State of Palestine

Social Work Curriculum including Child Protection Modules
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Acknowledgements

The child protection sector is particularly challenging, as it works to uphold the rights of children from increasing levels of both political and community violence. Its goal is to ensure that every child, irrespective of background or circumstance, has an equal chance to fulfil their innate potential.

Children are one of the most vulnerable groups in society and are often the main victims of violence. Bethlehem University’s mission is to provide the young generation with increased opportunities to learn, act, and live. Every year, Bethlehem University graduates around 750 students, 35 of them are graduated of social work.

It is with great pleasure that we present to you this curriculum that focuses on child protection. Hence, we see our contribution in preparing this curriculum a fulfillment of our mission. We hope that through this curriculum we are able to provide local and international academics and child protection actors an important reference and resource for working with children in need of protection.

The curriculum is a teaching tool for social work students, and a specialized training material for teachers, social workers, and parents.

This work is the fruit of a close collaboration with The United Nations Children’s Fund (UNICEF) and Royal Melbourne Institute of Technology RMIT. We acknowledge and thank all those who contributed to the preparation and publication of this curriculum. In particular, we thank the faculty members of the Department of Social Sciences at Bethlehem University for all their efforts and long hours of dedicated work in preparing the curriculum.
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## Child Protection Modules

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Module 1:

Human Rights, ethics and values in Social Work

To the tutor: This module is core to social work as it describes the foundational philosophies of human rights and social justice and how to apply them in social work practice through ethical decision making. The International Federation of Social Workers’ Code of Ethics commits social workers globally to these principles, challenging some people’s culture, religion and local practices.

Module Description

In the face of economic and social inequality, social workers need to identify and advocate for people’s human rights and work alongside people who are oppressed and marginalised within society. In this module we will not only look at what are human rights but trace the development of human rights over history. We will explore how to practice human rights using different ethical decision making models.

Module Outline

1. Definition of Human Rights
2. Origin of Human Rights
3. Critique of the notion of Human Rights
4. Why Social Workers need to think about Human Rights
5. How to practice Human Rights
7. Inclusive Ethical Decision Making
8. The DECIDE model for ethical decision making

Module Assessment

Assignment: Ethical legal contexts of social work practice  2000 words  50%
Task: Use one of the scenarios used in the course to demonstrate:
   a) your analysis of human rights abuses and the International Federation for the Code of Ethics for Social Work (IFSW) and how the Personal Support Worker (PSW) Codes of Ethics principles would guide your responses to the situation.
   OR
   b) how you could apply an inclusive model of ethical decision making with the person/s in the case Assignment: Select one of the case scenarios discussed in class and use either the Inclusive Ethical Decision Making (McAuliffe and Chenoweth, 2008) or the DECIDE model for ethical decision making (Lonne, Harries, Featherstone and Gray, 2015).

Lecture

1. Definition of Human Rights

Human rights are those entitlements that people possess simply by virtue of their humanity. They are considered to be universal - that is, they belong to everyone, regardless of their gender, age, ethnicity, religion or sexual orientation, simply on the basis of being human; *indivisible* because they are all equally important and *inalienable* because another person, government, organisation or other entity cannot take them away’ (Nipperess and Briskman, 2009).
2. Origin of human rights

Many principles of international human rights law have their roots in ancient societies and religions. Confucian thought is based around the teachings of Confucius, an ancient Chinese philosopher. In Confucian belief, individuals in society are dependent on each other and are encouraged to show respect to all. There is a strong degree of family piety and individuals are obliged to contribute towards a harmonious society. Mo Tzu followed from Confucian thought to propose that justice should be administered in society in a humane way so that the interests of all people are met. A similar perspective can be found in Islam where people are obliged to provide for Allah, each other and to cultivate wellbeing (AHRC, 2017). In Judaist, Muslim and Christian texts respect for life and for property of others, caring for the most vulnerable and forgiving one’s enemies are outlined.

Similarly, Buddhist teachings promote the value of compassion as a means of ending suffering, with a focus on human rights in the next life as well as the present moment. Codes associated with ancient rulers such as Menes, Hammurabi, Draco, Solon and Manu outline standards of conduct for their societies, which existed within limited territorial jurisdictions. Some of these codes have been interpreted as an acknowledgement of human rights.

The Greek and Roman empires gave free male citizens certain political rights. Human rights have originated in many different societies. Their development has occurred through moral and religious codes and through legal frameworks (AHRC, 2017).

The first known declaration of rights was in 539 BC when Cyrus the Great king of ancient Persia freed the slaves of Babylon, established racial equality and declared that all people had the right to choose their own religion. The idea of human rights spread to India, Greece and Rome. Documents asserting individual rights, such as the Magna Carta (1215), the Petition of Right (1628), the US Constitution (1787), the French Declaration of the Rights of Man and of the Citizen (1789), and the US Bill of Rights (1791) are the written precursors to many of today’s human rights documents (AHRC, 2017).

The Universal Declaration of Human Rights (UNDHR 1948) was adopted by the UN General Assembly on 10 December 1948 as a result of the experience of the Second World War. With the end of that war, and the creation of the United Nations, the international community vowed never again to allow atrocities like those of that conflict to happen again. World leaders decided to complement the UN Charter with a road map to guarantee the rights of every individual everywhere. The document they considered, and which would later become the Universal Declaration of Human Rights, was taken up at the first session of the General Assembly in 1946. The thirty articles articulate civil, political, social, cultural economic and collective rights (UNDHR 2017).

The UNDHR is a statement of principles for nations to aspire to, not international law. No direction provided as to how to achieve these goals so two covenants were subsequently declared: The International Covenant of Civil and Political Rights (ICCPR 1966) and the International Covenant on Economic, Social and Cultural Rights (ICESCR 1966). Together with the UNDHR they comprise the International Bill of Rights. Other human rights instruments followed:

- International Convention on the Elimination of all forms of Racial Discrimination (1963)
- Convention on the Elimination of all forms of Discrimination against Women (1979)
- Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment (1987)

The International Federation of Social workers subscribes to these articles which are fundamental to social work principles of human rights, social justice and professional conduct.

3. Critique of the notion of human rights

We can never say that human rights exist and will continue to exist in any place and time. Human Rights can be misused by Western, privileged legal and patriarchal people in power, to judge other nations while overlooking their own human rights abuses – for example, in relation to Indigenous people and treatment of refugees by states.

The notion of human rights is critiqued by some collective cultures for their emphasis on the rights of individuals as opposed to community expectations. This critique does not detract from the rights of all people to justice. Communities are in strong positions to advocate for the human rights of all individuals within their communities.

4. Why Social Workers need to think about Human Rights

Social workers operate in a context of government and non-government organisations that do not always uphold Human rights and social justice. In the face of economic and social inequality, social workers need to identify and advocate for people's human rights and work alongside people who are oppressed and marginalised within society. Critical social workers incorporate an analysis of power to explain oppression and marginalisation and will challenge dominant assumptions and beliefs about people's rights and work towards freedom, equity and justice for all people.

5. How to practice human rights

- Begin with the person’s lived experience. This means listening deeply to people’s stories with empathy and locating them within the context of societal or community oppression. It means reflecting critically on your own oppression and privilege and challenging your assumptions, prejudices and values.
- Explore the ethical context. This means considering what rights may have been violated in the person’s life, being well informed, or finding out what rights and responsibilities they are entitled to by law in the context and being careful in your choice of language so as not to label or disrespect the person.

**Morals** are general understandings of the right conduct and behavior for individuals.

**Ethics** is the study of morality – how people define good and bad, right and wrong conduct for example, lying, good and bad qualities of character for example, honesty, and the responsibilities attached to relationships for example, abuse and deception.

**Professional ethics** concern matters of right and wrong conduct, good and bad qualities and character of professional people and their professional responsibilities and relationships in a work context. Ethics can be prescriptive via Codes of Ethics that prescribe a set of guidelines about how to behave and how not to behave for a professional group like social workers. They do not always give the answer to an ethical problem. Ethics rely on the values of the profession and require critical judgment and practical reasoning in decision making.

**Values** are strong beliefs that people adhere to. They can be personal, familial, cultural, social, religious, organisational and national. Social work values include:

- respect for the unique and inherent equal worth all people and their right to wellbeing, self-fulfilment and self-determination, consistent with the rights and culture of others and a sustainable environment;
- social justice as a core obligation that societies should uphold to afford protection and provide maximum benefit for all members of society;
- Professional integrity through the values of honesty, transparency, reliability, empathy, reflective self-awareness, discernment, competence and commitment (AASW, 2010).

**Class Activity for students (individual):**

Spend a few minutes trying to identify your own personal values:

Was it difficult to name these values? Where do you think these values came from? Have you developed them or were they prescribed for you? Share your thoughts with the student next to you.

Ethics can be categorized by the following principles:

- **Principle-based social work ethics** draws on Kantian, utilitarian and radical approaches to ethics. Immanuel Kant (1724-1804) philosopher said that fulfilling your duty or obligation is more important than the consequences of the action. Kantian and utilitarian ideas ‘are premised on the assumption of the human being as a freely acting individual’ (Banks, 2012). In this principle-based approach, it is imperative to follow universal moral rules, such as ‘do not lie’, ‘do unto others as you would have them do unto you’. Respect for persons is an example of a universal imperative and is a value that appears in the IFSW.

- **Character and relationship values** including virtue ethics (from Aristotle, who said that good character traits can be learned eg. integrity), feminist ethics (that see women as equal to men and entitled to the same rights and opportunities as men) and ethics of care, as defined by Utilitarian theorists such as John Stuart Mill and Jeremy Bentham, were said to take priority over principles. You should consider the consequences of your actions on people, rather than just doing your duty through obligation. For example, means testing to achieve ‘the greatest good for the greatest number’.

The core values of social work are based on character and relationship-based approaches to social work ethics including: human rights, human dignity and worth, social justice, service to humanity, self-determination, professional integrity, welfare and social change, anti-oppressive principles to address inequitable impacts of social systems and social structures, virtue ethics and the ethics of care. In practice a combination of these theories are often used.

- **Ethical dilemmas:** An ethical dilemma appears when ‘two equally unwelcome alternatives’ in decision-making can be clearly identified (Banks, 2006:13). Identifying these alternatives, and therefore affirming a situation as an ethical dilemma may require assistance or a consultation with another professional, supervisor or in some instances a specific legal advisor. Identifying an ethical dilemma also involves a comprehensive assessment of our own position and mandate in the decision-making situation (McAuliffe, D. & Chenoweth, and 2008: 43).

Tensions occur when some of the values or principles you hold are in conflict for example an opposition between the law and ethics. Such dilemmas can be resolved through using the Code of Ethics, reflecting on values, context through practical reasoning, in collaboration with colleagues and your supervisor.
7. Inclusive Ethical Decision Making (McAuliffe, D. & Chenoweth, L. 2008)

As professional social workers, we strive towards enhancing the wellbeing of individuals and communities we work with. Accountability, critical reflection, cultural sensitivity and consultation are foundation platforms of the five-step inclusive model of ethical decision making in social work and human services.

**Step One. Define the ethical dilemma**

An ethical dilemma appears when two equally unwelcome alternatives in decision-making can be clearly identified. Identifying these alternatives and therefore affirming a situation as an ethical dilemma may involve consultation with another professional; a supervisor or in some instances a specific legal advisor. Identifying an ethical dilemma also involves a comprehensive assessment of our own position and mandate in the decision-making situation.

**Step Two: Map Legitimate involvement**

The second step of ethical decision-making according to McAuliffe and Chenoweth (2008, 2014) relates to practitioners’ reflection on who to legitimately involve in decision-making when presented with the ethical dilemma.

**Step Three: Gather Information**

The aim of gathering information is to reflect upon legal policies and procedures such as the IFWS Code of Ethics (2010) as well as personal, societal and professional values.

**Step Four: Consider Alternative Approaches and Action**

Social workers should be aware of potential abuses of power and try to mitigate the effects of a perceived breach of trust, for example, explain the situation to the client fully, and explain the course of action you plan to take, including what the client might expect to experience in order to minimize the inevitable loss of power and control.

**Step Five: Critical analysis and evaluation**

Critical reflection, evaluation and consideration of what could be done differently in the future cases can be performed only after the decision-making process is completed. Afterwards, consult with the supervisor and other people who could give their opinion on what to do in this particular situation.

8. The DECIDE model for ethical decision making

(Lonne, Harries, Featherstone and Gray, 2015). Inclusive Ethical Decision Making for complex situations:

- **Define the ethical problem**
  Determine the facts with as much evidence as possible, consult with stakeholders, such as family and other professionals

- **Ethical review**
  Consider the moral, ethical and professional values and principles under review, consider context and power relations, duty of care, minimise harm and safeguard children as priority

- **Consider Options**
  Consider the available options from different perspectives – legal, reasonable, ethical and practical

- **Investigate outcomes**
  Investigate likely outcomes - costs and benefits - of 3 choices. Consider each against the principles of duty, justice and respect for people. Decide which options is most ethical or least harmful.

- **Decide on action**
  Decide on a clear plan with a clear rationale and balance between principles and priorities

- **Evaluate results**
  Use reflective practice to learn from what worked in short and long-term outcomes.

After the lecture, allocate articles from the UNDHR to half the class in groups in the classroom. Each group to identify at least one right being denied to Palestinian people and to write it on paper and stick it to the board. The other half identifies aspects of the IFSW and Palestinian Social Workers’ Codes of Ethics and identifies how they can be used for people’s rights in Palestine. End with discussion.
Module Description:
The aim of the module is to understand the significance of power and critical thinking in social work theory and practice.

