Bouncing back:

How can resilience be promoted in vulnerable children and young people?

Believe in children

Barnardo's

By Jane Glover

Background

This briefing is aimed at children's services that use or wish to apply the concept of resilience to their work with vulnerable children and young people.

The briefing was conceived when research carried out by Barnardo's Policy and Research Unit in early 2008 threw up more questions than answers about how resilience can be nurtured in practice. Responding to a survey, managers and practitioners in over 100 of Barnardo's services questioned how resilience should correctly be defined; whether true resilience can be nurtured; how this can be done in a structured way; and how we can accurately measure what we have achieved.

This briefing addresses these issues and goes beyond the initial research. It looks at why resilience has become the buzz word in social care; it gathers tools and tips for promoting resilience from over 100 services across Barnardo's; it summarises what makes for good practice in a project that aims to promote resilience – using Barnardo's Arch Project as an example; and it addresses the sticky issue of how we can measure outcomes.

Our thanks go to all the Barnardo's services that contributed, and in particular to the staff at two Barnardo's services – the Arch Project and the Bo'ness Project – who gave so much of their valuable time. Also, to our co-collaborators on the original research project at the Universities of Edinburgh and South Australia, and particularly to Professor Brigid Daniel at Stirling University.

Introduction

Researchers from Barnardo's Policy and Research Unit surveyed a manager or a practitioner from 107 of Barnardo's services across the UK. They then spent significant time at two of these services – Arch in the Midlands and Bo'ness in Scotland – documenting the methods, tools and expertise, and gathering the opinions of managers, practitioners, children and families, and local health, education and social care professionals to build a detailed picture of how resilience is nurtured in practice.[1]

The survey results

Sixty three per cent of those surveyed told us that the concept of resilience is used explicitly in their work, and an additional 23 per cent use it implicitly. These respondents defined resilience in different ways, including: 'an inner strength'; 'an ability'; 'self-esteem'; 'attachment'; 'a genetic trait'; and 'a skill'.

Where the concept of resilience is used explicitly, Barnardo's services are working across a wide variety of disciplines, the most common being: behavioural problems; abuse; bereavement; emotional issues; sexual exploitation; and sexually problematic behaviours. The range of settings also varied and included individual, outreach and group work as well as work that is school-based and community-based.

In their responses, managers and practitioners were enthusiastic about what they consider to be the 'positive' and 'creative' approach to practice that the concept of resilience facilitates. However, some of the respondents shared concerns that they are unsure of the correct definition; do not know how to apply it appropriately in practice; or do not know how to measure it.

The survey also asked about 'resilience-based practice'. And it was clear that this can mean different things to different people. The most common explanations described it as, 'identifying, assessing or focusing on a young person's current strengths, skills or talents'; 'helping, encouraging or enabling a young person to develop their strengths, skills or talents'; 'offering praise'; 'enhancing coping strategies'; 'building self-esteem'; 'identifying goals'; and 'building strong relationships'.

The components of resilience

It is generally agreed that resilience is affected by the strengths of an individual, and of their family, as well as those of the community and the culture in which they live.

It is also accepted that resilience is made up of a number of different elements – the most well-known being self-esteem and attachment. It is probably fair to say that there is no 'true' definition, but a well-known clinical definition is: *'the maintenance of competent functioning despite an interfering emotionality'*. The International Resilience Project which surveyed almost 600 11-year-old children across 30 countries describes resilience as: *'a universal capacity which allows a person, group or community to prevent, minimise or overcome the damaging effects of adversity'*.[2]

1 Due to space restrictions, this document provides detailed information about the Arch Project only, but please contact us if you would like to know more about our findings from the Bo'ness Education and Family Support Service. Contact details for both projects are also provided at the end of this document and the service managers would welcome any enquiries.

2 Grotberg, E (1997) *A guide to promoting resilience in children: strengthening the human spirit.* Bernard van Leer Foundation. The Hague, p.7.

For the purposes of practice, it is helpful to focus on resilience in terms of the areas or 'domains' of a child's life that can be manipulated or changed. A useful framework for describing this is provided by Brigid Daniel and Sally Wassell[3] who split 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
- self-esteem – an internal sense of worth and competence.[4]

The extrinsic factors are:

- at least one secure attachment relationship
- access to wider supports such as extended family and friends
- positive nursery, school and/or community experiences.

This building block framework provides a useful basis for informing assessments of children, and designing and implementing targeted interventions. A later section looks at how Barnardo's Arch Project uses this framework to run a service that boosts resilience in five to 14-year-olds.

