DOMAINS PILOT: KCC HEADSTART

Case Studies in Promoting Resilience in Vulnerable Children

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1. BACKGROUND

This pilot exercise was undertaken as part of the Big Lottery funded HeadStart programme. HeadStart aims to improve the mental well-being of at-risk* 10 to 16 year-olds by investing up to £75m in up to 12 local partnerships to facilitate and support:

1. the implementation of a locally developed, cross-disciplinary, multi-layered and integrated prevention strategy, *with the young person and their needs at its core*
2. the development of the necessary local conditions to enable that strategy to become sustainable in time
3. the development of a more robust evidence-base around 'what works' in the area of mental well-being to be pro-actively shared beyond HeadStart with the aim of contributing to the national and local policy debate.

Previous stages of HeadStart Kent involved knowledge transfer exercises in the form of seminars. KCC staff and the HeadStart programme partners were introduced to the theory of resilience and its application with vulnerable children. A key aim of the seminars was to ensure projects focused on promoting the protective factors associated with resilience when designing and delivering their services.

The HeadStart seminars provided the knowledge transfer to partners delivering commissioned services specific to the programme. This pilot exercise will further contribute to the evidence gathering by working with KCC practitioners at the earlier stage of assessment using a resilience approach.

Increasing the chance of children and young people demonstrating resilience when faced with adversity requires the enhancement of protective factors (those factors which shield the young person from potential blows to their resilience) and the reduction of risk (the removal or re-framing of potentially threatening events or issues). Therefore, it is useful to focus on resilience in terms of the areas or 'domains' of a person's life that can be manipulated or changed. The introduction of a domains approach to resilience at the assessment stage, will better inform intervention and support strategies based on a child or young person's individual need.

2. RESILIENCE DOMAINS APPROACH

The increase in interest in resilience as an evidence based practice model has led to a proliferation of resilience practice models and tools of varying quality and evidence base. To test the potential suitability of a resilience practice model in

Kent, following consultation between the programme board and the academic partners, the domain approach developed by Daniel, Wassell and Gilligan was agreed as a pilot model. The justification for using this framework is:

1. It has been developed by an acknowledged international expert on resilience (Professor Brigid Daniel);
2. It has successfully been implemented in the UK and Internationally;
3. It has extensive practice resources for practitioners to use to implement;
4. It uses a domain approach that is appropriate for multi-agency approaches to service delivery;
5. It incorporates both risk and resilience in the assessment;
6. It allows for differing levels of need.

A strength of the resilience domain approach has been the consistent positive feedback from practitioners who have been using the model in the UK and Australia. It has the potential to provide a coherent framework to encompass much of what workers and carers instinctively aim to achieve anyway. It provides an opportunity to validate practice using a sound theoretical basis for purposeful intervention[i]. A further consideration is accessibility of tools for both learning and practice. The domains approach of Daniel and Wassell has significant resources and most are free.

The model divides resilience into intrinsic and extrinsic factors. The intrinsic factors are building blocks that are necessary for resilience

- A secure base - the child feels a sense of belonging and security
- A sense of self-efficacy - a sense of mastery and control, along with an accurate understanding of personal strengths and limitations
- Good self-esteem - a feeling of worth, importance and competence (a close fit between 'perceived' self and 'ideal' self)

The extrinsic factors are:

- At least one secure attachment relationship
- Access to wider supports such as extended family and friends
- Positive school and/or community experiences.

The resilience domain approach aims to increase the likelihood of positive outcomes for children by building a protective network around them. The development of the framework has been based on the work of Daniel, Wassell[ii]

and Gilligan[iii]. Six domains of a child's life that have been evidenced to be associated with resilience underpin the framework. The six domains are:

- Secure Base
- Education
- Friendships
- Talents and interests
- Positive values
- Social competencies

3. ASSESSMENT, INTERVENTION AND PROGRESS MONITORING

Although the practice framework requires an adherence to focusing on all six domains when working with children and young people, it is also flexible enough to allow for adaption to align with KCC's – and partner agencies - purpose and strategy. As an aid for practitioners and visual tool the domains are grouped in to a 'resilience wheel' as seen in *figure* 1

