Childhood Adversity: Recovery, Resilience and Prevention Seminars

Seminar 1: *Making a holistic assessment, and establishing a profile for intervention*

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The Childhood Adversity: Recovery, Resilience and Prevention

The ACAMH & CFT seminar series introducing

***The Hope for Children and Families* intervention resources**

5 May	Create an ecological trauma informed model of intervention based on a holistic assessment
12 May	Early intervention when children are exposed to significant adversity
19 May	Interventions to address overlapping mental health responses to adversity
26 May	Prevention: Work with parents and the family

Seminar 1: Create an ecological trauma informed model of intervention based on a holistic assessment

Part 1

- Models of childhood adversity
- A modular common practice elements approach
- *The Hope for Children and Families* intervention resources
- Create an ecological trauma informed model of intervention
- Gather and organise assessment information

Refreshment break

Part 2

- Analysis and develop a plan of intervention
- Engaging children, parents and families: Promoting hopefulness
- Setting collaborative goals
- Implement the plan of intervention, monitor and review progress

Models of Childhood Adversity

Direct forms of harmful adversity (ACEs), child maltreatment (Radford *et al*. 2011)

Child Maltreatment – physical abuse, emotional abuse, neglect. The rate for the whole sample (15.2%)- life-time rate for the oldest 14 -17 years, (38.1%)

Physical abuse: harsh parenting, hitting, shaking, throwing, physical harm to a child

Emotional abuse: a parent's negative perceptions of a child's needs – justifying harsh punishment or sexual activity

Neglect: failure to perceive children's needs justifying failure to provide adequate care

Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships

Attempted or completed sexual act within the family or social context

Witnessing family violence,, sexual and domestic violence domestic abuse

Felitti *et al.*'s research on ACEs – Classic ACEs profile

Felitti *et al.* (1998) defined the forms of Adverse Childhood Experiences as:

- Forms of maltreatment – traumatic events
- Emotional abuse, physical abuse, sexual abuse, physical neglect, emotional neglect, mother treated violently
- Household dysfunction- chronic stressors
- Household substance abuse, household mental illness, Incarcerated household member, and parental separation or divorce

Indirect forms of Adverse experiences in childhood (ACEs): significant stressors (Young Minds 2018)

Dislocation complex family breakdown, separation, divorce, being looked after, adopted or leaving care, being detained in a secure children's service, migration, asylum seeking

→

Death of parent, primary carer or sibling in childhood, involvement in an accident, acquiring an illness or surviving a natural disaster

→

Bullying, experiences of enduring discrimination, harassment, hate crime, prejudice resulting from homophobia, sexism, racism,

↓

Adult responsibilities

Caring for adults or siblings in the family and engaging in child labour.

→

Exposure to parental mental health, substance abuse or incarceration exposure to variable states and inconsistent care.

Definition of Adverse Childhood Experiences (ACEs)

- **An ACEs profile is a cumulative risk score** – reflects challenges across multiple domains (Dube *et al.* 2001)
- Childhood adversities
- Adolescent outcomes
- Adult outcomes and Parenting completes the cycle.
- Mitigated by protective factors

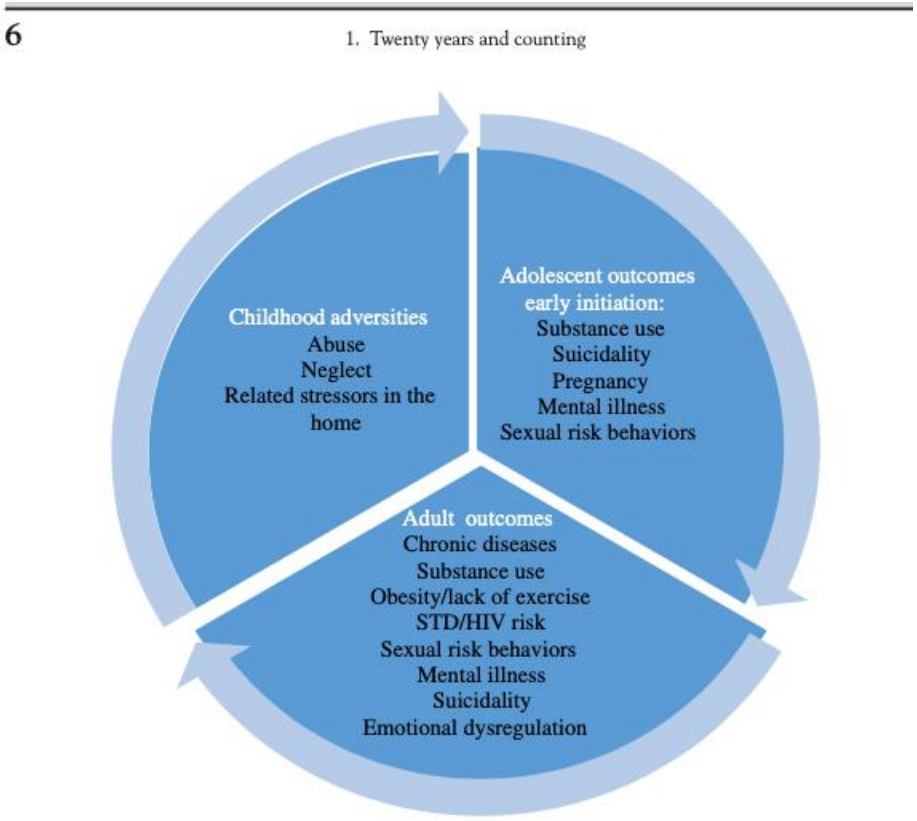


FIG. 1 The cycle and impact of ACEs across the lifespan and generations.

Expanding the range of Adverse Childhood Experiences

Turner et al. (2020) *Child Abuse & Neglect.* 107 104522

40 Adverse Childhood Experiences (ACEs) Eleven conceptual domains which predict trauma impact in childhood, family factors for younger children, community for older

Family instability - divorce homelessness

-**Family disorder** -mental health, drug, alcohol

-**Interpersonal loss** – death, illness, suicide

-**Natural disaster** – fire, flood, pandemics

-**Economic stress** - job loss, welfare

-**Child-maltreatment**-physical, sexual abuse

-**Exposure to community violence**

-**Threatened serious assault**, racial, homophobia,

-**Physical assault**

-**Sexual victimisation –** direct or on-line

-**Peer bullying –** cyber-bullying

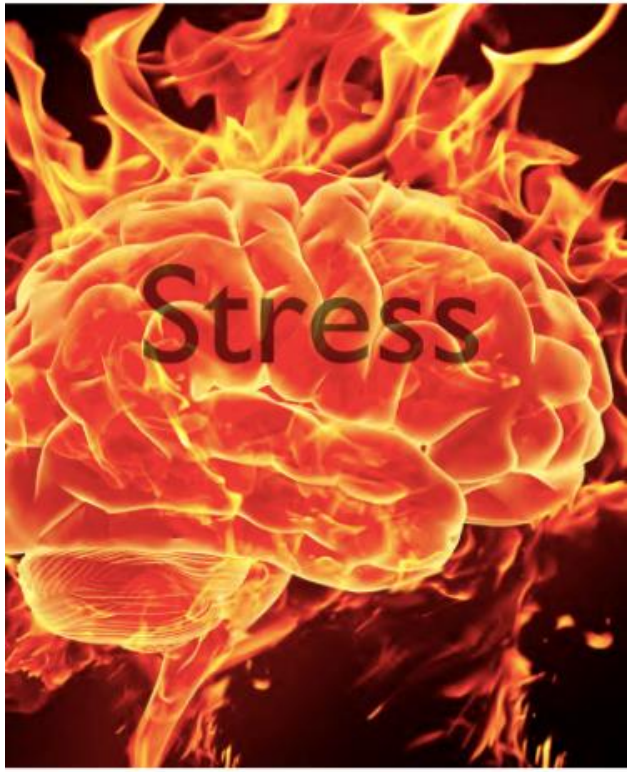
Multiple Adverse Childhood experiences

Hughes et al. (2017) meta-analysis multiple ACEs on health (37 studies, 253,719 individuals).