Rule of thumb

Based on current research and literature, Barnardo's policy and research unit takes the view that there is no one 'correct' approach to resilience based practice and that any, all, or a mixture of several approaches can be effective, provided that we try to stick to a basic rule of thumb.

The service must be clear which processes or factors of resilience it aims to foster or protect.[5] This is particularly important to enable the service to develop an outcomes framework and to be confident that the work is effective. In agreeing which processes and factors of resilience are important, it is recommended that three things are considered:

1.Capacity – How much time can be spent with the young person, both individually and within the context of their family and community?

Although we know that resilience is associated with the strengths of the individual, their family and the community in which they live, a service is rarely able to address all these factors. (A service which offers twice-weekly intensive support to a young person and their family may be able to address individual and family resilience, whereas one that sees a young person just once a week in a one-to-one session may prefer to focus on supporting that young person to develop self-efficacy through development of a housing or education plan).

Services can also take into account how their joined-up working with other services can add to the factors of resilience that are addressed.

2.Relevance – The different elements of resilience that are focused on should be those that are known to be important and relevant to the young person.

3.Using evidence – The approach that is decided upon should be evidence-informed (developed using current theory and the best available evidence). The Arch Project example used in this briefing is an example of how an evidence-informed approach can be used to boost resilience.

3 Daniel, B and Wassell, S (2002) *The School Years: Assessing and Promoting Resilience in Vulnerable Children*. Jessica Kingsley Publishing, London.

4 It should be emphasised here that good self-esteem rarely (if ever) develops in a 'vacuum', and services working to boost self-esteem in young people must therefore focus on the contributing factors such as enabling young people to develop their talents, or master new skills.

5 For many years different authors have laid claim to having identified the elusive processes or factors of resilience or those associated with resilience and these have included, but are by no means limited to: self-efficacy, an internal locus of control, being sociable, being independent, having a sense of humour, having hobbies, a willingness and capacity to plan, a close bond with one other person, being nurtured, having responsibility, enjoying good school experiences, attachment and positive peer relationships.

What is resilience and why is it relevant?

The concept of resilience dates back to the Second World War when clinicians noted that some evacuated children appeared to suffer more psychological damage than those who stayed at home to face the bombing. A further seminal paper was produced by Margot Hicklin (1946)[6] about the recoveries of 300 children brought to England in 1945 after their liberation from Nazi concentration camps Belsen, Buchenwald and Auschwitz. The concept has prospered and evolved over 50 years, and now informs and influences economics and politics at the highest levels.

Resilience is understood internationally as having the capacity to resist or 'bounce back' following adversity and is generally considered to be made up of individual, family and community factors. In his book, Newman (2004)[7] stresses that the importance of resilience is not only in safeguarding a child in adverse circumstances, but also enabling the child to grow and develop despite adverse circumstances. (This briefing does not go into detail about the theory of resilience, but a list of further reading is provided at the end for those interested to know more.)

This ability to bounce back from adversity is particularly relevant to the work at Barnardo's, where so many of the children and young people have experienced adversity, or transition. We aim to enable children and young people to cope with the challenges of changing schools; entering or leaving the care system; disability; loss or separation; violence; parental illness; entry to adulthood; seeking asylum... there is no Barnardo's service for which the concept of resilience does not have some resonance.

Resilience in government policy

The government's interest in resilience was influenced by Lord Layard[8], a government advisor who wrote an influential briefing in 2005[9], pointing out that the government spends more money on incapacity benefits for the mentally ill than it does on unemployment benefits.

This report coincided with a growing awareness that mental health has declined in all developed countries in the past few decades[10] – as we've all heard, the UK was recently listed last in a UNICEF hierarchy of child well-being.[11]

The idea of governments keeping children healthy and happy has therefore moved into the mainstream of policy making. Geoff Mulgan, the former head of the Number 10 policy unit said in 2008 that, *'well-being will be the major focus of government in the 21st century, in the way that economic prowess was in the 20th century and military prowess was in the 19th century'*.[12]

6 Hicklin, M (1946) *War-damaged Children. Some aspects of recovery.* The Heath Press. Thornton Heath, Surrey.

7 Newman, T (2004) *What works in building resilience?* Barnardo's, Barkingside.

8 Lord Layard was the founder-director of the Centre for Economic Performance at the London School of Economics and now heads the centre's programme on well-being.

9 Layard, R *Mental health: Britain's biggest social problem?* Paper presented at the no.10 strategy unit seminar on mental health on 20th January, 2005.