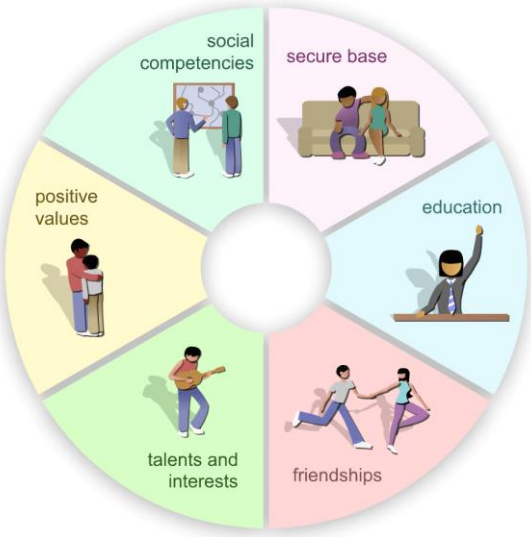

Figure 1: Resilience Wheel

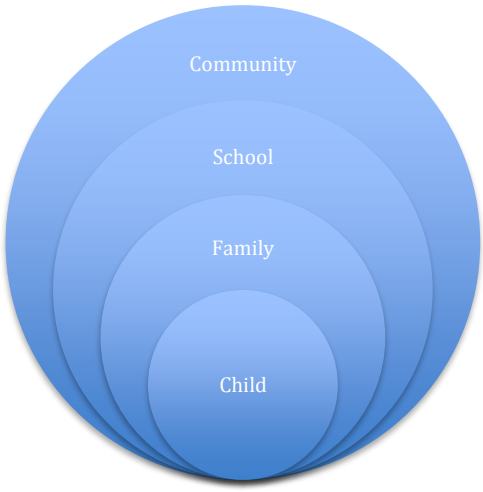

Figure 2: Ecological levels

This circular framework has been demonstrated to be successful and intuitive for practitioners when applied. When assessing the level of strengths and protective factors a child has, it is also important for practitioners to consider the whole ecology of a child and family. The widely accepted ecology to use when considering children and young people is highlighted in *figure* 2.

When combined, a simple but robust resilience framework is produced that is suitable to be meet the needs of most client bases from universal services through

to specialist children's services. An example the domain approach combined with the ecology mapping can be seen in *figure 3.* This framework can be used to guide the intervention from referral to case closure and suitable for use across most services including education, social care, youth work and mental health.

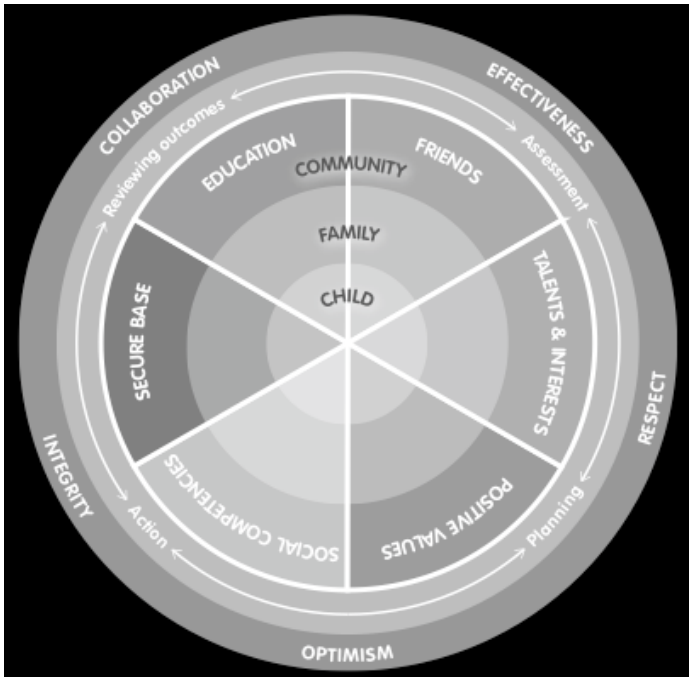

Figure 3: Resilience Domain Practice Model

4. PILOT

Three Early Help Practitioners working with four cases formed the pilot.

1. Practitioner 1: RM (Whitstable EH)
2. Practitioner 2: KB (Whitstable EH)
3. Practitioner 3: SB (Thanet EH)

The pilot began with a knowledge transfer day where the early help practitioners were provided with a basic understanding of resilience in practice and introduced to the model and associated tools. They were then supported to assess, refer and evaluate outcomes for four case studies using the domains approach. Early help identified case studies that were known to be at risk of, or have experienced diversity. i.e. that the child or young person is at risk of, or experiencing adversity.

