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# Appendix I – The developing concept of resilience, the Resilience Framework and Resilient Therapy

The formal study of resilience can be traced back to the 1970s and it's a controversial and developing concept. Resilience is hard to measure, can be slippery to pin down and thinking shifts as we learn more. For a long time, research largely focused on individual children and young people, in isolation from their environments and social situations, seeing resilience as a personal quality or a set of individual skills that 'enable one to thrive in the face of adversity' (Connor and Davidson, 2003). However, the value of a concept of resilience that focuses entirely on individual traits has been challenged for seeming to support a 'just deal with it' attitude to poverty and deprivation (de Lint and Chazel, 2013; Garrett, 2015; Harrison, 2012). While emerging research in neuroscience and genetics continues to explore biological factors (Dudley et al, 2011; Kim-Cohen, 2004), many researchers and theorists look beyond individual factors to a systems-based, social ecological approach to understanding resilience. From this perspective resilience in the face of adversity is not just about an individual's inner psychological resources or innate characteristics; it involves a combination of 'nature' (what a child is born with) and 'nurture' (what they learn and are offered along the way) and is a dynamic interplay between a person and their environment.

Building on the latest developments in resilience literature, the Resilient Therapy (RT) approach was created by Angie Hart, a research academic, practitioner and parent of young people with complex needs; Derek Blincow, a child psychiatrist; and Helen Thomas, a senior social worker and family therapist (Hart, Blincow and Thomas (2007). Practitioners and parents of young people with complex needs helped to develop and refine the approach. It was designed with the most under-resourced and socially excluded young people and families in mind. Based on hundreds of academic references, the *Resilience Framework* is underpinned by the key principles of "Noble Truths", which are important fundamentals for resilient practice, highlighting what preparation practitioners need and where they should start from. Each is drawn from a specific therapeutic school, as follows: Accepting (Rogerian); Conserving and Commitment (Psychodynamic); Enlisting (Family and Cognitive Behavioural Therapy).

The *Resilience Framework*, used as a framework for this guide, is part of the Resilient Therapy approach. It is available in many different languages and is free to download from www.boingboing.org.uk. There is an adult version of it there too if you want to look at your own life through the lens of the Resilience Framework or support another adult to do so. There is also a version that has been co-produced with young people from their direct perspective.

**Further reading on the Resilience Framework and Resilient Therapy**

Angie Hart & Kim Aumann (2017). Briefing paper: Building child and family resilience – Boingboing's resilience approach in action. Totnes: Research in Practice.

Angie Hart, Derek Blincow & Helen Thomas (2007) *Resilient therapy: Working with children and families*. Hove: Routledge.

Boingboing.org.uk This website has lots of free resources to download all of which are based on the Resilience Framework and Resilient Therapy.

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# Appendix 2 – Bronfenbrenner's ecological approach

This example of how Bronfenbrenner's approach works in practice draws on Angie Hart and Kim Aumann's more detailed briefing paper for practitioners on systems approaches to using Boingboing's resilience approach in practice (Hart & Aumann 2017).

In Bronfenbrenner's (1979; 2005) ecological approach, the **microsystem** is the immediate environment with which a child has direct contact, such as family, caregivers, peer groups, school and neighbourhood. The more encouraging and nurturing these are, the better the child will be able to grow. Furthermore, how a child acts or reacts to those people in the microsystem will affect how they treat the child in return. A child's genetic and biologically influenced personality traits (for example, temperament) may end up affecting how others treat them (and how children respond).

The **mesosystem** describes how the different parts of a child's microsystem interconnect, such as interactions between parents and teachers or relationships between the child's peers and their family. For instance, if caregivers take an active role with school, going to parent- teacher meetings or promoting positive activities, this will help the child's overall development.

At the **exosystem** level are people and places that are likely to have a large effect, even though the child may not interact with them very often. For instance, a parent's workplace does not involve the child but still affects them if their parent loses their job.

The **macrosystem** includes factors such as government policies, cultural values, the economy and political systems, which change over successive generations.

The **chronosystem** refers to life transitions and external environmental or socio-historical events that occur during a child's development and change how they interact with the other systems, such as increased educational opportunities for girls, the timing of a parent's death or physiological changes that occur as the child grows up.