Module Outline
a. What is Power?
b. Characteristics of Power
c. Language Discourse and power
d. Empowerment
e. Critical Social Work
f. Critical Reflection

Assessment: Critical self-reflection essay (2000 words) (40%)

To the tutor: This task is academically and personally challenging as it asks students to critique their privilege, power and oppression through theoretical lenses. You could use a well-known family from TV or a non-contentious public family to demonstrate the genogram and application of theories. It is an exercise in praxis (Friere, 1970): the integration of theory with practice that provides an opportunity for students to reflect on assumptions, biases and strengths that they bring to social work.

The assignment has two parts:

a. Family Genogram (10%) Draw a visual representation of your family (e.g., a genogram, ecomap or other creative response) to represent the significant people in the family you grew up in, with descriptors to indicate patterns and trends.
b. **Family Analysis (30%)** Analyse yourself and your family from a critical perspective e.g. describe how you experienced your social location in relation to universal intersections of power and oppression present in all societies: class, culture, religion, place, occupation, gender, age and ability and other forms of power or oppression. Describe the intersections of power and privilege and how you would adapt yourself to relate to someone who is different from you, using an example from a case scenario in this course.

**Assessment Criteria**

1. Accurately drawn, descriptive genogram family, community and culture 10%
2. Critical awareness of social location, intersections of power and privilege 20%
3. Example of ability to adapt self to relate across power and difference. 10%

**Lecture**

a. **What is Power?**

Thompson (2018) argues that understanding of the workings of power is an essential part of challenging inequality, discrimination and oppression. Power is conceived as the ability to influence or control people, events processes or resources, to be able to get things done and make progress in achieving one’s end. It is useful to analyses how power is used in different settings and by different people. Promoting equality can involve a ‘struggle’ against established structures and vested interests that might stand in the way of progress to equality.

Fook (2016) provides a summary of Foucault’s (1991) notions of power. The key concepts are:

- Power is both:
  - repressive (power over: subjugate, control, restrict) and
  - productive (power to inform, transform, think, act differently) or
  - productive (power with someone as they transform, think or act differently).
- Power comes from bottom up, from lived experiences of everyday life; we all have the potential to create some form of power (Fook, 2016:70).

Social workers may be given legitimate power through a role, expert power through acquiring knowledge and skills, reward power where you can give things as rewards, or referent power through respect (Thompson 2018).

Fook exposes some myths about how Power is seen as a commodity to trade or give away in binary oppositional relations:

Powerful or powerless good or bad in relation to sameness, not diversity without accounting for contradictions (Fook, 2016).

**Types of Power**

- **Power over:** The power of the strong over the weak – the power of a social worker to make decisions on behalf of a client, without asking the client. Includes authority, coercion, violence, inciting fear, manipulation, persuasion and inducement.

- **Power to:** The power of supporting and believing in someone to build their capability to make decisions for themselves. This could be through providing access to information or material resources, helping people advocate for themselves or speak up about oppression or injustice.

- **Power with:** The power of shared and collective power, through organization, solidarity and joint action. Social workers can collaborate with people by standing with them, sharing their knowledge (a form of power) to create a fair outcome together (Thompson 2018 in Foucault 1991).

Lavalette (2015) gives examples of ‘power with’ projects in the Jenin Disability Project and Balata Youth Project in Palestine. In the process of working with disabled people in Jenin, the project was able to challenge deeply conservative and medicalised notions of disability and develop social models of disability that included the struggle for the rights of people with a disability as part of the struggle for Palestinian freedom (Lavalette, 2015). The Balata Youth Project worked with young people’s trauma in refugee camps by providing a space where young people could ‘let off steam, organize trips across the West Bank, engage in sporting, drama, music and art activities, get homework support or, occasionally, more specialized support to address problems such as bed-wetting’ (p426). These projects are non-hierarchical, non-judgmental, without dichotomies between deserving and undeserving.
Class Activity: Ask the class to discuss in small groups

What is power? Who has it? When do you have it? When do you feel that you have no power? What power could you exercise at those times? Think of a time when you have used your power over someone else? What was that like? How come sometimes we feel powerful and other times we don’t? How do your different practices of power influence your personal and professional identity?

How do you notice power in interactions between others? Do you think you can empower another person? How might you do this in a way that they do not feel undermined?

Feedback to large group and a class discussion.

Social Work Power (Thompson, 2016)

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<thead>
<tr>
<th>Power over</th>
<th>Power to</th>
<th>Power with</th>
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<tbody>
<tr>
<td>The power of the strong over the weak – the power of a social worker to make decisions on behalf of a client, without asking the client. Includes authority, coercion, and violence, inciting fear, manipulation, persuasion and inducement. Some forms of power over may be necessary, such as disciplinary power, regulatory power, and surveillance.</td>
<td>The power of supporting and believing in someone to build their capability to make decisions for themselves. This could be through providing access to information or material resources, helping people advocate for themselves or speak up about oppression or injustice.</td>
<td>The power of shared and collective power, through organisation, solidarity and joint action. Social workers can collaborate with people by standing with them, sharing their knowledge (a form of power) to create a fair outcome together</td>
</tr>
<tr>
<td>Social workers have the power to give, but also to take away.</td>
<td>Social workers have the power to decide what people need.</td>
<td>Social workers can empower clients and support them to make their own decisions</td>
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b. Characteristics of Power

Thompson (2018) suggests five characteristics of power are:

1. **Choice, intention**: Power involves individuals making decisions that can enhance their power or give away their power so they become disempowered.

2. **Agency and desirable goals**: Power has a history of past actions and power relations so each action can be geared towards desired goals if we think consciously about them.

3. **Resistance and struggle**: Power is both constraining and enabling. The decision to use your power to achieve your desired goals may involve you using power over others or others using power over you to block or sabotage your efforts. Power is not a one-way phenomenon. Individuals and groups can ‘resist’ domination by powerful groups.

4. **Differences of interest**: Competition for resources can mean there is conflict between individuals and social groups who each exert their power to achieve their goals.

5. **Negative restrictions**: The exercise of power by one person or group is often experienced as domination, aggression or selfishness. One’s or a group’s agency can be restricted by structural constraints such as class, gender, dis/ability, age or sexual identity where the dominant group subverts and excludes the minority group. People make decisions based on unquestioned assumptions embedded in social structures of power, thus reinforcing those structures.

c. Language discourse and power

Language is a vehicle of power and can alienate, reflect and reinforce inequality. Social workers need to be sensitive in how they use language when working with people and problems in order not to replicate adverse power dynamics. Jargon, stereotypes, depersonalised and stigmatised language can reinforce power differences, exclude and dehumanise people eg saying ‘the unemployed’, ‘the homeless’, ‘the disabled’ rather than ‘people who are unemployed, experiencing homelessness, living with a disability’.

Language reflects and transmits values and relationships as well as actively creating and maintaining them. Powerful voices shape and constrain the way we see the world through discourses, the dominant narratives about events, people, values (Thompson, 2018).

d. Empowerment

Thompson (2018) defines empowerment as a process where those with less power are helped to become more powerful. Empowerment can be seen to apply at three levels:

- **Personal**: Individuals can be helped to gain greater control over their lives in a variety of ways, for example through locating personal issues eg domestic violence in structural discourses eg patriarchy.
• **Cultural**: Discriminatory assumptions and stereotypes can be challenged to break down an oppressive culture through consciousness raising (Friere, 1970), or challenging dominant discourses.

• **Structural**: Structural inequalities in society can be removed through legislation, policy and programs of action for social change. Change at this level is much wider than professional practice. The potential for change at this level depends on the degree of empowerment at the personal and cultural levels.

Interactions of person, cultural and structural levels of power (Thompson, 2018:84 Figure 3.1)

![](image)

Empowerment practice

Fook (2016) suggests an empowerment process in practice aims to:

- **Analyze the power relations** in the presenting situation, that is, deconstruct the situation about how power relations are created and supported. Some of the analysis may involve reflecting on the following questions:
  - What different assumptions about power support the status quo?
  - How are these power relations expressed and articulated?
  - What types of context are created by these ideas?
  - How is the context experienced by different people?
  - Who is empowered? Who is disempowered?
  - Who are the interest groups? What impact on different groups?
  - What types of power are used differently by whom?
  - What are some of the contradictions about power?

- **Redefine and reconceptualise the power** relations and structures in non-oppositional, non-binary terms (binary examples: good and bad, right or wrong) and focus and celebrate differences between different people. Use dialogue or a communication processes that allow for different parties to understand how they each experience their position. It may involve conflict.

- **Negotiate a changed system of power relations and structures** to empower all parties.

• **Reconstruct and reconceptualise situations in ways that are more empowering** to all parties. This may include reflecting on how can different players be included in the process of empowerment? How can powerful experiences be identified and valued? How can an empowering climate be created? (Fook, 2016).

Criticisms of the Empowerment Model

Although empowerment is an easy concept to understand, applying the ideas in practice is not easy. People do not fit into or necessarily identify with powerless or powerful groupings. Pease (2010) discusses the intersectional aspect of domination and oppression, highlighting that a person may experience oppression because of their gender, but may have privilege in their class or education. Pease cautions that there may not be agreement within the group of what is empowering. What one person may experience as empowering, another person may experience as being oppressive or patronising. The end goal of empowerment may not be clear: empowerment for what? For whom? What is equality? It is easy to equate equality with sameness. If power is conceived as a commodity then there is a risk of perceiving empowerment as giving power from a powerful group to a powerless group (Fook, 2016). It’s not that simple.

e. Critical Social Work

Critical Social Work (CSW) is derived from a host of critical social theories and approaches including Marxism, Feminist, anti-oppressive, anti-racist, anti-discriminatory models, postmodernism and human rights based approaches. Critical Social Work views many of the problems that social workers encounter as the outcome of hardships rooted in economic, social political and cultural structures rather than being individually generated. CSW critiques power relations to change them. Critical social work in practice can be characterised by:

- A holistic approach to presenting problems.
- A contextual understanding of a situation linking the personal and political
- A focus on the individual level at changing or inhibiting internalised patterns of dominance and oppression
- Consciousness raising at an individual and community level
- Strengthening a sense of community
- A heightened sensitivity to power imbalances between the social worker and individual so that power is openly discussed
- Social workers use their power to obtain access to resources
- Partnership between social workers, individuals, families, community & other agencies.
- An approach that emphasises, mutual respect, sharing of knowledge and insights
- A focus on individuals gaining control over their lives
Critique of critical social work

Critical social work has concentrated on theoretical notions with insufficient translation into direct practice which Weiss-Gal, et al (2012) provide.

f. Critical Reflection

To be cognizant of power relations between social workers and clients, we need to reflect on our own different and varying forms of power. ‘Provided with proper tools, individuals can gradually perceive personal and social reality as well as the contradictions in it, become conscious of his or her own perception of reality, and deal critically with it’ (Freire, 1970).

Three levels of reflection and analysis can help to do this:

1. **Social location:** (Lundy, 2004) Lundy suggests we form a critical awareness (that is, consider the inequities, injustices and contradictions) of identity markers such as class, gender, culture/ethnicity/religion/language, age, dis/ability, urban/rural remote to work out where we are seen in terms of our social location and status. Who is deemed powerful or less powerful in these categories? Consider the impact of inequality, discrimination, disadvantage and oppression.

2. **Unearned privilege:** Pease (2010) and others note that we can be born into positions of privilege and oppression, based on a complex hierarchy, diversity and difference. Those who have ‘unearned privilege’ may not recognise it and can inadvertently or purposefully dominate and reinforce the oppression of others. Pease (2010) alerts us to the cross or intersections of our power and oppression.

3. **Professional self-awareness of how to overcome difference:** (Heron, 2005) Heron identifies the difference between identifying your social location and how others may perceive you. She suggests we consider the biases and values that sit with unearned privilege of oppression. People who experience powerlessness may internalise that and assume they are inherently worthless, rather than seeing their oppression as cast on them by more powerful forces. With awareness of your subjective bias, you can oppose or resist the interlocking relations of power that pervade social work encounters with clients. Heron (2005) suggest a series of probing questions we might ask ourselves:
   - What beliefs and assumptions about power, privilege and entitlement do I hold?
   - What assumptions will others make about my values based on who I am and how I look?

Class Activity - Family Location and values

The aim of this activity is to share our family stories and explore how they shape our values and social work practice. This activity prepares students for writing the assignment. By interviewing each other about their family, social work students experience what it’s like to be asked questions or to talk about family, in the way we expect clients to talk about their family. The experience gives insight into the sensitivities needed to ask clients about private issues.

Description of students’ task by tutor:

a) Choose a partner with whom you feel safe. Each person speaks about their experiences of power for 20 minutes while the other person listens without interrupting, apart from minimal encouragers and to clarify. Make sure there is equal time for each of you. You can go elsewhere for privacy. Only share information that you feel comfortable with sharing.

During the interviews tutor will check that you are okay.

b) After 20 minutes, the listener gives feedback only on strengths you noticed in the speaker. Then they swap roles.

c) Return to the classroom after an hour for large group discussion about the process of being listened to and having the opportunity to talk without interruption. Tutor will provide access for counselling in case you become upset at talking about issues in their families.

Questions for the student interviews: Share stories or memories in relation to the following structures. What are some of the beliefs, values or myths that are strongly held in your family? How do or did they reflect dominant discourses? How have these things influenced you as an individual? What opportunities have they offered or prevented? Be careful to only talk about what feels safe.

Class: income, education, wealth, occupation, housing, neighbourhood, rural/urban...

Gender: roles, expectations, work, opportunities

Cultural and linguistic background: race, birthplace, rural/urban, ethnicity

Spirituality/religion

Health/disability/accidents/events

Family form (nuclear, extended, single parent household, multiple families, institution, grandparent carer).
Module 3:

Strength-based Practice

Strength-based practice

To the tutor: To teach this module, you need to

Read at least Elliott, Mulroney and O'Neil’s (2000) first chapter in Promoting Family Change. This chapter outlines the strength based philosophy and describes Solution focused, Narrative and Cognitive Behaviour Therapy (CBT) as strength based practices. Next priority is Egan and Papadopoulos (2016) Critical Anti-Oppressive Strength based practice. Other readings are specific to the different strength based approaches.