Training and support dates were:

17 November (Training session)

Support Sessions:

1. 10 December
2. 20 January
3. 18 February
4. 17 March
5. 28 April
6. 12 May

At the pilot conception stage it was expected that the project would have 4 distinct stages illustrated in *figure* 4.

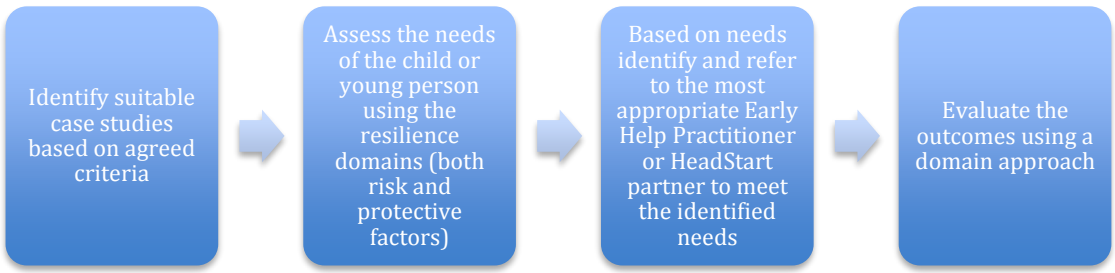

Figure 4: Pilot stages

Stage 1: Identification of case studies

The identification of suitable cases was an important element of the project. To maximize learning it was agreed from the outset that this pilot would focus on individuals with needs the existing evidence base indicates a resilience approach would be beneficial. However, it the criteria stipulated they could not be actively involved with CAMHS to avoid conflict in practice approach.

There were significant issues around allocation of cases suitable to the project due to cases not being suitable or they were engaged in other services. Due to the delay in suitable cases being identified, the timeline for the pilot had to be extended.

Stage 2: Assessment using domains

Key to the resilience domain approach is the non-prescriptive nature of the model allowing practitioners freedom to use their training to be innovative in their practice. However, practitioners were expected to systematically work through the domains with the child and any other family members the practitioner feels may add information to the assessment. To record the assessment practitioners were provided with blank resilience assessment wheel to complete using a traffic

light system. These assessments were to be completed at the initial assessment stage (Baseline) and at the end of the early help intervention (Case Close). An example of a completed wheel is shown in *figure 5*

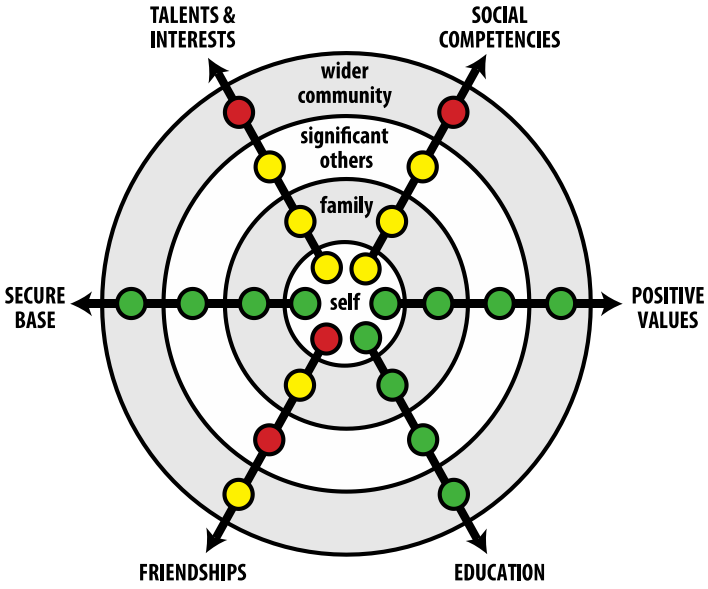

Figure 5: Resilience Wheel

Stage 3: Meeting needs / introducing protective factors

At the pilot design stage it was expected that where needs were identified Early Help practitioners would have resources available to take a resilience approach. This may be accessing services of a HeadStart partner or referring the child. For example, where protective factors were identified in the wider ecology of the child, the practitioner would work to help them navigate their way. This could be improving sources of a secure base or encouraging a talent or interest.

Stage 4: Assessment of outcomes

At the point of case close, the same resilience assessment chart used to collect the baseline information is completed for a second time. This allows for both practitioner and the child / family to identify improvements in domains.