10 It should be noted that some researchers remain sceptical about what lies behind these findings. Increased 'prevalence' of mental illness in the UK could be explained by the increase in screening of children and young people, a broadening of the clinical categories of mental illness and/or the increased availability of effective medication, and hence greater likelihood of people reporting illness.

11 *Child poverty in perspective: An overview of child well-being in rich countries.* Innocenti Report card 7, 2007. UNICEF Innocenti Research Centre, Florence.

12 Geoff Mulgan quoted in *The Times* February 18th 2008. *Teaching Happiness: the classes in wellbeing that are helping our children.* Julie Evans.

'Resilience' has been adopted as the 'antidote' to all this unhappiness, and seems to be used almost interchangeably with words such as 'well-being' and 'positive mental health' by government, local authorities and the media.

In terms of strategy, *The Children's Plan*[13] emphasises the importance of building resilience in children and young people no less than 10 times, and the government's recent *Families at Risk Review*[14] plants the nurturing of resilience firmly within the domain of universal service provision. As part of the review, the Social Exclusion Task Force identified key protective (or resilient) factors as being: authoritative, affectionate, positive parenting; the importance of the family; educational attainment; and social and emotional skills.

It is worth noting that resilience is a very challenging concept for policy makers and children's services for two important reasons identified by Newman (2004).[7] Child welfare services are rightly under increasing pressure to avoid exposing children to any manifestation of risk. Yet, there is an unfortunate contradiction, in that in providing support to children experiencing adversity, they may be insulating children from those very experiences that enable them to build resilience in the first place. Secondly, it is often assumed that resilient people are nice, pro-social, well-adjusted individuals.

Yet, Newman (2004)[7] asserts that some resilient people may be withdrawn, defensive, confrontational – not particularly nice individuals, and that these resilient characteristics have often been developed by the young person to enable coping. In fact, research has shown that those most resistant to stress often have a sociopathic aspect to their personalities.[15]

In terms of practice, various government initiatives have been launched to bolster resilience in children and young people. The most well known are the Family Nurse Partnership (FNP)[16] and the Social and Emotional Aspects of Learning (SEAL) Programme.[17]

A recent addition is the Local Wellbeing Project, a government backed three-year initiative[18] specifically focused on improving well-being at a local level. An important strand of the project is a three-year pilot known as the UK Resilience Programme, for 11 to 13-year-olds across 22 schools. The programme (adapted from a successful model in the United States) helps children to develop skills such as assertiveness, decision-making and relaxation, and teaches them how to cope with difficult situations and emotions. The government has described the work as, 'the most comprehensive exercise to date on public policy from a well-being perspective' and the London School of Economics is undertaking a three-year evaluation of the project to monitor its effectiveness.[19]

13 DCSF (2007) *The Children's Plan: Building brighter futures.* DCSF, London.

14 A cross-government review led by the Social Exclusion Task Force. For more information, see http://www.cabinetoffice.gov.uk/social_exclusion_task_force/families_at_risk.aspx

15 Rew, L, Taylor-Seehafer, M, Thomas, NY, Yockey RD (2001) Correlates of resilience in homeless adolescents. *Journal of Nursing Scholarship.* First Quarter 33-40.

16 The FNP is a community health programme providing intensive support to vulnerable first time mums from pregnancy through to when the child is two years old, to try to prevent problems linked to social exclusion. The DCSF and the Department of Health started piloting the programme in April 2007 as part of the Reaching Out action plan on social exclusion, and a further £30m funding was announced in October 2007. A recent evaluation (University of London, Birkbeck: July 2008) has shown positive early results and the recent government white paper *New opportunities: fair chances for the future* (January 2009) announces its intention to extend the programme under the Child Health Strategy.

17 The government's SEAL programme was introduced in primary schools in 2006, and a secondary school programme was introduced in April 2007. The programme aims to provide schools and settings with an explicit, structured whole-curriculum framework for developing all children's social, emotional and behavioural skills. The government reports that 60 per cent of primary schools in the UK have, so far, adopted the programme in the UK.

18 The Wellbeing Project is led by the Young Foundation, the Improvement and Development Agency and Professor Lord Richard Layard, from the London School of Economics Centre for Economic Performance

19 For more information about the Local Wellbeing Project see http://www.youngfoundation.org.uk/our-work/local-innovation/strands/wellbeing/wellbeing

How can we build resilience in practice?

The difficulty for practitioners has always been that descriptions of effective interventions to boost resilience are few and far between, and many strategies do not appear notably different from interventions that simply seek to promote positive child development.