Watch the Solution focused video and chose the time and case example

Work out practice responses for the safety of the children in Ashraf’s case example (Appendix). If possible, discuss the case with a practitioner and invite them to the class to assist students work out how to respond to assist Ashraf and strengthen his family.

You will need to adapt the Australian ideas to your context. That could be done in an open way, inviting students’ critical suggestions about how the ideas can be applied, or not, in your context

Role plays are used as class activities. To be effective, they need to be conducted in a way that is ‘safe’ for students to experiment and make mistakes, without ridicule or scorn from other students, or the teacher. Establish earlier that ONLY positive feedback should be given to people who play in role plays, explain the reason. Tell students you will stop them if they criticise

Module Description

This module introduces the notion of working with families’ strengths rather than focusing on their deficits, so that they strengthen their ability to care for and protect their children. Three strength based practices studied are: solution focused narrative and cognitive behaviour therapy (CBT).
Outline of the module

The module covers principles, skills and 3 examples of strength based practice: Solution Focused Practice, narrative practice and Cognitive Behavioral Therapy (CBT)- principles, processes and critique.

Assessment

Essay question:
Using a case example from the class, describe how you would use a strength-based approach to respond to either:

- a. a child or young person who has been and is at risk of being abused OR
- b. a member of the child or young person’s family.

Assessment criteria:

- a. Demonstration of understanding of a strength based practice.
- b. Effective application of one strength-based approach to a case example.

Lecture on strength-based practice:

1. Principles of strength based practice

In the past, social workers would focus on trying to identify and ‘fix’ defects and failures in the client’s character such as poor parenting or drug addiction. People who experience a deficit approach can feel blamed and that there is little they can do about their situation. The principles are:

- Strengths not deficits focus.
- Challenge oppression.
- Collaboration.

Strengths not deficits focus

Strength based practice assumes people have strengths that they have not been able to develop because of external forces. It looks for the source of ‘the problem’ outside the person and asks: ‘What’s stopping this person achieving their potential?’ instead of ‘What’s wrong with this person?’ SBP looks for and aims to strengthen overlooked resources and capabilities.

Challenge oppression

To actively challenge injustice and oppression (anti-oppressive practice), SBP aims to:

- name and expose historical, cultural, political, economic and personal oppression;
- raise awareness of people’s internalised oppression;
- encourage social change to end injustice through collective action.

Collaboration

To collaborate with and support people SBP aims to:

- work in partnership to empower people with minimal intervention;
- give maximum consent, agreement, negotiation and choice (Dulwich, 2014);
- reflect on and share power in client relations (Egan and Papadopoulos, 2016).

Skills in Strength-based practice

The main skills used in strength based practice are to:

- believe in people’s strengths and seek their ideas about what is best for them;
- listen to the person’s description of ‘the problem’;
- show empathy for the person and their situation;
- define aspects of ‘the problem’ that they can change;
- work with people to create alternative stories that work better for them;
- build people’s strengths to take responsibility and make amends for mistakes;
- use the worker as a commentator / audience;
- sow ‘Seeds of Hope and Optimism’ (Elliott, Mulroney and O’Neill, 2000).

Solution Focused Practice

Narrative practice

Cognitive Behavioural Therapy (CBT).
2. **Solution focused practice**

In this approach, a Solution is defined when clients behave in ways consistent with their desired ends. By focusing on solutions, you can address clients’ concerns in a brief way. Instead of evaluating and exploring past problems, target SMART Specific, Measurable, Achievable, Timely objectives for the future. The art of solution focused practice is to construct The Problem as something that has an achievable solution.

**Principles of solution focused practice:**
- Talking about problems can reinforce them. Talking about solutions creates opportunities for change.
- Problems are problems because they are so construed then maintained.
- Problems are held together simply by their being described as ‘problems’.
- Once this identification is broken, the individual gains the ability to do something different and discover new, constructive patterns that become solutions.

**Process of Solution focused practice**

- **Note to the tutor:** This methodology requires skills training through role plays, applying to case examples or role play demonstrations not just explanation.

The process of solution focused practice begins with the social stage where the social worker engages with the person.

1. **Listen for and use the client’s description of ‘The Problem’** Using the client’s description, together the social worker and client define ‘The Problem’ as some behaviour that the client can change.

2. **Ask about and listen for Exceptions** to find times when The Problem is not there and what might take its place.

   ‘I can see what happens when there are problems. To understand it better, I’d like to know about when the problem is not there. How do you explain when it doesn’t happen? What’s different at these times? What do you do different at these times? What would have to happen for that to happen more often?’

   Exception questions can establish short term goals, for example, at the beginning: ‘If on the way home from here, you felt that our meeting had been helpful, what would have happened here?’

3. **Negotiate a Solution.** Find out what the person wants that’s different and define the goal as behaviours that might replace any behaviour that maintains The Problem. Define the goal as what might replace The Problem. The art of the approach is to discover or invent solutions to fit the situation, then develop small steps towards solutions, one at a time.

4. **Ask Solution focused Questions**

   - **Coping Questions** are a way of looking for exceptions without minimising the gravity of the client’s situation: ‘How have you managed to get out of bed each morning?’ ‘Given everything that you have been through, how have you managed to keep going?’ ‘Where did you get the strength to go on?’
   - **Influence questions** establish that clients have influence and control over their behaviour: ‘Who would be the first to notice the difference if the solution occurred?’ ‘What effect would those differences have on your relationship with your children, partner?’ ‘How often does that happen now?’ ‘What would you have to do so that it would happen more often?’ (Bitter, 2009).
   - **The Miracle question:** “Let’s pretend that when you go to bed tonight, without you knowing it, a miracle occurs. The miracle is that (the problems we have named) are solved. When you wake up in the morning, what would tell you things are better? What would you be feeling and doing that’s different? The key phrase is ‘What would be different?’ (Elliott Mulroney & O’Neil, 2000; De Jong and Berg, 2002). Imagining that the miracle has happened implies that things can change.
   - **Scaling Questions** to help measure progress, energy or motivation. Where would you rate The Problem today if 1 is [low – eg you think you might die or kill yourself] and 10 is [high eg you have full control of your life]? Where would you like things to be? What would indicate that you have moved one step up [from a 3 to a 4]?

5. **Give compliments** (eg How did you find the strength to get up today? Are you surprised that you’ve been able to keep the children safe despite his violence?)

6. **Set observational and practice tasks for homework** (Keep a record of the times when you chose not to hit your wife to discuss next time) (Elliott, Mulroney and O’Neil, 2000).
Example of Solution focused practice using scaling questions

**Problem:** Ashraf (10) left home, living on the streets, does not attend school, is scared of his violent father, worries about his mother, sister and little brother, washes cars for money, steals from the market and has no hope for his future.

If 1 = Ashraf continues to live on the street, no family contact, subject to exploitation and violence and 10 = Ashraf has contact with his family, addresses father’s violence, attends school and believes in himself.

When you meet with him, Ashraf put the problem at 4. He says he is okay.

**Solution** In the interview, Ashraf identified his goal as 8: He can assert himself with his father, attend school and run a business in the market, washing cars.

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<th>10+</th>
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<tbody>
<tr>
<td>Ashraf lives on the street, no family contact, suffers violence and exploitation</td>
<td>Ashraf lives on the streets survives on money from car washing, does not attend school, steals from the market and has no hope for his future</td>
<td>Ashraf can assert himself with his father, attends school and plans to run a business in the market cleaning cars</td>
<td>Lives with his family safely, happily, attends school and believes in himself</td>
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**Critique of Solution focused practice**

Focusing only on future solutions can overlook the impact of the past. People can feel that their issues have not been taken seriously. The Miracle Question can be misused to create fantasy thinking if not worded carefully. It’s not: ‘If a Miracle happened and all your problems were gone, how would your life be?’ Instead the Miracle question asks specifically about The Problem behaviours and what (positive) behaviour might emerge. Problems and solutions need to include an analysis of structural oppression so the worker needs to add that as the Solution focused approach does not include it.

**3. Narrative Practice**

Narrative practice is the practical application of a postmodern post structuralist perspective in its focus on language, story and discourse. Narrative therapy was developed by Michael White (2007) an Australian social worker.

**Principles of Narrative practice**

- People’s lives, relationships and identity are shaped by the stories that people develop or have imposed on them about their experiences.
- Meaning and identity is ‘constructed’ through the way things are described, spoken and written about.
- We understand our lives by linking events in a sequence across time (the plot) to form a story (the meaning).
- Many stories occur at one time and are interpreted according to the meaning (plot) that is dominant at the time.
- Dominant stories have the power to minimise other interpretations of experiences.

**Processes of Narrative practice**

Locate the story in broader discourses.

- **Identify and contest the ‘Internalized Discourses’** that are part of the process of self-subjugation eg. Where did you get the idea that you shouldn’t complain or share that your husband is violent to you?
- **Externalize the problem** to separate the person from the difficulties they are experiencing eg How has ‘Using’ [Alcohol] affecting your relationship with your family?
- **Map the influence of The Problem on people’s lives’ and the influence of The Person on the problem’** eg. What has Depression and its Nasty Friends (Self Doubt, Isolation) robbed you of in your life?
- **Develop alternate stories** through plotting the significant and overlooked aspects of someone’s life, document and share people’s stories, skills and knowledge.
- **Respond to people’s responses** to develop their story. Build on what they say.
- ‘Create an audience’, for new descriptions, eg Who will notice when you start believing in yourself again? Eg Remember conversations ‘If your mother was alive, what aspects of your life would she be proud of?’
- **Create ritual, rites of passage ‘definitional ceremonies’, ‘witnessing circles’** and other group-based audiences that support more accountable, alternative practices, eg Kite of Life (Dulwich 2014).
To the tutor: Class Activity if culturally relevant

A. The 'Kite of Life' (Dulwich, 2014) is an activity that can be used to increase understandings of Ashraf’s story to include his gifts, hopes, values and skills. Students should have read the booklet before class. Discuss p 44 Kite of Life, and read the questions on p45).

In Pairs, students can apply the ‘Kite of Life” (narrative approach) to Ashraf’s story in a 7 minute role play. One person plays Ashraf and the other plays the social worker who interviews Ashraf.

Debrief and sharing. Still in pairs, students reflect on:
As Ashraf, what impact might the ‘kite of life exercise have on you’?
As Social worker, discuss the benefits or challenges of using the Kite of Life Narrative approach to work with Ashraf.

End with a class discussion about the strength-based narrative approach.

B. Plotting the alternate story (new case study)
Role play where the social worker invites and listens to the client’s story, noting and seeking alternatives to the problem story, which can be used in co creating an alternate pathway for the client and inviting him/her to decode which pathway he/she wants to embark on. At the end of the activity, seek students’ critique of Narrative practice in a class discussion, using the slide to affirm their ideas.

Critique of Narrative Practice
Narrative practice can be mis-used in an effort to be positive and empowering. Social workers can avoid exercising their power to assert justice by ‘siding with’ the client. For example, in trying to empower a parent or carer, the social worker can lose sight of prioritising the safety of the child or young person who has been abused. Small signs of progress can be magnified to seem as if ‘all is well’ to avoid talking about problems or risk issues (Trotter, 1995). Praise and empowerment should be offered along with the expectation that people take responsibility and make amends. The impact of dominant discourses such as patriarchy, classism racism, homophobia, occupation and other oppressions can be overlooked by social workers with a personal focus rather than a structural, feminist and anti-oppressive approach. Some learners confuse the complex aspects of narrative practice (listening to and co constructing someone’s story) with just listening to someone’s story.

4. Cognitive Behavioral Therapy (CBT)
The goal of CBT is to increase peoples’ awareness of the interrelation of their problematic cognitive, emotional and behavioural patterns then assist them develop strategies to modify their behaviour. It uses principles of learning theory (classical and operant conditioning) to develop and test hypotheses about what causes their automatic thoughts and feelings that produce negative behaviour. The social worker teaches the person how the theory of operant conditioning and automatic thoughts work, so they can disrupt them. CBT gives clients greater control of their emotions, behaviours and lifestyles (within physical, social and economic restraints). CBT is useful with people whose problems have a cognitive and psychological component eg. anxiety, depression, phobias, psychotic, personality, post-traumatic stress disorders or addiction disorders such as eating, obsessive compulsive disorders or alcohol and other drug addictions. It is sometimes used in conjunction with medication. The outcome is not predicted by the client’s level of intelligence. The outcomes can be profound, pervasive and lasting.

Principles of CBT
The basis of CBT is Albert Ellis’ (1957) ‘ABC Technique of Irrational Beliefs’ which analyses the process by which a person has developed irrational beliefs. ABC refers to A, an Activating event creates B, a belief, which has irrational emotional impacts that lead to C, Consequent problematic behaviours.

| Activating Event | Negative event or situation |
| Belief | Thoughts, Attitudes, Assumptions |
| Consequences | Emotions & Behaviors |

CBT sees feelings and behaviour as ‘Habits’ of thinking (cognition) so the goal is to identify the automatic thoughts and beliefs then work with the person to look for evidence (this is called ‘schema restructuring’) to discard beliefs that prove to be irrational or distorted.
CBT works with Cognitive Distortions such as

- **All or nothing thinking** - Thinking in extremes, such as everything is either all good or all bad, with nothing in the middle: ‘Since I failed that test, I might as well quit school as I’m obviously no good’.

- **Mind reading** - Believing that we know the thoughts in another person’s mind: ‘I know you don’t like me’.

- **Negative prediction** - Believing that something bad is going to happen despite no evidence to support this prediction: ‘I’m not going out. It feels too dangerous’.