- **At least four recorded ACEs increased risk for poor health outcomes**
- ***modest*** **-** physical inactivity, overweight, obese, diabetes;
- ***moderate*** - smoking, heavy alcohol use, cancer, heart disease, and respiratory disease;
- ***strong*** for sexual risk taking, mental ill health, and problematic alcohol use;
- ***strongest*** for problematic drug use and interpersonal and self-directed violence.
- ----------
- **ACEs predicts at a population level** is a **risk** for the individual but not predictive

The role of stress

- **The core response of adversity is to evoke a stress response,** which can have short or longer-term effects
- **There can be 'positive manageable stress', linked to 'mastery', associated with short lived physiological responses,** buffered through social support, attachment figures. Relevant skills promote mastery and maturity. Exposure to reasonable stress promotes resilience
- **When children are exposed to extensive adversity 'Complex trauma' - without social support - this is now described as 'toxic stress' and can evoke 'traumatic responses'.** The core response of adversity is to evoke a stress response, which can have short or longer-term effects



The Goal of intervention with ACEs

ACE-informed practice

Based on the evidence of potential harmful impact of ACEs and complex overlapping mental and physical health responses, Hughes *et al.* (2017) argue that **ACE informed practice can (should) be developed across multiple settings**,

- including schools
- criminal justice agencies
- social care assessments of children and their families
- when children are showing evidence of being subject to maltreatment, with associated parental mental health, substance abuse, or conflict.

A programme of **routine enquiry**

(REAch) (McGee *et al*., 2015) identification of need and early intervention or access to services.

Introduction of **Trauma –Informed Practice**

The 4 Rs of Trauma Informed Care

Figure 7. SAMHSA's Four Rs of Trauma-Informed Care

Source: Adapted from Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). SAMHSA's concept of trauma and guidance for a trauma-informed approach. HHS publication no. (SMA) 14-4774. Rockville, MD: Author.

Interventions for maltreatment

- **Macdonald et al. (2016) identified 198 studies including 62 trials**, the majority effective for single forms of maltreatment
- **They noted many children had multiple forms of maltreatment**
- **Trauma Focused CBT** reduced traumatic symptomology, and associated symptoms of depression
- **Limited availability of interventions** to deal with the complex overlapping responses associated with multiple ACEs (Bentovim, Vizard & Gray 2018).

A modular common practice elements approach

A modular common practice elements approach

- **A modular common practice element treatment approach** - therapeutic procedures for specific presenting problems from an **empirically derived bank** (Chorpita & Daleiden, 2009)
- **Common practice elements -** derived from single-focal treatment manuals (Chorpita & Daleiden, 2009) identified from more than **1,000 randomized control** trials and catalogued into an online searchable database (PracticeWise, 2018)

The MATCH-ADTC

- Chorpita and Weisz (2009) **MATCH-ADTC (Modular Approach to Therapy for Children with Anxiety, Depression, Trauma and Conduct),**
- **An intervention system** that incorporated **treatment procedures (elements) and treatment logic (coordination)** corresponding to four successful evidence-based interventions for **childhood anxiety, depression, and conduct problems, and trauma -** modifications allow the system to operate as a **single protocol.**
- The MATCH approach **out-performed focal treatment manuals** for anxiety, depression and disruptive conduct and was superior on clinical out- comes and functional outcomes (Weisz *et al.* 2012, Chorpita *et al*. 2013; 2017).

Developing the *Hope for Children and Families* Intervention Resources.

- **'Hope for Children and Families Intervention Resources' *(HfCF) builds on and includes MATCH model***
- ***47 common practice elements*** from **22 evidence-based RCTs preventing maltreatment** added
- ***Common factors* framework** personal and interpersonal components of intervention e.g. alliance, client motivation, practitioner factors
- Focus on children, parents and the family, organised around the ***Assessment Framework***
- Accommodates **limitless presentations of children, parenting and families**

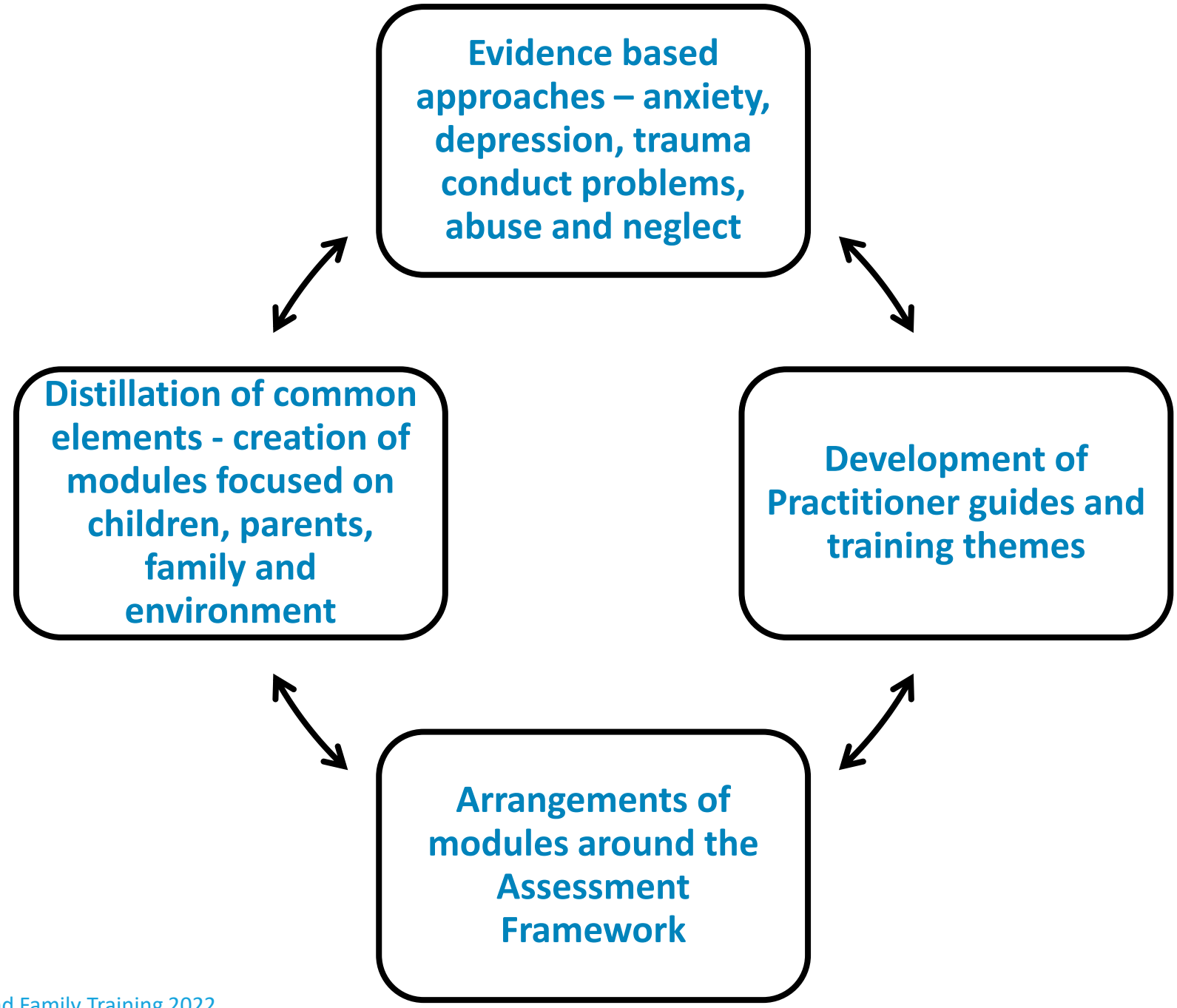
Examples of Common Practice Elements With children and young people