In his book *What works in building resilience*, Tony Newman[7] reviews the resilience research and provides a list of practical strategies that hold the most promise. A selection is presented here:

Promoting resilience in the home environment:

- the presence of at least one unconditionally supportive parent or reliable adult
- maintenance of family routines and rituals
- manageable contributions to the household that promote competencies, self-esteem and problem-solving.

Promoting resilience in the school environment:

- creation and maintenance of home-school links for at-risk children and their families, which can promote parental confidence and engagement
- positive school experiences: academic, sporting or friendship-related
- good and mutually trusting relationships with teachers
- the development of skills, opportunities for independence and mastery of tasks
- structured routines, and a perception by the child that praise and sanctions are being administered fairly
- provision of breakfast and after-school clubs.

Other resilience-promoting strategies:

- a sense of mastery and a belief that one's own efforts can make a difference
- the capacity to re-frame adversities so that the beneficial, as well as the damaging effects, are recognised
- participation in a range of extra-curricular activities
- the ability, or opportunity, to make a difference on the world around you (perhaps through part-time work, providing mentoring to another young person, or involvement in community-based activities).

It is worth remembering that...

When children themselves are asked what helped them 'succeed against the odds', the most frequently mentioned factors are: help from members of their extended family, neighbours or informal mentors, and positive peer relationships, rather than the activities of paid professionals (Newman, 2004).
The role of professionals must therefore be, where possible, to create and to nurture these relationships.

Boosting Resilience: The Arch Project

Barnardo's Arch Project (Achieving Resilience, Change, Hope) applies the six domains of emotional resilience identified by Daniel and Wassell[3] to build resilience in children and young people. Based in central Birmingham, and headed by managers Nicola Myhill and Teresa Quinn, the service is a good example of the value of evidence informed practice. The project works with children aged five to 14 who have emerging emotional and behavioural difficulties, and with their parents or carers. Over 200 children and 90 parents received a service from the Arch Project in 2007/08.

Although the focus is on the individual and their family, the work also relies upon close working relationships across health, social care and education. Funding comes via a four-way partnership[20] and referrals come from a range of sources including education, CAMHS (child and adolescent mental health services) and self-referral. Collaborative working is further enhanced by sharing the building space with the citywide CAMHS learning disabilities service.

The Arch Project works to four main aims:

- to **build emotional resilience** – to promote positive mental health and encourage social inclusion
- to **strengthen protective factors** associated with resilience and reduce risk factors
- to **reduce progression of challenging behaviour** by increasing effective and appropriate parenting
- to **increase the confidence and skills of parents** in responding to the emotional needs and behaviour of their children.

Arch in action

Referrals are accepted when children are showing 'emerging' emotional or behavioural difficulties which are starting to impact upon their personal development, home life or education. The symptoms range from antisocial behaviour, violence or verbal aggression, through to severe withdrawal from family or peers. Common sources of difficulty include experience of family breakdown, loss or bereavement, exclusion from school, substance misuse, parental mental health problems or bullying. If emotional or behavioural difficulties are deemed to be too established for an early intervention service, the family are re-referred to CAMHS.

The six domains of resilience identified by Daniel and Wassell (2002)[3]:
secure base
education
friendships
talents and interests
positive values
social competencies.

20 Funding comes from Barnardo's voluntary funds, Birmingham City Council, Sure Start and CAMHS.

Initial assessment

An initial assessment takes place involving the child, the main care provider(s)[21] and the Arch project worker. These initial discussions often naturally focus on the very overt behaviours, and the more subtle issues are often uncovered during the detailed assessment phase.

Detailed assessments

Detailed assessments are undertaken separately with each parent and child. These are structured by the six domains identified by Daniel and Wassell[3] (secure base, education, friendships, talents and interests, positive values and social competencies), with a different domain covered at each weekly session. Use of this very structured model aids practitioners in two important ways:

- Pertinent questions can be asked of parents without seeming judgemental. *('I can ask them something about how well their partner gets on with their child, without seeming like I'm judging, because I can honestly tell them that we go through issues like this with everyone in the 'secure base' session.')*
- Practitioners are themselves reassured that if they go through each domain, they will not be missing any important elements of the child or parent's life where support may be needed.

In consultation with the parent and the child (individually), a shared action plan is developed. This is important in engendering shared ownership and commitment between practitioner, parent, and child and starting to build trust. The action plan is usually structured around all domains (although domains can be dropped if it is felt that support is not needed) and will list the intended outcomes. The value of using a structured model is clear here – the Daniel and Wassell[3] domains are carried right through from assessment to intervention to measurement of outcomes – providing a clear pathway for practitioners to follow, and for service users to understand.