- **Catastrophizing** - Exaggerating the potential or real consequences of an event and becoming fearful of the consequences: ‘If my husband hears I forgot to buy coffee, he’ll hit me’ (for some this may be true).

- **Overgeneralization** - An example of distorted thinking that occurs when individuals make a rule based on a few negative or isolated events and then apply it broadly: ‘I always forget the important things’.

- **Labeling** - Creating a negative view of oneself based on past errors or mistakes that one has made. It is a type of overgeneralizing which affects one’s view of oneself. ‘I’m hopeless at friendships’.

- **Magnification** - A distortion in which an imperfection is exaggerated into something greater than it is.

- **Minimization** - Making a positive event much less important than it really is: ‘He didn’t really mean it when he said he liked me. He said it because he had to’.

- **Personalization** - A cognitive distortion in which an individual takes an event and relates it to themselves when there is no relationship. An example would be, ‘Whenever I want to go walking, it rains.’ Wanting to go walking does not cause it to rain.

*The Processes of Cognitive Practice*

- **Explain the theory** Change the thinking and the feelings and behaviour will follow.

- **Identify the person’s automatic thoughts**, such as ‘I’m a failure’. The social worker asks: Where does that idea come from? What are you doing and feeling when that thought occurs?

- **Address automatic thoughts** ‘What’s the evidence for that? What other explanations might there be? What are the advantages and disadvantages of thinking that?’

- **Work with beliefs** Link beliefs with past events, then discuss the validity or evidence for the belief in the current context. Seek evidence. Eg ‘Where did that view come from? Can you visualise when it began? What convinces you that because that happened in the past, it will happen in the present and future? What are some other explanations for those beliefs?’

- **Teach ideas about change**: explain the approach; educate about the relationship between thoughts, feelings and behaviour Educate about how we can change our automatic thoughts

Homework is given to apply problem-solving strategies and increase activities they are doing that work, for example, practise ‘Noticing Automatic Thoughts’ and reject them with alternatives. Keep records of how it works (Payne, 2014).

To the tutor:

**Class Activity** - Example of CBT practice with the new case study

*Find the right methodology to apply the ideas, develop questions to engage the class.*

Critique and limitations of CBT

CBT is less effective with cognitively impaired clients (acquired brain injury, intellectual disability), people with little insight, severe depression or severe psychosis or paranoia. Interpersonally avoidant people do better in CBT than interpersonal psychotherapy.

The greatest misuse of CBT is when it is used to address cognitive distortions that are due to oppressive structural or environmental factors without also addressing those factors. For example, helping a woman deal with her panic attacks without exploring the context that her husband is violent to her, and not stopping his violence or helping her to end the relationship (Cousins, 2005).

To the tutor:

**Summary Class Activity:**

Distribute the Solution focused, Narrative and CBT Comparison Chart (Appendix)

Play the Solution focused video and ask students in different groups to watch, observe and take note to report back on the different strength based practices.
References:


Appendix

Strengths and Deficit Chart

<table>
<thead>
<tr>
<th>Life experiences</th>
<th>Deficits and weaknesses</th>
<th>Strengths and resources</th>
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<tbody>
<tr>
<td>1. Roles</td>
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<td>2. Parents</td>
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<td>3. Money</td>
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<td>4. Relationships</td>
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<td>5. Control over life</td>
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<td>6. Responsibilities</td>
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Strength-based practices

<table>
<thead>
<tr>
<th>Narrative practice</th>
<th>Solution-focused practice</th>
<th>Cognitive Behavioural Therapy</th>
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<tbody>
<tr>
<td>1. Locate story in broader discourses</td>
<td>1. Listen for and use the client’s description of ‘The Problem’</td>
<td>Explain the theory: Change the thinking and the feelings and behaviour will follow</td>
</tr>
<tr>
<td>2. Externalise the problem</td>
<td>2. Ask about and listen for exceptions</td>
<td>Identify and name automatic ‘rogue’ thoughts and distorted thinking</td>
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<tr>
<td>3. Map the influence of the Person on the Problem and the Influence of the Problem on the Person, over time</td>
<td>3. Negotiate a Solution (through the Miracle and other questions)</td>
<td>3. Address automatic ‘rogue’ thoughts - seek evidence - what would you say to someone else who thought that? - what are some other explanations for those thoughts?</td>
</tr>
<tr>
<td>4. Develop alternate stories – replot the story</td>
<td>4. Ask Solution-focused questions</td>
<td>4. Work with Beliefs – link to the past and seek evidence - what convinces you that because that happened in the past, it will happen in the present and future? What are some other explanations for those beliefs?</td>
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<tr>
<td>5. Respond to responses</td>
<td>5. Compliments</td>
<td>5. Teach ideas about change: explain the approach; educate about the relationship between thoughts, feelings and behaviour</td>
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Challenges

All strength based approaches can be misused by focusing only on strengths without challenging inappropriate behaviour, or focusing on parents’ strengths and overlooking their abuse of their children, or noting behavioural strengths without acknowledging the oppressive context of the person’s life.

Narrative approach is confused with simply listening to someone’s story. Co-constructing an alternate story is much more than that. Can jump too quickly into solutions without hearing clients’ stories. Miracle question is often misused as wishful thinking.

Can focus on changing thoughts, feelings and actions of the presenting issue and overlook the oppressive context.
Module 4:

Case Management

Module Description
Case management is the systematic coordinated process of working with individuals or families to assess, plan and implement responses to address problems they identify. This module describes social workers’ roles in face-to-face relationships with clients working through a systematic process of case management.

Module Outline
Case management.

Forms used in social work practice and case management: Family Assessment, Case Plan, Case record and Case Conference process.

Module Assessment
Family Assessment and Case Plan
From a case study chosen by the tutor write a:

a. Bio psychosocial assessment of a child, young person or adult affected abuse or neglect, from the position of a practitioner. Define your organisation and role at the beginning of your response. Write in the first person.

b. Case plan for working with the person and family.

Address the headings detailed below:

1. Bio-psycho-social Assessment: The assessment should include:
   • A genogram.
   • A formulation of the biological, psychological and social factors affecting the family, identifying risk and protective factors such as community stressors and family members’ strengths and problems.

2. Case plan: The case plan should demonstrate how you or other professionals might work with the individual and family:
   • Using social work values and ethical decision making processes.
   • From culturally-respectful, empowering, inclusive and theory-informed perspectives.

• To mitigate and manage potential or current risk factors for vulnerable family members.
• To advocate for children’s rights and parents’ responsibilities according to relevant laws.

Assessment Criteria
Your case study should demonstrate your capacity to

1: identify the biological, psychological, social and legal contexts of the family, with insights into the lived experiences of vulnerable children youth and family 30%

2: assess a complex situation identifying risks, strengths, relevant legislation and ethical dilemmas 30%

3: create a rights-based collaborative family-sensitive case plan in response to the presenting issues, cognizant of child protection legislation. 30%

4: communicate clearly, with a well-structured, researched, substantiated and evidenced argument for your opinions through critical application of theories 10%

Lecture

Case Management (CM)

To the tutor: This model of case management practice describes the process of each stage. In the risk assessment module, the process is similar but conceptualized in a different way, identifying a circular process with 4 stages, Information Gathering, Analysis and Planning, Action and review.

Case Management was implemented as a method for managing cases where there are several service providers involved in assisting one child or family. Case management coordinates case workers’ assessment, planning, implementation, monitoring, advocacy and evaluation of clients. This framework reflects a ‘problem-solving’ model which is client-centred and responsive to client needs, that is, ‘relational case management’ (Davidson, Marston Mays & Abdelmalik, 2018). The quality of the case manager and client relationship is central in achieving successful outcomes for clients (Guransky et al., 2012).
**Class Activity**

In groups, prepare a flipchart presentation of a case where several organisations have been involved with the same family. Draw an ecomap to identify each organisation, their perception of the problem, their roles and goals. Identify consistencies and tensions in approaches.

**Concept and practice of case management (Treadwell et al., 2014)**

Social work case management is a method of providing services where a social worker collaboratively assesses the needs of the client and arranges, coordinates, monitors, evaluates and advocates for services to meet the client’s complex needs.

Case management is useful for populations at-risk or people in difficult circumstances, such as separated children, abused women, the elderly, victims of armed conflict and natural disasters, persons with disabilities and the chronically and mentally ill (i.e. extremely vulnerable individuals) because they often have multiple needs.

As a case manager, the social worker assumes responsibility for working with clients to assess the services or assistance that they need and help obtain those services. The social worker assists by linking, mediating, networking and coordinating to help bring about the resolution of clients’ problems.

The situation of clients with multiple problems usually calls for a variety of services that the social worker’s agency may or may not be able to provide. Thus, the social worker assumes the role of case manager, coordinating and facilitating the work of other services, facilitating communication among them to work together.

All the service providers comprise a case management team or system and the case manager of the team assumes responsibility for coordinating the services for the well-being of the client while avoiding doing for the client that which the client is capable of.

Case management relies on building a trusting working partnership between the social worker and the client.

**Principles for Case Management (Treadwell et al. 2014)**

Guiding principles for case management include:

- A person-centred, collaborative partnership approach.
- Facilitating self-determination and self-care through advocacy, shared decision making and education.
- Using a comprehensive, holistic approach.
- Practising cultural competence with awareness and respect for diversity.
- Promoting optimal patient safety.
- Promoting the integration of behavioural change science and principles.
- Linking with community resources.

- Assisting with navigating the health care system to achieve successful care, for example during transitions.
- Pursuing professional excellence and maintain competence in practice.
- Promoting quality outcomes and measurement of those outcomes.
- Supporting and maintaining compliance with federal, state, local law and culture.

**Principles for case management in child protection**

The key elements of the process include:

- Engaging and building key relationships with the child/young person and family;
- Emphasis on supporting families rather than child removal;
- Emphasis on building on enhancing parent-child relationships;
- Screening and holistic assessment of risks, strengths, capacities and needs;
- Joint planning with other relevant agencies to drive the process of case management;
- Determining goals and identifying strategies to address physical, emotional, educational, social, spiritual and cultural needs of the child/young person;
- Monitoring and review through eliciting feedback from children/carers/service providers;
- Transition and closure including supporting transitions, reunifications (Fernandez, 2013).

**Major Functions of Case Management:**

1. **Engagement- making connections and building relationships**

   (Chenowith & McAuliffe 2017)

   Potential clients can have access to the agency and its services in any of the following modes:
   1. Self-referral or Walk-in
   2. Referrals from other services, family members.
   3. Outreach or court ordered.

   Engagement requires social workers to be mindful of:

   Who are we connecting with: is the client voluntarily coming to the service? Is it someone else’s idea? What are the consequences if the client does not engage with the service if they are court ordered?
What we are connecting with them about and what they need to know? for example: clients being made aware of their rights, what can be kept confidential and what cannot, duty of care obligations and legal requirements, written information and considering is this appropriate.

Where this takes place: initial contact may occur in a range of locations, at an office, home visit, neutral location, at a school. The physical environment can have an impact on the level of engagement, the trust established and the accessibility of the service.

When this contact takes place: the timing of meeting with a family will impact on who can be present and how responsive a service is perceived.

Why we are making the contact: Sometimes clients are not clear why they have been contacted and what service might be helpful.

How the contact is initiated: Showing empathy, respect, authenticity and good listening skills so the social worker can ‘start where the client is at’.

2. Assessment (Chenowith & McAuliffe 2017)

Assessment involves the critical scrutiny of the clients’ biological, social and psychological situation to understand their needs, rights, dangers or risks, personal and structural difficulties. It starts from the moment the social worker begins to engage with the person. It is an ongoing collaborative process. Strength based approaches can be used to gather information for assessment and planning what needs to be done to bring about changes for the client and their environment. Assessment may involve interviews with third parties such as parents, grandparents, teachers and extended family. Assessing risks can include reading documents, medical reports and contacted schools and police. The outcome of an assessment is a written report, developed through meeting with the client, relevant family and community members over several weeks.

The case manager needs to reflect on:

- Who needs to be the focus of assessment?
- In what sequence should assessments occur and what protocols should be followed?
- What needs to be assessed?
- What are you trying to find out about the situation?
- How is the assessment to be documented? (NASW, 2013)

Depending on the nature of the service and the role of the case manager, headings in a report may include:

1. A biography and genogram of the family
2. Presenting Concerns
3. Background
   Housing and living arrangements
   Work, income and education
   Physical and Mental health status
   Cultural consideration
   Risks
   Previous services
   Strengths and support networks
4. Child’s Developmental milestones; Parenting Capacity; Environmental Factors
   impacting on risk and protective factors
5. Summary and recommendation (Fernandez, 2013).

3. Service or Case Planning (Chenowith & McAuliffe 2017)

Together, the case manager and the client develop a Case Plan, collaborating with services involved. They set a goal that is specific, measurable, achievable, realistic and with an agreed-on timeframe for achieving this goal (SMART). Short-term, task-centered work is emphasized over long-term treatment. Together, the case manager and client/s define the tasks necessary to achieve the goals. The case manager reviews the client’s strengths and identifies those that are helpful in achieving the identified goals. The case manager engages all the parties involved in developing the Case Plan, including formal and informal sources of social support for the client.

4. Intervention (Chenowith & McAuliffe 2017)

Intervention is purposive action undertaken to achieve the goals in a way that is meaningful for those involved. Every situation is different and requires a tailored response depending on circumstances and context. Intervention should occur once transparent goals have been established with the client and agreement has been reached on how these goals will be met ie the case plan is established. At all stages through the phase of intervention, ongoing assessment should be conducted and interventions should be reviewed and potentially abandoned if they are not meeting the agreed purpose.
Types of Intervention: (Chenowith & McAuliffe 2017)

1. Resource Provider

In this role, the social worker provides material aid and other practical resources to address people’s needs. This role requires the social worker to make a careful evaluation of what the client needs and to know what resources are available. Resources usually cost money so need to be funded by an organization or person. Resources include money, things, information, practical help and services. A social worker can be a resource.