Psychoeducation and abuse specific

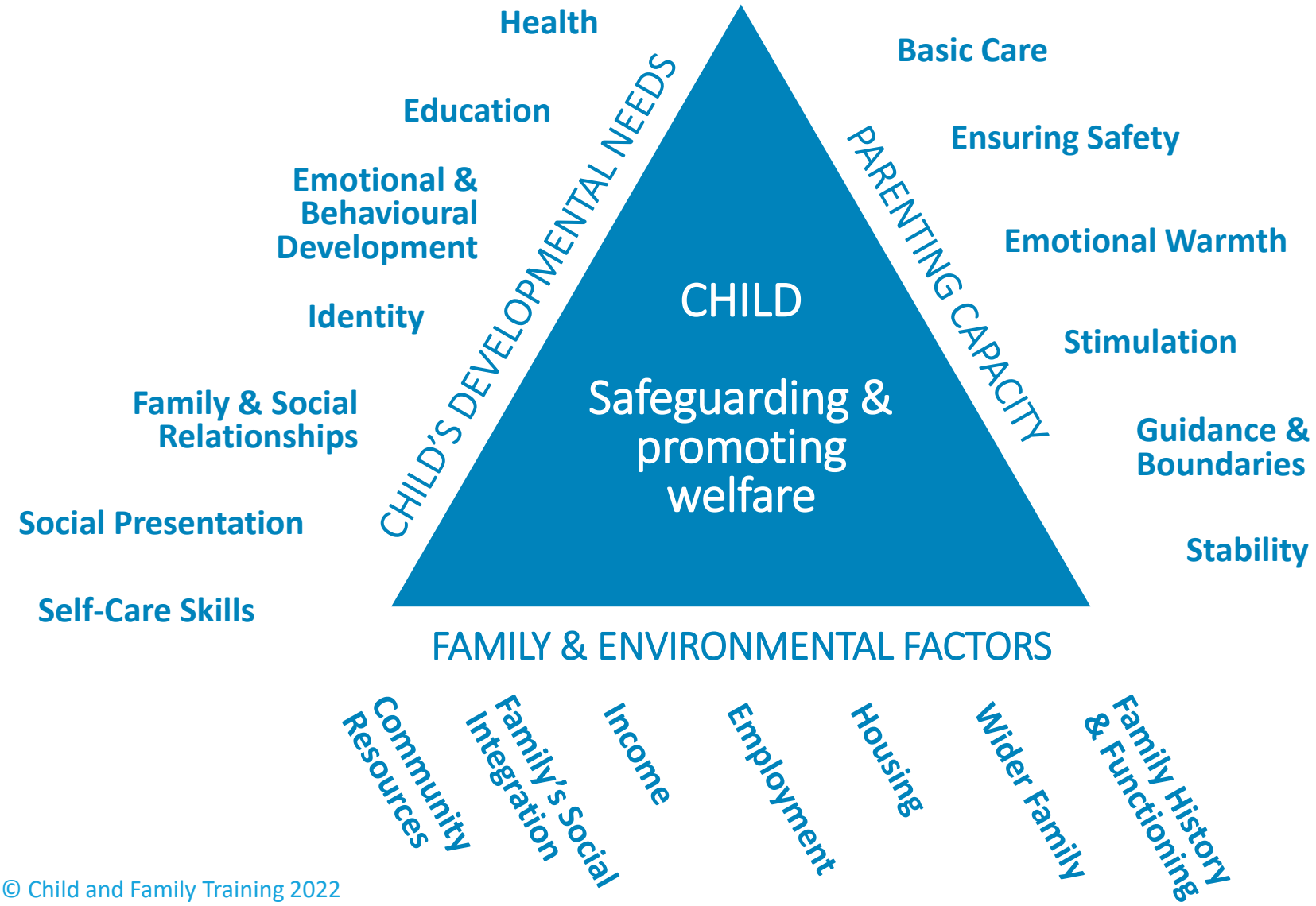
- Impact of abuse
- Creating a trauma narrative of stressful traumatic events
- Managing and exposing traumatic thoughts, feelings
- Managing harmful angry & sexualised behaviour.

Generic interventions

- Communication, Safety skills
- Relaxation, Problem-solving. Relationship building. Social Skills Talent/Skill Building
- Self-Reward/Self-Praise
- Self-Monitoring
- Assertiveness



Assessment Framework (DH *et al.* 2000)
A map of relevant data to be collected



Components of the guides

Each module includes:

- **Practitioner briefings** summarising theory, research, and approach
- **Content and materials** focusing on children, young people, parents, or families.
- **Relevant steps** to achieve an evidence-based goal, and the particular focus
- **Suggested scripts** for working with children, parents and families, to help practitioners understand the aim of the module and practitioners find their own voices and approaches
- **Guidance notes** - understanding the background to the particular steps
- **Activities** supported by worksheets to help achieve a particular planned outcome
- **Practice – role plays** and **coaching approaches** reinforce learning
- **Handouts for parents** to remind them of particular approaches outlined
- **Worksheets** for children and parents to negotiate the various steps.

Relevant steps

To achieve an evidence-based goal, and the particular focus

Introduce problem-solving S-T-E-P-S

Describe each step and encourage the child to give you specific detailed examples.

S: Say what the problem is: Describe it specifically and concretely.

T: Think of solutions: Brainstorm at least three solutions.

E: Examine the solutions: Identify the pros and cons of each, including the likely consequences.

P: Pick one and try it out: Use the 'pros and cons' to choose the best solution.

S: See if it worked: What was the outcome? If it didn't work, choose another solution to try.

You can practise using S-T-E-P-S in the session with a fun problem like moving an object from one part of the room to another without using hands.

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The value of a modular, multi-focal, therapeutic approach to addressing child maltreatment: *Hope for Children and Families Intervention Resources* – a discussion article

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ABSTRACT

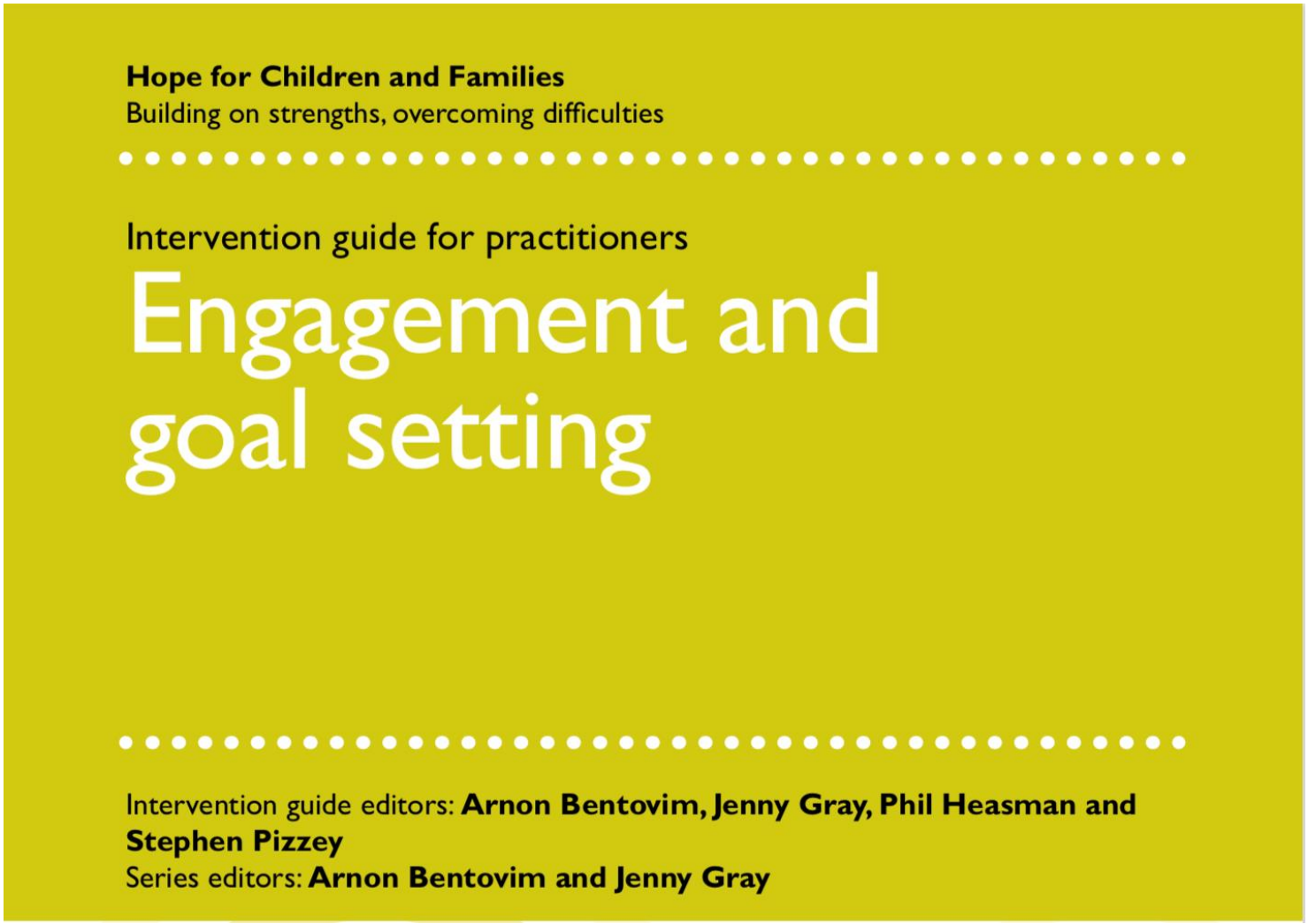
This discussion article begins by highlighting two trends apparent in the field of child maltreatment. The first, an awareness that multiple forms of maltreatment – polyvictimization - is the rule in populations of abused and neglected children rather than the exception. The second is that current types of child maltreatment are being extended to include Adverse Childhood Experiences (ACEs). These include intra-familial violence, mental health, substance misuse, and inter-generational abuse. The paper introduces an innovative strategy to help the field better organise and prevent the extensive sequelae of polyvictimization and ACEs. This strategy involves