Planning outcomes

Intended outcomes are chosen from a standard list of 22 (for the child) and 24 (for the parent). The intended outcomes on the action plan relate to the needs of the child and how the parent can support the child to achieve these outcomes. In some cases, it is also deemed that the parent's difficulties are impacting negatively on the child's resilience, so the action plan will also focus on these issues.

Individual intervention sessions

These sessions are carefully structured to reflect the action plan, and followed over a 6-12 week period. For each domain, a variety of tools and techniques can be tried, and the practitioner will focus on the ones which work well for the individual parent or child.

In this way, the model is empowering for the child and the parents because the worker is not a 'crutch' for them, but is simply giving them the tools and techniques with which to start to gain some additional control over important aspects of their life.

The value of the model's flexibility is clear at this stage. Practitioners described how it could be adapted to suit any family's needs, and adjusted as little or as much as needed. *('It allows workers to try different options within the same domain until we find a suitable tool or strategy that the parent or child feels comfortable with.')* It also allows for the 'easy' domains (such as talents and interests) to be worked on first, followed by more difficult areas that families may struggle to discuss.

21 Siblings are also invited to attend if it is felt to be in the child's and family's interests.

'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.' (Daniel, 2008)

This flexibility also befits the project's purpose of being a short-term intervention service. Issues need to be quickly identified and prioritised, and this model allows for time spent on domains to be increased or decreased depending on priorities. For example, one worker focused on secure base because it was felt that once the child had a secure and happy time at home with the family, that other issues such as friendships would resolve themselves naturally.

At this stage, the practitioner would also work with other significant adults in the child or parent's life, including professionals from education, health and social care. The value of an evidence-based approach is apparent here. *('It gives us the credibility to engage and enthuse teachers or other family members.')* This buy-in from external sources ensures that consistency can run through the child's life at home, school and within the community. As one parent explained, *'my ex [partner] wasn't interested at first, but when I showed him the plan and the different areas, he kind of understood it a bit more, and took it a bit more seriously'*.

Measuring outcomes

Outcomes for the child and parents are assessed at the end of the intervention period in three ways:

1. Pre- and post-questionnaires filled out by the child (about themselves), the parent (about the child) and the parent (about themselves). The questions asked are carefully matched to the list of outcomes that the project works towards (although not all will have been chosen for that particular child and parent).

2. Practitioner observations.

3. Feedback from the referring agent and other relevant professionals.

In 2007/08, a Barnardo's internal evaluation graded the success of the Arch Project in achieving its aims as 'very high', and, in their feedback, most parents reported positive change as a result of the service they had received. More detail about the project's outcomes are available in the annual report, and the project will be implementing a new outcomes tool in 2009 which it is hoped will provide more information about the success of the project over the coming years.

As the service offered is a relatively short term intervention, it is vital that parents and carers are given the support, information and skills to be able to promote their own and their child's resilience beyond the involvement of the project. For this reason, administrators at Arch have started to gather follow-up information from families six months after withdrawal of the service. The project hopes to be able to publish results of these follow-ups in its next annual report.

Case study – Danny

Danny is seven years old and lives with his mum, Helen, her partner Paul and his younger brother, Marc. Danny was referred by CAMHS in June 2007 when he had become increasingly violent towards Marc. He had also started to swear, had been bed-wetting and was rarely able to sleep through the night. The psychologist assessing Danny was concerned that he was becoming increasingly isolated both at home and school.

The Arch assessment revealed that Danny's difficulties stemmed from three domains: secure base; positive values; and friendships. Following a difficult pregnancy, Helen had failed to bond with Danny, and while Paul and Marc enjoyed a close relationship, Danny had been left isolated. His self-esteem was low and he lacked the social skills to make and keep friends. The parental assessment revealed that Helen herself was isolated and depressed, having moved to a new area following the breakdown of her relationship with Danny's dad.

The action plan focused on helping Helen to understand the effect that her and Paul's behaviour was having on Danny, and on helping Danny to cope with his situation. Danny was taught to recognise the early signs of his anger and how to calm himself down. His worker also introduced some relaxation techniques to help him sleep, and showed him strategies for getting along better with peers. He was also helped to understand that the strained relationships in the home were not his fault. Danny's teacher was involved from the outset and was able to support Danny with some of the techniques.

