduce exposure to risk'; 52 – 'reduce chance of chain reaction'; 63 – 'increasing the child's self esteem' and 60 – 'create opportunities for growth'. The authors concluded that the data 'indicates that many of the respondents did employ strategies to promote resilience'.

Survey - UK

Many respondents equated a resilience based approach with particular principles for practice. For example, several participants stressed that the approach should be particularly child centred and that professionals needed to really listen to children, work alongside them and involve them in intervention. There was an emergent view of a resilience-based approach involving a specific nature of engagement that was inclusive and respectful.

> *'Practice in which the professional does not dominate, dictate or "know best", but one which listens to the individual and is supportive in encouraging the individual to problem solve. Practice which encourages this also in both internal and external support structures within the individual's life.'*

Another principle implied by a resilience-based approach was the use of solution-focused and / or strengths based practice . 37 participants described resilience as a 'strengths based' approach, 10 people said it focused on the positives in a child's life rather than the negatives and four people described it as an approach that was empowering for the service user. In similar terms seven people said that a resilience approach would look similar to a solution focused approach.

> *'I believe it is a strengths based approach rather than a deficit approach and as such focuses on maintaining identified positives within the person and their situation'.*

> *'Resilience has strong links to solution focused thinking and any work which used the latent or inherent skills of service users to develop survival strategies that are consistently successful must be grounded in "resilience" also'.*

This finding links with the response to the question that asked whether, apart from resilience, their service promoted particular theoretical approaches to practice. Just under three quarters (73%) said their service did promote particular theoretical approaches to practice. A solution focused approach was the most often cited approach (by 18 participants). All those who said their service used particular theoretical approaches felt these were useful or very useful.

There was a view that a resilience-based approach was one that targeted different ecological levels ; one practitioner explained the need to target all three areas thus:

> *'Resilience is part of an ecological framework where the needs of say a young person are assessed not just as an individual but as part of their wider family and in the wider community. Resilience is about helping people at these different levels to develop protective factors that can help them to manage their life better.'*

However, when referring to practice 75 people gave responses where the ecological focus of intervention was discernable and the indications were that the focus was often on the child -:

- child focus (54)
- child, family and environment focus (9)
- child and family focus (6)
- child and environment focus (6).

Three people stressed that a resilience based approach needed to be a multi agency approach and several people described resilience as a holistic approach:

> *'A resilience based approach, has to be a multi agency approach, no one person could meet all the needs of an individual or a family... the approach draws on the strengths of individual agencies in terms of their skills and knowledge, and brings them together, to provide an overall package to suport an individual or family....'*

Attachment theory was the second most commonly cited theoretical approach to practice (by 15 participants). Working to promote attachment emerged as highly linked with a resilience-based approach and five participants described the ways in which work around attachment was key to promoting resilience:

> *'… they can be helped to improve their resilience by improving their attachment skills.'*

Participants identified a number of areas that practitioners should focus on in terms of intervention, the majority of which clustered as follows:

- Self esteem /self image/self worth (23)
- Attachment/secure base/relationships (13)
- Problem solving skills/coping strategies (11)
- Education (8)
- Interests/activities (6)
- Building confidence (6)
- Building support networks (6)

- Assessing/reducing risks (5)

The largest proportion of responses as to what a resilience-based approach involves in practice fell into the themes of:

- Identifying, assessing or focussing on a young person's current strengths/skills/talents (18)
- Helping, encouraging or enabling that young person to build on/develop their strengths/skills/talents (26).

Eighty per cent of respondents said they had successful strategies in place to increase a child's resilience. Some of these strategies involved individual work, some involved groupwork. Box 1 provides three examples given by respondents. In summary the strategies included:

- activities such as board games that encourage problem solving or increase self-esteem, or drama whereby young people 're-script' scenes to demonstrate resilience
- play therapy
- life story work, charting life changes and identifying lessons learnt
- discussion groups or group work to explore how to cope with knock-backs and to enhance peer relations and social networks
- including the views of young people and making them feel valued as an individual, listening to the views of the child at Child Protection conferences
- peer support and mentoring
- dealing with the source of the problem, for example, using parenting classes to improve attachment and help parents understand the effect of their volatile relationship on their child
- understanding the child's history
- providing clients with the space and time to reflect and explore their feelings
- counselling
- offering positive role models and building trusting relationships with the child
- providing positive feedback

- Using programmes and publications, including -
    - *Assessing and promoting resilience*
    - Webster Stratton Programmes
    - *The Emotional Competence Model* (as described in .

Box 1. Examples of described interventions aimed at promoting resilience

'We have provided a young person's age specific group programme which focused on ... helping the young people identify their strengths and areas where they were not fully understanding why they struggled with problems that arose. Young people were given disposable cameras and encouraged to take photos of people, places and animals that they thought were important to them. These photos were then used throughout the programme to allow the children to talk in third person about themselves.'

'Alan (changed name) came to us with an inability to look people in the eye, he was overly compliant sometimes and at other times defiant. He was excluded from school and near to family breakdown because his behaviour was harmful to others. The work with Alan has concentrated on building his self esteem (very detailed work) and supporting him in social situations. The work helped Alan identify his strengths initially through externalisation and then through his own endeavours. He was helped to speak to his family, peers at school and eventually at professional meetings.'

'A young adolescent male, with a degree of learning difficulties, assessed as vulnerable to authoritarian parenting style... opportunities were created for him to take part in demanding and challenging supervised activities within an after school club setting.'

In summary, therefore, the main themes emerging from the survey in the UK relate to principles for practice and specific practice suggestions. The key suggested principles were:

1. respectful engagement with, and involvement of the service user in practice
2. the use of solution-focused and strengths-based approaches to practice
3. the need to target all ecological levels
4. the need to take a holistic and multi-agency approach.

Themes in relation to practice included:

1. an emphasis upon raising self-esteem as a focus of intervention
2. problem-solving and coping as a further focus of intervention
3. the identification of attachment as a focus of intervention and practice based upon attachment theory as closely allied to a resilience-based approach
4. examples of resilience-based practice that described assessing, and promoting children's strengths, skills and talents
5. descriptions of interventions that draw on a range of methods and creative approaches to direct work with children and their parents.

Survey – Australia

Australian respondents referred to a resilience-based approach to practice as one that includes:

- identifying, building and supporting individual strengths and capacities;

- promoting skills, characteristics and interests that enable coping and positive adjustment; and

- building and reinforcing connections to community and social support networks.

'A framework of practice which fosters the development of resilience through connecting children and families with support networks within their home, school and community, encouraging the development of skills, interests and talents, education around health relationships and the need for strong, safe, sustainable and secure base (eg. family, friendship networks)'.

'The foundations of Early Intervention case management support, as well as the vision and values of [the organisation], reflect the concept of resilience both implicitly and explicitly - creating strong, healthy, and inclusive communities, working with families from a strengths-based approach, connecting communities, providing access to quality Early Childhood education experiences and promoting positive outcomes for families through implementation of case plans developed in consultation with families to maximise parenting outcomes'.

Overwhelmingly, resilience-led practice was identified as commensurate with a strengths-based approach. This included features such as identifying, assessing, and building on existing strengths, as well as the development of new skills and talents.

'…it is a strength-based approach, which focuses on the individuals positive attributes which can be used to overcome crisis situations'.

'Exploring and acknowledging with the family their strengths, times in their past when they may have overcome challenges and identifying what assets helped, encouraging families to identify processes that can strengthen their ability to overcome challenges'.

Some respondents also noted the need to acknowledge and address clients' difficulties and weaknesses as part of a strengths-based approach.

'A resilience-based approach acknowledges the difficulties / traumas and hurts in lives while supporting the client to build upon and recognise skills and supports that they have available to them'.

'A resilience-based approach to practice allows a worker to look at strengths and build on these. During this period some weaknesses will be identified and this can be incorporated into the work'.

The development of connections to community supports and of strong social relationships and networks were seen as key protective factors for children and families.

'Ensuring that families are linked to services available through local communities - that is, encouraging participation in school & community for example, as a buffer against an adverse home environment. Where kids and families are connected to the wider community there is a greater probability for kids developing strong relationships outside their home and having others in their daily lives who can detect vulnerabilities. eg. childcare/preschool for infants, school, PCYC & youth connect programmes'.

A smaller number of respondents also identified the need for clients to be able to reflect on their resilience, make meaning from their experiences and take a positive perspective.

'Encouraging people to find meaning in the dominant story of oppression/suppression and to reform this in a way that will provide a sense of one's ability to manage one's life in a holistic and positive way. Allowing space to reflect on life's difficulties and celebrating the passing of the 'hard times' so that the person can 'see' the good things that happen'.

As well as describing what a resilience-based approach incorporates, some respondents described the importance of their engagement and relationships with clients as part of a resilience-based approach.

'A resilience based approach in practice may look like working through the strengths of the relationship, the therapist- client- child relationship so that as a result of a good therapeutic, and trustworthy relationship, the family gain strengths which aid them in dealing with the tough times that may follow'.

Reflecting the breadth of issues addressed in work by the Australian practitioners, a wide variety of settings, approaches and content areas were

identified as successful resilience-based strategies for practice with children. These strategies included those which focused on specifically on the child (and developing their confidence, skills, talents and behaviours), specifically on the parent (and developing their parenting knowledge, skills and behaviours), and/or those which focused on developing and supporting relationships (e.g., between parents and children, between families and the wider community, and between organisations and agencies). As such, the strategies incorporated a variety of settings such as individual work (centre- or home-based), group work, child care settings, camps, and after-school hours care. One respondent described a comprehensive resilience-based approach:

> *'Identify and assess all the resilience features present or possible in the child's personality or environment (See 40 Developmental Assets - www.Search Institute.org)   Build on these strengths/assets to increase the child's resilience.   Multi-targeted approach - enhance child, parents and community. Keep working with the strengths - esp with adult allies and child's education.'*

Other approaches included:
- parent education and parent-child attachment programs (e.g., the Incredible Years, Marte Meo);
- quality child care
- using games, play and outdoor activities;
- mentoring for children and young people (e.g., Big Brother/Big Sister programs);
- tutoring;
- the use of praise and positive reinforcement with children;
- improving interagency responses;
- the use of role play, modelling and coaching with parents and children;
- reflective techniques and therapeutic letter writing;
- counselling; and
- referral to other services.

'Quality child care to develop cognitive and social skills in children where there is a lack of stimulus in the home. Involvement of older children in local after school youth projects or sport to enhance social skills with peers, to promote a sense of belonging to something outside of school & home and to develop positive relationships with other adults.'

'Allowing children to explore nature, camping out in the cold, going for bush walks, adventure through safe creek areas, supervised from a distance, be able to challenge their own ability with nature, climb trees, rock throwing in a safe place, riding bikes safely.'

'Giving children examples modelling and using the language and actions they can use when in difficult situations. Role playing situations during story time. Reading story books'

Again, given the broad range of services included in the sample, the content of these strategies also varied widely and included general areas such as 'strengths' to more specific areas associated with resilience such as:

- problem-solving skills;
- goal setting;
- positive behaviours;
- social skills;
- coping strategies;
- emotion regulation (e.g., the Seasons for Growth program);
- empathy;
- communication skills;
- help-seeking behaviour;
- stranger danger; and
- parenting knowledge and parents' knowledge of attachment and child development.

'running groups for children to build social skills, problem solving,   liaising between services/ significant persons ie home and school   providing play/toy tools to enhance relationship through play'

All such strategies described as being relevant to or underpinning a resilience-based approach to practice were also commensurate with the other theoretical approaches that respondents named as being promoted by their service or organisation:

- Strengths-Based Practice (39 respondents); and
- Attachment Theory, including Circle of Security (Cooper, et. al 2005) (33 respondents).

These approaches were also consistent with the professional development and training sessions that respondents had recently undertaken:

- Strengths-Based (17 respondents);
- Attachment Theory (14 respondents); and
- Resilience (6 respondents)

In summary, a significant degree of congruence with the UK survey findings of resilience-based practice was seen, with a number of common principles and themes identified, particularly as regards the use of a strengths-based focus and the need to connect with other services and agencies.

Specifically, the Australian sample identified the following principles as key to resilience-based practice:

- The use of solution-focused and strengths-based approaches to practice;
- The need for a holistic and multi-agency approach;
- The need to build and reinforce connections to community and social support; and
- The need to acknowledge strengths and skills, as well as difficulties and weaknesses, as part of a holistic approach to practice.

Themes in relation to practice included:

- A tendency toward pragmatic strategies and solutions (e.g., tutoring, childcare, education) to achieve the goals of the case plan or intervention;
- A strong focus on attachment processes; and
- A degree of emphasis on enhancing emotional regulation and interpersonal skills.

Case studies – UK

There were some similarities with the survey findings as well as some differences in emphasis. There were also some differences between the two services. Like the survey respondents, the practitioners equated a resilience-based approach with particular principles and styles of working. Most notably the concept of involving the service user was to the fore and in every case there was evidence that the child was involved in the work and that practitioners viewed this as a key aspect of resilience-based practice:

> *'we always talk about coming to the group to practice things, making friends, and sometimes it's controlling your anger, just different things with different children, but we do talk about it in that way with them…'* *(nurture group workers S).*

> *'[child worker] doesn't shout at you, like teachers do, when you've done something wrong. She just sits down and talks to you nicely like'* (child E).

There was less explicit reference to solution-focused and strengths-based approaches, although it was mentioned, and was certainly implicit in the descriptions of practice.

In keeping with taking a broader ecological approach in the English service parents (usually mothers) were involved in the intervention because there was a child and a parent worker in every case, and the Scottish workers engaged with the parents in at least three of the cases.

'You know [child's] views and opinions were taken on board as well and to sort problems out you need to have both parties involved with and both bodies pulling together and working together, that was definitely done' (mother E).

In six of the cases there was also explicit reference to involving the school, although, as will be expanded later, in several other cases the teachers appeared not to have been involved in the process.

'so we were looking at building her communication with the school' (parent work E)

'I think that was brilliant, because it meant educating the teachers as well' (mother E1).

'I think it's really great to have parallel working, working with parents, family and child' (child worker E).

'…it was like a bridge between the school and us...' (mother E).

There was far less reference to involvement of the wider community or other professionals, although a worker from an alcohol service noted that *'we were going in the same direction'* (alcohol service E).

