RESILIENCE AND SAFEGUARDING CHILDREN
strength based practice

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We are assuming a certain basic level of understanding around childrens' care, child welfare/protection and where resilience theory and practice might fit in (any terms, abbreviations, not understood please ask/shout!)

We are not intending this to be full of answers, more about questions/ideas and where future lies in safeguarding practice. This is not a lit review

Safeguarding children across services

(Davies and Ward 2012)

‘’Decision makers need to develop the ability to analyse and understand the implications of complex constellations of risk and protective factors and indicators of maltreatment, supported by the practice tools available to them’’

(page 67)

Brigid Daniel's work (with others, see www.boingboing.org.uk)

Use of solution focused and strength based approaches

- It may be that these terms are being used as 'shorthand' for more positive approaches to practice that counteract the preoccupation with risk and problems that can characterise bureaucratic systems

- Further research needed to examine whether the adoption of optimistic discourses can lead to better outcomes for children over and above specific model of intervention used

Adaptive qualities

In context of adversity:

- The individual has access to internal/external resources
- And has adaptive ability to make use of those resources to buffer the effects of adversity
- Resource factors can be ADDITIVE/COMPENSATORY, PROTECTIVE/MODERATING, CHALLENGING/INNOCULATORY

Additive/compensatory

- Independent effect from risk factor
- Co-exist with risk factor
- Convey benefits whatever level adversity
- ‘lifting all the boats’

Protective/moderating (Especially effective under circumstances of ‘risk’)

- (Luthar) Good parenting is especially beneficial in contexts of high risk (strictness can be helpful)
- R’ships with teachers and +ve school experiences are especially helpful for children facing risks at home or community
- High quality childcare is esp. helpful for children living in high risk

Challenging/Innoculatory

- The risk factor can also be the protective factor ?a moderate amount of adversity protects from negative effects of future adversity

Do we all agree with these positions?

BD'S CONCLUSIONS:

- Respectful engagement with service users
- The concept of resilience appears to provide a structure for some creative effective work with children/families
- A wide range of interventions are described as 'promoting resilience'
- Far more research and precision needed if we are to confidently prove efficacy

Implications of using these ideas:

- Be clear whether focusing on general pop-wide additive factors or targeting specific risk situations with specific moderating factors
- Take time to understand the processes *(is this done in SW/HV training? Capacity-building)*
- Take account of culture

NEED TO TARGET ALL ECOLOGICAL LEVELS: associated with resilience-building

‘Signs of Safety’

Innovative strength-based approach to CP casework created W Australia (Turnell and Edwards 1990’s with 150 practitioners)

‘How can the worker actually build partnerships with parents and children in situations of suspected or substantiated child abuse and still deal rigorously with maltreatment issues?’

Building Strength-based Tools for CP practice: a case of parallel process (De Jong, Kelly, Berg, Gonzales, in Michigan, using 'ROPES' Graybeal 2001)

'little empirical evidence indicating the extent to which practitioners consciously make use of client strengths in their practice'

They feel there are 2 approaches:

- Develop and use tools in contrast to those that are deficit-based
- Develop practices that guide in the broader process of continuously drawing on client strengths to improve the client situation…including mobilising resources that directly/indirectly work on improvement of clients situation

Graybeal advocates a dynamic process which should include ‘meaningful questions that will combat the relentless pursuit of pathology and …help discover hidden strengths that contain seeds to construct solutions to otherwise unsolvable problems’

= ***ROPES, resources, options, possibilities, exceptions, solutions***

‘Partnerships for Safety’ practices within CPS – parallel process, organisational change between workers and supervisors, reflecting change in ways of working with clients/families

(paper available)

Brearley model of assessing risk (UK)