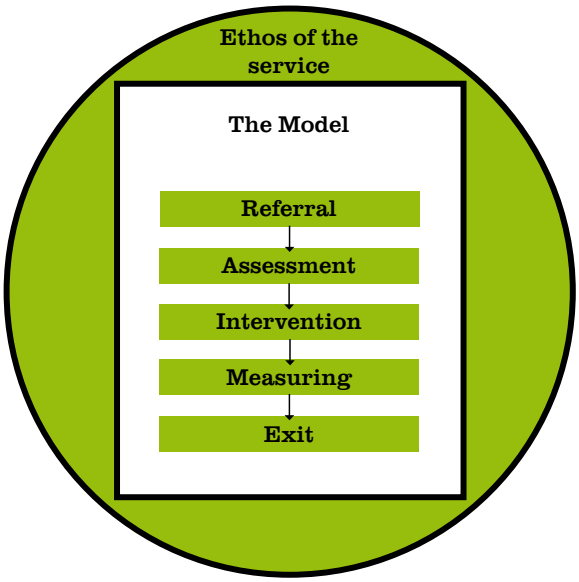
Although Paul was unwilling to be involved, Helen learned to support Danny with his anger management which provided an opportunity for her to spend time alone with him. She has also ensured that he spends more time with an older cousin who is supportive of him. Helen was also helped to find support for her depression and given some relaxation strategies of her own.

Although Helen still struggles with her depression, both she and Danny have described how they are much happier now. Helen no longer avoids physical contact with her son, and this seems to have helped Marc and Danny to bond more closely. The relationship with Paul is still strained, but Danny described how he understands that, *'it's not my fault if Paul doesn't like me, it's just because we don't get on'.*

The Arch worker feels that the family benefited from the work because both Danny and Helen were so keen to make changes, and were so responsive to the suggestions made.

What elements help a service to boost resilience?

Research at the Arch and Bo'ness projects enabled us to document the key components contributing to good service provision. They are separated here under the seven headings shown in the diagram:



1. Ethos of the service

- **An evidence-informed approach to practice** helps services achieve funding and gives practitioners confidence that what they are doing works.
- **Involvement of the whole family** ensures buy-in from the important people in the child or young person's life. Parents reported that they continued to use the strategies with other children in the family long after exiting the project.
- **Focusing on delivering non-stigmatising support** ensures trust and a strong relationship between the family and the practitioner.

2. The model

- **Using a structured model** can help practitioners to focus interventions effectively, particularly when the intervention is time-limited.
- **Using a model that is empowering** for the child, young person and family (through helping them understand their problems, and learn new skills and techniques to cope and prosper) ensures that the practitioner does not become a 'crutch'.
- **A model with a clear and documented thread** which runs through assessment, intervention and outcomes ensures that overall aims are clear to both practitioner and parent. In the Arch example, it is the six domains which underpin each stage.
- **An approach that acknowledges that the parent and wider family must adapt and change** as well as the child ensures that it is not just the child or young person who shoulders the responsibility for change.

3. Referral

- **The referral process needs to be well thought out** so that the 'quiet' or withdrawn children as well as more disruptive children are identified and offered referral.

4. Assessment

- **An agreed, shared action plan** developed at the assessment stage with the parent and the child encourages ownership and commitment.
- **A structured approach to assessment** allows practitioners to address areas of sensitivity in a less stigmatising way – it allows practitioners to explain that these questions are asked of all families.

5. Intervention

- **Incorporating some flexibility** into the intervention enables the practitioner to work in a way that they, the parent and the child are comfortable with.
- **Joined-up working** with other professionals including teachers and psychologists increases the chances that any skills learned by a child, young person or family member are not only applicable to the isolated setting of the project, but can be practised, internalised and extrapolated to situations in the outside world.
- **Regular, structured communication** between referrers and the service ensures that referrers understand when referrals are appropriate (and inappropriate) and what is expected to be achieved through the intervention.

6. Measuring impact

- **Clear, measurable outcomes should be set from the start** and continually referred to and discussed with the child, young person or family member.
- Where possible **follow-up outcomes measurement** provides important depth to understanding how the service has helped the child, young person or family.

7. Exit strategy

- **A clear exit strategy** that both practitioner, parent, child and relevant professionals have planned in advance allows practitioners to withdraw at an appropriate point, and families to gain confidence in managing alone.