Create an ecological trauma informed model of intervention based on a holistic assessment

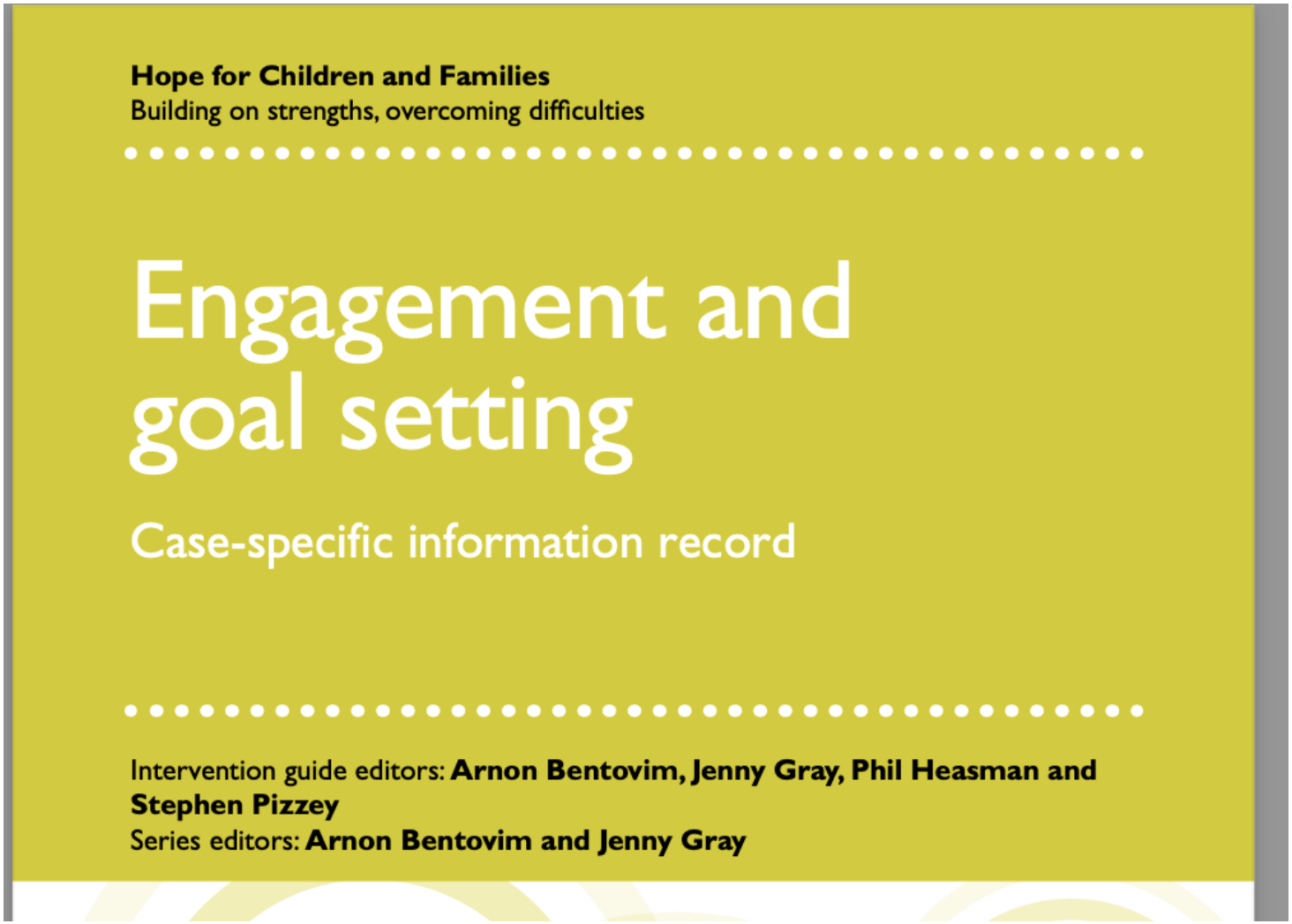
Department of Health *et al.* (2000) *The Framework for the Assessment of Children in Need and their Families.*

A parallel development to ACEs

Engagement and goal setting guide (ES)



Engagement and Goal Setting – Case specific information record (CsIR)



Engagement and goal setting (ES & CsIR): Contents

Briefing papers

- Engagement, establishing a profile for intervention, goal setting and measuring progress (ES-B1)
- Engaging children, parents and families: Promoting hopefulness and establishing goals (ES-B2)

Modules

- Engaging children, parents and families: Promoting hopefulness (ES-M1)
- Goal setting (ES-M2)

Materials for use in sessions

Case-specific information record (CsIR)

Assessment, analysis, planning and reviewing and interventions: A seven-stage model (ES-B1, pp. 1-2)

(Pizzey et al. 2016; Bentovim et al. 2017)

Stage 1: Consider the referral and aims of the assessment

Stage 2: Gather information on the child's developmental needs, parenting capacity and family and environmental factors

Stage 3: Organise the information using the Assessment Framework and a chronology

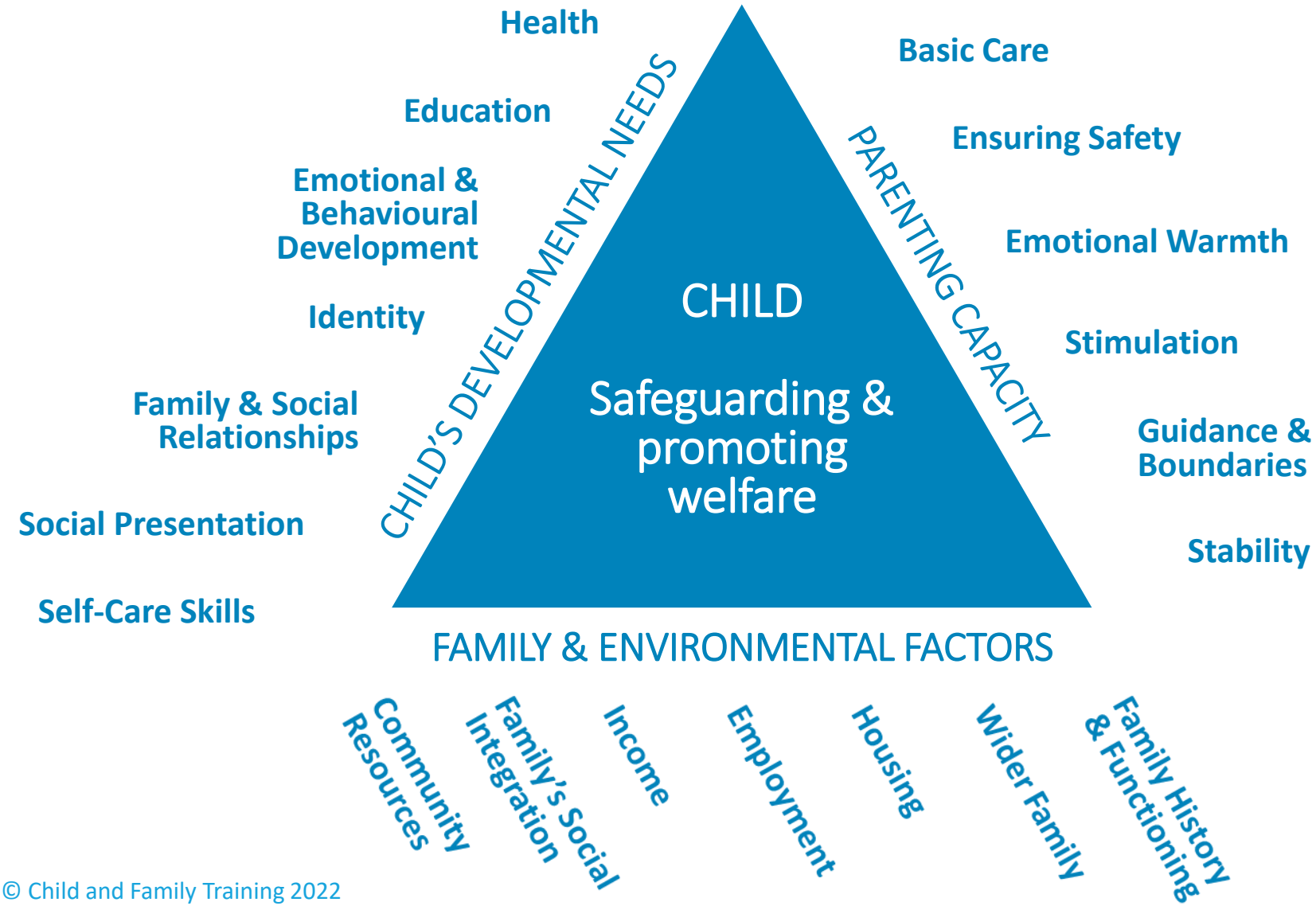
Stage 4: Analyse the patterns of strengths and difficulties