5. CASE STUDIES

The pilot was planned to have 4 case studies to provide learning about the effectiveness of the approach, and the potential for it to work within Kent as part of the next phase of HeadStart. However, only 2 case studies have been able to be completed. This due to one case being stepped up to specialist children's services, and a second case when at the end of the pilot the practitioner failed to provide

the required documentation or respond to communications. The cases are now considered individually.

Case: A	Practitioner: RM
Reason for referral : Anxiety, Low mood, Social isolation	
Assessment summary: A is 15-year-old girl who lives at home with her Mum, mums partner and a half-sister and attends a local secondary school. A's needs were mainly emotional following a catalogue of adverse experiences. A believes her problems started when she was 12. A has experienced the separation of her parents, bullying in primary school and in her local community. A has a good relationship at home with her mum and mum's partner A also has a difficult relationship with her half-brother following an incident where he assaulted her in 2014, the same year her Father left the family home. Health issues identified include poor diet and eating habits as well as lack of exercise. A's low mood is also exasperated by a lack of motivation in all areas of her life. She is not motivated to complete homework or socialize.	
Outcomes: 1. For A to be more engaged in school where she will be completing her homework and attending lessons by 22nd February 2. For A to have a better understanding of the importance of a healthy lifestyle to improve her wellbeing; 3. For A to start building trusting relationships to improve friendships.	

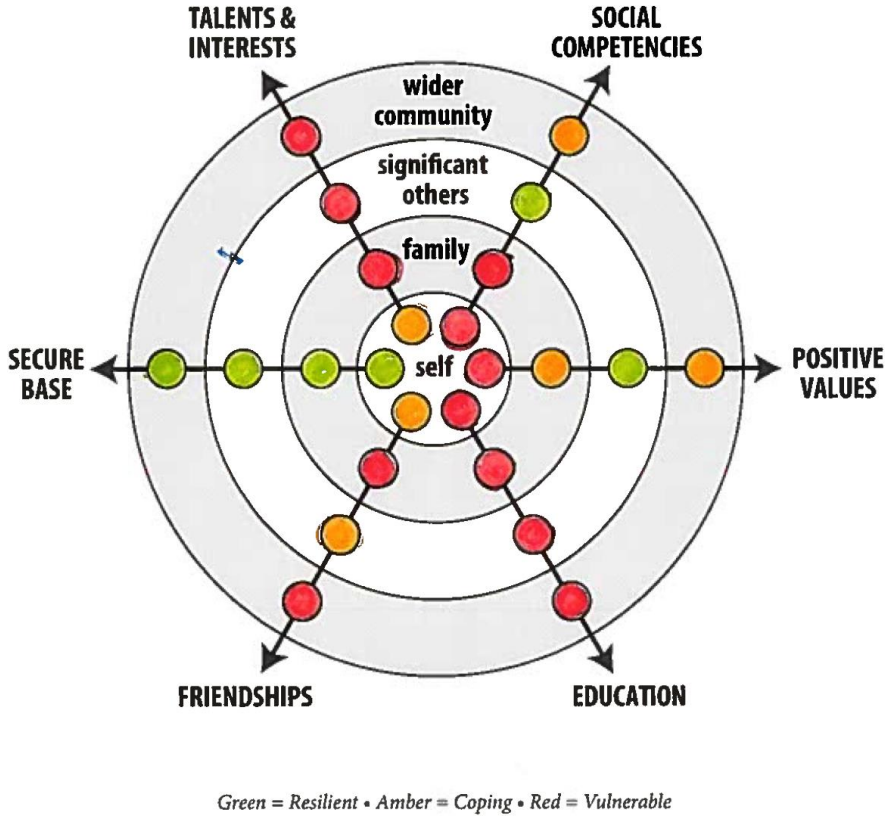

Figure 6: Case A Baseline domain assessment

The domain assessment exercise (*figure* 6) demonstrated that A had a secure base, but no engagement with life outside of the security offered in the home.

Overall the resilience worked well with Case A with both practitioner and case fully engaging with the framework. The early help support was in place for 14 sessions over 19 weeks. At the first assessment using the resilience assessment chart once completed A commented at how many reds there were (and greens) highlighting the value of completing the chart with the child. She understood the domains although there were challenges with the social competencies domain with the practitioner needing more information to explain about that domain.