Measuring outcomes

In the UK there is a significant policy emphasis on ensuring that interventions for children and families are outcome focused. For example *Every Child Matters* (DFES, 2004), *Getting it Right for Every Child* (Scottish Executive, 2005), *Rights to Action* (Welsh Assembly Government, 2004) and *Our Children and Young People – Our Pledge* (Office of the First Minister and Deputy First Minister, 2006) all focus on the achievement of key outcomes for children and young people.

So what are outcomes?

- Outcomes are the changes or benefits that occur for children, parents, families and communities as a result of our activities or interventions – for example, increased resilience.
- They concern the effects of what we have done, not just the service that has been delivered.

In setting and measuring outcomes we can seek to answer important questions such as:

- Did things get any better for service users?
- Is the service making a difference to the people using it?
- Is the service making the right kind of difference to the right kind of people?

If we don't ask ourselves these challenging questions then:

- Services may become ineffective or irrelevant.
- We may lose funding if we can't demonstrate positive outcomes.
- We won't know what difference we're making and whether we are doing the best we can for our service users.

In order to ensure that services are progressing towards achievement of our outcomes, Barnardo's has a clear expectation that all children's services will set and measure outcomes.

For example, services that aim to promote resilience in children and young people need to be able to demonstrate whether or not the children they are working with have developed an increase in their levels of resilience as a result of the services or interventions they have received. Children's Services are therefore expected to:

- use Service User Recording systems to set, measure and report on outcomes
- produce annual reports which demonstrate the achievement of the service against its outcomes
- develop service business plans which detail the outcomes for the service and how information about these outcomes will be collected.

Recommended measurement tools

There are a number of tools available to help us to measure resilience in children and young people. The following are recommended by Barnardo's policy and research team and are free to use:

The Framework for Assessment

The development of the Framework for the Assessment of Children in Need and their Families (jointly issued by the Department of Health, the Department for Education and Employment and the Home Office, 2000) has drawn heavily on research and accumulated practice experience about the developmental needs of children. All the scales are relevant to different aspects of resilience and so the practitioner can select which ones he or she deems most appropriate.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008144

Rosenberg Self-Esteem Scale

The Rosenberg scale contains 10 items which are answered on a four point scale: from strongly agree to strongly disagree. The scale was developed from a sample of 5,024 high school juniors and seniors from 10 randomly selected schools in New York State. See Appendix 1 for a copy of this scale, which is free to use.

The Resilience Scale

The Resilience scale was created by Gail Wagnild and Heather Young in 1987 and is a 25 item Likert scale with possible scores ranging from 25 to 175. The higher the score, the stronger the resilience. See Appendix 2 for a copy of this scale which is free to use.

Reading list

This section offers recommendations for further reading. Firstly, we list papers that Barnardo's staff can obtain electronically by contacting Barnardo's library service.[22] The second list includes online resources under specific headings which may be of interest. The links can be followed by accessing this briefing directly from the Barnardo's website. Finally, we provide a list of resources recommended by Barnardo's practitioners, which are loosely based around the concept of boosting resilience.

Library resources

Anthony, E and Cohler, B (eds.) (1987) *The Invulnerable Child*. Guilford Press, New York. .

Antonovsky, A (1987) *Unraveling the Mystery of Health*. Jossey-Bass, San Francisco. .

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22 Barnardo's staff can obtain electronic copies of these resources by contacting Barnardo's library service at Library.mailbox@barnardos.org.uk

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Online resources

Advice for parents on helping build children's resilience http://cecp.air.org/familybriefs/docs/Resiliency1.pdf

Building resilience though participation http://www.auseinet.com/journal/vol5iss1/oliver.pdf

Resilience and adventure education http://www.outward-bound.org/docs/research/Neillresearch.pdf

Prevention programmes http://www.cce.umn.edu/pdfs/NRRC/capt_pdf/competence.pdf

Recommended by Barnardo's practitioners[23]

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Cairns, K (2002) *Attachment, Trauma and Resilience: Therpaeutic Caring for Children*. British Association for Adoption and Fostering, London.

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23 These resources were recommended by Barnardo's practitioners in responses to the Resilience Survey conducted in November 2007. These have not been verified by the policy and research team.

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For more information about **Barnardo's Arch Project**, please contact the service managers Nicola Myhill or Teresa Quinn on 0121 359 5333 or at arch.project@barnardos.org.uk.

Also included in Barnardo's research but not included in this briefing due to space was the **Bo'ness Education and Family Support Service** (BEFSS). This project works with children, young people and families through all their major developmental and transitional stages and therefore supports families with young children, right through to teenagers, parents and grandparents. A unifying theme for the diverse work of the project is resilience which informs the work of all the sub-teams – from the mentoring service, play work and systemic family work through to the nurture group, learning mentoring scheme and parenting group. For more information please contact the acting service manager Aileen McCusker on 01506 823118 or at boness@barnardos.org.uk.