Stage 5: Make judgements based on a systemic analysis

Stage 6: Make decisions and develop a plan of intervention

Stage 7: Implement the plan of intervention, monitor and review progress

The Assessment Framework (a map of relevant data to be collected)



Principles Underpinning the Assessment Framework

Assessments:

- are **child centred**
- are **rooted in child development**
- are **ecological** in their approach which means **the child must be understood within the context of their family** and this includes the:
  - role of economic disadvantage
  - cultural context and cultural norms
  - impact of supportive extended family and friendship groups; and
  - the main areas which need to be taken account of include:

    child's developmental needs

    parents or caregiver's capacity to respond appropriately

    wider family and environmental factors.

Stage 1: Consider the referral and the aims of the assessment (ES-B1, p. 2 & CsIR, pp. 3-4)

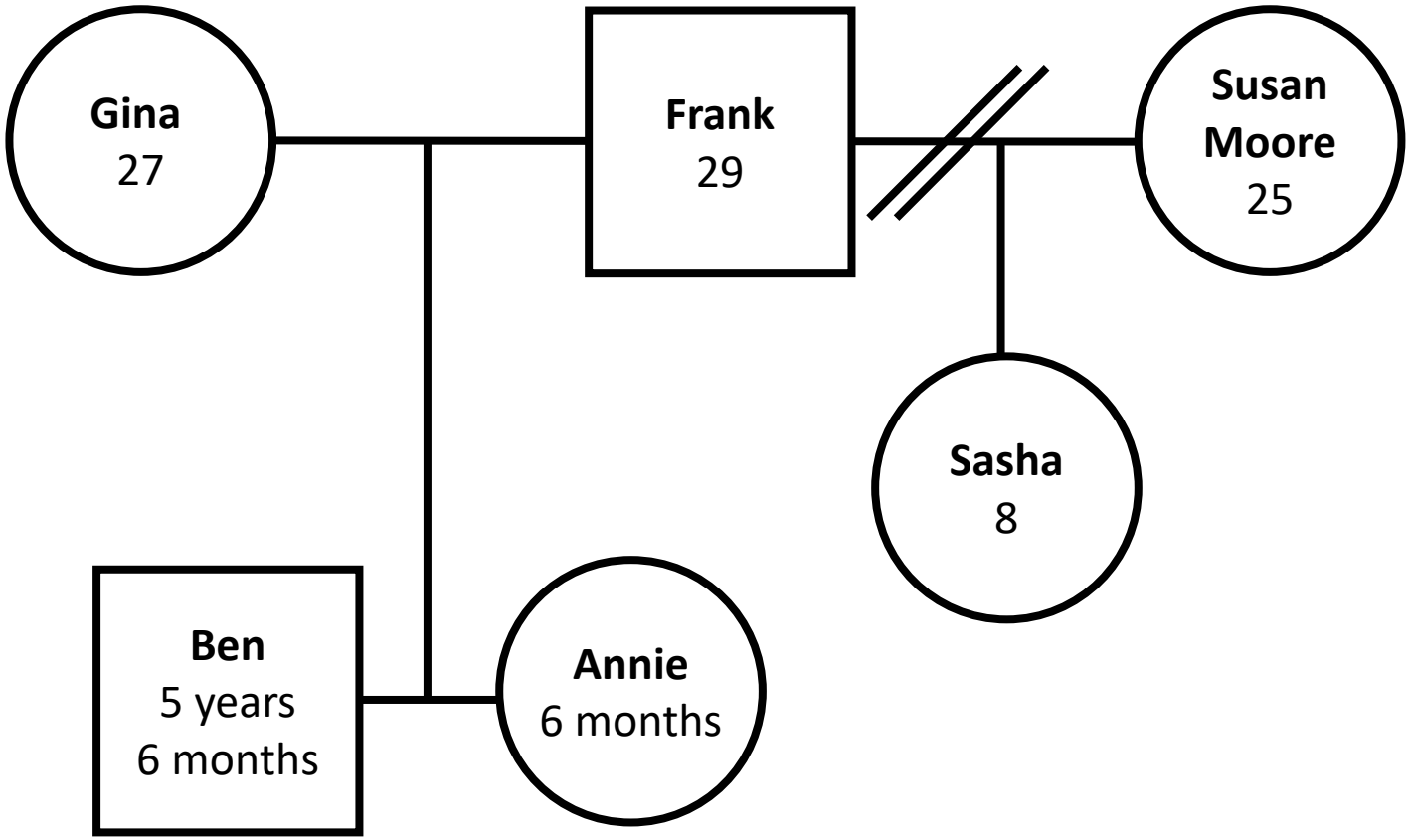
Stage 1 involves:

- Considering whether the child is at immediate risk of suffering harm
- Reviewing the referral information
- Establishing the focus and aims of the assessment

Engaging children, parents and families: Promoting hopefulness (Module ES-M1, pp. 17-22) provides approaches for initial meetings

The *Case-specific information record* provides a template for recording relevant information

Stage 1: Case study
Ben Bradshaw



Stage 1: Ben Bradshaw
Referral from health visitor

The health visitor reports that Gina Bradshaw is:

- caring well for Annie who is thriving
- making over frequent visits to GP with Annie
- finding Ben's behaviour increasingly difficult to manage

The health visitor is concerned about:

- Ben's aggression towards Annie
- Gina's hostility and high level of verbal aggression towards Ben

Stage 1: Ben Bradshaw
Additional referral information

Information from school:

- Hit teacher and aggressive to other children

Historical information:

- First 9 months poor weight gain and frequent minor accidents as a toddler questioning supervision; social services twice involved

- Aged 2 fractured elbow and dislocated shoulder.
  - Inter-agency strategy discussion, child protection enquiries by police, health and social services.
  - Gina reported pulling Ben away from electric stove. Professionals accepted explanation

Gina Bradshaw: Background History

Gina Bradshaw had a troubled adolescence and early adulthood:

- truanting, aggression to staff and exclusion from school
- running away from home and accommodated by local authority
- extensive drug use
- termination aged 15
- series of violent relationships
- overdosed twice
- convictions for shoplifting to fund drug habit

Frank Bradshaw: Background History

Frank Bradshaw's early experiences included:

- disruption in early childhood – older brother aged 8 sent to grandparents
- regular school attendance
- occasional drug use
- a series of brief relationships
- unhappy relationship with Susan mother of his daughter, Sasha
- lost contact with Sasha following court proceedings
- clinical depression.

Stage 2: Gathering Information

Watch short extracts from:

- a *Family Assessment* interview with the whole family

Take detailed notes of what observed and what reported

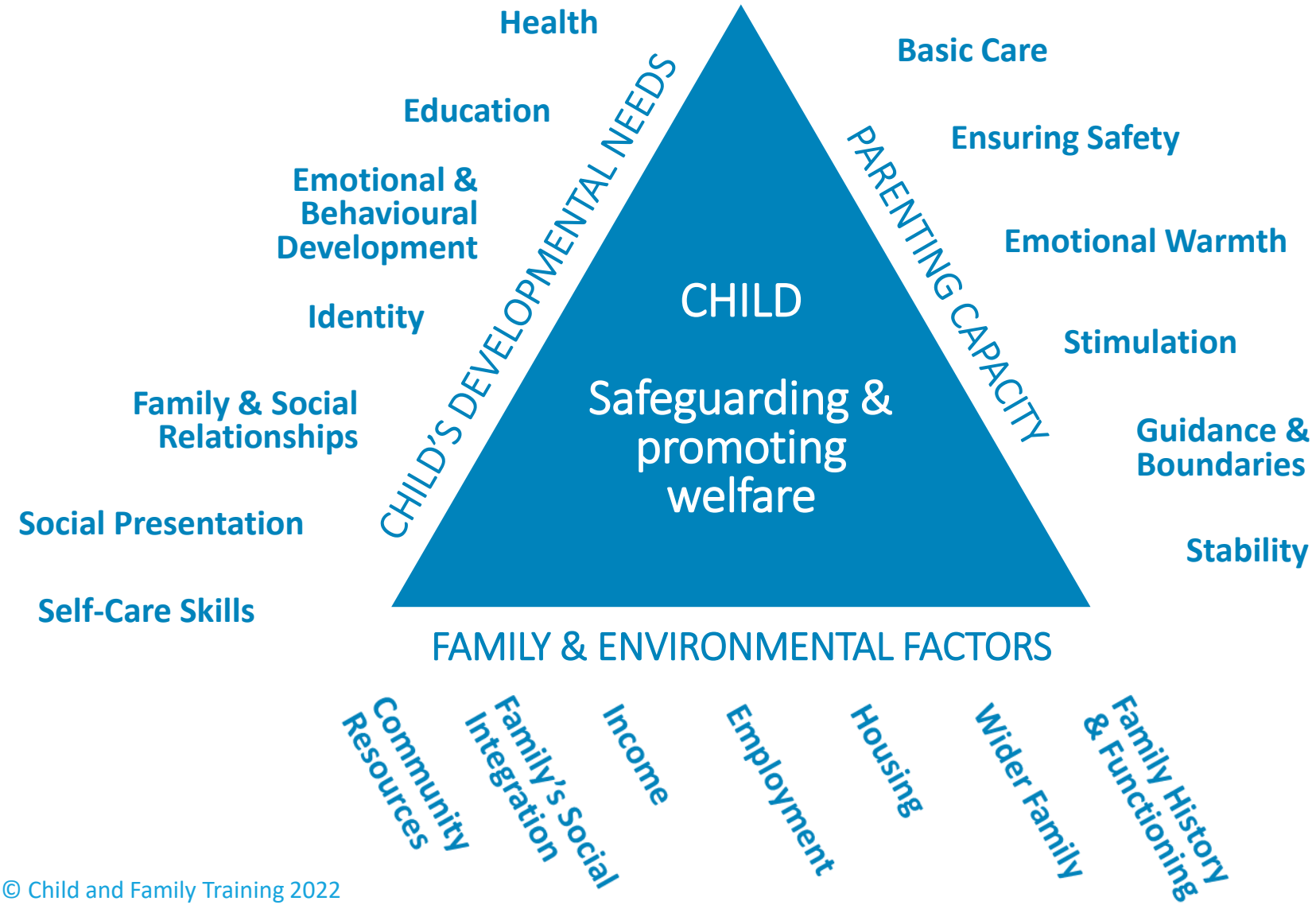
The Family Assessment: Assessment of family competence, strengths and difficulties (Bentovim and Bingley Miller 2001)

- **A systemic approach:** Engages with all members of the family,
- **Explores family life** through interviews and tasks, observing, describing and assessing family life and relationships, parenting and the impact of family history

Interviewer: Liza Bingley Miller


4:00:00

Stage 3: Organise the information using the Assessment Framework (a map of relevant data to be collected)



Stage 3: Organise information using the Assessment Framework (ES-B1, p. 3)

In pairs, record information on the Assessment Framework (Handout 1) in the following dimensions:

- Emotional & Behavioural Development
- Family & Social Relationships
- Emotional Warmth
- Guidance and Boundaries
- Family Functioning

Refer to the description of each dimension (Handout 2, pp. 12 to 19)

Organising information using the Assessment Framework triangle

Ensure that data (information) is placed in the appropriate dimension and domain by recording:

- Into the **Child's Developmental Needs** domain enter things that **Ben says, does, and is reported and observed to do**
- Into the **Parenting Capacity** domain enter things that **Frank and Gina say, do, and are reported and observed to do**
- Information about **family history, parental mental health, relationships and physical and social context** place in the **Family and Environmental Factors** domain

Stage 3: Organise the information using the Assessment Framework (CsIR, p. 7)

Focus on evidence and record what was actually observed or reported:

Note strengths as well as difficulties

'Hypotheses' should be noted and 'put on hold' until all the information has been organised

Parental problems such as domestic abuse, substance misuse and mental illness should be noted under 'Family history and family functioning'

Indicate where there are differences of views

Check: what is not yet known which it is important to know?

Organising the information gathered

How did you find

the process of organising the information

using the *Assessment Framework*?

Stage 4: Analyse patterns of strengths and difficulties (ES-B1, pp. 4-5)

- What is central is whether there is impairment or likelihood of impairment of the child's health and development.
- Difficulties/impairments in Parenting Capacity or broader Family and Environment **may or may not** be producing impairments in the child's development.
- In analysing the organised information consideration should be given to:
    - **Processes** – the pattern of influences; and
    - **Impact** – the weight/effect of factors/processes

Stage 4: Summary of principles underlying analysis

In general:

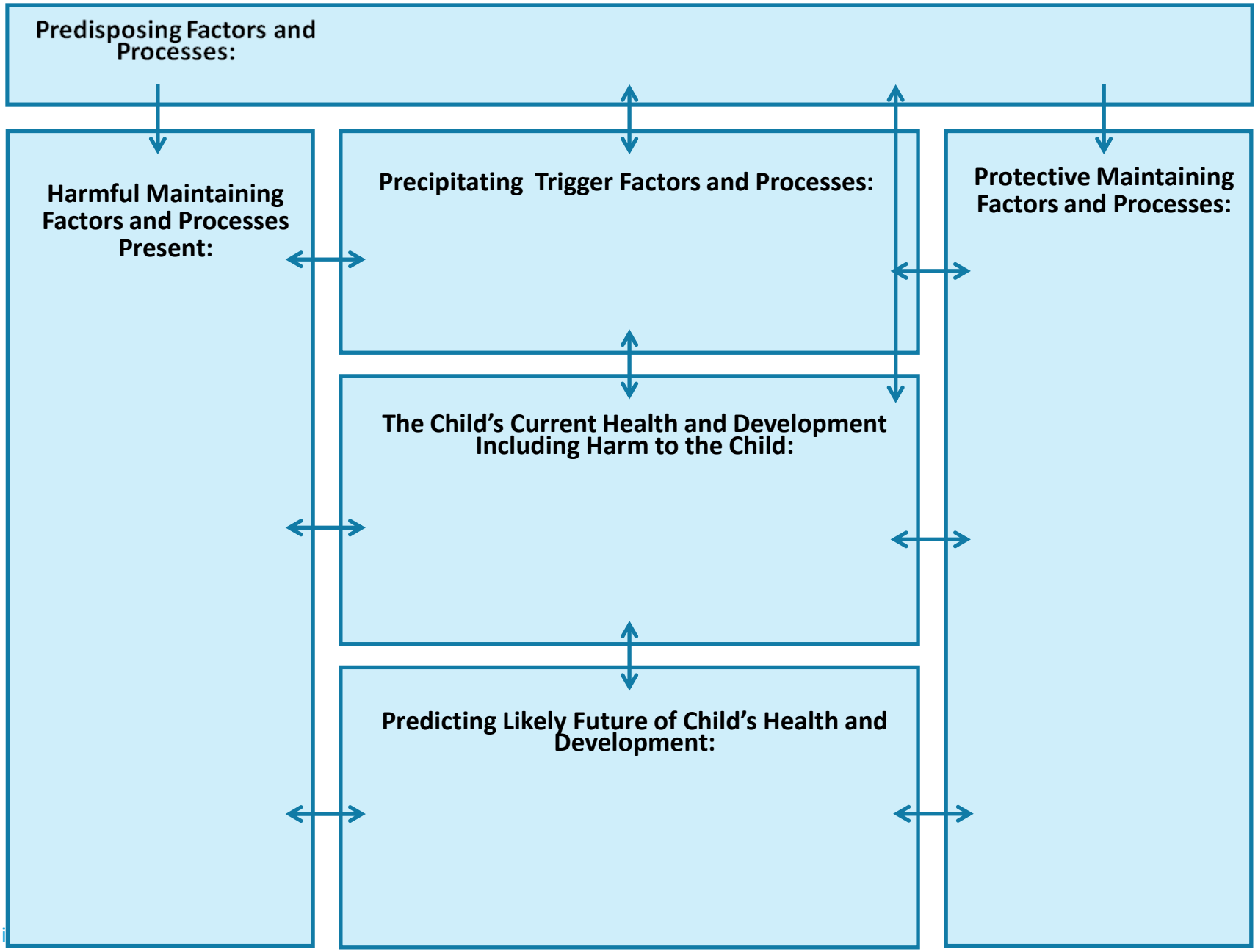
- the more dimensions of domains that show difficulty;
- the more frequently those difficulties are manifest;
- the longer the difficulties have existed;
- the less the difficulties are modifiable;

then the greater the severity of the problem

Stage 5: Make judgements based on a systemic analysis (ES-B1, pp. 5-7 & CsIR pp. 13-16)

- Predict the likely outlook for the child if nothing changes (the systemic analysis)
- Consider the resources available that protect the child and/or promote their health and development
- Determine the prospects for successful intervention
- Summary of analysis and evidence

Systemic Analysis (CsIR, p. 14) (Weerasekera 1996 & Bentovim *et al* 2009)



Exercise: Systemic Analysis: Predicting the outlook for Ben

Complete the Systemic Analysis for Ben (Handout 3) and consider:

- What is the outlook for Ben's health and development if nothing changes?
- What are the risks of re-abuse and future harm?