In comparison with the survey there was also less emphasis upon in-depth strategies to improve attachment relationships. Attachment issues were recognised as key in many of the cases, and several of the children were affected by issues of separation from their father. However, structurally the services were less able to tackle these with much intensity – in the English service because of time limits and in the Scottish service because the main emphasis was upon groupwork with children. However, there was an emergent theme in the cases of encouraging an environment of consistency and clear boundaries and one that would promote better attachment relationships. Parent work encouraged more positive attitudes towards the children, more praise and support for children.

'…help for her to bond with [child]' (parent worker E).

'…helping [child] with alternative strategies for his emotions' (child worker E).

'…[mother of child] had the skills, all I had to do was to polish up the skills to enable her to believe in herself that she has got the skills…' (parent worker E).

'every parent, like, they try their utmost to bring up their child as best they possibly can, but sometimes somebody from the outside can teach them and what the thing was, we were giving praise for little things when they should have got praise for bigger things...' (mother E).

The described resilience-based practice was wide-ranging. For the English cases the plans were built around the 6 domains of secure base, education, friendships, talents and interests, positive values and social competence, with varying levels of emphasis depending on identified need:

- all six domains (3 cases)
- positive values and social competences (2 cases)
- friendships and social competences (1 case)
- education, talents and interests and friendships (1 case).

The domains provided an organising structure for practice, however, the strategies varied depending on the needs of the children and work in different domains was often linked. Because of the time limits for intervention the practitioners reported that they were unable to go into depth on some issues, such as long-standing attachment problems. Box 2 gives an example of an intervention plan that included all domains.

BOX 2: Example of intervention plan with 'John'

John lives with his mother and younger sibling. There are some attachment problems with his mother. He was close to his father but has had no contact with him for some years. His mother has a new partner who is close to John's younger sibling but not to John. John was becoming violent towards his younger sibling and sometimes his mother. He swore a lot and was rarely able to sleep through the night. He was unable to enjoy positive relationships and was becoming very isolated. The project worker assessed that the attachment problems could not be addressed in six months, therefore the focus is placed on helping John to deal with his life as it is now.

The intervention work is focusing first on exploring how John feels about the loss of his father and how this can be addressed. John will also be helped to understand how to express appropriate affection towards his mother. The worker is working with John on relaxation techniques to help him sleep. John's anger will be addressed with anger management techniques and strategies, and school will also be involved with this. They will also explore ways of helping John to concentrate at school. John will be learning techniques to enable him to get on better with peers, such as ways to be assertive, and methods of managing disagreements. John will be helped to understand what a positive friendship is. The worker will explore body language and the importance of eye contact to help him make and maintain friendships.

The parenting work is focusing on introducing his mother to strategies to help her strengthen her relationship with her son, and possibly strengthen her new partner's relationship with him. The parent worker is also exploring ways that John might be able to spend more time with the wider family to raise his self esteem and feeling of belonging. The parent worker supporting his mother in finding interests for John to pursue which should also help his confidence and esteem. The parent worker aims to help his mother with her own stress and worry so that she can start to support her son with his worries and help him to express his emotions to her.

For the Scottish children the plans were developed on the basis of the Boxall profile, for the majority the focus tended to be on improving aspects of negativism towards self and others. Box 3 gives an example of a plan.

BOX 3: Example of intervention plan with 'Ryan'

Ryan was referred because of a tendency to fall out with his classmates and difficulty sharing toys and resources in class. He tended to 'absent himself' from activities, which was worrying in a class context given that he could fall behind if he wasn't paying attention; and he was unable to accept when he made a mistake. Ryan's mother commented that her son had been disruptive and under-performing at school, while at home he was cheeky and could be nasty to his younger sibling.

The main areas targeted for Ryan are his disengagement and tendency to absent himself from the group (e.g. missing his turn at games), and his negativism towards himself and others. They focus on helping him cope when he makes a mistake, and admit that he has done so, through conflict resolution techniques. In order to address Ryan's excitable behaviour, Ryan's workers use therapeutic games to help him develop his emotional literacy and use body language when he is feeling excited. Ryan has been praised and encouraged to build his self esteem and has been entrusted and supported with tasks such as the 'snack rota'. Ryan's mother commented that nurture group helped him improve his attitude and behaviour, so that he is easier to handle at school and home.

Ryan's mother continues to have problems with his behaviour at home, and feels that additional support would be helpful, so a homelink worker will be introduced to the family soon.

Taking all the data together from interviews and case files the following intervention themes emerged as key in many of cases:

- improvement of self-esteem / to like self more
- improvement of peer relationships
- improvement in school experience / behaviour
- control of anger / managing disagreements
- naming feelings / emotional literacy.

Just as raising self-esteem was highlighted in the survey, in the majority of case studies self-esteem was mentioned as a key aspect of the work:

'It was to do with issues around self-esteem….for her to be proud to be E2 to be happy in E2's skin, to walk with her head held high and she knows that she does have an internal self control, but she is in charge of her own life and she can be confident in the fact that she can make decisions' (child worker E2).
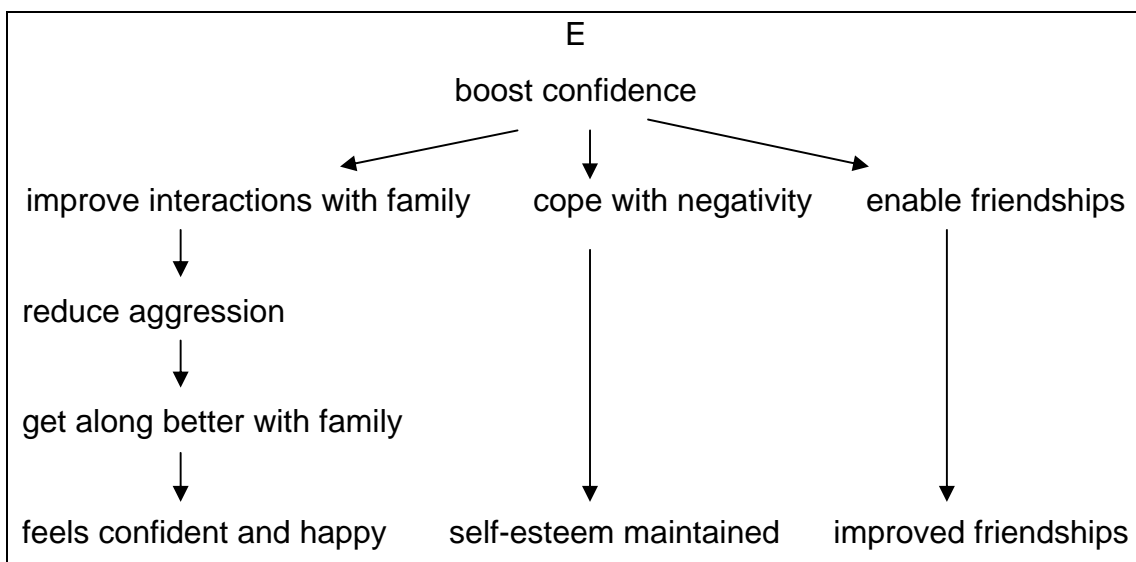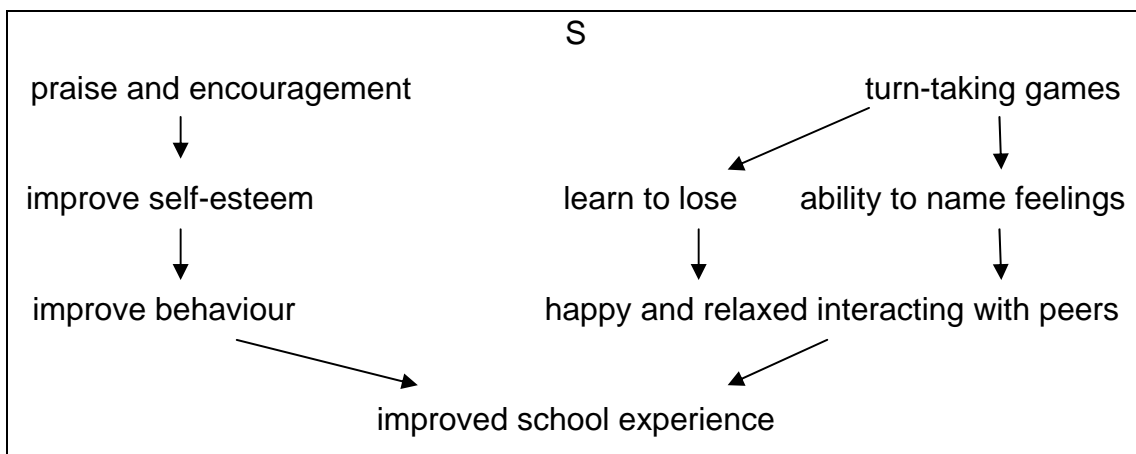
'In the beginning it was self-esteem…I mean we're still working on self-esteem, that's still an emotional issue, but otherwise she's fine, she's coping well, but I think she needs a bit of support just now' (worker S6).

In delving deeper the circularity and inter-connectedness of many of these themes becomes apparent. Improved self-esteem, for example, can be described simultaneously as an intended outcome, but also as a route to outcomes. Similarly, improvement in peer relationships can be seen as a positive outcome, but a route to better outcomes. For each case we constructed 'chains' of intervention from the data that traced strands of intended routes towards improved outcomes. Figure 4 shows some examples of chains of explanations where these themes are components.

From such chains of intervention it was clear that strategies for intervention focused on a blend of approaches that included a focus on the underlying processes seem to be associated with better outcomes (and therefore resilience) as well as the external manifestation of underlying processes such as behaviour. As suggested by the survey respondents, intervention was linked with the promotion of coping strategies and problem-solving, although not always described in those exact terms. In addition, there was attention to the human environment around the child – the messages about self and the structure of responses to behaviour.

Figure 4: Examples of 'chains' of explanation for intervention strategies in the UK

E

Strategies to control anger

ability to control anger

no longer feels letting self down

likes self more

better concentration in class

S

praise and encouragement

improve self-esteem

improve behaviour

turn-taking games

learn to lose   ability to name feelings

happy and relaxed interacting with peers

improved school experience

E

boost confidence

improve interactions with family   cope with negativity   enable friendships

reduce aggression

get along better with family

feels confident and happy   self-esteem maintained   improved friendships

S

praise and encouragement   naming feelings   reduce controlling activities

↓

improve self-esteem   better able to engage with peers/less isolated in class

↓

improved school experience

E

identify physical and mental manifestations of anger

↓

better able to control anger

↓

friendships maintained

S

name and discuss behaviour   close adult attention   praise good behaviour

adult accompanies on all   positive behaviour rewarded

included in activities/able to contain emotions

improve self-esteem

improved school experience

As described, the two centres used different assessment frameworks and had different timeframes for intervention. The main apparent difference in descriptions of practice lay in a greater overt emphasis on the provision of strategies to control anger in the English setting and a greater emphasis upon emotional literacy in the Scottish setting. Despite this, there was much overlap in the descriptions of the work.

Overall, the data seems to suggest that improvement of self-esteem, peer relationships and schooling emerge as key intended outcomes, with strategies to control anger and improve emotional intelligence as the main routes to these outcomes (see figure 5).

Figure 5: The inferred main strategies and intended outcomes running through the UK case study data.

STRATEGIES
anger control / emotional intelligence

INTENDED OUTCOMES
raised self-esteem / better peer relationships / improved school experience
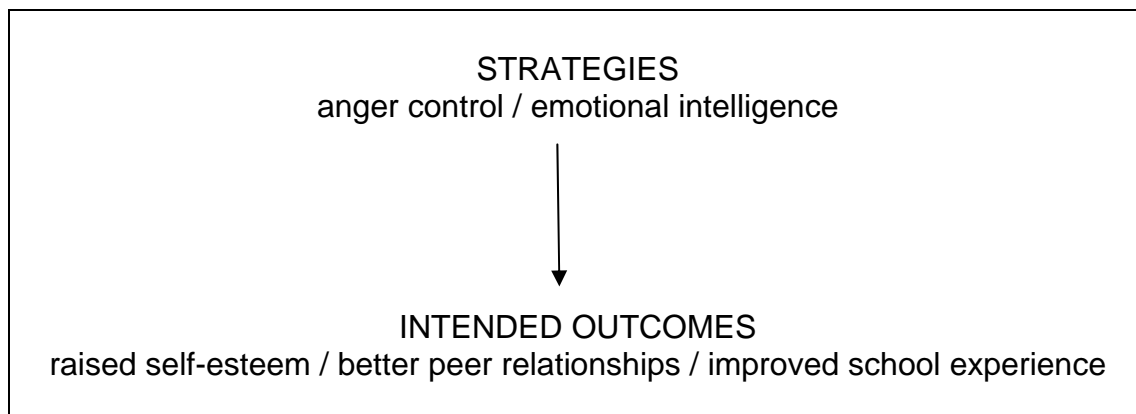
The survey respondents also identified schooling as an important area of focus, but in comparison, appeared to place greater emphasis upon talents and interests and less upon peer relations than in the case studies. This could be related to the fact that the case study children were often referred because of their problems in school, which were, in turn, often associated with poor peer relationships and poor anger control. Related themes include strategies to improve:

- sharing
- being able to deal with surprises,
- improving concentration
- increasing assertiveness
- coping with losing games
- acceptance of disappointment.

A range of specific activities were used to assist children to control their anger and behaviour. A number of the English children were taught 'cool down' techniques. These included the use of pictures of volcanoes to illustrate the concept of the point of explosion. The children were supported to understand the feelings associated with anger and to use techniques such as counting to ten and visualising a cool drink to combat anger. The children were given laminated cards to remind them of the techniques and in some cases a set of cards was made for them to keep at school – and a teacher set up a 'cool down' zone in school for one child.

> *'he was sick with all these emotions inside him, he didn't know how to cope with them… When I would say, quite early in the work, "we'll look at ways for how to manage your anger" and he would say "really, can we really do that?"'* (child worker E).

> *'different strategies have been put in place, like when feeling angry to go and do such and such…'* (mother E).

> *'helping him recognise why he's got anger'* (mother E).

> *'We did these cards, like for cool drinks and stuff to calm you down, thinking on a beach - a cold drink'* (child E).

> *'To get over my anger, and be responsible towards other people'* (child E).

> *'Sometimes we played strengths cards and sometimes we did pictures of when we feel angry….When I was angry and I'd get into fights and get excluded. But [worker] would say "don't let your anger out, just count to ten and breath in and out"'* (child E).

In the Scottish service practitioners used group activities to assist the children to learn different ways of reacting. With the close support of the groupworkers children could be 'coached' to identify trigger points and shown conflict-

resolution techniques. There was an emphasis on learning to share and to understand feelings.