The practitioner used a range of strategies when working with A and the family with a special focus on using a cognitive approach to try and improve A's confidence e.g. 'Think good, feel good". The practitioner also used some of the resilience intervention strategies from the Daniel and Wassell workbooks and these were said to offer valuable strategies.

The weekly sessions highlighted that the problems making friendships for A was exasperated by her not being picked to be in teams or other self-selecting group exercises. At weekly meetings A was up and down each week but after 6 weeks

the feedback from the school was good with improvements in her emotions and focus on work. This in turn led to the practitioner seeing improvements in A in terms of looking happier and in her presentation.

Around week 10 there was a temporary relapse where the pressures at school and the still unresolved issues around the bereavement were too much for A. RM worked with A to try and reinforce the cognitive strategies to try and manage or reframe her negative thoughts. A was also able to demonstrate resilience by reframing problems at school that had developed. By week 14 there was a clear improvement in A that was recognized by those around her including her Mum, practitioner and school with her teachers stating that she is a million better. However, a week later A's underlying vulnerability returned following problems with friendships that led A to becoming upset and low again. However, this was a short set back and A soon recovered.

By about week 15 both the school and family reported significant improvements. Key areas of success included:

- School stating A was 'a million times better'
- A less emotional and more in control of her work
- No more negative internal emails about A in school
- School emailing Mum with positive feedback on A
- Improved self-care and presentation
- Attending social events such as pub quiz with Mum and partner

The success of the Early Help intervention is reflected in the completed resilience wheel – *figure 7.* Improvements were made in all domains. Not only does this method of outcome monitoring help the practitioner evaluate the progress, this simple tool also allows the young person and relevant others to see the progress.

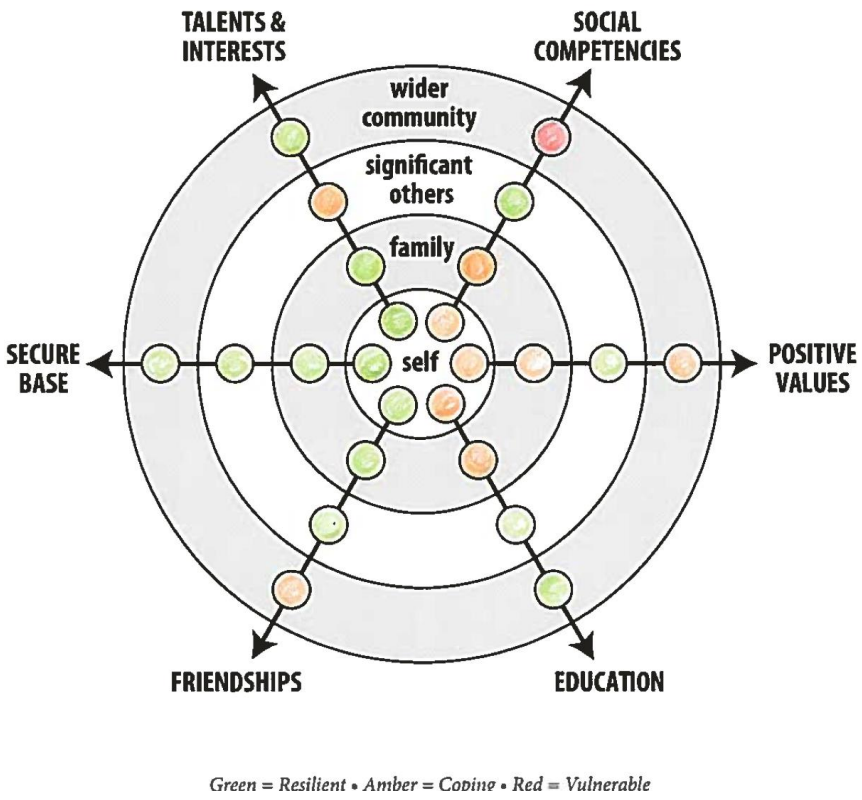

Figure 7: Case A Case close domain assessment

Practitioner feedback

Main focus of practice was on education and friendships. The improvement in education through school attendance combined with lunchtime groups in school improved relationships with peers. The Resilience Assessment Chart has been good for keeping focused. It highlighted to me the need to work in a resilience informed way because of the impact domains have on each other, producing a better outcome.