Providing resources is a good way to engage people who are in difficulty. It shows them you take their problem seriously and shows them you have things to offer. Receiving goods, especially cash can increase people’s dignity, self-esteem and options. Having resources to offer puts the social worker in a position of power in deciding who and how much to give. It can also make the social worker vulnerable to persuasion, pressure or aggression from people with desperate needs.

Examples: Distributing food, clothing and hygiene packs, providing information about resources, giving school supplies to school age children or finding safe accommodation for a homeless child or family.

2. Social Broker and Referrer

The social worker requires a good knowledge of services in the community and what they do and have a working relationship with those services. Then they refer or connect people to services when they need them. Referral is the act of directing clients to another agency because the service or assistance needed by the clients cannot be provided by the social worker’s agency. However, it is not just a matter of informing the clients what agency offers the service that they need and where to find it. An effective referral requires the social worker to do her best so that clients are able to access the services and assistance that they need.

Four Aspects of Effective Referrals:

Information about resources

The social worker should have a good knowledge of the available resources and services, including where they are located, who provides them, and who may benefit from them. The social worker should know the key persons in the resource system and cultivate professional relationships with individuals in the system in the interest of clients.

Preparing the client

This means discussing with the client what the referral will involve, including the services of the referral agency. It includes explaining the reasons why the client is being referred to another agency.

Preparing the referral agency

This involves sharing information about the clients with their consent. The social worker prepares a referral summary on the clients. In addition, her recommendation or participation for referral is usually helpful in facilitating the clients’ acceptance in another agency that can provide the service that the clients need. It is highly recommended that the social worker share a copy of the referral summary with the client.

Follow-up

The social worker makes follow up contact shortly after the client makes initial contact with the referral agency. The social worker checks whether the client is receiving the expected services and is moving towards the objectives set.

3. Mediator

A mediator is a person who acts as an intermediary between two persons or organisations in dispute or conflict. In work with individuals, families, groups and communities, the social worker often has to engage in efforts that will resolve disputes and conflicts. The mediator should be neutral, not takes sides or provide solutions. The idea is to:

- invite each person at a time to describe the problem and solution they want.
- the other person listens silently, writes notes of anything they want to remember or say then repeats back what they heard the other person say.
- the mediator identifies commonalities and differences and establishes with both sides a combined list of problems to be resolved and the order they want to discuss them in.
- proceed through a rational process of problem solving of prioritized list using the solutions the people identify themselves.
- only offer your ideas as a last resort as once you have given advice, people may feel obligated to follow your suggestion, even if it does not suit them (Trotter, 2013).

Mediation is not usually suitable when there are power differentials, for example, a child and teacher, an abusive husband and his wife or a boss and worker. In these situations, someone needs to support the less powerful person in working for what they want, usually away from the dominant person. After preparation and empowerment, and if it is safe to do so, mediation may be used.

Examples: a. Forming Healing of Memory Support Groups; b. Helping resolve conflicts between neighbours; c. Chairing a meeting making sure that everyone’s views are heard, managing conflict and reaching some agreed on decisions.
4. Advocate

Like a lawyer, the social worker takes up the client’s cause. The objective is to influence, in the client’s interest, another party who has some power or authority over the client. A social worker has the power and ability to argue, bargain and negotiate on behalf of the client and the power to influence others to give your client access to needed resources. This helps reduce their stress, validates the client’s problems, assuring them that the worker recognizes that they deserve assistance. Advocacy can help break down barriers of power by giving some agency back to the client. Teaching and practising how to advocate shares power between the social worker and the client. It can help in building a trusting relationship and makes it more possible to achieve a positive outcome.

Examples:
- Community education on the rights of children.
- Talking to an exploitative employer about improving his treatment of his worker/s.
- Making representations to doctors to ensure someone receives proper medical care in a local hospital.
- Talking to police about how they can support abused women.

5. Counsellor/Therapist

In this role, the social worker meets with people to give them a chance to talk about their problems, express their feelings and understand their situation. Through building trusting relationships with people, the social worker helps people discover new positive ways of seeing themselves and their problem in its social context and helps people find the strengths and resources within themselves to cope with and solve the problems they are experiencing.

6. Facilitator

This requires the case manager to bring others together for a common purpose or bring a situation to a logical conclusion, for example facilitating a support group with a shared need.

7. Teacher

The case manager models a particular skill, technique or information that may result in behavioural change. The worker may model as well as facilitate the client role playing various communication skills (Trotter, 2013).

5. Termination or Closure (Chenowith & McAuliffe 2017)

Some of the most common reasons for termination are the following:
- When the client thinks that the social worker has provided sufficient help so that it is now possible to pursue problem solving by him/ herself.
- When the agency does not have the resources needed by the client.
- When the system in the client’s environment makes it difficult for him/ her to continue with the helping relationship or when these systems influence the client to discontinue the relationship.

Termination should involve the following steps:
- Reviewing goals together and highlighting achievements or unmet expectations.
- Reviewing compliance issues and completing documentation
- Facilitating transfer or referral to another social worker or service
- Attend to discharge planning requirements including developments of maintenance plans or safety plans for the future
- Facilitate closure rituals where appropriate.
- Acknowledge and validate emotional responses to the closure process.
- Establish boundaries for any ongoing relationships or future relationships.
- It is important to reassure clients that they can contact the service again if they need to. This is a planned process rather than an abrupt ending. It is important to give people as much notice as possible.

6. Review (Chenowith & McAuliffe 2017)

The review phase involves evaluating the gains/goals that have been achieved/ not achieved, the new skills and knowledge that they have learned, it is a formal or informal way of reflecting on practice in a critical way. The process may be through supervision, with peers and meetings. Review should cover 3 areas:

1. Client outcomes
2. Self outcomes
3. Program outcomes.

Reviews and evaluations are essentially about accountability.
Basic Steps in Case Management

Step 1
- This is the Social Worker’s first meeting with the Client.
- The social worker establishes a trusting, respectful working relationship
- SW gathers basic information about the Client (e.g. name, education, residence)
- Fill out Case registration form and intake form

Step 2
- Assessment means working with the Client to understand the nature of the family’s problems.
- This entails assessing the risks to family members plus the strengths of the Client
- Start using Case Record
- Complete Family and Risk Assessment form
- Referral Form with client consent.

Step 3
Together, the Case Manager and the Client develop a Case Plan:
- They set goals that are realistic, specific and measurable.
- They define the tasks necessary to achieve the goals.
- The Case Manager reviews the Client’s strengths and identifies the strengths that will be helpful in achieving the goals.
- They identify formal and informal supports for the client that can help in achieving the goals.
- They agree on a timeframe for achieving this goal. Short-term, task-centered work is emphasized and not long-term treatment.
- Case Plan
- Continue using Case Record for family or client contacts

Step 4
Intervention
- Tase Manager provides direct service (e.g. counseling, skills building & resources)
- Case Manager links the Client with the needed services (e.g. referrals) and coordinates multiple services (case conference)
- The Case Manager monitors how the services are delivered to respond to the client’s need (case review).
- The Case Manager follows up the Client to make sure that he/she is progressing towards the goals and that progress on the case plan is maintained. The Case Manager checks to see if there are any new problems.
- Continue using Case Record for family or client contacts
- Case Conference record
- Referral Form, if necessary
- Use and review Case Plan

Step 5
Termination
- Following the evaluation, if the goals have been met and there are no new problems, the helping relationship is terminated.
- The Case Manager informs the Client of the new relationship and the conditions under which they may be accepted again for assistance.

Step 6:
Review
- The Case Manager evaluates with the Client if the services agreed on were effective in solving the problems and in achieving the goals set in the Case Plan.
- The case manager reflects critically on their practice.

To the tutor: Step 1 is equivalent to Information Gathering, Step 2 and 3 are equivalent to Analysis and Planning, Step 4 is equivalent to Action, Step 5 and 6 are equivalent to reviewing outcomes in the risk assessment casework process described in the module on risk assessment.

Effectiveness of Case Management
A number of randomised trials of case management with children and young people with high needs have demonstrated positive improvements over time. However, many of the reported improvements are found in relation to the use of services, such as decreased hospitalisation and increased use of community-based services, rather than in individual and family functioning. A ‘convincing evidence base’ is developing for case management as a ‘promising’ or ‘potentially efficacious’ service in reducing antisocial behaviour and the risk of use of restrictive settings. The effects of case management need to be evaluated systematically to determine the impact of other interventions that the young person and their family receive. The difficulty is in determining whether it is the case management itself or particular services among those being ‘case managed’ that are more or less critical to positive outcomes (Schneider, Brownhill & Walsh 2006).

Strengths and limitations of case management in the context of child welfare

Strengths
- An essential component of various services and interventions (including Wraparound), providing individualised and tailored services to the particular needs of the child or young person and family.

Limitations
- Lack of consensus about definition, conceptualisation or service parameters.
- Difficulty in determining necessary ‘dose’, fitnetions and intensity of effective case management.
- Difficulty in determining whether it is the case management itself or particular services among those being ‘case managed’ that are esitical.

(Schneider, Brownhill & Walsh, 2006)

References:


Forms used in Case Management

**FAMILY ASSESSMENT FORM**

**Family Code:**

1. **Family Members** (Include everyone living in the family household)
   Draw genogram

2. **Current Home Address** (Include map or directions how to find the family)

3. **Family Support Systems:**
   a) Health and Medical Support:
   b) Emotional Support:
   c) Financial Support

**Present Situation – Assessment of the family’s main problems and needs:**

**Risk Assessment – Assessment of harm or potential harm to the child and Family**
   a) Likelihood of further harm
   b) Cumulative harm – e.g. prolonged exposure to neglect and family violence
   c) Strengths and protective factors in the family
   d) Risk Judgement

Harm consequences: Extreme Serious Concerning

**Immediate Plan of Action: (most urgent or emergency need/ action plan)**

**Long-term Action Plan for Sustainable Solutions**

Name of social worker, signature and date:

Name of volunteers, signature and date:

Name of Supervisor, signature and date:

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**CASE PLAN**

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<tr>
<th>Goal or outcomes</th>
<th>Activities to achieve goal</th>
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Signed: .............. Client name: ............ Date: ...........

Signed: .............. Social Worker: ............ Date: ............
CASE RECORD

Registration No.____

Family code:

Location of the visit:

Date of visit:

Name of support workers:

Purpose of visit: (Plan of Action, including any resources that are needed)

Results: (What Happened?)

Next plan of action: (Include resources you will need.)

Name of social worker, signature and date _______________________________

Name of volunteer, signature and date _______________________________

Name of supervisor, signature and date __________________________________

Case conference process

A Case Conference is a meeting where all the people working with a family come together to confer or discuss and share information and opinions about the family. The purpose is to coordinate a case plan so that everyone is clear on their roles and responsibility and working towards the same goals for the family.

The Case Conference is usually chaired by the case manager, if someone has taken that role. Otherwise, the case manager should be assigned during the meeting.

The social worker uses professional judgment to decide if it is in clients’ Best Interests to attend the meeting. Being part of a decision-making process such as a case conference can be empowering for the client if:

• there is likely to be agreement between the workers
• there are no immediate risk issues to the client
• there is no danger to the client in attending, that is being abused by another family member
• the workers are likely to be respectful to the client.
• If a child, young person or other family members attend, the social worker needs to 'look after them' – ensure they are introduced, treated with the same respect that other workers receive. The social worker should prepare the person, sit next to them and interrupt the meeting to advocate for the client if anyone is disrespectful.
• If the client does not attend, the social worker should advocate for the conversation about them to be respectful, as if they were a fly on the wall listening to what is being said.

The chairperson facilitates the process of a case conference:

• welcomes everyone, introduces self, organisation and role as Chairperson and role as worker in clients' life.
• explains purpose of meeting: clients' names, problems and appoints a minute (note) taker to record peoples' roles and decisions made.
• invites everyone to introduce themselves, their organisation and roles in relation to the family then thanks them for their contribution and compliments their work with the client if appropriate.
• summarizes workers' input, invites comment from client if present, invites discussion and mediates differences.

It is the Chairperson’s responsibility to develop a case plan that everyone agrees on

When all goals, roles, responsibilities and timelines are decided, Chairperson appoints a case manager, sets another meeting date and closes the meeting.

The minutes are sent to all attendees, including the family where safe to do so.
Module 5: Crisis Intervention

To the tutor: Crisis intervention is the short term work that is part of the case management process described in the module on risk assessment. Crisis will usually occur at the beginning phase of engaging a client in case management. Crisis is made of the Chinese symbols opportunity and threat: an opportunity for the family to change and a threat of danger. Social workers are faced with this challenge of juggling these notions.

Module Description

The module defines crisis and crisis intervention as a model of social work practice. The ongoing crisis in Palestine mean that most people social workers see will be experiencing some form of crisis. The module focuses on theories for practice foe crisis and generalist social workers.

Module outline

Definition and critique of crisis; crisis intervention model and stages; skills in crisis intervention, crisis with children, working with involuntary clients, practice strategies for working with angry, aggressive and resentful clients, power and authority, safety protocols for work with potentially aggressive people.

To the tutor: before the lecture, present this case scenario to the class to consider during the lecture: Case scenario (from O’Leary, Hutchinson and Squire 2015) in Appendix: Nadia (15) works as a hairdresser with relatives and neighbours are helping her mother and 21-year-old sister who has a disability. Nadia calls the social worker to say her 10-year-old brother Kasem has been detained by Israeli forces while going to school.