'we always use the 10 minute time in the planning group to help them stay on task…the anger took time, it was really just talking about it all the time' (worker S).

'giving him his words, acknowledging the feelings that were obviously around for him although he couldn't say' (worker S).

'Every chance to praise and mention a behaviour that you're trying to encourage' (worker S).

'I think it's to boost self-esteem and help the children cope with, if they've got anger management problems…and giving them other strategies of communicating and work with others….If you tell him to take a deep breath, I think that's what [worker] does with him and talk about his problems, that seems to be a beneficial strategy' (teacher S).

'He plays with dough, plays in a group and interacts with other children….they're training him, like if he wants to play with dough, he's got 10 minutes and then he'll have to allow someone else a go. He's learning how to share' (mother S).

'they kinda help his attitude' (mother S).

'Being nice, sharing and stuff…playing games' (child S).

'Needed to learn to share toys' (child S).

'To behave better' (child S).

'To get more confident talking to people' (child S).

Although the work was aimed at improving the child's engagement with education, the teachers interviewed were not always clear about the nature of the work:

> *'To be honest I'm not sure. I've been told that they'll go along and have a bit of toast or a drink and things like that and then play games. I've seen the notes, you know, about the games that he has played and how he has reacted…'* (teacher S).

> *'I think a lot of group activities, turn-taking, and really just a snack time and they all helped…'* (teacher S).

Overall the practitioners described a large range of creative and detailed work with children and their parents in individual and group-work settings. In summary, their accounts of practice were similar in some ways to that described by the UK survey respondents. The principles of involving the service user in the work certainly emerged as central in both services. Solution-focused and strengths-based approaches were not emphasised in the same way, but elements of them were implicit. Attachment and attachment problems were identified as key, but there were limits in the extent to which attachments were the focus of specific intervention strategies. As with the survey respondents, the actual descriptions of practice tended to highlight the direct work with children, and, in many cases, the parents. The extent to which practice was able to target all ecological levels and to be wholly multi-disciplinary was less clear. Again, as with the survey respondents, there was a focus on equipping children with coping skills, but there was a greater emphasis in the case studies upon the control of anger, the improvement of peer relationships and emotional literacy.

Case studies – Australia

The notion of harnessing resilience to guide practice in the Australian data was primarily focused on how resilience might align with *other* methods or models that are more frequently used or preferred by practitioners, which contrasts with the explicit usage of the Daniel and Wassell (2002) resilience domains framework by the service in England. In the Australian services, the

majority of practitioners did not, in fact, see themselves as conducting explicitly resilience-led practice; rather, the concept of resilience was either seen as inherent in or complementary to strengths-based practice, or was just one component of a whole collection of possible theories and frameworks that workers might draw upon as part of a more eclectic approach. Indeed, the words 'eclectic' and 'holistic' were used by 4 out of the 8 service practitioners when describing their approach to practice:

> *'…it's very practical and holistic… it's about digesting issues' (worker, NSWa)*

> *'…I don't work to a specific model. My thinking is informed by lots of different approaches and lots of different knowledges' (worker, NSWa)*

> *'…it's very holistic and eclectic. There's no one size fits all for anyone, you need to draw on the best parts' (worker, NSWb)*

In regards to the 'strengths-based' approach mentioned above, 3 out of the 8 case workers stated that this would be the one predominating model or theory used to guide their practice. One of these workers went as far as to say that the strengths-based approach underpinned the entire service's philosophy. It seemed, however, to be more a key component of a 'mixed bag' of methods by the other workers, including those who saw themselves as primarily 'eclectic' in their approach, sometimes just listed in passing as 'relevant'. The strengths-based approach was typically seen as useful due to the empowering potential it invoked for clients:

> *'…we use a strengths-based model, because when I do the case plan, I do it with the client, with the family, to make it totally about them. That works extremely well as it gives families total ownership of their problems' (worker, NSWb)*

> *'…I believe everybody's got the potential to change, and focusing on people's strengths is, in my experience, the only way you can do that… the key to resilience or strengths-based work is the relationship you*

begin with I guess… I'm understanding more and more about this as I do this work for longer and longer' (worker, NSWa)

Two service workers also noted potential problems or challenges surrounding this strengths-based approach, however, in terms of the limits it might impose on best practice:

'…it can be a bit patronizing for clients' (worker, NSWb)

'…It's pretty easy when you spend most of your time or a lot of your time with the adults in these families to forget – not 'forget' about the children – but to really hold in your head that these children are being seen by this service because there are some pretty big risk factors. And to keep always weaving it back to the child or children in families is quite challenging I think, and that's one way where maybe if you focused entirely on a strengths model, you could easily lose sight of some of the risks. So you really got to hold that in your head as well' (worker, NSWa).

It is interesting to note that all three non-service practitioners interviewed also cited strengths-based approach as their primary guide to practice:

'…I do like strengths-based, working with, you know, really good support for systems they've got in place, and really focusing on how we can use those to make them better and other thinks happening in their life… we focus on the positives really… with all our kids' (non-service practitioner, NSWa).

Attachment theory and the 'Circle of Security' (Cooper, et. al. 2005) model was a strong feature of responses made to the survey items investigating theoretical usages, however only 3 of the 8 service workers involved in the interviews mentioned this area of work. Only one worker provided any sort of detailed insight into this aspect of research utilization, citing that it was an extension of Bowlby's work, and that:

> *'…you can help parents to create better attachments with their kids, because we know that parents and kids with better attachments have better relationships in general and better relationships with others in the future. So we help parents connect with children, and then we know kids are happier, and parents are happier, and there's more harmony in the family' (worker, NSWa).*

In the other 2 cases where attachment was raised as potentially relevant, it was mentioned as more of an aside, as something not especially pertinent, or even useful:

> *'…attachment, circle of security – I think, well to me, it's a bit of a commonsense thing.... it's experience I guess' (worker, NSWa).*

Thus, notions of attachment seem to be less useful or salient to practice than other preferred frameworks, the predominating one being Strengths-based.

Other 'theories' or frameworks mentioned by respondents included (n = frequency of worker citations): Systems or systemic theory (4); Relationships approach (1); Trauma counselling (1); resilience (1); families (1); Solution-focused theory (2); Behavioural Intervention (2); Child Development theory (2); Family Counseling (1); Bronfenbrenner's diagram (1); Change theory (1); and the ABCD approach to Community Development (1). Such theories were typically mentioned in passing, with little detail provided – no doubt at least partially attributable to the interview schedule itself, and workers having no opportunity to expound any further. Taken together, these theories were all seen as capable of contributing useful 'parts' (worker NSWb7) to practice. As one worker quaintly put it,

> *'…they all contribute to a pot-pourri of knowledges…' (worker, NSWa)*

Finally, two workers cited a more alternative approach that had nothing to do with specific theories or models, one preferring to adopt guiding principles of being:

> *'…very caring and very loving; I'm a very kind person, but I'm a very firm person as well' (worker, NSWa)*

And the other, who also cited her 'eclectic background' as most relevant to her practice, talked of:

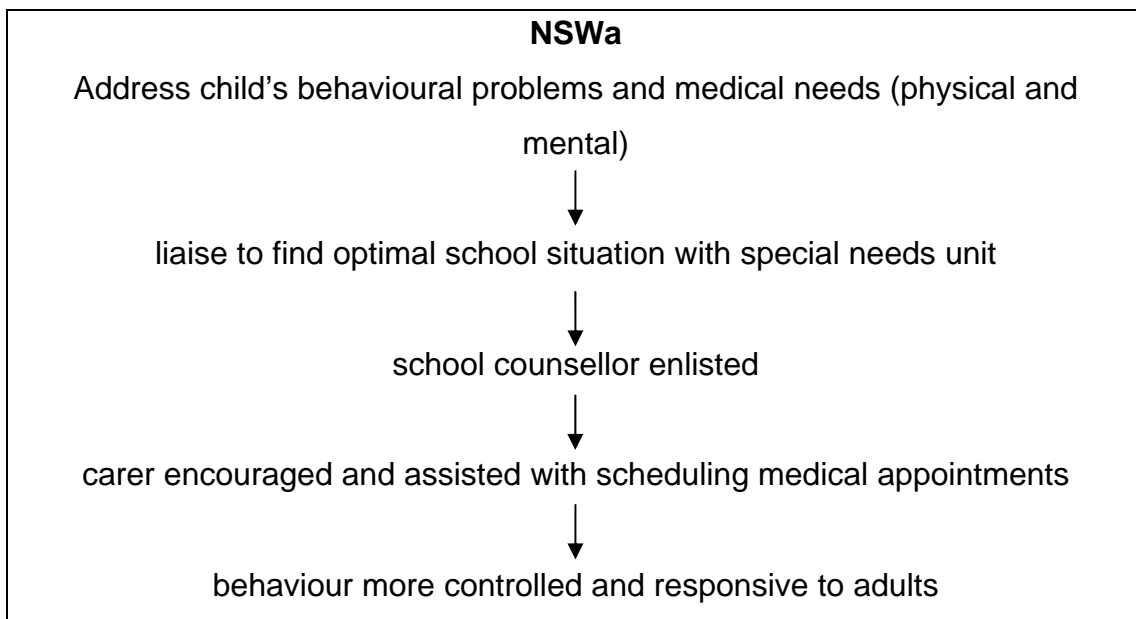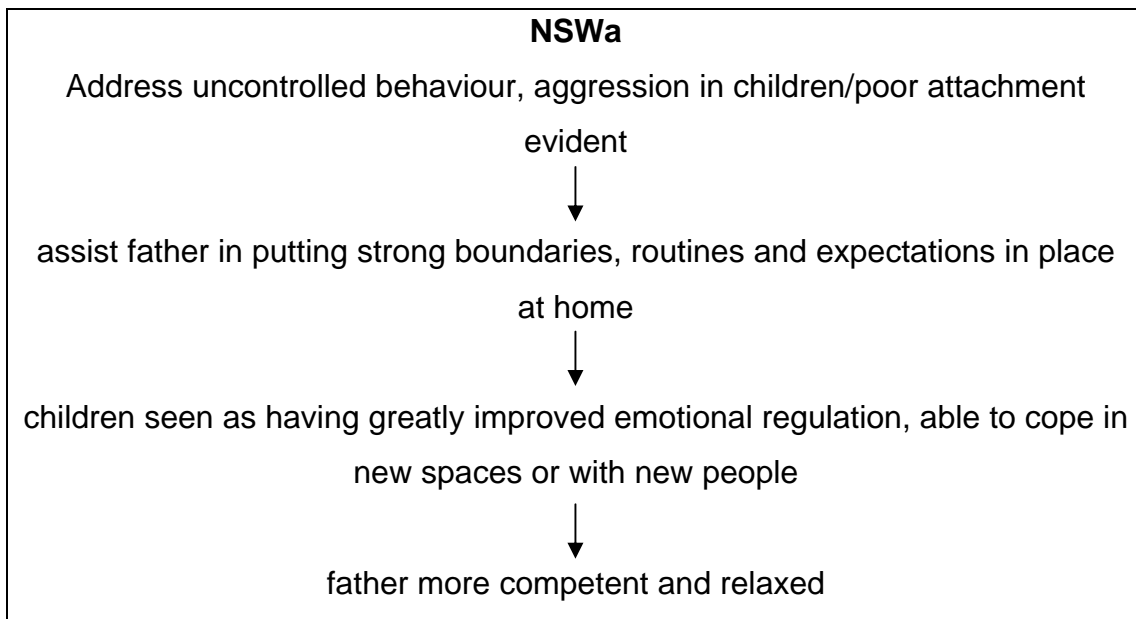> '…a spiritual framework that is about respecting and honouring people' (worker, NSWb)