Appendix 1

Rosenberg Self-Esteem Scale (Rosenberg, 1965)

Below is a list of statements dealing with your general feelings about yourself. If you strongly agree, circle **SA**. If you agree with the statement, circle **A**. If you disagree, circle **D**. If you strongly disagree, circle **SD**.

1.	On the whole, I am satisfied with myself.	SA	A	D	SD
2.	At times, I think I am no good at all.*	SA	A	D	SD
3.	I feel that I have a number of good qualities.	SA	A	D	SD
4.	I am able to do things as well as most other people.	SA	A	D	SD
5.	I feel I do not have much to be proud of.*	SA	A	D	SD
6.	I certainly feel useless at times.*	SA	A	D	SD
7.	I feel that I'm a person of worth, at least on an equal plane with others.	SA	A	D	SD
8.	I wish I could have more respect for myself.*	SA	A	D	SD
9.	All in all, I am inclined to feel that I am a failure.*	SA	A	D	SD
10.	I take a positive attitude toward myself.	SA	A	D	SD

Scoring: SA=3, A=2, D=1, SD=0. Items with an asterisk are reverse scored, that is, SA=0, A=1, D=2, SD=3. Sum the scores for the 10 items.

The higher the score, the higher the self-esteem.

The scale may be used without explicit permission. The author's family, however, would like to be kept informed of its use:

The Morris Rosenberg Foundation
C/o Department of Sociology
University of Maryland
2112 Art/Soc Building
College Park, MD 20742-1315

Appendix 2

The Resilience Scale

Please read the following statements. To the right of each you will find seven numbers, ranging from 1 (Strongly Disagree) on the left to 7 (Strongly Agree) on the right. Circle the number which best indicates your feelings about that statement. For example, if you strongly disagree with a statement, circle 1. If you are neutral, circle 4, and if you strongly agree, circle 7.

Q26 is an optional measure of the validity of the scale and can be included at your discretion.

		Disagree				Agree		
1.	When I make plans, I follow through with them.	1	2	3	4	5	6	7
2.	I usually manage one way or another.	1	2	3	4	5	6	7
3.	I am able to depend on myself more than anyone else.	1	2	3	4	5	6	7
4.	Keeping interested in things is important to me.	1	2	3	4	5	6	7
5.	I can be on my own if I have to.	1	2	3	4	5	6	7
6.	I feel proud that I have accomplished things in life.	1	2	3	4	5	6	7
7.	I usually take things in my stride.	1	2	3	4	5	6	7
8.	I am friends with myself.	1	2	3	4	5	6	7
9.	I feel that I can handle many things at a time.	1	2	3	4	5	6	7
10.	I am determined.	1	2	3	4	5	6	7
11.	I seldom wonder what the point of it all is.	1	2	3	4	5	6	7
12.	I take things one day at a time.	1	2	3	4	5	6	7
13.	I can get through difficult times because I've experienced difficult before.	1	2	3	4	5	6	7
14.	I have self-discipline.	1	2	3	4	5	6	7
15.	I keep interested in things.	1	2	3	4	5	6	7
16.	I can usually find something to laugh about.	1	2	3	4	5	6	7
17.	My belief in myself gets me through hard times.	1	2	3	4	5	6	7
18.	In an emergency, I'm someone people can generally rely on.	1	2	3	4	5	6	7
19.	I can usually look at a situation in a number of ways.	1	2	3	4	5	6	7
20.	Sometimes I make myself do things whether I want to or not.	1	2	3	4	5	6	7
21.	My life has meaning.	1	2	3	4	5	6	7
22.	I do not dwell on things that I can't do anything about.	1	2	3	4	5	6	7
23.	When I'm in a difficult situation, I can usually find my way out of it.	1	2	3	4	5	6	7
24.	I have enough energy to do what I have to do.	1	2	3	4	5	6	7
25.	It's okay if there are people who don't like me.	1	2	3	4	5	6	7
26.	I am resilient.	1	2	3	4	5	6	7

More details can be found in the original paper: Wagnild, GM & Young, HM (1993) Development and psychometric evaluation of the Resilience Scale. *Journal of Nursing Measurement*, 1, 165-178.

Bouncing back:
How can resilience
be promoted in
vulnerable children
and young people?

By Jane Glover

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