Work with the class through these questions:

a. In what ways is this a crisis?
b. What steps would you take in response to the situation?
c. How would you know when the crisis is over?
d. What follow up work would you do after the crisis is resolved?
Assessment

Exam question: Provide case scenario of an involuntary client in a crisis

Q: Answer the following questions in response to the scenario
   a. In what ways is this a crisis?
   b. what steps would you take in response to the situation?
   c. how would you know when the crisis is over?
   d. what follow up work would you do after the crisis is resolved?

A: Distinguish crisis versus emergency, Robert's steps for crisis intervention, particular attention to working with the child at their developmental level of immediate response, control, assessment, respond, refer follow up; emotional first aid, role clarification, model prosocial behaviour, use empathy to engage with the person, identify the problem, calming techniques, safety measures for self and others to avoid danger and prevent violence.

Lecture

1. Definition of crisis

Crisis is a feeling of being totally overwhelmed, out of control, of hopelessness, helplessness, isolation, a subjective experience. The situation in Palestine is an ongoing crisis so most people social workers will be experiencing some form of crisis. Crisis is a ‘perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person’s current resources and coping mechanisms’ (James and Gilliland, 2006:26). Crisis intervention is an important response to crisis that offers brief, structured models of intervention which address clearly definable problems that will respond to active efforts to resolve them (Payne, 2014).

Crisis versus emergency

A Crisis is a vital and critical moment, a turning point in a life story, when a decision involving opposing or hostile elements is necessary. Greek: krisos = decision.

An Emergency is a sudden and urgent occasion which realistically requires action for survival (of a life or the status quo)

Urgency implies the pressure of time. Trauma may follow a crisis.

Crisis Intervention and critique

The key difference about responding to a crisis is the emphasis on responding to what is happening now, rather than future planning. Crisis intervention is short term work where the social worker works with or for the person to resolve the immediate issues only. While social workers need to be empathetic and relational when working with a person in a crisis, they may need to use professional judgement to make decisions and take actions without the client’s consent to resolve the crisis and make the person safe, for example, call an ambulance or the police despite the client’s fear of that action, inform parents of a young person’s suicide plan or remove a child from an abusive parent who may harm them.

Crisis intervention may be less helpful when dealing with long term individual care and social issues. As crisis intervention only deals with the immediate issues it has also been criticised for taking an uncritical approach to dealing with social oppression. Although social workers may find the clarity in crisis work appealing it has also been argued that there is a danger of oversimplifying the complexity of the issues to people’s lives in order to resolve a single issue. Crisis intervention often does not allow enough time to effectively address people’s internal emotional reactions and could be improved by addressing a client’s social support system (Payne, 2014).

2. Crisis Intervention model – 7 stages (Roberts, 2005)

These are the steps for social workers to take in response to a crisis:

**Stage I: Rapid Psychosocial and Lethality Assessment** (Information Gathering in Case Management)

In a crisis, the social worker must conduct a swift but thorough biopsychosocial assessment. At a minimum, this assessment should cover the client’s environmental supports and stressors, medical needs and medications, current use of drugs and alcohol and internal and external coping methods and resources. Asking about suicidal thoughts and feelings (e.g., ‘When you say you can’t take it anymore, is that an indication you are thinking of hurting yourself?’)

**Stage 2: Rapidly Establish Rapport**

Rapport is facilitated by the presence of genuineness, respect and acceptance of the client. This is the stage where strengths of the crisis worker are needed to instil trust and confidence in the client. Skills include good eye contact, nonjudgmental attitude, creativity, flexibility, warmth, strength based, positive attitude, reinforcing small gains and resilience.

**Stage 3: Identify and Analyse the Major Problems or Crisis Precipitants** (Analysis in Case Management)

Crisis intervention focuses on the client’s current problems, which are often the ones that precipitated the crisis. The crisis worker is interested in elucidating what things in the client’s life have led her or him to require help at the present time so asks ‘Why (has this happened, have you come for help) now?’ Roberts (2005) suggests inquiring about the precipitating event and prioritizing problems in terms of which to work on first. While understanding how the event escalated into a crisis, the social worker gains an evolving conceptualization of the client’s ‘coping style’—which will likely...
Stage 7: Follow-Up:
Crisis workers should plan for a follow-up contact with clients after the initial intervention to ensure that the crisis is on its way to being resolved and to evaluate the post crisis status of the client. This post crisis evaluation of the client can include

- physical condition of the client (e.g., sleeping, nutrition, hygiene);
- cognitive mastery of the precipitating event (does the client have a better understanding of what happened and why it happened?);
- an assessment of overall functioning including, social, spiritual, employment, and academic;
- satisfaction and progress with ongoing treatment (e.g., financial counselling);
- any current stressors and how those are being handled.

Stage 4: Deal with feelings and emotions
There are two aspects to Stage 4. The crisis worker strives to allow the client to express feelings, to vent and heal and to explain her or his story about the current crisis situation. To do this, the crisis worker relies on ‘active listening’ skills like paraphrasing, reflecting feelings and probing. Very cautiously, the crisis worker must eventually use challenging responses. Challenging responses can include giving information, interpretations, reframing and playing ‘devil’s advocate’. Challenging responses, if appropriately applied, help to loosen clients’ maladaptive beliefs and to consider other behavioural options.

Stage 5: Generate and Explore Alternatives with client (Planning in Case Management)
This stage can be most difficult to accomplish in crisis intervention. Clients in crisis, by definition, lack the equanimity to study the big picture and tend to cling to familiar ways of coping even when they are not working. However, if Stage 4 has been achieved, the client in crisis has probably worked through enough feelings to re-establish some emotional balance. Now, the social worker and client can begin to put options on the table.

Stage 6: Implement an Action Plan (Actions in Case Management)
Here is where strategies become integrated into an empowering treatment plan or co-ordinated intervention. In crisis intervention with high-risk, suicidal youth, a shift occurs at Stage 6 from crisis to resolution. For suicidal youth, an action plan can involve several elements:

- removing the means of harm—involving parents or significant others in the removal of all lethal means and safeguarding the environment;
- negotiating safety—time-limited agreements during which the client will agree to maintain his or her safety;
- future linkage—scheduling phone calls, subsequent clinical contacts, events to look forward to;
- decreasing anxiety and sleep loss—if acutely anxious, medication may be indicated but carefully monitored;
- decreasing isolation—friends, family, neighbours need to be mobilized to keep ongoing contact with the youth in crisis;
- hospitalization—a necessary intervention if risk remains unabated and the patient is unable to contract for his or her own safety.

Stage 7: Follow-up:
Crisis workers should plan for a follow-up contact with clients after the initial intervention to ensure that the crisis is on its way to being resolved and to evaluate the post crisis status of the client. This post crisis evaluation of the client can include

- physical condition of the client (e.g., sleeping, nutrition, hygiene);
- cognitive mastery of the precipitating event (does the client have a better understanding of what happened and why it happened?);
- an assessment of overall functioning including, social, spiritual, employment, and academic;
- satisfaction and progress with ongoing treatment (e.g., financial counselling);
- any current stressors and how those are being handled.
3. Skills in Crisis intervention (Thompson 2011)

Principles
- Focus on emotional reactions and external factors;
- Look for social resources: family and social networks, barriers due to social divisions;
- Focus on positives: strengths and easy wins;
- Avoid medical labels: behaviour is a crisis response, not a mental disorder;
- Identify problem focus: main issues may not be the precipitating factor;
- Formulate clear plans;
- Balance potential gains against risk.

Strategies
Thompson (2011) suggests that social workers keep the three-point strategy in mind as crisis intervention can present as chaotic and overwhelming.
- Rapport and positive interest offers calming reassurance and supporting self-esteem;
- Mobilise appropriate support systems through advocacy, family and community engagement;
- Facilitating learning more effective coping mechanisms through therapeutic interventions.

Interventions
- Use other approaches to helping for example, advocacy, groupwork, cognitive behavioural work, task centred practice, and solution focussed work.
- Systematic practice offers clarity through actively working with the client.
- Goal setting offering a feeling of control over the situation as success with one realistic goal leads to greater self-confidence.

Skills
- Listening skills; remove barriers to listening such as the client’s anxiety or depression, others’ interference and preconceptions.
- Redirecting feelings as you experience them raises clients’ awareness, checks your understanding.
- Reinforce successful coping: Clarify strengths, check responsiveness to new situations, engage in building the relationship, recognise and reinforce the positives.
- Gather information about emotional responses, through ventilation and the options clients may be willing to try.
- Be calm.
- Manage your time.
- Holistic thinking: keep the three-point strategy in mind throughout.

4. Crisis Intervention with children
Children who experienced crises are particularly vulnerable as they have less power over their lives, less developed understanding of why the crisis happened and fear about who will look after them. The social worker should first plan and address what safety is needed for the child. Reduce the number of people the child must interact with to a minimum. Recreate a comforting home environment and normal routines and maintain stability. Continually assess and monitor the child’s responses through a warm non-touching relationship, in case the child has experienced physical or sexual assault and is fearful of touch. Refer to known or trusted colleagues only, or else speak to and assess them first.

4. Working with Involuntary Clients
Who are involuntary clients? People who have not chosen to receive the services they are given or who do not want the service but are mandated by a court order, legal sanction or other forms of pressure by family members, school, workplace or community (Trotter, 2006).
Involuntary clients might be people in prison, on probation, parole or court diversion programs; court ordered for drug treatment, families charged with child abuse and neglect, people institutionalised with disabilities; a potentially suicidal person; young people in youth detention, older person in aged care facility, children placed out of the care of their family. What choices do they have?

To the tutor: The following is a collection of classical practice theories by social work academics and practitioners. Some are written from a context of an established statutory system of laws and policies against violence and child abuse. Select some points that fit within your context.

Practice Strategies for working with clients who are angry, aggressive and resentful
Trotter (2015) suggests three interventions for work with involuntary clients, balancing the contradiction in social work’s dual care and control roles.

Care role Control role
helping legal
therapeutic mandated
problem solving surveillance, monitoring
rights responsibility

Role clarification: Social workers should be clear, honest and frequently discuss the extent and limits of worker’s and client’s roles responsibilities.
Promote pro-social outcomes: Social workers should model, notice and reinforce ‘appropriate’ behaviour and values (for example, “I appreciate you being on time”; do what you say you will), identify and challenge anti-social behaviour or comments, or behaviours, that is, say that you do not agree with certain behaviour and explain why not. It’s important that your body language is consistent with what you say, for example, do not smile nervously when you are talking serious business.

Problem Solving: Focus on the person’s definition of the problems and goals using casework steps: Take a Problem survey – list the things the client is unhappy about and identify risks; Problem ranking – assess the risks, address crisis issues and their immediate needs, work on problems that are easier to resolve first; Explore The Problem, set goals, develop a contract, make referrals, develop strategies and tasks and regularly review whether the goals have been met or changed.

Kagan and Schlosberg (1989) say that some families live in perpetual crisis because of trauma in their past or present. Some people maintain crises to avoid the pain of trauma. Fear of abandonment can result from trauma which, combined with shame means that the person remains secretive and vulnerable. Since the person feels too fearful or unable to talk about what happened, they cannot deal with the triggered anxieties directly. Family members see the behaviour but do not understand what the person is going through. They can blame and reject the traumatized person. The person ends up isolated, empty, lonely and defensive which leads to increased depression and acting out behaviour. As levels of internal pain (emptiness, depression, terror, nightmares or flashbacks) rise and fall, the person acts out their pain within the family (including neglecting or abusing their children) until the person is seen as ‘out of control’ needing external controls and police, psychiatry or child protection services steps in. When outside controls and police are imposed (police, child protection) and the person feels resentful, angry but less anxious as someone else is in control. Once their autonomy is gone, however, they feel more vulnerable, dependent and fears of abandonment deepen, and the whole cycle starts again.

Using social work power and authority

It is important to use power and authority appropriately. Kagan and Schlosberg (1989) suggest that social workers should be honest and direct in communication with families. For example, say: ‘I’m not going to mislead you, the accusations are serious. I’ll tell you exactly what they are’ or ‘we both know that what you have done is wrong and harmful to the children’ or ‘You don’t have to trust us as we must report what we observe to the authorities so be careful what you tell us’. Involuntary clients can feel safer and more trusting if the social worker is open about their authority. Under threat, all humans use defence mechanisms. When an accusation of abuse or neglect against a parent is made, parents may react with denial, fragility, anger, rationalisation, projection or blaming to avoid workers raising issues that may trigger past traumatic pain. Therefore, social workers should identify and understand what’s behind the behaviour and realise it is not about them. With the power to make decisions against parents’ wishes eg to remove children, social workers can use their power to establish a collaborative relationship with parents.

How to talk about inappropriate behaviour in respectful empathetic ways?

It is helpful to get students to reflect on how clients may feel when they are involuntary clients having to see a social worker. Some of the challenging and aggressive behavior may come from their feeling blamed, powerless, betrayed, untrusting, angry, shamed and helpless. Identifying feelings can help social workers engage with involuntary clients, for example, ‘I imagine you might be feeling angry that the [court] has ordered you to accept our services, is that right?’ This can help develop engagement and understanding with the client without excusing their behavior.

5. Safety Protocols

Workers are entitled to safety as a priority and should be free to state fear and avoid threatening situations. Supervisors should provide debriefing after confronting or emotionally challenging sessions. Agencies should take responsibility for establishing protocols for safety and supporting staff in implementing them (Trotter, 2006) such as establishing rules for social workers visiting clients in their homes (Home visits) for example, Don’t go alone, know beforehand who you will be seeing and who will be there, take a mobile phone, inform someone where you are going – provide the address and time due back, learn what to wear, how to walk assertively and how to manage violent behaviour. For interviews in the agency (office interviews), arrange a safety protocols for staff and client safety in case there are dangerous situations, inform police if threatening people arrive, sit near door with an exit plan, call Security or report to police violent behaviour of any sort, which should not be accepted.

What challenges the protection for social workers in Palestine when they are under threat?