It should be noted that the vast majority of practitioners interviewed used the terms 'theory', 'framework', and 'model' interchangeably; thus limiting the information about 'theories' that might underpin preferred models or frameworks.
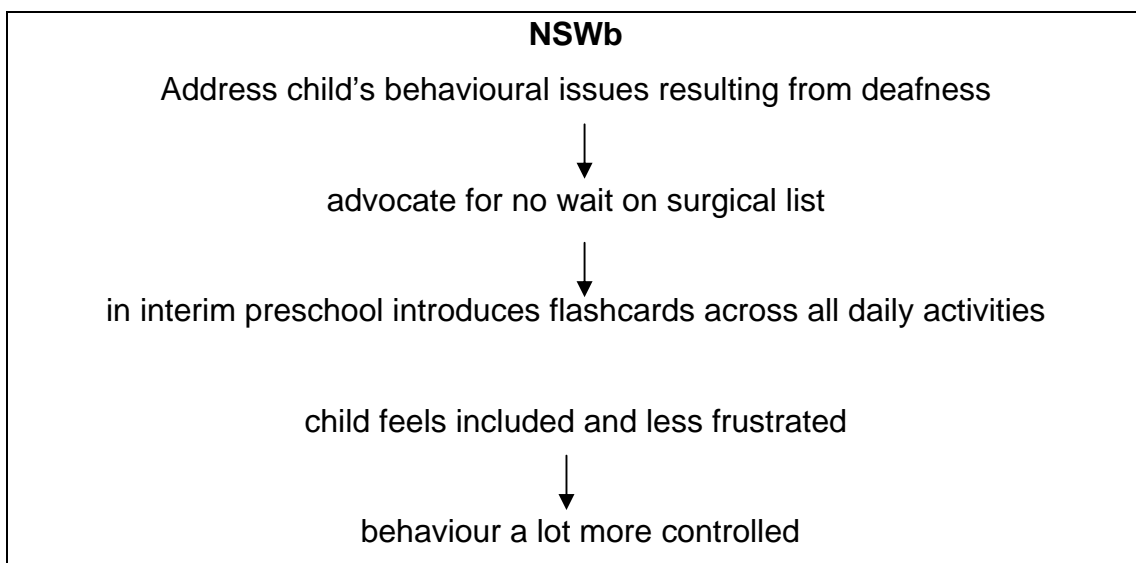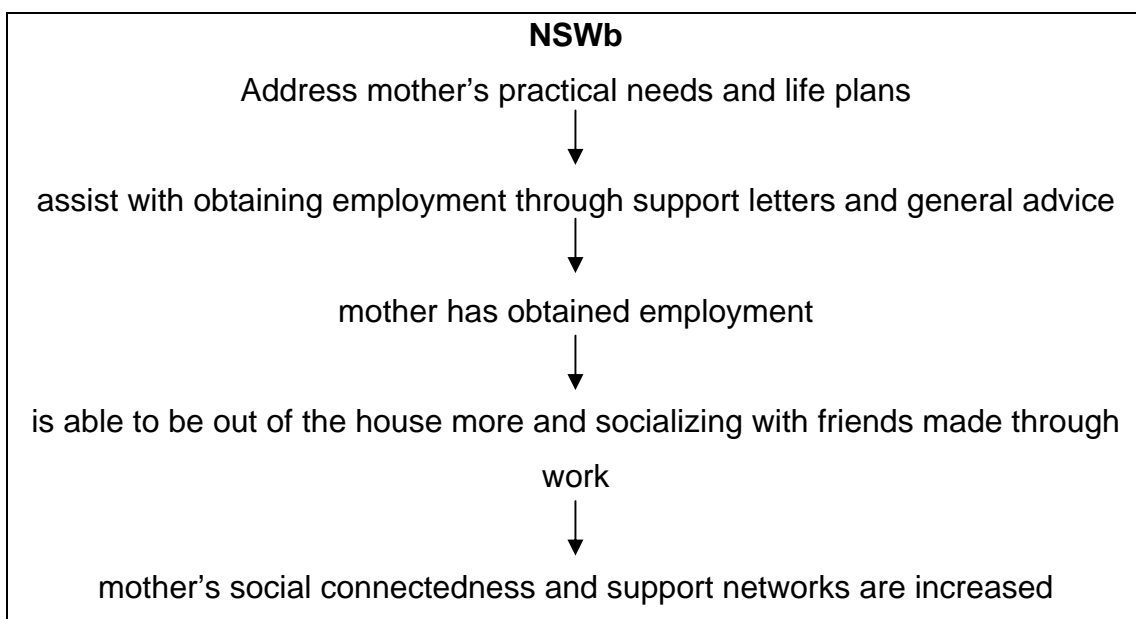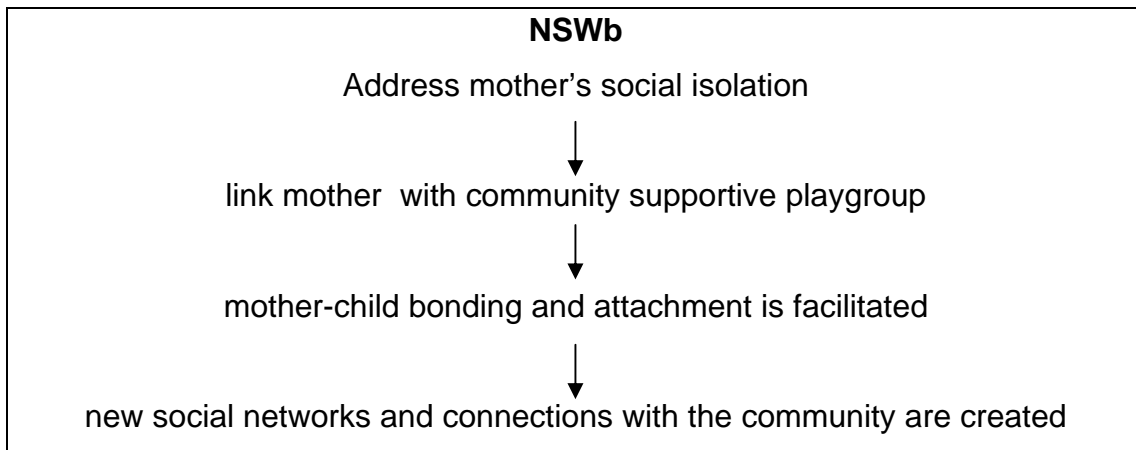
Even at a very cursory level of analysis, it became rapidly clear that a very common focus of the case management plans across both services was *building connections.* This broad theme extended from fostering connectedness and strengthening relationships within the family, to linking parents and families in with their community to increase their social support networks. Another common aspect of relationship building seemed to revolve around fostering attachment between children and parents or carers. Further, a number of more practical considerations, such as housing, finances, and access to education, emerged from the data surrounding intervention goals and plans. The need to liaise constantly with other professionals and services was seen as critical to the work of both services, and was in fact an aspect of their work that the majority of workers enjoyed and found very easy to do:

> '[NSWa] offers a fairly comprehensive range of services to families, but we don't work in isolation! Part of the role that I like a lot actually is making those connections with other agencies that could do certain aspects of the work really, really well… it's making connections outside that's the important part' (worker, NSWa)

The 'intervention chains' shown in figure six demonstrate the varying and eclectic types of interventions seen in the Australian case plans.

Figure 6: Examples of 'chains' of explanation for intervention strategies in Australia

NSWa

Address uncontrolled behaviour, aggression in children/poor attachment evident

↓

assist father in putting strong boundaries, routines and expectations in place at home

↓

children seen as having greatly improved emotional regulation, able to cope in new spaces or with new people

↓

father more competent and relaxed

NSWa

Address child's behavioural problems and medical needs (physical and mental)

↓

liaise to find optimal school situation with special needs unit

↓

school counsellor enlisted

↓

carer encouraged and assisted with scheduling medical appointments

↓

behaviour more controlled and responsive to adults

NSWb

Address mother's social isolation

↓

link mother with community supportive playgroup

↓

mother-child bonding and attachment is facilitated

↓

new social networks and connections with the community are created

---

NSWb

Address mother's practical needs and life plans

↓

assist with obtaining employment through support letters and general advice

↓

mother has obtained employment

↓

is able to be out of the house more and socializing with friends made through
work

↓

mother's social connectedness and support networks are increased

---

NSWb

Address child's behavioural issues resulting from deafness

↓

advocate for no wait on surgical list

↓

in interim preschool introduces flashcards across all daily activities

child feels included and less frustrated

↓

behaviour a lot more controlled

NSWb

Address mother's life plans and options

↓

discuss options for balancing study, work and family

↓

encourage mother to pursue personally or intellectually satisfying jobs rather than lucrative jobs

↓

mother seen as less violent and angry as plans are made

A total of eight distinct intervention themes were identified in the data, with a number of these having relevant component subsections. These intervention themes, or 'types', pertain to the targeted focus of the intervention being undertaken; for example, the main focus of one aspect of the case plan may be targeting a mother's severe post-natal depression. Or, the main focus of another planned intervention might be obtaining more appropriate housing for a family. These emergent intervention themes that were seen in the data are set out in Table 3, with notes on their relevant content. The frequency (and percentage) by which these intervention 'types' were seen across all the case plans of the two services (N = 14 families) is also presented in Table 3.

As Table 3 shows, the most common types of intervention foci were, implementing boundaries and routines in the home to address behavioural concerns, fostering attachment between parents/carers and children, and addressing physical or medical health needs – comprising 22%, 14%, and 11% of all intervention plans seen, respectively. Reducing social isolation was also a common type of intervention, comprising 10% of the interventions outlined across all the case plans.

Table 3   Intervention themes or types identified in the family case plans of both services, and their frequency and percentage representation in all families' case plans (N = 14)

Intervention Themes	Content	Frequency	Percentage
Health			
a. Physical/Medical	Including: disability, hygiene, past medical neglect	8	11%
b. Mental/Behavioural	Including: depression, anxiety, and hyperactivity	3	4%
Emotions & Attachment			
a. Parent-Child Dyads	attachment and bonding	10	14%
b. Broader Family Relationships	Broader family bonding, connectedness, cohesion	2	3%
Parenting Confidence & Skills			
a. Expectations & Consistent Boundaries	Implementation of boundaries and routines to address behavioural concerns	16	22%
b. Support: Parent Peer Groups and Playgroups	Group settings to increase parenting confidence and support networks	5	7%
Legal Issues	Dealing with Children's Court, Divorce Court, Civil litigation	4	5%
Employment & Education/Training	Seeking employment, planning or undertaking further education or training	6	8%
Finances and Housing	Housing provision, basic needs, financial counselling	4	5%
External Supports for CHILDREN			
a. From the School	Including: Enrolment in special needs units, counseling, classroom support	5	7%
b. From the Community	Including: Activities through social clubs, therapists, confidants (e.g., Big Brothers Big Sisters)	3	4%
Reduce Social Isolation	Linking parents, children, families in with their community and peers	7	10%

When practitioners were explicitly asked about their intervention priorities and reasons for those goals, building connections *to* families as a practitioner, *within* families to strengthen relationships, and *across* to their wider community, was a major component to their case management:

'A lot of it's about building support networks. Also… building respect, and trust between the client and myself' (worker, NSWb)

'…To make connections in the community and with other agencies. To get children to a "safe place" and support the needs of parents and carers' (worker, NSWa)

'…Lots of talking and engaging, both with the client and their family, and other services. We have… the luxury of time… to allow clients to explore their inner worlds and make their own personal journey' (worker, NSWb)

It was not possible to synthesise the Australian intervention themes completely with the UK themes, most likely due to the salient differences in the referrals prompting intervention and the different emphases of intervention. Thus, it was determined that it would be useful to re-code the Australian intervention themes in terms of their links to the resilience literature on intervention. Specifically, a number of processes to 'boost' or address resilience are present in the published literature, and the intervention foci identified here were aligned with these processes such that: 'External supports for children' linked with the literature regarding resilience as ecological and building caring relationships; 'Reducing social isolation' also links with ecological and building caring relationships, as well as opportunities to contribute; 'Employment and Education' and 'Finances and housing' link in with creating opportunities; 'Emotions and attachment' and 'Parenting confidence' link to building caring relationships and mobilizing protective processes; 'Health' interventions could relate to 'establishing and maintaining self-efficacy (in the sense of taking control of one's health); and 'Legal issues' to general fostering of resilience strings or coping.

Thus, a graphical representation of the types of interventions undertaken in the Australian services, as a function of how they reflect the key processes of resilience highlighted in the literature, is provided in figure 7.

Figure 7 Frequencies of interventions as a function of Literature Processes across all families (N = 14)
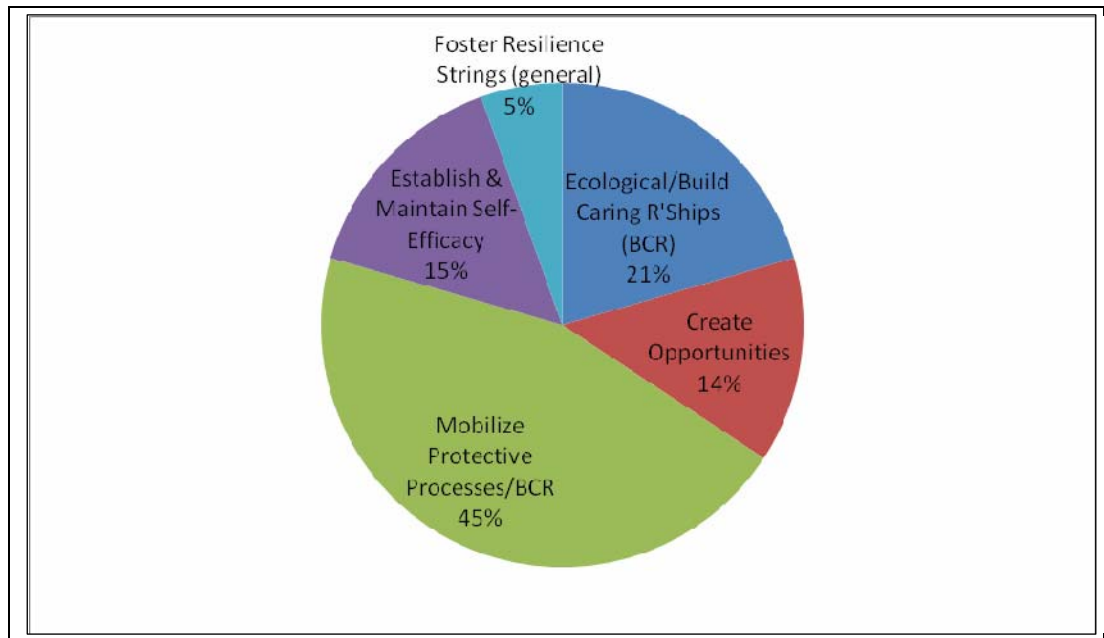
International comparison of findings: UK vs. Australia

There was a significant degree of congruence between the UK and Australian survey findings, with a number of common principles and themes identified as being linked to resilience based practice, particularly as regards the use of a strengths based approach and the need to connect with other services and agencies. The UK respondents tended to place greater emphasis upon the concept of self-esteem than the Australian respondents, whilst the latter tended to place greater emphasis upon community links and social networks. Taken together the responses encompass a vast array of creative approaches to work with children, families and communities.

The case study analysis suggested that the Australian approach was highly similar to the work of the UK practitioners in terms of the capacity and desire to work creatively and reflexively. However, the findings from both Australian services indicates a less structured approach than that taken in the UK services. Practitioners in Australia draw on a range of activities and methods for their case management, tailoring their approach with individual families in

holistic and reflexive ways. The described reason for this approach lies in meeting the specific and unique needs of individual families, rather than taking a structured approach which may not be flexible enough to meet families' needs. The practitioners in the UK services also aim to work in partnership with parents and children and also draw on a range of models and methods in practice; however, their work is more overtly structured around specific frameworks: the Daniel and Wassell (2002) framework in the English service and the Boxall profile in the Scottish service. Without detailed measurement of outcomes we cannot draw conclusions about the relative merit of these variations.

In the Australian services, the focus is very much on the families' or parents' goals or hopes. For this reason, most of the interventions involved varying emphases on surface concerns and underlying issues, with parents tending to emphasize more surface considerations in their interviews, and practitioners much more likely to relate plans back to the key underlying process of 'building connections'. Unlike the practice described in the UK direct work with children was rarely detailed. The majority of child-relevant case management pertained to advocacy or liaison on children's behalf, addressing the environments and supports children had or needed, and fostering their resilience and well-being in these lee proximal ways. The concentrated work with children's parents too, was viewed as a mode of increasing children's resilience as a function of the resources and supports available in their life. The UK practitioners placed greater direct emphasis upon promoting children's self-esteem, peer relationships, school, behaviour, emotional literacy whilst the Australian practitioners tended to emphasis fostering parental networks and supports.