Gathering further information

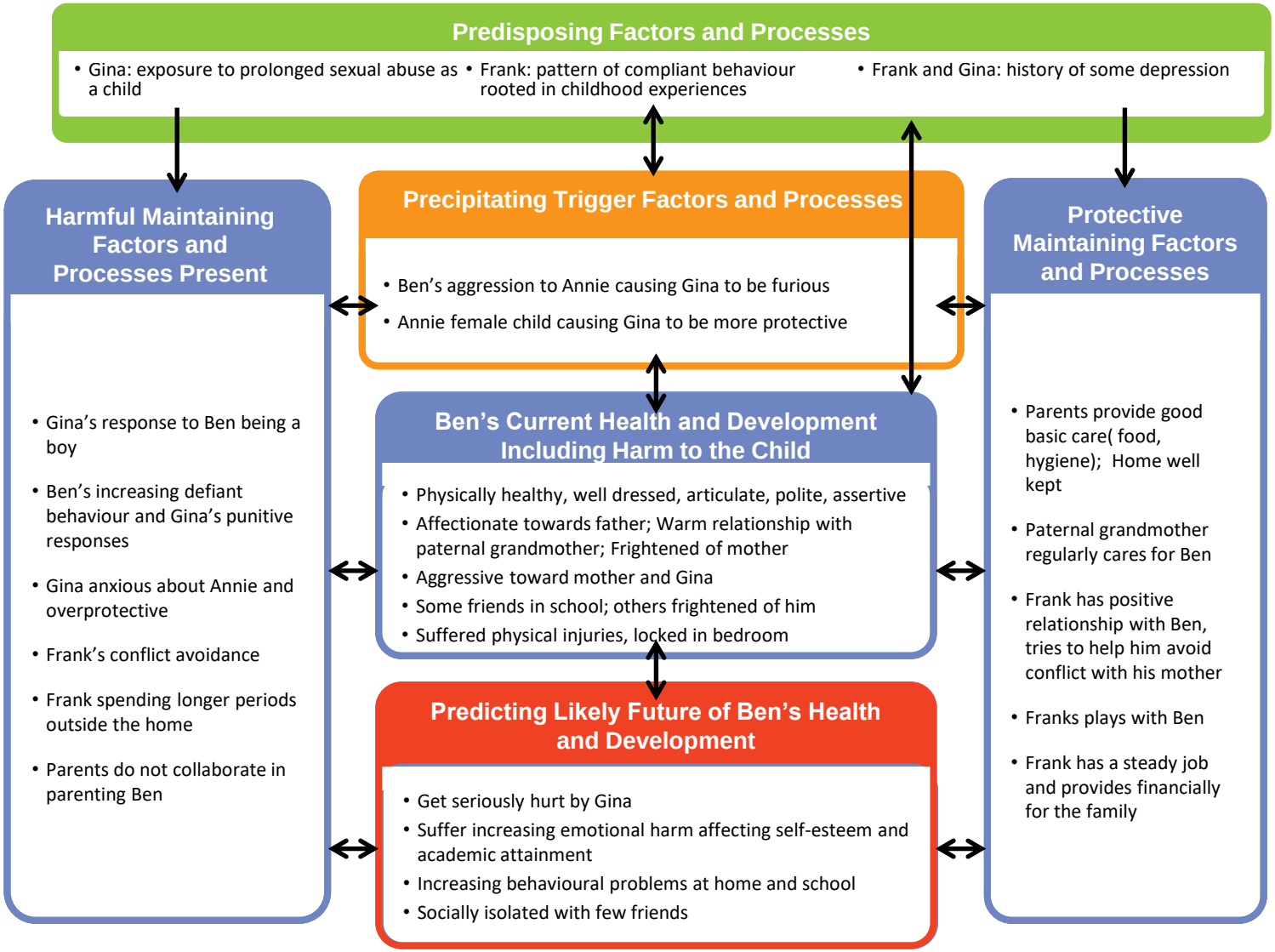
Gina had indicated to the worker that there was something she wanted to talk about and she wanted Frank to be present during the interview

Watch further extracts from:

- A *Family Assessment* interview with Frank and Gina about their history; and
- Take detailed notes of what was observed and what was reported


AFCSD
With the Bradshaws, we're looking

Ben Bradshaw: *Systemic Analysis*



Analyse the prospects for successful intervention: Ben Bradshaw

***Case-specific information record*, pp. 15-16**

Consider the prospects for successful intervention with Ben and his family (p. 15)

- nature of harm suffered and the child or young person's wishes and feelings
- the capacity of the parents to recognise, understand, acknowledge and take responsibility for difficulties (Parental child-centredness)
- the parents level of motivation and capacity for change regarding the identified difficulties (Modifiability); and
- whether the child's circumstances can be improved with safety within a reasonable period taking account of the child's developmental timeframe
- parent's ability to co-operate with professionals and agencies

Prognosis for change chart (p.16)

Prognosis for Change (CsIR, p. 16)
(Bentovim et al 1987; 2009)

Hopeful prognosis:

- Good possibility of change within child's timeframe
- Reasonable degree of responsibility taken
- Reasonable flexibility of relationships and balance of family strengths and difficulties
- Potential for individual change with facilities and resources available
- Not too negative an attitude to professionals

Poor prognosis:

- Child subject of serious abuse
- Failure to take responsibility
- Considerable family difficulties with few strengths
- Severe parental pathology, personality disorder or level of addiction which implies changes cannot be made in child's timeframe
- Resources unavailable to intervene given severity of situation
- Negative attitude to professionals

Doubtful/Uncertain prognosis:

- Whether or not change can be achieved within the time frame of the child?
- The degree of responsibility taken?
- The potential for collaborative work?

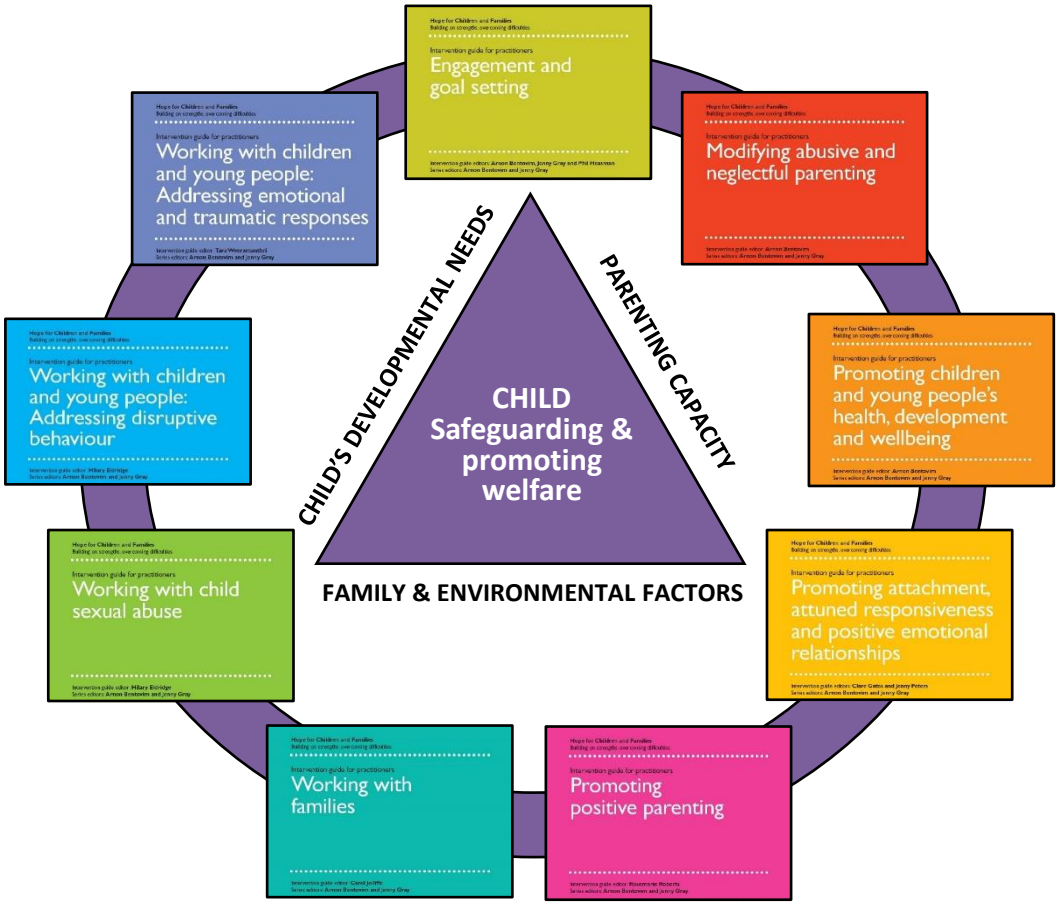
Therapeutic Interventions Stages 6 and 7