Case: B	Practitioner: KB
Reason for referral :	
Assessment summary:	
Outcomes: NO CASE DOCUMENTATION PROVIDED	

Case: C	Practitioner: SB
Reason for referral: Behaviour in school, home and community	
Assessment summary: C is a 12-year-old girl who lives at home with her mum and brother. C has been referred due to concerns about her behavior. She attends a local secondary school but has low school attendance (80%). C's Mum and Dad are separated and Dad does not have contact – Mum states ' he doesn't want to know'. The family are well known to services with her family having a reputation for drugs offences; brother and father have received custodial sentences. Mum and school were worried about the deterioration in C's behavior stating that she is becoming unmanageable. Mum has seen texts from others on her phone asking for drugs. Mum states there is a weed problem at school. Mum believes that C's behavior is due to her associating with inappropriate peers and C cannot remove herself as frightened from the 'gang' negative peer pressure. C loves horse riding and Mum is looking in to getting her a horse. The family have support in the ecology from Mum's family. C has said to SB she would like someone to talk to and help her address issues.	
Outcomes: 1. C to be responding to boundaries within school and at home and to have an understanding of risk taking behavior and where to go for support 2. C to be attending school every day unless she is unwell and unable to do so	

CASE STEPPED UP TO SCS

Case: D	Practitioner: SB
Reason for referral : Emotional wellbeing; anxiety; self-harm	
Assessment summary: D is a 17-year-old girl who lives at home with her parents and brother. D has been referred due to concerns about her emotional wellbeing and mental health as well as failure to attend college. Overall D and her family have had a difficult time following the death of a younger sibling. The family has not received any bereavement counseling for this and there have also been problems in her parents' marriage. The referral and assessment indicated poor emotional wellbeing with anxiety being identified as a key issue. D's anxiety is preventing her engaging in social events and also her engagement with education. She has not been out on her own or with her peers since June 2015. Due to this she is becoming increasingly isolated. D has also been self-harming, poor sleep patterns and problems with diet. She has a need to be near her Mum most of the time. D is willing to engage and has interests in horse riding and photography.	

Outcomes:

1. D to be aware of her options in respect of further education, employment and training and accessing one of these by 29th April with support having been provided;
2. D to presenting as more confident at home, in education and in the community. She will be able to manage her emotions better at home, in the community and in education.

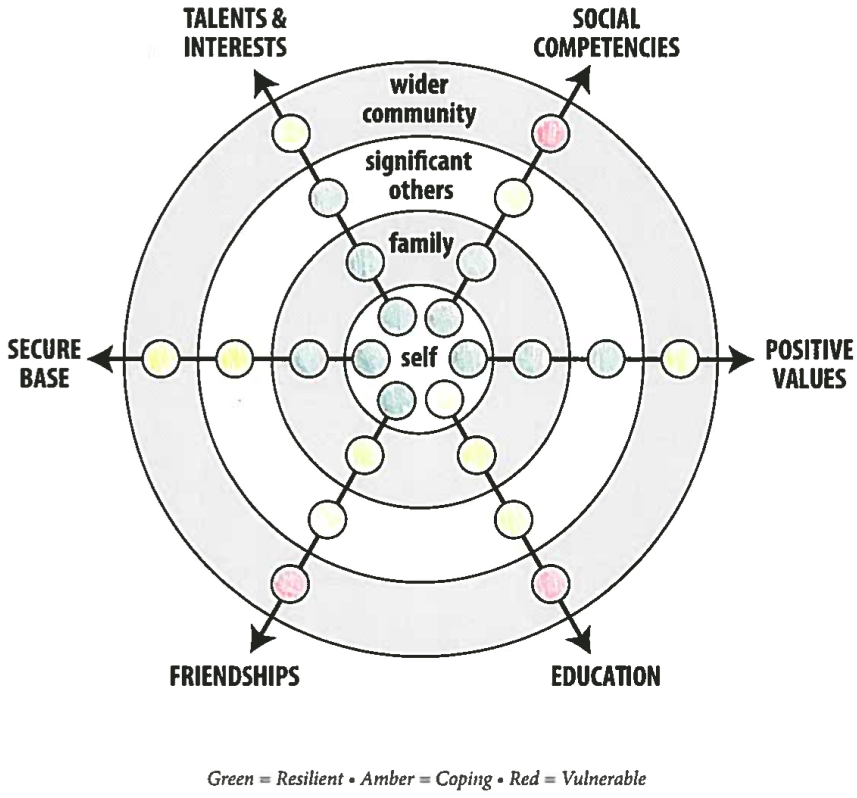

Figure 8: Case D Baseline domain assessment

NO DIARY OR CASE CLOSE ASSESSMENT CHART PROVIDED

7. REFLECTIONS

WHAT WENT WELL?