Congruence with the literature

The findings from the UK suggested that, for many practitioners, the concept of resilience denotes a number of principles for practice. The first of these is that practice should be respectful and involve service users. This is a principle that is congruent with most, if not all, current practice frameworks and is not uniquely relevant to resilience. However, it could be argued, that for

vulnerable children this kind of approach to practice could contribute to the development of self-efficacy. Many vulnerable, abused and neglected children have few opportunities to make choices about their lives or to impact upon the decisions made on their behalf. Neglect, in particular, can render children vulnerable to developing the internal, stable and global pattern of attributions associated with learned helplessness. Such attributions are characterised by the belief that bad things happen to you because of who you are, that they will go on for a long time and will affect all aspects of your life . By engaging with children in a way that involves them in assessment and planning, that encourages them to contribute to decisions about their lives and that provides them with positive choices. Practitioners could help to shift such attributions and create the conditions for the development of better self-efficacy.

Concepts of solution-focused work and strengths-based practice are often linked in discourses about resilience. The research on resilience does not, of necessity, directly imply that such approaches are key. However, the research into what is associated with good outcomes is intrinsically optimistic and therefore has a resonance with these frameworks for practice. Without detailed analysis of the individual practice of the respondents we cannot say whether either of these models for practice are being applied precisely as set out by their proponents such as De Shazer and Saleeby . It may be that all these terms are being used as shorthand to denote more positive approaches to practice that counteract the preoccupation with risk and problems that can characterise child protection and safeguarding bureaucratic systems . Further research could explore this in more detail, and in particular, examine whether the adoption of optimistic discourses can lead to better outcomes for children over and above the specific model for intervention that is used.

The importance given to attachment in our study is highly congruent with the literature on resilience. In all the research the existence of a secure attachment relationship emerges as a key protective factor in the face of adversity . The practitioners in the UK survey and case studies could identify the impact of insecure attachments upon children's development; evidently

attachment theory informs assessments. The Australian case practitioners also aimed to improve attachment relationships. However, because we did not ask the question directly, we cannot draw strong conclusions about the extent to which interventions are directly aimed at improving or repairing attachment relationships. Further, there is a need for more research about the extent to which a focus on other factors associated with resilience may be compensatory in circumstances where attachment problems are intractable.

Our respondents also spoke of the importance of intervention that targets different ecological levels and is multi-disciplinary. The extent to which they were able to put these principles into practice appeared to be more restricted in reality and to vary between the UK and Australia. However, the research showing factors at different ecological levels to be associated with resilience supports this approach . As Newman and Blackburn indicate, interventions that build on naturally occurring resources in the child's network are likely to be more effective and enduring. The role of schools is also crucially important and therefore it is important that strategies are developed with consistent and complementary approaches across the professional network .

There appeared to be slightly different ecological emphases in the UK and Australia. In fact, it could almost be said that the UK and Australian services taken together in their entirety represent a more complete and multi-level approach to promoting children's resilience and well-being, the former focusing heavily on the coping and skills of the individual child with associated support for the parents or carers, and the latter dedicated to improving the well-being of parents and family unit and placing that unit within the best possible community network. If Bronfenbrenner's (1977) model is utilized, this notion might be illustrated in the following way (figure 8):

Figure 8. An Ecological Model of the Main Emphases in the Approaches to the Promotion of Children's Resilience
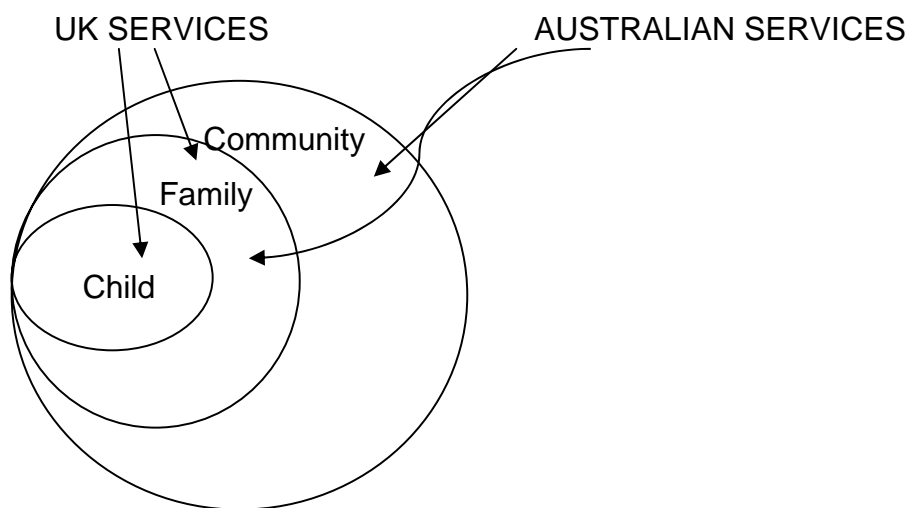
In our study, as in Newman and Blackburn's, self-esteem emerged as a key concept, especially in the UK data. There has been much debate about self-esteem in the literature and the evidence is coalescing around a view that direct attempts to raise self-esteem may not be helpful . Self-esteem should, instead, be linked with the development of mastery and with achievement through effort . In fact, our UK respondents talked of building resilience by working with children's strengths, skills and talents and in supporting coping and problem-solving– so are likely to have been targeting the underlying processes associated with resilience. The Australian respondents were also aiming to mobilise protective processes, but the conduit for these was via parents and social networks. Again, without further comparative research incorporating outcome data it is difficult to gauge the relative efficacy of these different emphases.

In the UK case studies, strategies focused on anger management and understanding the emotions of self and others are congruent with the evidence about the role of emotional regulation and the capacity to interpret the emotions of the self and others . The focus on promoting good peer relationships is also congruent with the research, especially if it aims to foster

friendships with children in the mainstream who are not experiencing problems. As Luthar warns:

> 'Affiliation with deviant peers is a factor well known to exacerbate vulnerability among at-risk youth, particularly in relation to conduct problems and substance misuse' .

As described, therefore, resilience-based practice was congruent with the principles implied in the literature, but was varied and entailed different emphases. Encouraging a discourse that more overtly explores the underlying processes that are being targeted could be helpful.

Measuring resilience and outcomes

In the UK there is a significant policy emphasis in *Every Child Matters* and *Getting it Right for Every Child* for intervention with children and families to become more outcome focused. But the research evidence and research framework for gauging outcomes is still sparse. For example, it is some years since Parker et. al developed the *Looking After Children* framework for measuring outcomes; and since Hill et. al's large scale study of outcomes for children. Policy and practice has developed significantly since then. In particular, there is still no agreed rigorous method for measuring outcomes; there is a lack of quantitative data about the impact of practice upon children's well-being and evaluation still tends to collect data that is available rather than necessarily informative . Despite the introduction of a pack of standardised scales , social services do not routinely make use of validated measures of well-being.

With regard to research on resilience a number of attempts have been made to produce a single measure that can capture all the elements of resilience in one scale . But, rather than trying to produce a single measure of 'resilience' the majority of studies have used multiple measures to attempt to capture the two dimensions of relative well-being and of adversity. There is some debate about whether resilience should be gauged by superior functioning or the absence of symptoms. Luthar and Zelazo suggest that usually adaptation is shown by relative success, but when very severe trauma is considered then

the absence of psychiatric diagnoses is sufficient. Anderson (1997) also argues that in relation to sexually abused children to base resiliency on definitions of competence is too restrictive. In their study of maltreatment Bolger and Patterson did measure resilient adaptation in these two ways . In a measure of positive adaptation in at least one of the domains of - peer acceptance, internalising, externalising and academic achievement - fewer children were defined as 'resilient' than by the more conservative measure of being above the median on a composite measure of adaptation, derived by factor analysis.

The indications are that in order to measure for resilience it is essential to look at both the internal and external protective factors that may be available to the child, the adaptive qualities of the child and the outcome as shown by their demeanour and behaviour. Measures of the level of adversity are also required. The most important message from Heller's review of empirical considerations in assessing resilience in maltreated children is that multiple factors must be measured and that multiple sources of data are required, both internal and external, in order to capture the complexity of the phenomenon .

Survey – UK and Australia

Participants in both the UK and Australian samples mentioned a range of indicators which they would measure as evidence of resilience. The following were most frequently cited:

- increased confidence
- improved behaviour, emotion regulation, and reduced conflict
- increased self esteem
- improved family relationships
- improved social skills and peer relationships
- better school attendance/achievement etc
- improved ability to make decisions/choices
- increased happiness and positivity
- participation in activity, club etc and connectedness to community
- reduced risk taking

- demonstrated learning from previous experience and ability to deal with similar situations in the future.

They measured these indicators in the following ways:

- feedback from parents and carers
- feedback from other agencies
- observation
- before and after questionnaires
- progress towards reaching agreed outcomes
- feedback from young people
- through reviews
- evaluation
- anecdotal evidence
- children's art.

In the UK, one participant said they used the Strengths and Difficulties Questionnaire (SDQ), one said they used Harter's Self Perception Profile , one said they used the ONSET youth justice assessment tool (Centre for Criminology, University of Oxford) and another said they used psychometric instruments. Respondents in the Australian sample also reported using the SDQ as well as the Pianta Child-Teacher and Pianta Child-Parent Relationship Scales , the Brief Infant Toddler Social Emotional Assessment , the Leiden Inventory of Child's Wellbeing in Day Care , the Parenting Stress Index ; the Parenting Sense of Competence Scale and the Depression, Anxiety and Stress Scale . In both the UK and Australian samples, some participants said that their service did not measure resilience. Box 4 gives examples of two cases where the respondents gave detailed descriptions of the intervention and associated outcomes for children or families as a result of resilience based practice.

Box 4: Examples of desribed outcomes as a result of resilience-based interventions

'A young person whose parent has significant mental health problems and finds it difficult to keep boundaries in place. This young man often became a target for bullying, as he found it

difficult to act appropriately with his peers, as he was used to getting his own way at home and also had low self-esteem. He would often aggravate his peers by being argumentative or boastful. [The organisation's] group leaders worked with him to discuss his behaviour and devise strategies with him to develop his personal strengths and to make him aware of and avoid behaviours that provoke others. He was also able to identify strategies for reducing his anger. The young person was able to put these strategies into practice on a residential, and got on well with his group mates. His self esteem was enhanced and his social skills developed; this made him more resilient.'

'Our programe works with families who have access to education, social networks, and parenting programmes that encourage parents and children to improve and strengthen their relationships. Specific parenting programmes are available to address attachment issues at an early stage. We offer both group and individual parenting work e.g Mellow parenting (The Association for Child and Mental Health ACAMH) and Moving pictures, which is a video based intervention encouraging positive interaction between parent and child'. The programme uses a solution based approach as well as possitive feedback with parents using video. Parents identify achievable goals and work with their children on existing strengths to build confidence in their parenting skills. Parents have reported that after this programme they feel that they have a better understanding of their childen.

Outcomes for children; behaviours more balanced, child has a positive relationship with main carer, child experiences routines and appropriate boundaries, child has stable and secure home, improvement in communication, child experiences autonomy and individuality.'
*we have been unable to find a reference for this material

Case studies - UK

As the survey indicated, outcomes are not routinely measured in a systematic way across all services. Some services reported using before and after questionnaires, and in the English centre this method is used - the parents and children fill out post-intervention questionnaires which are compared with pre-intervention questionnaires. The project workers also produce an evaluation report for both the parent and the child. Decisions as to whether outcomes have been achieved rely on accurate completion of the post-interview questionnaire, worker observations, and other professional

observations. The project used to use the SDQ to measure some outcomes, but found that their own questionnaire was more meaningful and easier for service users to complete. The project workers found the measurement of outcomes to be a most difficult part of the work. Workers reported that answers given by service users on post-interview questionnaires sometimes understate achievements (due to lack of confidence) or over state them (due to reluctance to see failings). Workers also rely very heavily on observations, which although often accurate are not robust measures. The workers also stated that they would like to be able to do follow-up evaluations with families three, six and twelve months later to establish whether the work has had a long term impact.

In the Scottish centre the nurture group practitioners undertook an initial assessment with each child using the Boxall profile. The children were then regularly assessed (at the end of each school term) against their Boxall profile to gauge how well they were doing.

From the information gathered on the cases the overall judgement from practitioners was that outcomes were reported to be good in eight cases and partially good in nine. In one case the work was ongoing and judgement had not yet been made on outcomes. Children were described as being more confident, calmer, happier, more relaxed, more able to identify their feelings, to get on better with peers and to control their anger. Practitioners also referred to assisting the children to identify the changes. When discussing outcomes practitioners referred back to the original aims of the intervention. Changes were also observed in parents, for example in setting boundaries and limits for children and in their confidence as parents.

> *'I saw in her [mother] the fact that she's able to put in a lot of boundaries and she is consistent with them, and consistent in saying "if you don't do this [child] then you will go to bed'* (parent worker E).

'So he knows, that we know we've seen a difference, and it's trying to put that into his consciousness – awareness that this - he is managing that now' (worker S).

'The change in him, he accepts disappointments, he accepts when he cannot do something that he wants to do…He's not been on time-out for a long time' (worker S).

'*The first time a couple of weeks ago, he was able to do a feelings game. That was the first time we were able to do that, and that was just a tiny, tiny little breakthrough'* (worker S).

Teachers were not all able to see differences in the children, and, in Scotland, one of the benefits identified was the respite for the rest of the class while children attended the group. However, some changes were observed.

'*now he will sit and I can see that he's getting annoyed, and I think when I see the signs I can help him get out of it before…so I think that he's doing that a lot more for himself now, he'll come and see me or he'll move – so he's coping with the sitation by getting out of it, which he wasn't able to do before'* (teacher S).

'We did a healthy lunch thing in class and he was the one that was brilliant at helping all the rest' (teacher S).

The 12 parents interviewed all gave some views about outcomes. Three could see improvements but still encountered some problems such as lying and sulking. One was unsure whether the noted improvements could be attributed to the nurture group. One parent appeared too preoccupied with her current difficult circumstances to focus on any changes in the child. Seven were very positive about the outcomes.

A Scottish parent and grandparent (carer) made interesting comments on the demeanour of the children on the day of the nurture group:

'He goes to school happy and comes home happy…It's because he feels important, he's not just one of the class' (mother S7).

'First thing she said to me this morning was "I've got Nurture Group today"' (grandmother/carer S).

Comments from parents on outcomes included:

'it's almost like 360…' (mother E).

'The problem is that [child] would never say there is a problem, would just get on with it. But now I think she's more likely to ask for help' (mother E).

'He seems to be getting on with his teachers…he's a happier boy' (mother S3).

'…he's a more happy wee boy now…He's more mature now, he doesn't cry as much. He can play with other children…I just think they're absolutely brilliant.' (mother S).

[he doesn't have to] *'bottle it up…it's really good….it's all done well'* (mother S).