Stage 6: Make decisions and develop a plan of intervention (ES-B1, pp. 8-11)

- What are the **options** for interventions which might:

  (a) help support strengths in health and development and/or

  (b) help meet impairments in health and development?
- Towards which strength/impairment in health and development is each intervention **targeted**?
- What **resources** are available?
- Which of those available is the family most likely to **cooperate** with?
- Which intervention is likely to produce the most **immediate** benefit and which might **take time**?
- What should be the **sequence** of interventions and why?
- What is the likelihood of achieving **sufficient** change within the **child's timeframe**?



Working with child sexual abuse

Safety and care for children and young people abused in the family

Parents/carers support work with children responsible for harmful sexual behaviours

Working with younger and older children displaying harmful sexual behaviours

Addressing emotional and traumatic responses

Create a positive emotional environment for Ben through individual work:

- psychoeducation to help Ben understand his experiences and reducing his self-blame,
- promoting Ben's capacity to be safe:
  - learn problem solving skills,
  - learn about feelings,
  - develop relaxation skills and cope with stress,
  - find activities to 'feel better',
  - improve his social and peer relationship skills and integration
  - into school
- Interventions to reduce traumatic responses:
  - construct trauma narrative with Ben

Implement the plan of intervention, monitor and review progress (1)

(*Case-specific information record* (C-sIR), pp. 23-31 & 33-42 and *Engagement and goal setting*, p. 12)

In stage 6 the **measures to be used to assess change** following **the planned interventions** are set out in the:

- '*Measures to assess change*' column of the *'Goals, priorities, resources and outcome measures'* recording form, (section 6.4, C-sIR pp. 23-31)

In stage 7, when **implementing the plan of intervention, monitoring and reviewing progress** use:

- The record of **the resources actually used** is set out in the:
- *Record of resources used and views on how effective they are when working with this child and family* form (section 7.1, C-sIR pp. 33-34)
- The **review** of whether the goals set out in the plan (section 6.4) were achieved and the areas requiring work is set out in the:
- *Review of goals and notes for further work* form (section 7.2, C-sIR pp. 35-36).

Make decisions and develop a plan of intervention: Using the *Case-specific information record* (2)

(*Engagement and goal setting*, p. 11 and *Case-specific information record* (C-sIR), pp. 17-32)

The *Goals, priorities, resources and outcome measures* recording form enables practitioners to set out the **specific goals and priorities** within the plan and record the resources to be used.

It invites practitioners to:

- identify specific intervention goals
- indicate priorities
- note the HfCF intervention resources and other resources thought to be helpful in work with the child and family
- note the measures to be used to assess change

(section 6.4, C-sIR pp. 23-31)

Summarise the plan of work in the *Summary of priorities and planned order/sequence of work* form

- this can be used in conjunction with the *Management plan.*

(section 6.5, C-sIR pp. 32 and Engagement and goal setting, (ES-4), p. 36)

Module (ES-M1)
Engaging children, parents and families: Promoting hopefulness

***Engagement and goal setting*, pp. 17-22**

The main steps in this module includes:

- Reason for the child and family being referred to the practitioner
- Establishing a team around the child
- Discussion with parents and child about child protection concerns and expectations (where appropriate)
- Discussion of the practitioner's understanding about when children are harmed
- General statement about what can go wrong in families
- Addressing specific types of maltreatment
- Discussion of the benefits of working with the practitioner
- Special cases: When families are not together

Reason for the child and family being referred to the practitioner

Engagement and goal setting, pp. 18

This step includes:

- During introductions with the child, parents and referrer, remind the family:
  - how the current situation has arisen
  - the reason the child and family have been referred to the practitioner
  - of any child protection concerns.
- Indicate that the outlook may be positive provided the family, parents and child work with the practitioner to:
  - address and overcome difficulties, and build on strengths to prevent future impairment/harm and
  - ensure the child or young person's health, development and wellbeing.
- If children's social care services or the court are involved and the practitioner is from an organisation other than children's social care:
  - make clear that they will continue to be concerned about the child's progress, and
  - will want regular reviews and reports.

Establishing a team around the child

Engagement and goal setting, pp. 18

A team around the child is an essential supportive structure. This may include:

- extended family members, if involved in the care or support of the child
- the allocated practitioner and their line manager/supervisor
- health, education/school, social care or criminal justice professionals who may be involved with the child and family members
- foster carers or residential workers, if at this point the child is living in alternative care.

Discussion with parents and child about child protection concerns and expectations (where appropriate)

***Engagement and goal setting*, pp. 19**

Ascertain the child and the parents' views of the concerns about abuse or neglect that have been raised/identified. **Be clear that you understand**:

- the child and the parents' views as well as
- the concerns of children's social care, or the court if involved.

The authority for intervention lies in the concerns about the child's health, development, wellbeing and possible impact on them of abusive or neglectful parenting.

Whilst supporting and helping the parents to build on strengths and overcome difficulties:

- children and young people have to be supported, be safe and their development safeguarded.

Sometimes **adverse factors are overwhelming** and cannot be modified sufficiently within the child's timeframe.

Exercise: Discussion of the practitioner's understanding about when children are harmed

***Engagement and goal setting*, pp. 19-21**

Establish a **mutual understanding** with the child and family:

- select the statement that most closely fits the child and her/his family's context and practice using it (p. 19)

Help the family see you have a **clear picture of how things can go wrong in families**, which result in a child being harmed or being at risk of being harmed

- practice using the *General statement about what can go wrong in families* (p. 20)

See *Guidance for practitioners in discussing various forms of child maltreatment with families* (ES-1) pp. 30-32. The scripts refer to different types of maltreatment, as well as health concerns :

- choose the maltreatment description(s) which best fits the family from the information that is available, (pp. 30-32)
- make the discussion of these different types of maltreatment into a conversation with the parents and children (p. 21).

Discuss the benefits of working with the practitioner (p. 21 & ES-2, p. 33)

- "many parents find it helpful to …"

Module (ES-M2)
Goal setting

***Engagement and goal setting*, p. 23-28**

Goal setting

Engagement and goal setting, pp. 23-28

The main steps in this module include:

- Discuss the children's, parents' and professionals' views about goals
- Discuss potential collaborative goals
- The child and family agreement
- Family safety plan
- Making an agreement
- Special cases: A solution-focused approach to establishing goals

Goal setting

***Engagement and goal setting*, pp. 24-25 and ES-3 & ES-4, pp. 34-36**

Discuss the children's, parents' and professionals' views about goals

- Discussion of professionals views and the referral (p. 24)
- Ways for the practitioner to communicate a sense of hopefulness (ES-3, pp. 34-35)

Discuss potential collaborative goals

- Discussion about the management plan (p. 24)
- Management plan: Practitioners and parents (ES-4, p. 36)

The child and family agreement

- Scripts to help engagement in forming an agreement (p. 24)

Goal setting: Family safety plan

***Engagement and goal setting*, pp. 27-28 and ES-5 pp. 37-38**

Family safety plan (p. 27)

- the family safety plan is in place for the duration of the intervention
- the goals should be aimed at achieving some of the goals of the overarching plan for the child

Making an agreement (p. 28 & pp. 37-38)

- the child's timeframe in terms of what would be expected on the basis of impairment to the child's health and development/the risks of harm and the prospects for intervention
- the arrangements for liaison with other professionals and ongoing assessment of change
- the likely consequences if it were not possible to achieve the success the agreement is seeking

A solution-focused approach to establishing goals (p. 28)

Review – application to work context?

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