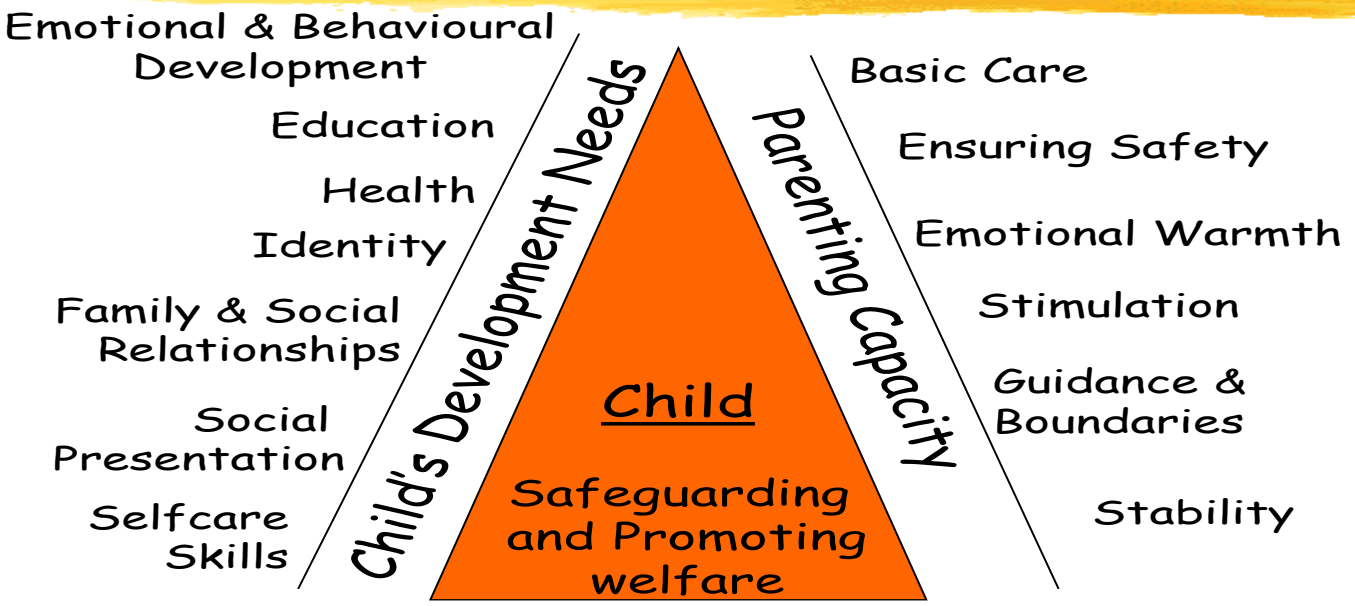
(used in health service trusts london and local)

- Name of child: _____ D.o.b. _____
- POTENTIAL RISK IDENTIFIED
- BACKGROUND FACTORS
- CURRENT FACTORS
- STRENGTHS

- ANALYSIS (Evidence based)
- PLAN (Action based)
- Review Date

- Signature : _____ Designation: _____ Date: _____

Assessment Framework Triangle



FACTORS WHICH MAKE THE POTENTIAL FOR RISK TO THE CHILD MORE LIKELY (following slides are from Brearley training)

THOSE FACTORS WHICH CAUSE VULNERABILITY

- Previous violence/domestic violence.
- Parent child separation.
- Poverty.
- Physical/learning disability in a child or parent.
- Unstable mental/physical illness.
- History of victimisation of a child.
- Age, gender, race.
- Isolation.
- Drug and alcohol abuse.
- Lack of support or other environmental factors.
- Failure of inter-agency communication.

CURRENT RISK FACTORS TO CONSIDER:

- Abuse
- Not attending appointments
- Not attending school
- School exclusion
- Aggressive behaviour
- Support networks breaking down

PRACTITIONER HAZARDS

- Pressure of more urgent cases.
- Belief in natural love between parents and children.
- Faith in the particular family (rule of optimism).
- Disbelief.
- Over pessimism regarding “care”.
- Lack of experience.
- Burnt out/high thresholds.
- Fear of upsetting a “good” relationship.
- Fear of violence.

STRENGTHS

THOSE FACTORS WHICH MAY LESSEN OR COUNTERACT THE POTENTIAL RISK TO A CHILD AND MAKE THE RISK LESS LIKELY TO HAPPEN.

- Child has a good relationship with a friend or relative.
- Allows child to receive help in their own right.
- Parents who are able to reflect on their behaviour and show willingness to change.
- Range of ways to cope.
- Helpful relatives/friends/neighbours.
- Parents who accept responsibility for the circumstances.
- Parents who have engaged with professionals and given consent for family support.
- Parents who have been observed to “parent” appropriately in some ways.
- Stable relationship.

- Analyse the information you have to the child's safety and actual or likelihood of significant harm.
- Define and evidence the type and level of risk (or likelihood of risk) as part of your analysis, explaining why you have come to that decision.
- Recognition and appropriate referral is a primary task for health practitioners
- The plan will reflect the outcome of the analysis and may include an urgent referral as a child protection issue, referral as a Child in Need, or a referral to some other service provider.

Does this framework allow for sufficient use of strength based focus with families?

FNP: *family nurse partnership* - evidence based practice with young parents – trial across UK (strength based, motivational interviewing…)

Where to now?

Sarah will look at current UK developments in safeguarding and her own use of RT practice with foster carers

Time for discussion