The example below provides an illustration of working across the five systems within a school context:

- **Micro**: The school's mental health worker supports a teacher to improve the anger management skills of an individual child by honing in on the 'understanding boundaries' potion on the Resilience Framework. They enlist the child's parent in that task, having explored with them some of the underlying causes of the child's behaviour, which were partly down to issues at home.

- **Meso**: The class teacher offers adapted curriculum and new strategies such as 'time-out' cards, responsibility for extra tasks and attendance at after-school club activities; the child needs more adult support so the mental health worker engages community based mentors.

- **Exo**: The school mental health worker engages the whole school to increase staff understanding of behaviour issues, increase support skills and work with parents on joined up strategies. The student council considers the issue of behaviour support and offers its perspectives at meetings with senior leaders and at a series of assemblies.

- **Macro**: Parents and staff encourage Ofsted to reward behaviour support success, and lobby national education policies to promote behaviour support expertise.

# Appendix 3 – Assessing risk from self-harm

The following are areas to cover when assessing risk from self-harm.

**Nature and Frequency of Injury**

- Are there any injuries requiring immediate attention?
- Has the young person ingested/taken anything that needs immediate action?
- Establish what self-harming thoughts and behaviours have been considered or carried out and how often?

**Other Risk Taking Behaviours**

- Explore other aspects of risk - fast driving, extreme sports, use of drugs/ alcohol.

**Child Protection**

- Consider whether there are child protection issues and, if so, discuss and/or refer.

**Health**

- Ask about physical health issues such as eating, sleeping.
- Ask about mental states such as depression, anxiety.

**Underlying Issues**

- Explore the underlying issues that are troubling the child/young person, which may include family, school, social isolation, bullying, and relationships.

**General Distress**

- Assess current level of distress.
- Ascertain what needs to happen for the child young person to feel better.
- Ask about what current support child/young person is getting.

**Future Support**

- Elicit current strategies that have been used to resist the urge to self-harm or stop it from getting worse.
- Discuss who knows about this situation that may be able to help.
- Discuss contacting parents if that would be helpful.
- Discuss possible onward referral with child or young person.
- Discuss who you will contact and what you will say.

| Level of Risk: Lower | Action |
|---|---|
| • Self-harm is superficial<br>• Underlying problems are short term and solvable<br>• Few or no signs of depression<br>• No signs of psychosis<br>• Current situation felt to be painful but bearable<br>• Suicidal thoughts are fleeting and soon dismissed | • Ease distress as far as possible<br>• Empathic listening<br>• Joint problem solving for underlying issues<br>• Discuss harm reduction, other strategies used<br>• Advise on safety<br>• Use safety plan resource<br>• Link to other sources of support/ counselling<br>• Consider support for others who know about the self-harm (peers/parents)<br>• Make use of line management or supervision to discuss particular cases and concerns<br>• Ensure there is ongoing support for child/ young person and review and reassess at agreed intervals<br>• Some young people find the 'five-minute rule' helps - if they feel they want to self-harm they have to wait 5 minutes. Then another five minutes if possible, until 'the urge is over' (Mental Health Foundation, 2006, p.9)<br>• Keep channels of communication open so that you can monitor the situation and identify any worsening |

| Level of Risk: Moderate | Action |
|---|---|
| • Current self-harm is frequent and distressing<br>• Situation felt to be painful, but no immediate crisis<br>• Suicidal thoughts may be frequent but still fleeting with no specific plan or immediate intent to act<br>• Drug or alcohol use, binge drinking | • Ease distress as far as possible<br>• Empathic listening<br>• Joint problem solving to resolve difficulties<br>• Consider safety of young person, including possible discussion with parents/carers or other significant figures<br>• Use/review safety plan<br>• Seek specialist advice<br>• Discuss with Primary Mental Health worker, Child & Adolescent Mental Health Service, Educational Psychologist or advise talking with GP<br>• Consider consent issues for the above<br>• Consider support for others who know about the self-harm (peers/parents)<br>• Consider increasing levels of support/ professional supervision<br>• Ensure there is ongoing support for child/ young person and review and reassess at agreed intervals |