'It's a good project, aye….it's safe in there' (grandmother/carer S).

'his reading and maths is brilliant, I'm really pleased' (mother S).

'Yes, it seems to be working…amongst other things' (mother S).

The 12 children interviewed all gave views on outcomes. Three did not know whether they had changed as a result of intervention, two could see some changes for the better, one felt things had not improved. Six were very

positive about the outcomes. Interestingly some of the children's comments were more specific about the impact than parents' comments.

> *'The cool down techniques have helped me….Yeah, I'm a bit calmer now in lessons and I find the work more easier now'* (child E).

> *'Behaviour and good work and now I concentrate more…I don't be naughty no more, but I've still got a bad temper'* (child E).

> *'I think I have changed. Now I'm like a good me, not like a bad me'* (child S).

> *'I've got lots of friends now'* (child S).

> *'I feel different'* used to have *'loads of tantrums'* better at doing things now (child S)

S7 thought that his behaviour at the nurture group had improved, but that he still behaves badly in class and the playground and S8 gave an appraisal of the mixed result:

> *'Yes, Because it helped my behaviour, I used to hit people (sometimes still do)'* (child S).

Case studies – Australia

As the survey indicated, outcomes for clients tend not to be assessed to any great extent through quantitative methods or delineated evaluative frameworks in the organisation. While some empirical measurement does occur within the two services participating in the case study component of this project, this seems to take a lesser role or degree of importance in the face of more holistic and eclectic approaches to assessment, including discussions, observations, and feedback pathways from the wider community.

To elaborate on the more quantitative measures that are used in the two services, measurement of ongoing progress is sometimes gauged through the re-administration of the tools used at the point of assessment. In the main, this relates to the Strengths and Needs questionnaire. The case plan itself

however becomes a utilizable tool of the measurement of outcomes, in that it includes likert-type rating scales about clients' lives and well-being that practitioners and families can revisit to ascertain where gains have been made and where further attention is required.

In terms of responding to evident outcomes or lack thereof, the case plan is also reviewed every 6 weeks at least within both services (more frequently if there are any major changes within families or new imperatives to consider in the case management), and are also formally reviewed every 3-6 months. This review process allows practitioners at both services to reflect on the progress that has been made in concert with parents, and consequently determine new directions for the case plan in response to parents' and carers' evolving needs and priorities. Most of the practitioners interviewed also emphasized that the case plan is constantly 'under review' in their heads week by week, so that they can easily tailor and reconfigure their approach if and when required.

In the main, however, the workers laid the greatest emphasis on more practical modes of indentifying 'outcomes' and change, such as verbal feedback and observations, as was noted above. Specifically, the practitioners felt well-equipped to gauge progress on the basis of their observations of family and individual dynamics and behaviours, further backing up their impressions with discussions sought from the clients themselves as well as from third party sources in the community such as teachers, doctors, and psychologists.

Further to this more grounded and practical approach to measuring outcomes, many of the main goals or priorities of the case plan (in the shorter term at least) related to highly practical needs and concerns, such as appropriate housing, day care, or school enrolment). Therefore, the measurement of outcomes was able to reduce back to simple observations of achievement, of physical change, of lifestyle shifts. Such outcomes are self-evident over time, making the need for investigative tools and evaluative frameworks for change

rather redundant in that context. At a surface level, these pragmatic goals were being achieved, and practitioners seemed content to observe the concomitant reduction in families' stress and dysfunction without trying to quantify it:

> *'One has to be a good observer, and a good listener… a good observer can communicate over language and cultural barriers, which is so important… And you need to have a bag of tricks up your sleeve with families' (worker, NSWa)*

> *"[NSWa] had sort of this massive impact, and positive impact, on the family…" (worker, NSWa)*

To sum up, not a great deal was said by the workers with regard to the measurement of outcomes. Most felt able to point to real and enduring change in their clients, but rather than feeling the need to back this up with quantitative or empirical evidence, they seemed to feel that it was more in keeping with their philosophy and holistic, strengths-based approach to let outcomes emerge over time, in clients' own time:

> *'More subtle changes may take place that won't be apparent until years later... And it's better to close a case because the service is not a good fit, than to labor on when it's not working… you do have to just trust in the process though' (worker, NSWb)*

Only one worker pointed out the lack of outcome assessment tools available to them as a matter of concern:

> *'We haven't had a formal measuring tool or process… only the case plan review, which has rating scales… (worker, NSWb)*

This service worker noted that while larger statistical data about families were collected by the Data Information Branch of DOCS, these Family Surveys were too onerous for families, and not "user friendly". This worker alone pointed to the development and implementation of more rigorous evaluative tools as a potentially useful direction for the service to take in the near future.

In terms of the actual outcomes observed by practitioners, the majority of cases (N = 11) were seen as achieving good or excellent outcomes since case work commenced:

> *'This mother is much more active and sociable, she's really moved out of her comfort zone… in getting involved with the swimming lessons [a community-led initiative by local mums], she's really experienced a real sense of achievement and recognition' (worker NSWb1)*

> *'She's got more local connections… she's definitely overcome the isolation she did feel' (worker, NSWb)*

Parents too were mostly very positive about the changes they had experienced since beginning their involvement with the services:

> *'They have made things so much better… I've never been this good, forever, I reckon! I'm at my best, the best I've been' (father, NSWa)*

> *'We can function as a family now… they [sons] have become more secure, more loving; they know how to hug me, to receive love…' (mother, NSWa)*

> *'…I've managed to come out the other side, well, and happy' (mother, NSWb)*

A few had ongoing concerns (N = 6), and a few clients (N = 3) were seen by workers as only having partial or limited gains at the time of the interview. In both cases, the ongoing issues, or constraints upon achieving good outcomes, were often seen as outside the province of the case management role. For example, ongoing psychiatric treatment or court involvement, both of which are undertaken by or involve other non-service professionals, was seen as likely to limit complete progress in a client's life.

Other risks to clients' longer term resilience and well-being included placement strain, battles with sobriety, and health concerns like a worsening

disability. A predominant theme though, was the influence of non-participating spouses, partners, or ex-partners in clients' lives. Specifically, parents who were *not* involved with the service provided by [the organisation] were seen as massively undermining progress when they still had contact with the children. In NSWa this often related to parents who had had children removed whilst in their care, with children subsequently restored to the care of the other parent or a new carer. In the NSWb early intervention service, cases frequently involved ex-partners who were still exerting a negative influence over the family by virtue of sabotaging behaviour plans, delaying divorce settlements, or acting in inappropriate ways around children (sometimes due to drug and alcohol misuse). All in all, the deleterious influence of non-participating partners and ex-partners was seen as very significant by the workers interviewed here.

Where good outcomes *were* observed, however, most workers felt that such changes were likely to be sustained over time. Typically, this was seen as due to new structures and supports in place in client's lives, and also as attributable to the hard work being put in by the clients themselves. Where clients were seen as willing and motivated, the chances of sustained and beneficial change were seen as quite high.

International comparison of findings: UK vs. Australia

With regard to this domain of the measurement of outcomes, the pattern of results seen between the Australian and UK services was remarkably similar. While the survey results in both continents indicated that outcomes are not routinely assessed in any systematic way in the organization's services, the case studies of all four sites indicates that a degree of formal measurement does take place. It is not, perhaps, done to the extent that pure research would deem 'rigorous' or 'systematic', but it is in all places nested within the goals of the service and intervention, and relevant to the priorities and reflections of practitioners and parents alike.

Congruence with the literature

The survey findings tend to suggest that outcome measurement is still patchy and that many different methods are used. The case study services are using more systematic, although different, approaches. Using different measures across one organisation will make it more difficult to collect larger datasets about outcomes.

The development of systematic approaches to measuring outcomes would be of benefit for the study of any intervention, not just resilience-based approaches. With regard to resilience-based practice the question arises as to whether it would be fruitful to try and capture 'resilience' on a measure, or whether it would be more useful to use consistently some of the conventional developmental measures of development and well-being such as the SDQ. To be more complete this would need to be coupled with proper assessment or measure of levels of adversity.

Strengths and weaknesses of the concept

The extent to which the concept of resilience has been embraced in policy and practice is a testament to perceptions of its strengths. However, it has been subjected to some critique. For example, some young people who appear to be resilient may in fact be internalising their symptoms and showing 'apparent resilience' . Although individualism is not an inherent aspect of the concept of resilience, its translation into practice does tend to become individualised . The tendency for social work practice with vulnerable children to overlook structural issues and fail to address them effectively has been highlighted by Jack .

The lack of research into the effectiveness of resilience-based intervention is also a significant gap. Much of the recent empirical research into resilience has focused on refining understanding of the concept of resilience: for example, about which factors confer protection only in the presence of adversity and the exact pathways of effects. However, with the surge in 'resilience-based' practice, it is crucial to undertake systematic research into

intervention strategies aimed explicitly at boosting a child's resilience in the face of abuse and neglect.

Survey – UK and Australia

The survey gave us information about what practitioners perceived to be the strengths of the concept of resilience. Most practitioners liked the concept because of its focus on strengths and positives rather than negatives.

> *'All work with children and young people should be based on their needs and undertaken at their pace, including and involving them wherever possible. Working with resilience should be central to all practice, as it means working with strengths, optimism and respect for the young person and their experiences.'*

Strengths-based approaches to work were also seen as positive in areas that may be prone to worker stress.

> *A strengths-based approach is beneficial to the clients as well as the workers. It decreases burn-out in workers and makes them have a more positive approach to their work whilst achieving good outcomes.*

As shown above, the majority of respondents were of the view that the concept of resilience could be applied in practice and were working in settings where it was used. Some offered suggestions as to why they thought it might be difficult to apply the concept in practice.

> *'The concept of resilience can be difficult to put into practice and requires a full understanding and depends on the worker and their ability and knowledge of how to implement it.'*

A comment by one participant suggests that some service areas might be more reluctant to adopt a resilience based approach to practice than others. This participant went on to say that if they worked in a different area they would have probably been more likely to use resilience in their practice:

> *'I work with young people who exhibit sexually harmful behaviour and this is an area of practice that is characterised by thinking about risk and deficit. We always look for ways of promoting resilience with our*

service users, (and I personally think we need to be using the literature on resilience - and desistence - a lot more) but it is often a challenge: strength based models are often resisted by anxious colleagues who sometimes just want us to label risk and suggest what should be done to manage that risk in the community.'

Other practitioners made interesting comments about why they thought the concept was not used more widely.

'In my experience more conscientious practitioners use this approach. Sometimes you have to search for resilience indicators and when social work becomes reactive this task is not given priority. It is also not measured well in audits/inspection.'

'At times it feels that some of our policies around practice hinder practice around resilience. I can't think of any situation in service delivery… that focus on resilience as a key aim/theme in any way. Those that work in the play field may be more aware but it still is not outlined as a definite aim of practice'

'In my understanding of resilience all key stakeholders have to have a a belief in the concept, there are still too many medical models in place for this to happen.'

Resilience in practice has to come from within the worker to be able to be practiced. If workers don't know the concept it'll be hard to practice it with other people/clients or pass on the idea.

There was also some information about what practitioners perceived to be the weaknesses of the concept. A few people suggested that practitioners needed to beware of the dangers of mistakenly interpreting maladaptive functioning in children as indicators of resilience.

'But, there is always a risk in interpreting maladaptive coping with resilience, and we should consider issues such as de-realisation and

dissociation, as well as more obvious things such as alcohol and substance misuse.'

'I'm not convinced that resilience is the best framework to apply. It can be a mask on occasions to more maladaptive functioning.'

Another respondent suggested:

'A resilience-based approach does not assume that the individual or community in question simply needs to adapt to their environment. In many cases the environment – social, political, economic or physical – needs to change.'

The very fact that resilience is a concept that is not widely understood by some workers and families and is perceived as poorly operationalised makes its application difficult for many workers. This was highlighted by a number of respondents in the Australian study.

"I think people have different understanding about what resilience includes and thus may not be aware of its role in their therapy."

I think that there is not a common understanding of resilience and so it is difficult to say whether it is implied in our work or not.

Resilience is jargon that most people don't know but once you explain to them the term they are able to apply it to their daily lives. In our work we see this time after time.

I feel that we don't often openly talk about building resilience with people, it is something that is often done via other methods

Case studies - UK

Case study practitioners were generally positive about the concept of resilience and the associated practice models. Probably because of the way

we structured the interviews it was difficult to separate comments about the frameworks in use from comments about the concept of resilience itself. It was clear that practitioners valued the structure of the domains model or the Boxall profile. Practitioners in the English service commented on the benefits of working through the domains:

> *'I think it works really well. It breaks down all areas in a child's life, or the family's life. Where in each of those areas how the resilience can be built up, how they can learn those skills...to be much more confident and to succeed'* (parent worker E1).

> *'very useful to have a structure to work to, to be able to work in that way'* (child worker E4).

The downside of having a very structured approach was also mentioned and several referred to adapting the model and being creative in how they used it:

> *'….I like the flexibility…..What I don't like is that sometimes I find the action plan can be a bit prescriptive'* (child worker E2).

> *'yes it's helpful, but it's also the fact that it can be quite flexible because not every structure is going to help every parent that I work with, and as long as I can flip it on its side, then, use it one way with one person, but then find another way to use it with another person that that's a good thing about it'* (parent worker E5).

The practitioners in the Scottish service found the Boxall profile useful, both for planning their work in the group, and for communicating with teachers *'to give them a guide about where'* the children were on the various dimensions.

One person in the English group described a concern about their approach:

> *'you can also open up a can of worms, and what do you do if that child comes up with something, or something comes up out of an assessment and if you don't have the skills to deal with it you can, in my opinion, be detrimental'* (parent worker E5).

In retrospect we did not include enough probing questions about the perceived strengths and weaknesses of the concept itself to allow us to draw strong conclusions on this theme. The previous section on outcomes shows that people could identify positive aspects of their work.