Practitioners and Young People Finding Assessment Tools Useful

Practitioners reported that the assessment process using the domains was useful and they could identify with the value of the approach. They have found the traffic lights system as an aid to assess strengths and weaknesses in each domain useful commenting that they feel young people 'get it'. They have also been using it with young person, parents/carers and others in the young person's life. This was done with the young person collaboratively and they reported this was an effective way of using the tool from a young person's perspective. This produced lengthy discussions about the value of such approaches and the potential to use the tool with more than one significant adult in a child's ecology. By introducing different viewpoints of a child's strengths and weaknesses a more detailed understanding of the child's ecology can be achieved.

Practitioners also used the resilience intervention chart (see appendix 1). This has been helpful in structuring their thinking about the domains they were going to be focusing on. Initially practitioners felt overwhelmed by it as they thought they had to complete it for each domain. However, as trainers we need to make this clearer that there is no need to do all the domains, it is for the areas practitioners will be focusing on.

Interventions Strategies

The practitioners have found the intervention ideas in the resource books helpful. They felt it changed the focus from what you cannot do, to what you can do. Shifting the focus from the problem or the risk factors to developing strengths and promoting protective factors. It also allows for a focus beyond the young person as it focuses on system around the young person. It also includes activities (Talents and Hobbies, friendships) rather than dealing with intrapsychic issues. This was found to be particularly effective in cases C & D where both young ladies had a strong interest in horses. They are also age specific and when used together provide informative evidence based practice guidance throughout a child's life.

Overall practitioners felt that the resilience domain model was a way of working they could implement without and major changes to the way they practice. Currently the Signs of Safety approach requires the use of the 'three houses' as an assessment tool and they need to use that for interventions. Due to this, using the resilience intervention chart would be duplicating the information.

WHAT ARE SOME OF THE CHALLENGES?

Use of Outcomes Measures

The practitioners have been unable to make use of the various outcomes measures offered in the domains approach. This has to do with these not fitting the outcomes process dictated by the dashboard that uses the menu of items from the troubled family programme. Whilst the clear focus on outcomes is to be welcomed and good practice, if outcomes are to be used in such a prescribed way, the menu of outcomes have sufficient range to select from that encompass the whole child, family and ecology.

The problem with such a restrictive outcome menu is highlighted when considering cases C & D that were held by the same practitioner. Comparing the two demonstrate the diversity in the needs of children referred to the early help team have. One could argue that Case C has a number of features that may meet the criteria of a troubled family, whereas Case D does not, instead clearly being a family in need following a tragic event in the family.

When considering this in the context of the resilience approach, a further issue is the process creates a pressure on practitioners to work in a constrained way. For example, a young person who is NEET will have a focus on education, however getting the young person out the house and focusing on talents and hobbies may create a better long term outcome – including ceasing to be NEET.

Disconnected practice and outcome framework

A key challenge to implementing a resilience approach to early help is the current service design. For a service to be effective practitioners should assess, intervene and evaluate using a single theoretical practice model and framework. Currently there are a variety of systems including

- Troubles Families for outcomes
- Early help and Signs of Safety for assessment questions
- Cognitive approaches

The first two approaches are not conducive with the domains assessment or for strengths based approach. Signs and safety and the 3 houses do not focus on what is positive and it is not systemic in its assessment. Cognitive approaches can be useful but are only as good as the level of training (and quality of) the practitioner has. It should also be used alongside other domain targeting.

Current System Is Process Driven Rather Than Young Person Focused
Issue of supporting vulnerable young people and part of that is disengagement and the system does not accommodate that also not being allowed to got to hobbies with the young person. This is a common problem associated with systems that focus on process.

Pressure to meet a process rather than a focus on families and young person
If it is outcomes focused, then it needs to allow appropriate indicators and flexibility. This does not seem to be offered in the current system:

- The way the goals are set and the dashboard demands, it is hard to change focus according to the needs of the young person
- Often have to walk away when goals are met as you've met the outcome s even though new issues emerge
- No options for them coming back
- There is pressure to meet outcomes – need to ensure outcomes are described in a way so you can achieve them.