At the personal level: There is little provision for the protection of social workers. Currently, a law is being reviewed by the government but in West Bank, while the Palestinian Legislative Council is not functioning effectively, social workers remain vulnerable to threats and attacks by people who do not like external intervention into their lives.

At the National level: Social workers face access movement restrictions affecting service delivery due to closures and the presence of the separation wall. Security procedures at checkpoints, including incidents of Israeli soldier’s harassment, can affect adults and children and limit the number of social workers who can respond to the needs of children at school, in hospitals or at home and at risk.

At the Organizational level: Because of the restrictions, there is limited capacity for strategic planning; funding is declining which cause projects to be seen as temporary or unsustainable; there are limited experts in mental health in Palestine and weak coordination and cooperation between the institutions. Security related closures affect programs and community activities. Community stereotyping prejudices people who have mental health and psychosocial support and other services (Qassis-Jaraysay and Daqaq, 2017).

Working with involuntary clients is personally and professionally challenging. We will have emotional responses to clients and their situations – fear, frustration, anger, sadness, helplessness and incompetence.

The key issues for the worker are to be honest and clear about the limit and extent of our role, empathise with the client’s feelings and experiences while remaining clear about their need to take responsibility, reflect on our responses to the client and what happens, access supervision and support and hold the two roles – care and control – in an open, respectful, realistic and challenging way.
References


Appendix:


Nadia (13 years old) was referred by the school counsellor to the Terre des Homme (TdH) service because she had stopped attending school. The social worker visited her at home where Nadia said she was not interested in returning to school because there was too much to do and that she had many worries. She said that chunks of her hair had been falling out over recent weeks. Here two young brothers Kaseem 10 and Lufti 8 were finding it hard to continue at school. Their widowed mother was struggling to gain enough income to support her four children (the eldest child Nesma 20 years old is severely disabled with cerebral palsy).

Over several home visits, the children rarely spoke and seemed quite isolated. Neighbours who gathered on the visits empathised with the family, saying how they missed Salah who died two years earlier - he was a good father. Problems included extreme poverty, poor living conditions including basic furniture made from old boxes, exposed electricity wires, and the fact that Nesma required 24-hour care. It was revealed that Nadia is often the main carer.

TdH Response

The TdH social worker discussed the family’s needs with the mother. TdH offered some help to improve the living conditions of the home by providing furniture and ensuring safe electric wiring. The children were reluctant to leave the house but the social worker persisted, calling often on the family for short visits, and gradually a trusting relationship was established. The two boys returned to school and Tdh provided some resources for their studies.

Nadia, however, remained resistant to school or to engage in any activities outside home. Nadia said she felt responsible for the daily care and support of her sister Nesma. Tdh examined ways to encourage Nadia to engage in other activities, such as vocational training. This required working with the whole family, particularly supporting the mother to encourage Nadia to visit some vocational centres and ensuring responsibility for Nesma is shared. Relatives and neighbours agreed to provide some care when the rest of the family are out, for example.

Six months later, Nadia undertook a hairdressing course and was happy to engage with the social worker in conversation about her wishes for her future as a hairdresser. This marked a significant change from previous visits when she was withdrawn and would not make eye contact.

While Nadia was still attending training in hairdressing six months later, she expressed worries about her future once the course was finished. A local hairdresser offered her work but for very low wages. The social worker facilitated a meeting with the vocational training centre and the employer. An agreement was reached that Nadia would attend another year of training and would work 2 days a week for the employer for an agreed fee.

Social Work Curriculum Including Child Protection Modules
Module 6:

Advocacy

Module Description
Advocacy is social workers’ tool for asserting social justice. Advocacy requires social workers to take a position on social justice, be able to support people who have been denied social justice and to speak out against injustice.

Outline of the module
The module covers definitions of advocacy, roles, skills, principles and processes of an advocate. The structure of the module is:
1. What is Advocacy?
2. Types of Advocacy
3. A Framework for Advocacy Strategies
4. Advocacy and Power
5. Roles of an advocate include
6. Skills required for advocacy
8. Key Ethical Principles of Case Management Advocacy

Assessment
Advocacy can be a criteria for assessment in assignments that ask for students to respond to children or young people who are disadvantaged or have been harmed or are at risk, such as a child with a disability who doesn’t attend school, a preverbal infant who is witnessing domestic violence, a young person whose parents use corporal punishment to the point he or she is physically harmed, or a girl whose father sexually assaults her. To make changes for justice in these cases, what are some of the advocacy principles and strategies that a social worker may employ at a client/case management, organisation and community level?

Assessment criteria:
Demonstration of understanding of social workers’ advocacy roles, skills and processes and how to be an advocate in the Palestinian context. Demonstration of applying Tahan’s (2016) and Mclaughlin’s (2009) concepts.

Lecture:
1. What is Advocacy?
‘Advocacy entails the pursuit of influencing outcomes – including public policy and resource allocation decisions within political, economic and social systems and institutions – that directly affect people’s lives.’ (Tahan, 2016:165). Advocacy is a well-established strategy for achieving social justice (Gehart & Lucas, 2007) and considered a professional social work obligation. National and international professional social work bodies entrench professional social work practice, advocacy and social justice through their codes of ethics (British Association of Social Workers, 2002; International Federation of Social Workers, 2004; National Association of Social Workers, 2008). The Canadian Association of Social Workers (2005) explicates the link between advocacy and social justice:

Social workers advocate for fair and equitable access to public services and benefits. Social workers advocate for equal treatment and protection under the law and challenge injustices, especially injustices that affect the vulnerable and disadvantaged. (CASW, 2005).

To the tutor: Advocacy is often represented in the literature as a strategy more closely aligned with macro or policy practice (Wolfer & Gray, 2007). However, social workers in direct practice are intimately involved in many aspects of individual client lives, including financial, cultural, medical, legal and spiritual issues, and are therefore able to assess and intervene in many areas in which injustice may occur. The advocacy role appears to be a hand-in-glove fit with generalist practice (Hoefer, 2006.)

2. Types of Advocacy
Advocacy can be targeted at different levels: client, organisation, community and global (Tahan, 2016).

Cause Advocacy is collective action to address injustices affecting many. It can include group work, research, social or policy change, social action, community organizing or political activism such as strikes, protests and street marches. Advocates work together to change laws and practices towards a more just society.
Case Advocacy provides support to enable individuals or families to obtain something from someone with power, express their views and concerns, access rights, benefits, information and services, explore choices and options and achieve rights and social justice. What the advocate achieves with or for one person should benefit many which may require cause advocacy to change the social system (Bateman, 1995). In case advocacy, the aim is to redress power imbalances and promote the rights of individuals who are marginalized or vulnerable. Narrowly defined case advocacy “assure[s] that the services or resources to which an individual client is entitled are, in fact, received” (Sheafor & Horejsi, 2008:55). Case advocacy definitions/ primary focus in the literature are summarised in the table below (Tahan, 2016:167).

### Table 1: Primary Areas of Focus for Advocacy in Case Management Practice

<table>
<thead>
<tr>
<th>Author, Year</th>
<th>Primary Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cesta &amp; Tahan, 2016</td>
<td>Ethical obligation: Doing what is in the best interest of the patient family Safeguarding client’s autonomy and right to self-determination, choice, independence, and informed decisions Essential characteristic of shared decision making Promoting, respecting, and protecting the health, safety and rights of clients and the quality of the care they receive</td>
</tr>
<tr>
<td>Daniels, 2009</td>
<td>Scope of practice in hospital-based care management that reflects professional code of conduct and standards of care Primary role of the case manager reflecting the voice of the patient Viewed as an unwritten contract between the patient and the case manager</td>
</tr>
<tr>
<td>Hawkins et al, 1998</td>
<td>Client’s empowerment, independence, and autonomy</td>
</tr>
<tr>
<td>Hellwig et al, 2003</td>
<td>Ethical and legal practice as a philosophy foundation Moral commitment for client’s autonomy Protection of client’s freedom of self-determination</td>
</tr>
<tr>
<td>Pinch, 1996</td>
<td>Bridging ethical and legal practices Client’s informed decision making Protection and support of client’s rights</td>
</tr>
<tr>
<td>Raiff &amp; Shore, 1993</td>
<td>Eliminating deficiencies from the delivery of health care services (securing service/resources) Being fair and just in the distribution of resources</td>
</tr>
<tr>
<td>Trieger &amp; Fink-Sanbick, 2016</td>
<td>Moral obligation of professional practice Professional and ethical conduct Powerful contest for the case manager’s tasks, roles, responsibilities, and functions</td>
</tr>
</tbody>
</table>

### 3. A Framework for Advocacy Strategies (McLaughlin 2009)

McLaughlin identified that Clinical Mental Health Social Workers saw social justice as a driving value underpinning their work and this social justice is linked to the advocacy that they carry out in their work. McLaughlin (2009) characterized 3 types of strategies: instrumental, educational and practical strategies across three different dimensions: individual, marginalized groups and at a societal level. The tasks are categorized below:

<table>
<thead>
<tr>
<th>Table 1: Advocacy Strategies and Dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual</strong></td>
</tr>
<tr>
<td><strong>Instrumental</strong></td>
</tr>
<tr>
<td>• lobby on behalf of</td>
</tr>
<tr>
<td>• liaison between services</td>
</tr>
<tr>
<td><strong>Educational</strong></td>
</tr>
<tr>
<td>• educating individuals about rights, options or choices, the system</td>
</tr>
<tr>
<td>• committee work</td>
</tr>
<tr>
<td>• anti-poverty groups</td>
</tr>
<tr>
<td>• school systems</td>
</tr>
<tr>
<td>• multidisciplinary teams</td>
</tr>
<tr>
<td>• Public education initiatives</td>
</tr>
<tr>
<td><strong>Practical engaged in action</strong></td>
</tr>
<tr>
<td>• assist by filling out forms</td>
</tr>
<tr>
<td>• accompany to appeals or interviews</td>
</tr>
<tr>
<td>• locating housing</td>
</tr>
</tbody>
</table>

(To the tutor:

**Class Activity:**

Ask students to think of examples of advocacy strategies within Palestine and reflect on what dimension and strategy they fall under according to McLaughlin’s framework. To what extent have those strategies been effective in achieving change?.)
4. Advocacy and Power

The advocate engages with those who own resources, have authority over their use and have the capacity to change the way things are done in society. People in power may be unwilling to give it up, may or may not be willing to change or listen to an advocate so an advocate needs to use persuasive power and leadership to achieve change. Tahan (2016: 168) identifies 4 basic perspectives on advocacy in Case Management practice, all conceptualising power from a different position:

<table>
<thead>
<tr>
<th>Perspective/Framework</th>
<th>Main Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paternalistic</td>
<td></td>
</tr>
<tr>
<td>Traditional</td>
<td>Assumes the client is powerless, passive, and lacks knowledge</td>
</tr>
<tr>
<td></td>
<td>Assumes the case manager as the 'boss'</td>
</tr>
<tr>
<td></td>
<td>Case manager is directive</td>
</tr>
<tr>
<td>Empowering</td>
<td></td>
</tr>
<tr>
<td>Contemporary</td>
<td>Assumes that clients are able to be their own advocate and voice own opinions</td>
</tr>
<tr>
<td></td>
<td>Clients are empowered participants in their own care</td>
</tr>
<tr>
<td></td>
<td>Case managers are client supporter and educator</td>
</tr>
<tr>
<td>Shared Responsibility</td>
<td></td>
</tr>
<tr>
<td>Contemporary</td>
<td>Objectivity is relative</td>
</tr>
<tr>
<td></td>
<td>Assumes a joint decision-making process between the client and the case manager</td>
</tr>
<tr>
<td></td>
<td>Respects the contributions made by both the client and the case manager</td>
</tr>
<tr>
<td></td>
<td>Case managers have a moral obligation to share their professional opinions with the clients</td>
</tr>
<tr>
<td>Engaging</td>
<td></td>
</tr>
<tr>
<td>Contemporary</td>
<td>Thought to influence individual and population health</td>
</tr>
<tr>
<td></td>
<td>Protection of client’s freedom of self-determination</td>
</tr>
<tr>
<td></td>
<td>Reliance on patient activation: understanding patient’s readiness to change and willingness to participate in self-care and self-management</td>
</tr>
<tr>
<td></td>
<td>Counselling and supporting rather than judging and demanding</td>
</tr>
<tr>
<td></td>
<td>Clients are in control of their own health while case managers function as a catalyst for change</td>
</tr>
</tbody>
</table>

5. Roles of an advocate include

1. Educator for clients about their rights and how to get them, to professionals when the system fails.
2. Power broker: redresses power differences between clients and professionals.
3. Representative who pleads the cause of, speaks on behalf of, represents and stands alongside another person (Faust, 2007).
4. A watchdog – a human rights defender who names and questions injustice, identifies and provokes what needs to change in the system.

6. Skills required for advocacy

- Confidence and skills in speaking up against injustice.
- The ability to develop and deliver a logical, evidence-based argument either verbally or in writing with well organised materials – facts & figures.
- Skills in the strategy of persuasion.
- Challenging or influencing authority (Baines, 2007).
- Making a request before you make a complaint.
- Persuasion, using legislative evidence for your argument.
- Being assertive, creating discomfort, standing alone.
- Brokering, referral, linking, going with and speaking for someone.
- Developing open communication, transparency, connection, honesty, respect, truthfulness and trust with the person you are advocating for (Tahan, 2016).


- Be likeable, charming and human.
- Be good at your job so you are credible.
- Use your privilege (power) to...
- You are an instrument, a channel.
- Build your allies and networks.
- You are not ‘The system’ so can critique and challenge it.