Case studies – Australia

The service practitioners were generally very positive when describing the practical utility of the concept of resilience. Interestingly, however, the seeming confluence with the notion of strengths-based practice again came to the fore. Specifically, while most practitioners were able to articulate specific and mostly clear definitions of resilience itself, when aligning it to *practice*, the organizational-wide preference for utilizing a strengths approach tended to colour their perceptions of the benefits it might hold. To illustrate, when asked what benefits resilience held for practice, ideas surrounding people's strengths and the 'strengths-based approach' were prominent:

> *'Resilience is something that sits very well side by side with strengths-based practice. The two intermix and intertwine at times. And I think that's the basic premise from which we all work… strengths-based practice allows parents to look at things through different eyes and recognize that they do have those qualities that will strengthen them to manage challenges as they arise' (worker, NSWb).*

> *'…The fact that we're taking into consideration the strengths of the families, not the weaknesses. And the fact that we are working with them and making them realize they have past successes and, with whatever situation, they can do it again' (worker, NSWb).*

Along with the focus on *strengths* as inherent to resilience-led practice, more esoteric considerations about *hope* were also present in workers' responses. This sense of hope related both to the client and to the practitioner:

> *'The benefit is it helps them [clients] to keep focused on hopeful solutions…' (worker, NSWb).*

101

> *'It helps me to maintain a relationship with hope, about some of my high-risk families. It also principally keeps me focused on children… and help parents and carers move forward, make changes in their lives' (worker, NSWa).*

Practitioners extended upon the ideas that came up about resilience as a useful concept for practice when they were asked to consider what works well, and what does not work so well, about their service's approach to case management. In line with the idea that resilience predicates a more hopeful approach, the methods of both services were seen as focusing on the positives and empowering their clients, and also as allowing workers to pursue their goals flexibly and eclectically. The more holistic and eclectic philosophy that seemed evident at both services was very central to this idea of empowerment and trust-building:

> *'…Our more informal, holistic approach lends itself very well to building trusting relationships between clients and workers… able to feel comfortable and fell that clients are willing to participate and listen. It's respectful and relationships-oriented' (worker, NSWb).*

> *'This work is about listening, and really focusing on what they're saying to you, and sometimes what they're not saying to you' (worker, NSWb).*

> *'…Sitting with the family in their space, in their time, and working at their pace… it's their journey, I do that walk with them' (worker, NSWb).*

In addition, the very practical approach of both services was seen as very advantageous by workers at both sites. Specifically, the capacity to be able to focus on clients' actual material needs as well as their emotional needs was seen as a cornerstone of their practice. This sense of practicality and initiative was seen as central to their efforts to address their prime goal of building connections – visiting parents at home, linking parents in with other services and professionals, getting them 'back on their feet', and encouraging them to connect with their local community and peers:

'…A great feature is the way the program's designed, the flexibility of the program, and the fact that we can put our money where our mouth is financially – I think that's a huge plus! There's brokerage and childcare funding… access to the corporate mastercards is great too, it means I can buy groceries for my families when they need them…' (worker, NSWb).

Parents also supported the advantages that accrue from a very practical approach to practice:

'…I'm a lot less stressed, I know I'll never be at a complete loss for money now… if my pay is late or whatever… she can help, buy groceries, buy nappies…' (father, NSWb).

'…They help holistically, with the whole process… [NSWa]'s more practical, more personal' (carer/uncle, NSWa).

Most intriguingly, practitioners saw the strengths-based approach that seems to predominate in their practice as directly allowing them to be more 'resilient' in their workforce, as a case manager. As social work is notoriously intensive and at times confronting, a number of the practitioners pointed to the sense of perspective and self-efficacy that almost seemed to 'innoculate' them against the potential demands and strains of their work:

'…I would hate to think I was all things to all people, I have strengths and areas of expertise that I'm very happy to share in my work with families, but I'm aware of the limits of my expertise too… my counselling is generalist, there are specialists who could do a better job… I don't ever want to take a family to a place I can't bring them back from' (worker, NSWb).

'…[Psychologist] is the expert, I never try to be all things to all people … it's important to recognize that one is the case manager, but is not everything… and I'm fine with that' (worker, NSWb).

In terms of what might not work so well about their services' approach to practice, workers extended upon the idea of empowerment and motivation highlighted as a good feature of their work as also representing a potential pitfall to progress - where clients are seen as unwilling and unreceptive, the vast majority saw their approach as likely to fail in its efforts.

> *'Families need to want to have us on board. They have to be prepared to acknowledge challenges and… to be willing to make some changes. Motivation is a very big thing!' (worker, NSWb).*

> *'Any sort of intervention is good, if people have a willingness and are ready to jump on board… [but] it's what I call 'groundhog day' families who are a little but ambivalent about the process who are more difficult to work with… They will welcome the financial support and practical support, but aren't willing to take the steps to bring about change… if there is a willingness to bring about change, then [the service's approach] will work' (worker, NSWb).*

This was almost uniformly seen as an issue of *readiness*, and the majority of service workers indicated that engaging with unwilling families or parents was one of the more difficult aspects of their work. The fact that unwilling or resentful clients were involved at all was seen as at least partially attributable to the DOCS referral pathway that underpins most families' participation in the project. The only sense of agency or autonomy that practitioners felt the NSWb could harness independently from DOCS pertained to *community education* – educating their peers and colleagues in the field of human services to more fully understand the role and function of early intervention, so that appropriate and high-priority referrals could be made from community agencies accurately and easily.

International comparison of findings: UK vs. Australia

A common feature was the considerable amount of overlap between views of the service and views of the concept of resilience. It is understandable that it would be difficult to discuss the concept abstractly without reference to its operation in a particular context. The interviews undertaken with the

Australian practitioners yielded a wealth of information as to what they believed worked well about their approach, situations where it might not work so well, and avenues for future consideration and improvement. The service workers at both sites were enthusiastic and dedicated to a vision of empowering people and capitalizing on strengths, and as such needed no probing to expound upon these subjects. The UK workers were also very positive about the work that they were undertaking and the services offered to children and families.

Perhaps in a direct reflection of the complex and family-centred work they undertake, the Australian workers' thoughts about the service and the concept of resilience were found to be quite holistic and nuanced, relating not only to how well their services were able to meet the needs of clients, but also to how it served them as a practitioner. For the UK staff the positive nature of the approach emerged most strongly from the descriptions of the direct work they undertook with children, and the connections with the children that underpinned that work.

Congruence with the literature

Our data has shown that many practitioners are enthusiastic about what they consider to be the positive and creative approach to practice that the concept of resilience facilitates. The views of the practitioners who expressed a concern about misreading resilience were congruent with Luthar's finding on apparent resilience. Apparent resilience may also mean that a child who needs some extra support will be overlooked in favour of a child showing more obvious symptoms of distress.

The comment about a need, on occasion, to address the adversity rather than try to change the child's level of resilience is also an important reminder of the need for attention to structural issues.

Our findings have also reinforced the concern that 'resilience-based' practice can mean a range of different things to different people and confirms the need for more explicit explanation of terms of reference and aims of intervention.

LIMITATIONS OF THE STUDY

Although this study provided useful information in relation to how practitioners operationalise the concept of resilience and the extent to which their described practice is congruent with the principles indicated by the current literature on resilience there are inevitably a number of limitations. First and foremost we did not measure outcomes. While this was a deliberate decision it does mean that the findings are necessarily limited.

The case study approach yielded valuable in depth information but there were a number of limitations. Firstly the proposed triangulated methodology – parent/child, project worker and non service worker interviews was not always achieved as a result of difficulties in recruitment in Australia and difficulties accessing respondents in the UK. We, therefore, acknowledge that the data may be biased towards the perspectives of project workers. The differences in emphases we found in practice could also be due more to the different service arrangements than to different interpretations of resilience.

Where we were able to obtain the views of parents and children this was a considerable strength of the study. We acknowledge, however, that we could have sought more information from parents and children in terms of their understanding of resilience.

Another limitation is that we relied on project workers being able to articulate what they do or think but it can be difficult for them to reflect on their work in a considered way 'on the spot'. The findings are, therefore, limited by practitioners' ability to explain themselves. To some extent the findings were verified by case file analysis but this was not undertaken in Australia and the quantity and quality of case file information varied considerably in the UK and the amount of data we were able to obtain from case files was, therefore, limited.

Additionally, although we intended to use the same research tools in the UK and Australia we found that the interview schedule did not always lend itself

well to the family focus of services in Australia and had to be adapted significantly as the interviews proceeded. The fact that interviews were conducted by a number of different people and both by telephone and face-to-face inevitably would lead to some differences in emphasis.

There was a further important limitation in relation to the survey. Because the questionnaire was sent to practitioners electronically and the accompanying information explained that the study was about resilience we are concerned that some practitioners' 'academic' answers to questions might reflect the fact that they consulted the literature before completing the questionnaire. We had initially hoped to obtain spontaneous answers but came to the conclusion that we could not do this without explaining to participants what the study was about which would have been unethical. It is difficult to say whether this would have had an impact on the overall findings.

CONCLUSION AND IMPLICATIONS FOR PRACTICE, POLICY AND RESEARCH

This study has illustrated the extent to which resilience as a concept has become highly influential in practice with vulnerable children. Like attachment theory it is referred to as informing intervention in many different settings and contexts. However, unlike attachment theory, 'resilience' is not a theory as such, rather more a term to describe a cluster of processes that can be explained by attachment theory in conjunction with other developmental theories.

Technically, resilience is a term that describes the product of a combination of coping mechanisms in the context of adversity. The practitioners in this study used a variety of definitions that coalesced around concepts of 'ability' and 'capacity', but understandings of adversity and the mechanisms by which factors potentially compromise development were less clearly articulated,

although, to be fair, we did not enquire in detail on this issue. Precisely because 'resilience' is so often used as shorthand to denote both a developmental trajectory and a set of principles for practice there is potential for the term to denote different things for different people or aspects of an organisation.

One of the important effects of the research on resilience is that is has alerted us to the extent to which each individual has a unique developmental trajectory. Precisely because of this recognition it is not possible to set out a specific recipe for intervention with vulnerable children – instead a number of principles for practice must be extrapolated.

We did not set out to measure outcomes as a result of the interventions described and therefore are not in a position to make recommendations about specific interventions. However, from our findings it is possible to draw out some messages for practice, policy and research.

Understanding of resilience:

Practice

- When an organisation, service or individual practitioner refers to resilience as a guiding principle for practice then it would be helpful for understandings of the concept to be set out explicitly.

Policy

- Policy documents are increasingly referring to the promotion of resilience as an aim – it is important that such documents set out their operational definitions.

Research

- Further research would illuminate the extent to which different organisational, service and individual definitions may directly be

associated with different forms of intervention and, in turn, different outcomes for children.

Resilience based practice

Practice

- Practice should aim to target all ecological levels, including the child, siblings, significant adults in the immediate and extended family, including fathers, and the community networks and assets.

- Assessment should set out the exact nature of the adversity that the child is subject to, the potential mechanisms by which it could affect development and the anticipated impact on developmental outcomes.

- Frameworks for assessment and practice are clearly helpful, however, if applied too rigidly may impede practitioner creativity on the face of individual variation of need.

- It may be helpful for organisations to map and audit the range of assessment and practice tools and frameworks in use across services, to gauge their efficacy and to provide opportunities for good practice to be shared across services.

- Whether children receive a group-work or individualised approach or long term or short term support may depend more upon the service model than the particular needs of the children. Organisations need to be clear about the rationale for different service models and consider the relative merits of individual and group-based work, and short and long term provision.

- The principle of user participation was clear in our study and it may be helpful for organisations to articulate the extent to which that nature of engagement can be part of the therapeutic process itself.

- All professionals in the protective network around children, especially teachers, need to be clear about the aims and strategies of intervention.

- The introduction of more focused work on children's attachment relationships would be congruent with a resilience-based approach.

Policy

- Policy should aim to create the conditions that support practice at all ecological levels, especially at the community level.

- Resilience can be a helpful unifying concept for the different professions and disciplines that are involved in protecting and safeguarding children and multi-agency guidelines and forums could build strategic approaches around a common language of resilience.

Research

- Comparative research would help to identify the most effective strategies for nurturing resilience, for example, by comparing approaches that focus on underlying processes with those that focus on behaviour or talents and interests; and comparing the impact of attention to different ecological levels.

- Given the centrality of attachment as a protective factor it would be helpful to research the extent to which a focus on other domains may make up for insecure attachments, or whether such intervention is impoverished.

- More research is needed on how parents and children define adversity and what intervention is regarded as most helpful.

Measuring resilience and outcomes

Messages for practice

- A more rigorous and consistent approach to short term and long term outcome measurement would allow intervention to be evaluated.

- It is important that organisations, services and practitioners clarify both the intended outcomes and the proposed processes by which outcomes will be attained. For example, whether raising self-esteem is a proposed outcome or process or both should be explicit.

Messages for policy

- There is a need for a more deliberate and focused policy drive to ensure that all services incorporate outcomes measures and that there is some consistency in the information collected.

Messages for research

- There is a need for more systematic research into the outcomes associated with intervention strategies aimed at boosting resilience.

Strengths and weaknesses of the concept

Practice

- It is important to disentangle the appeal of the concept of 'resilience' from different models for practice based upon the concept.
- Assessment should incorporate attention to 'apparent' resilience.

Policy

- Policy-makers need to beware of using 'resilience' as a 'buzz' term in an uncritical manner and without attention to the potential pitfalls of individualisation and the lack of an evidence base about outcomes.
- There needs to be careful consideration of the articulation of statutory and non-statutory services with clear agreements about understandings of the concept of early intervention.

Research

- More research is needed into how practitioners can support children who may have developed coping strategies that may be of benefit in the short term, but may not be helpful in the longer term.

APPENDIX 1: QUESTIONS USED FOR THE SURVEY

Part 1: Concept of Resilience

1. **Have you heard of the concept of resilience?**

   If No, please go to question 8.

2. **Could you tell us, in no more than a few sentences, what you understand by the concept of resilience?**

3. **Could you tell us, in no more than a few sentences, what you think a resilience-based approach to practice looks like?**

4. **Please use the drop-down menu to rate these statements (strongly agree – strongly disagree):**
   a. The concept of resilience is difficult to apply to practice.
   b. The concept of resilience is explicit in our work.
   c. The concept of resilience is implicit in our work.
   d. I don't know enough about the concept of resilience to know if it is applicable to our work.

   If you would like to explain your responses to the above, please note your comments here:

5. **a. Do you have examples of successful strategies that you have used which, in your view, were aimed at increasing a child's resilience:**
   b. If Yes, please could you give us details of these examples

   If No, please go to question 8.

6. **How do you know whether a child's resilience has increased as a result of your intervention? (i.e. what success factors or outcomes do you use, implicitly or explicitly, and how do you to measure changes in resilience?)**

7. **a. Do you measure any other outcomes?**

   b. If 'yes' how do you do this?