Challenges around working with schools
They feel Early Help is not responsive to the needs of the young person, which is leading to partnership working with schools. Schools feel out of the loop.
Schools also seen as not supporting the young person rather contributing to the issues.

A further challenge identified is the increasing fragmentation of the school's network. For example, there are a number of horse-based courses offered by education providers that would have been a significant benefit in two cases, but no established referral pathways exist for the Early Help Practitioners. Further, equine courses have an increasingly robust evidence base demonstrating their effectiveness.

Issue of Complexity
The role of resilience when working with young people who have mental health problems was highlighted at the beginning of the pilot. It seemed practitioners thought they needed to have lower level cases (in terms of complexity of issue) to support. The focus needs to be on developing the protective factors in the life of the young person. This should not replace the need for specialist mental health interventions however these young people will need support with friendships, developing their talents and ensuring they are engaging with education. The resources offer some clear examples of these.

Issue of Access to Resources and Services

The value of the talents and interests domain as a protective factor has been highlighted throughout the knowledge transfer. As a domain it has the potential to generate positive resilience 'strings' benefiting multiple domains. However, an immediate barrier identified is a lack of appropriate resources and activities / services for workers to make use of.

System barriers / Context

As already highlighted there has been significant transformation of processes and systems within KCC in recent years. These changes include the introduction of Signs of Safety, the Newton Europe dashboard system, the introduction of the troubled families 'outcomes' as well as changes to case management to improve efficiency. These changes to service delivery produced three challenges to the domain pilot:

1. We were going to be introducing an additional method of assessment
2. Whether the domain model is able to work in harmony with existing systems
3. The prescribed outcomes practitioners are forced to use do are not suitable for holistic support or practice that takes a strengths based approach.

A key problem identified is the use of the Troubled Families outcome framework to prescribe outcomes that the EHP must focus on achieving. We do not understand why the outcome framework from the Troubled Families programme is being used by EHP. This is problematic for 4 reasons:

1. If EHPs are receiving appropriate referrals with needs that meet the criteria, then they should not already be a 'troubled family';
2. EHPs are expected to work holistically with families in need of support, the outcome framework prevents that;
3. The current TF framework is inadequate to identify outcomes to work toward due to its glaring omission of emotional and mental health.
4. To maximize the chance of a practice model to be effective, the assessment, intervention and outcomes *must* be from the same theoretical model. Currently Kent has a pick and mix that means EHPs are working with an un-evidenced and largely ineffective practice model.

8. CONCLUSION

The timing of this pilot exercise has overlapped with wider systemic change within KCC that the practitioners are required to adapt to. The introduction of the Newton Europe 'dashboard' that monitors the processes of the practitioners has proven to be challenging. The new system has increased administration and consequently there is less time for practice including the HeadStart domain work.

Overall the practitioners were able to learn the basic skills to use resilience as a framework for practice in a short period of time. The feedback from the practitioners resonated with established evidence supporting the value of the framework. The client group the practitioners worked with also positively engaged with the approach, and in the cases where it was fully implemented successful outcomes were achieved.

This small pilot did not produce any findings that indicate that implementing a resilience domain approach is incompatible with Early Help. However, systemic barriers exist to strengths based holistic practice that any resilience approach requires. If KCC are successful in the Big Lottery bid and continues with the resilience domain approach, it must do so acknowledging it cannot be an isolated 'add-on' to the current Early Help practice. To do so would add to the complexity of the workplace for practitioners already working with a confusing combination of approaches.

Practitioners need to fully understand the concept of resilience before using the domains approach making high quality training vital. In this pilot the results were positive but it must be acknowledged that 3 practitioners had training and support from a clinician and expert in the area. One of the most attractive aspects of the resilience domain approach is its successful implementation in other comparable services with similar client groups.

Appendix 1: Reilience Intervnetions Chart

Resilience Domain	What are the child's protective factors?	What are the risks factors of significant harm for the child?	What can be done to maximise the protective factors?	What can be done to minimise the risk factors?	What areas of resilience, at any ecological level, will we target now and how will we do this?	Who will be responsible for this?	How and when will we measure progress?
Secure Base							
Education							
Friendships							
Talents and Interests							
Positive Values							
Social competencies							

[i] Daniel et al., 1999: 14
[ii] Daniel and Wassell (2002)
[iii] Gilligan (1997).