| Level of Risk: High | Action |
|---|---|
| • Increasing self-harm, either frequency, potential lethality or both<br>• Situation felt to be causing unbearable pain or distress<br>• Frequent suicidal thoughts, which are not easily dismissed<br>• Specific plans with access to potentially lethal means<br>• Significant drug or alcohol use | • Liaise with School Safeguarding lead<br>• Ease distress as far as possible<br>• Empathic listening<br>• Joint problem solving to resolve difficulties<br>• Review safety plan<br>• Discussion with parents/carers or other significant figures<br>• Follow guidelines for CAMHS referral<br>• Consider consent issues for referrals<br>• Consider support for others who know about the self-harm (peers/parents)<br>• Consider increasing levels of support/ professional input<br>• Link person to existing resources<br>• Monitor in light of level of involvement of other professionals<br>• Ensure there is ongoing support for child/ young person and review and reassess at agreed intervals |

**Scaling**

Scaling can be a useful way of exploring where the child or young person is at in terms of the level of risk regarding their harming behaviour. For example, you can ask the child or young person to think about where, on a scale of 1-10, they would place themselves in terms of how worried they were that they will self-harm again? Then be really curious and put the solutions back to the child or young person.

**1. Ask about the current position**

a. Where are you now on the scale?

**2. Ask about what is already there**

a. How did you manage to get to a number 7 on your scale? What has helped you to get there?
b. What worked well? Who else has helped you to get there? How do you know that you are a 7 and not a 2?
c. When you were at your lowest, what number would it have been? How did you get from there to a 7?

**3. Ask about a past success**

a. When has the problem been even higher than 7 on the scale? What was different then? What did you do differently then? What worked well? Who was helping at the time? What did you feel at the time?

**4. Visualise one step higher**

a. Can you describe to me (vividly) what being one step higher on this scale would look like? What would be different? Who would notice? What would your friends notice? What would you be doing more of? What will you be able to do then? How will that feel different?

**5. Ask about a small step forward**

a. Now that we have had this conversation, what ideas have you got about what you can do to take one tiny step forward? What might that step be? What situation might you take that step in? Who should know about this plan?

Scaling can also be used to make an assessment of frequency and severity of self-harming to ascertain the risk and whether there is a need to refer to CAMHS, for example:

On a scale of 1-10 how often are you harming yourself?

On a scale of 1-10 how severely (deeply) are you hurting yourself?

# Appendix 4 – Lesson plan: Loneliness

This exercise is designed for use with any secondary year group, but can be adapted for use in primary school groups, with use of age appropriate images.

There are many examples of lesson based activities that promote resilience on the Boingboing website (http://www.boingboing.org.uk/academic-resilience-resources-directory/).

| **ACTIVITY** |
| --- |
| The aims of the session are to support young people to develop their awareness of their loneliness, what it means to them and how they can manage the feeling. |
| **Introduction:**<br><br>Can you spot when others are feeling lonely? Show pics of celebrities and invite the young people to think if there are any signs that let us know when others are feeling lonely. (Try and choose pictures where perhaps body language and facial expressions are conveying loneliness.)<br><br>**Questions to support this activity:**<br>I. Is there any way of knowing if someone is feeling lonely (facial expressions and body language in some circumstances)?<br>2. How do people currently communicate their loneliness?<br>3. How does this way of communicating support the loneliness? |
| Loneliness is a signal, like any emotion in our body that we need something, whether that is to talk to someone, make more connections or find comfort in some way.<br><br>**Exercise:**<br><br>Invite the group to think of a time when they felt lonely, what was their loneliness signalling to them? What did they need?<br><br>Think together as a group of ways in which loneliness could be supported. Stress the importance of our feelings being acknowledged, feelings are like people that they need to be recognised, otherwise they feel ignored and they become stronger rather than going away.<br><br>**Session tip:** Try and normalise the feeling of loneliness as something that everyone feels at times, it doesn't mean that you have a mental health difficulty if you are feeling lonely, yet if it is not addressed then over time it could have an impact on your mental health. |