Part 2: Use of other theoretical approaches

8. **(Apart from resilience) what theoretical approach(es) are most useful in your own practice with children/young people and their families?**

9. **(Apart from resilience) does your service promote particular theoretical approaches to practice?**

   If YES, please note what they are, putting the most important approach first. Please also rate how useful you find them for day to day practice (1 = not useful at all; 5 = very useful)

   Theory

Part 3: Guidance and Training

10. **a. Does your service provide access to a written framework, materials or guidance on how theoretical approaches (including resilience) should be put into practice?**

    If YES please note what kind and the titles if possible (e.g published book, materials produced 'in-house'):

    b. How useful do you find this guidance for your day to day practice?
    Usefulness on a scale of 1 (not useful at all) to 5 (very useful)

11. **Apart from any 'official' materials provided by your service, are there other written materials, books or guidance that you use to guide your own practice?** *(Please could provide us with names if possible)*

12. **When did you last attend training on any type of theoretical approach?**

    What theoretical approach was covered?
    Who provided the training?

Part 4: Background information

Below are some general questions about your job. These will help us to understand if issues are different for different types of professionals.

13. What type of service do you work in? *(Please tick no more than the 3 most common/relevant areas of work)*

☐ Abuse	☐ Mental health
☐ Substance misuse	☐ Offending
☐ Behaviour issues	☐ Parenting issues
☐ Bereavement	☐ Poverty
☐ Disability	☐ Racial Harassment Issues
☐ Educational Issues	☐ Refugee/Asylum seekers issues
☐ Emotional difficulties	☐ Relationship Issues
☐ Employment issues	☐ Sexual Exploitation
☐ Health issues	☐ Sexually problematic behaviour
☐ Housing issues	☐ Teenage pregnancy
☐ Missing children	☐ Travellers' issues
☐ Welfare Rights issues	☐ Other *(please specify)*

14. **Does your service work with:**
(Please click all that apply)

- ☐ Children
- ☐ Parents/ carers
- ☐ Children and their parents/ carers
- ☐ Other family members
- ☐ Professionals

15. **Does your service do:**
(Please tick all that apply)

- ☐ School-based work
- ☐ Individual work
- ☐ Group work
- ☐ Community based work
- ☐ Outreach work
- ☐ Other (please specify)

16. **What is the main focus of your own work?**
(Please tick all that apply)

- ☐ Staff or service management
- ☐ Direct work with children/young people
- ☐ Direct work with children/young people and their families
- ☐ Direct work with parents or carers
- ☐ Other (please specifiy)

17. **Does your service do any of the following:**
*(Please tick all that apply and provide us with specific examples of strategies you have used)***:**

- ☐ Help strengthen social support/friendship networks
- ☐ Assist with the development of positive attachment relationships
- ☐ Try to promote positive education/work experiences.
- ☐ Seek to promote self-esteem
- ☐ Encourage positive and constructive styles of thinking
- ☐ Teach problem-solving and/or coping skills
- ☐ Develop awareness of personal strengths and limitations

☐ Develop talents and interests

☐ Encourage consideration for others

☐ Other *(please specify)*

If you would like to provide us with some specific examples of strategies you have used, please note them here:

18. **What is your professional background (e.g qualified social worker, teacher, youth worker)?**

Thank you very much for completing this questionnaire.

APPENDIX 2 INTERVIEW SCHEDULE - CHILDREN
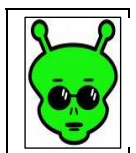
MESSAGE TO ALIEN c. 15-20 minutes

- Explain that we can stop at any time

- Introduce tape recorder

(READ OUT) This alien is from another planet and is visiting earth for a week. He wants to know all about humans, so he'd like to find out about <u>you</u> and the things that you do when you're with [project worker] - Would that be ok?

1. (WARM UP) Ask child their name and if they know who chose their name. If they moved to the alien's planet and could chose a new name, what name would they pick?

2. Why does [project worker] meet up with you?

3. What kinds of things do you do with [project worker]?

4. What are the best things that you do?

5. What are the worst?

6. Have any other adults helped you? How is it different with [project worker]?

7. (Refer back to answer for q2) To end, probe around how child's attitude/behaviour has changed since coming to [the service], and why.

APPENDIX 3 INTERVIEW SCHEDULE FOR PARENTS AND CARERS

c. 30 minutes

Introduction: My name is Jane/Barbara and I'm researcher working with [the organisation]. As you may already know, we're working alongside our colleagues at [name] services to carry out a research study. The research involves finding out about the support that [name] offers children and families like yours. The reason we're here today is that we're interested in hearing about your family's experiences of the [name] services – such as how you got involved, the help your family receive and how useful you find it. Anything you tell us will be treated with the utmost confidentiality: we will not share the information or tell anyone that you are taking part. Your name will not be used in any reports we write.

Thanks for taking the time to talk to us today. The interview will take around 30 minutes – we can stop at any time if you have any questions.

- Introduce recorder.

First can we have a quick chat about the family…?

1. Who lives in the household?

2. How are your child's relationships with other members of the household?

3. Who else, either in the family or outside the family, is important to your child?

4. Who else, either in the family or outside the family, is important to you?

Think back to before you were involved with [the service]…

5. Can you tell me a bit about what your child was like then? (prompt on emotions and behaviours)

6. Was there anything about him/her the worried you?

7. Was there anything about him / her that worried other people (professionals, members of the extended network)

8. Was there a particular event in your or your child's life that you feel may have contributed to some of his her difficulties?

9. Who decided that you needed more help?

10. How did he or she end up coming to a [organisation] service? (probe: how did you hear about it, referral pathways)

11. Before the support started what was the main thing you hoped to change as a result?

Now let's talk about the support your child is getting from the service…

12. Can you describe the kind of support he or she is getting? (group, individual)

13. How was it decided that this was the best kind of support for him / her?

14. What kinds of things are [the service] doing with him / her? (what are they trying to change?)

15. Why do you think they are offering that kind of support?

16. Do you think they are doing the right kind of things to support him/her?

17. Have any things that [the service] has done with your child worked particularly well?

18. Have any been problematic? Was this overcome?

19. Do you think the things that you or others were worried about for your child have stayed the same, got better or got worse?

Now let's talk about the support that you are getting from the service (if any)…

20. Can you describe the kind of support you are getting (group, individual)?

21. How was it decided that this was the best kind of support for you?

22. Why do you think they are offering that kind of support?

23. Do you think they are doing the right kind of things to support you?

24. Do you think the support you got has made things worse, better or made no difference?

Let's talk briefly about anyone else who may be offering support as well as the service…

25. Are there other people who are offering support to your child or you (professionals or others)?

26. Does it feel to you as if they and [the service] are all pulling together, don't know what each other is doing or aiming for different things?

27. 16. How (if at all) is [the service] support different from other supports?

Now I'd like to ask you to think overall about whether you think the service's support has helped you and your child…

17. Is there anything at all that you think could be done better?

APPENDIX 4 INTERVIEW SCHEDULE PROFESSIONALS

30 minutes

Name of professional _____

Job title_____

Child ID _____

Purpose of the professionals' interviews is to discuss their understanding and use of the resilience concept, and to document how they complement the work at [the organisation].

Nb. Not all questions will need to be asked of all professionals. Use discretion.

Background and general usage of resilience concept (5 mins)

a) Please could you give me a brief outline of what your role as a [job] involves generally?

b) Are you aware of the concept of resilience?

c) If yes, how would you describe resilience?
   (Prompt for clarification of anything vague, for example, 'what do you mean by self efficacy'?)

d) Would you say that you draw on the concept of resilience to inform your work? In what ways? *(Prompt for implicit and explicit use of the concept, and for any theoretical or practical models)*

_____

Case study questions (total 25 mins)

We will now move onto the specific questions about [child]. As we go through, I will be challenging many of the answers you give me with questions such as 'how?' and 'why?' This is so that I can build up a complete picture of the way that you work and the reasons behind the methods

1 Referral (5 mins)

a) How long have you worked with [child]?

b) *Why and how was [child] referred to you? (Prompt for emotional and behavioural issues)*

c) *What is your understanding of why [child] was referred to [the organisation]? (Probe to find out what they see as [the organisation's] role)*

2 Assessment (5 mins)

a) Have you conducted a comprehensive assessment with [child]? *(Ask for description)*

b) Having assessed or worked with [child], what did you feel were the key issues that required support or intervention? Why? *(Prompt for emotional and behavioural issues?)*

c) *And are there any other external factors that you feel are affecting [child's] behaviour, development or wellbeing? (Probe for related difficulties within school, family or peer groups)*

d) *What do you hope to achieve with [child]? (Prompt on emotional and behavioural issues. Find out why the focus is on these particular outputs and outcomes)*

e) When assessing [child] and creating a programme of support, did you take into consideration the work that [the organisation] was or would be doing with him / her?

3 The intervention (5 mins)

a) Please describe the work that you do with [child] *(Probe on why this is done and what outcomes it will move the child towards)*

b) And what do you understand to be the aims of the work that [the organisation] is doing with [child]?

c) Are you aware of the why [the organisation] is working towards these particular goals with [child]?

d) Please tell me about the ways, if any, that you work with the [organisation's] project?

e) If there is joint working, how do you feel that your work complements that of [the organisation] and vice versa? How does the joint working help or hinder [child]?

f) And in what ways (if any) are others involved in the work that you do with [child]?
(family / health and social care professionals / teachers etc.)

4   Outcomes (5 mins)

a) What changes have you, personally observed in [child] since you started to work with him / her? What has been achieved? *(prompt for emotional and behavioural outcomes)*

b) In your opinion, in what ways has the support provided by [the organisation] helped [child]? *(Prompt for emotional and behavioural outcomes. Probe on <u>why</u> this has helped, and <u>in what way</u>)*

5   Reflection (5 mins)

a) Are there are any particular theories / techniques / elements of practice used by [the organisation] that you have noticed working particularly well for [child]?

b) What do you feel that the project could improve on?

c) If not doing so already, would you consider using the concept of resilience to inform your practice in the future? In what ways?

Thank you!

_____

APPENDIX 5 INTERVIEW SCHEDULE PROJECT WORKERS

(70 MINS)

Project worker _____

Child ID _____

Warm up and background to the project (5 mins)

- How would you define resilience?
- What would you say are the main benefits of using a resilience based approach?
- Do you work to a specific model?
- Please briefly describe the theory behind the model (Prompts: focus on specific domains or issues? / focus on internal factors (e.g. self efficacy) / focus on external factors (e.g. building support networks)?

_____

Case study questions

We will now move onto the specific questions about [child]. As we go through, I will be challenging many of the answers you give me with questions such as 'how?' and 'why?' This isn't because I think that what you say is wrong. It is so that I can build up a complete picture of the way that you work and the reasons behind the methods. It would be also be helpful if you talked me through the relevant documents as we go along.

1   Referral (5 mins)

d) Please tell me a bit about why [child] was referred, and who by?
(Try to get as much information as possible about the factors that led to referral – e.g. specific behaviour patterns / evidence of distress / difficulty in engaging etc.)

e) Why was it felt that [refer to reasons for referral given above] were of a level that required support from [name]?

(E.g. is the current behaviour causing harm to the child or others, or is there concern that the behaviour is a predictor of other behaviours? Probe the possibility that the behaviour could be a protector for something else or could be a symptom of something else?)

f) What did [the referrer] hope that that [name] could achieve?
E.g. (specific behaviour change, or investigation into underlying issues?)

g) Was there a key identifiable trigger in [child's] life that changed his / her behaviour?
(E.g. bereavement / bullying / illness)

2   Assessment (20 mins)

If child and parent were assessed separately, ask the following questions about the child, and then about the parent as appropriate.

f) Were [child] and [parent] assessed separately?

g) What did you identify as the key risks when you assessed [child]?

h) Were there any particular strengths that you identified that could help [child] in being resilient?

i) Why do you see these behaviours as risks?
(Are they concerns in themselves or are they symptomatic of something else?)

j) What do you want to achieve for [child] in terms of outputs and outcomes?

k) Can you explain what you mean by [refer to words used above]?
(If any words used could be confused e.g. 'increase resilience', 'increase self efficacy', 'bolster coping' ask for explanations of each, with examples if possible)

l) Why did you feel it is important to [refer to outputs and outcomes given above]?
(Try to probe on why it is important that the child gains this particular skill or changes this particular behaviour rather than any other. In addition, try to understand whether the behaviour itself is addressed – for example, aggressive tendencies – or whether the underlying causes are addressed instead, and how decisions are made on this)

m) How do you know that these outputs and outcomes are the best ones to focus on with [child]?
(e.g. experience, theories used within the project, research read, input by the child or parent)

n) Did you prioritise particular skills / behaviours over others? Why?

o) Are there any issues that you consider to be risks to [child's] resilience that you are unable to control / work with? *(e.g. peer groups, family life)*

3   The intervention (20 mins)

If child and parent were assessed separately, ask the following questions about the child, and then about the parent as appropriate.

g) How did you decide which parent(s) or family member(s) to involve?

h) What interventions did you decide to use with [child]?

i) Why were these particular interventions chosen? What is the end goal?

j) Is [child] or anybody else involved in decision making – in what way?

k) Please talk through the tools / techniques / activities that are used for each of the issues that are being worked on.

l) In what ways (if any) are other people involved in the intervention?
(other family / health and social care professionals / teachers etc.)

m) What have been the successes and difficulties about involving others in the intervention?

n) Which issues have you found easy to work on with [child]? – why?

o) Which have been the more difficult issues to work on with [child]? – why?

p) How rigidly is the intervention plan followed?

q) Are there regular reviews or assessments? – when?

r) How long has [child] been using the service?

4   Outcomes (10 mins)

(Ask for child first and then for parent as appropriate)

c) What changes have you, personally observed in [child] since the intervention started?
(Probe for overt behaviour as well as underlying emotions, worries)

d) Which outcomes have been measured for [child] and how are they measured? – tools / techniques for each intervention
(Probe for who is involved in assessment e.g. child / parent / health and social care professional / teacher / other family / friends?)

e) How reliable do you feel that your measure of outcomes is? – what are the strengths and limitations?

5   Follow-up? (5 mins)

a) Any formal follow up / informal follow up – when?

b) In general do you feel that outcomes are sustained?

6   Reflection (5 mins)

a) In your experience, are there some children and families that this approach works better with than others, or does not work at all? – examples

b) What do you feel works really well about the work that you do?

c) What do you feel your service could improve on? – what do you need more help with?

Thank you!

_____

Remember to examine and record all other relevant documents relating to the case study

REFERENCES

Abidin, R. (1983). *Parenting Stress Index (PSI)*. University of Virginia: Institute of Clinical Psychology.