6. Processes of Advocacy

1. Name the injustice, to the client and others; raise critical consciousness
2. Consult with clients about if and how they want the situation addressed.
3. Offer options of actions.
4. Tell what you can and are mandated to do.
5. Decide what level of the system should be addressed.
6. Coach and prepare the person to advocate for themself.
7. Consult with the person about what you do to advocate with and for them.
8. Recruit support for the person.
9. Negotiate between the individual and the agency.
10. Use expert knowledge and skills to address people’s concerns within the agency, and to influence decision making on their behalf.
11. Use social action to influence social policy in the larger society (Faust, 2007).

7. Key guiding questions for case advocacy.
The case manager embeds an advocacy role throughout the case management process and can achieve this by continually asking the questions:
- What are the client’s care goals, wishes and preferences?
- What is the best interest of the client and client's support system?
- Is the client/support system capable of self-advocacy? (Tahan, 2016).

8. Key Ethical Principles of Case Management Advocacy
The key ethical principles of case management advocacy identified by Tahan (2016) are:

<table>
<thead>
<tr>
<th>Principle</th>
<th>Highlight/Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objectivity</td>
<td>Maintaining an approach or position that is based on facts and truths, focused on the other (i.e. the client), and void of personal interpretations, feelings, attitudes, positions, biases, and/or perspectives</td>
</tr>
<tr>
<td>Goal orientation</td>
<td>Acting in a way that is focuses, intentional, and purposeful around realizing articulated aims and end results rather than the tasks themselves while motivates achievement</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>Protecting or safeguarding information a client has disclosed in a relationship or trust and with the expectation that it will not be divulged to others without prior permission from the client</td>
</tr>
<tr>
<td>Altruism</td>
<td>Acting in a selfless manner, sacrificing one’s own interests for the sake of the greater good and welfare of others</td>
</tr>
<tr>
<td>Accountability</td>
<td>Obligation to accept responsibility and authority for certain tasks or interventions</td>
</tr>
<tr>
<td>Obligation</td>
<td>A sense of commitment or duty toward someone or about something. It is demonstrated in behavior such as respecting and adhering to the client’s wishes, preferences, and desires about a particular action or situation</td>
</tr>
<tr>
<td>Full Disclosure</td>
<td>Telling the truth about something and sharing all available information with no limitations to ultimately facilitate the client’s ability to make informed decisions</td>
</tr>
<tr>
<td>Informed decision</td>
<td>Taking a stand about something or a situation after learning all the available facts and information concerning it</td>
</tr>
<tr>
<td>Shared decision making</td>
<td>A collaborative process that allows the client and the provider (i.e. case manager) to come to a stand about something or a situation while considering the best available and relevant information and in consideration with the client’s values and belief system</td>
</tr>
<tr>
<td>Empowerment</td>
<td>Facilitating one’s ability to recognize own unique individual characteristics including the development of confidence and strength to the think, take independently; set realistic goals and fulfill them; and take control of own circumstance</td>
</tr>
<tr>
<td>Engagement</td>
<td>Enhancing clients comfort in functioning as partners and active participants in their care including decision making regarding care options. Such partnership should facilitate their self-management skills and abilities demonstrated by the actions they must take to obtain the greatest benefit from the health care services available to them</td>
</tr>
<tr>
<td>Autonomy</td>
<td>Self-governance; exercising independence and freedom in taking actions, and demonstrating self-determination</td>
</tr>
</tbody>
</table>

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References


Module 1:

Contexts of Child Maltreatment, abuse and neglect

To the tutor: The topic of child maltreatment, abuse and neglect is disturbing so in teaching the Child Protection course, it is important to prepare yourself and students for the content of the modules. Many students will have experienced violence and abuse themselves and may find it difficult to hear and discuss the issues that some students will be visibly distressed, some will distract with inappropriate behaviour and for some, the content will trigger trauma responses. At the beginning, let students know who they can talk with if they become upset and have a class discussion about how everyone can take care of themselves and each other when distressing material is discussed.

Before teaching this module, you should familiarise yourself with the content of UNICEF (2017) Review of the Child Protection System in the State of Palestine and Price-Robertson, Bromfield and Lamont’s (2014) article that describes 3 international child protection approaches.

Module Description

This module defines types of child maltreatment, including physical, sexual, emotional abuse and neglect, and cumulative harm, defines child protection, gives an overview of international child protection systems and considers the contexts and impacts of violence, abuse and neglect for children and young people in Palestine.

Outline of the module.

1. Child maltreatment, definitions, types, including physical, sexual, emotional abuse, neglect and cumulative harm.
2. Child protection definitions and international systems

Assessment for the module.

1. Essay or exam question: Tutor to provide a Palestinian case example.
Student task: Describe and identify the types of risks the children in the case scenario are exposed to and identify what protection could be provided to the child/ren and your rationale for selecting that approach.

Assessment criteria

Physical, sexual, emotional abuse and neglect and cumulative harm identified accurately.
Rationalised response to protect the child from harm.

Lecture on the contexts of child abuse and neglect

1. What is Child Maltreatment?
Definition: Child maltreatment is the abuse and neglect that occurs to children under 18 years of age. It includes all types of physical violence, and/or emotional ill-treatment, sexual abuse, neglect, negligence, including commercial exploitation, trafficking, child labour and harmful traditional practices such as female genital mutilation cutting and child marriage, or other exploitation, which results in actual or potential harm to the child’s health, survival, development or dignity in the context of a relationship of responsibility, trust or power. Exposure to intimate partner violence is also sometimes included as a form of child maltreatment (WHO, 2016).

Types of child abuse

Physical Abuse – any non-accidental injury to a child by a parent of caregiver. This injury may take the form of bruises, cuts, welts, burns or fractures, internal injuries, shaking injuries in young infants
**Sexual Abuse** – occurs when an adult or someone older/bigger than the child uses power or authority over the child to involve the child in sexual activity. Physical force is sometimes involved. Can involve a wide range of sexual activities including fondling of the genitals; masturbation; oral, vaginal or digital penetration by a finger, penis or other object; exposure of child to pornography. May involve ‘grooming’ behaviours eg ‘this is our secret and we won’t tell anyone. Your mother or father will be angry with you if you tell them about this.’

**Emotional Abuse** – occurs when a child is repeatedly rejected or frightened by threats. May involve name calling; being put down or continual coldness to the extent that it affects the child’s physical and emotional growth and development. Can occur when the child is exposed to significant or sustained family violence

**Neglect** – is the failure to provide the child with the basic necessities of life, such as adequate food, clothing, shelter, health care and supervision to the extent that the child’s health and development are at risk

**Cumulative harm** – repeated patterns of circumstances and events over time in a child’s life, which diminish and harm a child’s sense of safety, stability and wellbeing (AIFS, 2016).

**Who is likely to be abused?**
Abused children come from all levels of society, although most abused children who are reported to authorities are from families where there is high mobility, a lack of education, social isolation, poverty, unemployment, or inadequate housing. With physical abuse, emotional abuse and neglect, boys are somewhat more at risk than girls. However more girls are sexually abused than boys. Abuse may be directed at only one or several child in the family. Children can be abused at any age. Children under 2 years of age and children with disabilities are more at risk of abuse. Many adolescents are victims of child abuse and neglect, sometimes due to parents having difficulties dealing with the adolescent’s behaviour and desire for independence.

**Cumulative harm**
The effects of cumulative patterns of harm on a child’s safety and development was realised in the 1990s. Cumulative harm refers to repeated patterns of circumstances and events in a child’s life, which diminish and harm a child’s sense of safety, stability and wellbeing. Harm may be constituted by a single act, omission or circumstance or accumulate through a series of acts, omissions or circumstances. For example, multiple episodes of abuse, experiences of chronic neglect, a pattern of family violence and ongoing fear of conflict, humiliation or attack are examples of circumstances in which cumulative harm is likely to accrue for a child.

**What is the impact of child maltreatment, abuse and neglect?**
Child maltreatment causes suffering to children and families and can have long-term consequences. Maltreatment causes stress that is associated with disruption in early brain development. Extreme stress can impair the development of the nervous and immune systems. Consequently, as adults, maltreated children are at increased risk for behavioural, physical and mental health problems such as:
- perpetrating or being a victim of violence
- depression
- smoking
- obesity
- high-risk sexual behaviours
- unintended pregnancy
- alcohol and drug misuse.

Via these behavioural and mental health consequences, maltreatment can contribute to heart disease, cancer, suicide and sexually transmitted infections.

Beyond the health and social consequences of child maltreatment, there is an economic impact, including costs of hospitalization, mental health treatment, child welfare, and longer-term health costs. Children may experience a range of emotional, psychological and physical problems and trauma because of being abused or neglected. All forms of abuse are likely to result in emotional problems for the child - a lack of self-esteem and distrust of adults. The longer the abuse goes on, the more serious are the effects. Abused and neglected children are more likely than other children to be self-destructive or aggressive, to abuse drugs and/or alcohol, or become young offenders or ‘street kids’. In some situations, abuse and neglect may result in permanent physical damage. In the longer term, adults who have been abused as children are also more likely to abuse their own children and often experience difficulties in forming satisfactory relationships with other adults. The most serious effects are likely to occur when no one acts to stop the abuse and to protect the child (WHO, 2016).

**What is Child Protection?**
UNICEF (2006) uses the term ‘child protection’ to refer to preventing and responding to violence, exploitation and abuse against children, including commercial exploitation, trafficking, child labour and harmful traditional practices such as female genital mutilation cutting and child marriage. Article 19 of the UN Convention on the Rights of the Child provides for the protection of children in and out of the home.

**The goal of Child Protection is to** guarantee the right of children to be protected from violence and witnessing violence, sexual and emotional abuse, exploitation and neglect of their basic physical and emotional needs, both within the family and community.

**The role of a Child protection system** is a coordinated response by government and community organisations to prevent and respond to violence, abuse and exploitation of children. Child Protection systems and responses to child abuse and neglect are shaped by how the child and young people are constructed in public and community discourse.
2. International Approaches to Child Protection Responses

Example 3: Community-based child protection models
(from Price-Robertson et al, 2014: 9-10)

Child-focused, community-based groups have emerged as a key child protection response in emergency, transitional and developmental contexts around the world, most notably in Africa and Asia. In countries where local and national governments are unable or unwilling to care for and protect children, the approach has been a prominent humanitarian response, particularly in communities affected by armed conflict, displacement and/or natural disasters. The groups are usually developed with support from an external agency to respond to large numbers of children who have experienced abuse and neglect or have been displaced from their homes. Although the function of child-focused community groups (also known as Child Protection Committees) varies according to the context, the main purpose is to respond to significant child protection risks and advise the community about child protection issues (Wessells, 2009).

The role of some community groups may also be to mediate, problem-solve, provide support for survivors or refer more serious cases to higher authorities where possible. Committees usually consist of 10–20 voluntary members and include teachers, children’s group representatives, health professionals, parents and other community members. Child Protection Committees have usually been formed to address issues of sexual abuse, loss of parents or other caregivers, child labour and child trafficking. The committees/groups provide a safe and supportive environment for children and families to seek support, advice and protection. Community-based Child Protection Committees are most effective when integrated and coordinated within a national child protection system, however in most communities where committees are established, national child protection systems do not exist.

Strengths and limitations

In an unpublished UNICEF International review, seven areas were identified as influencing the effectiveness of child-focused community groups. These included:

- community ownership over processes and activities;
- building on existing resources;
- support from leaders—namely traditional leaders, community officials, religious leaders or respected elders;
- child participation;
- diversity and inclusivity of affected groups including members from diverse sub-groups;
- adequate array of human (appropriately qualified/skilled) and material resources; and
- linkages with formal systems for support and expansion, enabling effective referrals for formal child protection systems to intervene (Wessells, 2009).

Child-focused community groups have the potential to become essential components of a national child protection system as they provide a strong community presence. However, effective systematic evaluations of such programs have been rare and it is therefore difficult to determine their overall effectiveness. In a large-scale UNICEF systematic review of child-focused community groups around the world, it was found that in the seven areas identified as influencing their effectiveness, incorporating all areas was an exception rather than a rule. The review highlighted that a stronger evidence base analysing effectiveness, cost, scalability and sustainability was needed (Wessells, 2009). The lack of systematic evidence makes it difficult to obtain funding and encourage policymakers to promote such practices.

Case study: Gaza Strip Child Protection Committees

In the Gaza Strip, where half of the population of 1.5 million are children (69% of which are refugees), Save the Children Alliance helped facilitate village level Child Protection Committees. Typically the committees have 10–20 members consisting of influential community members, representatives from primary health clinics, community-based organisations, schools, the police and religious leaders. After an initial brainstorming session, the committees highlighted the need to intervene in the domestic, school and peer environments of children’s lives through awareness raising and capacity-building. They did this by establishing a monitoring system to detect children at risk of violence and created referral mechanisms. Young adults were chosen for training to help them raise awareness of children’s rights and child abuse and neglect risks. Children from the three communities, supported by Child Protection Committee members, were asked to identify trusted individuals in the community to act as focal points for receiving children’s reports and concerns and for providing advice and guidance (Sbardella, 2009 in Price et al., 2014). Referral mechanisms linking the committees to health clinics, schools
and other organizations were established to strengthen the cooperation between caregivers and service providers (Sbardella, 2009 in Price et al., 2014). Children’s sub-committees were also established to increase children’s participation in decision-making. Ongoing monitoring data is being collected to determine the effectiveness of the committees. Early monitoring indicates that they have helped in encouraging and facilitating open discussion about child protection risks and increased knowledge regarding the responsibilities of government and caregivers in protecting children (Sbardella, 2009 in Price et al., 2014).

Class Activity 1:
Use Price-Robertson et al’s (2014) questions for a class discussion: Reflections on the context:
- What aspects of community-based child protection models are relevant?
- What might be the strengths and limitations of integrating child-focused community groups with formal and informal child protection systems?
- How could community groups be harnessed to mediate, problem-solve, provide support for survivors and refer more serious cases to higher authorities? What would be the strengths and limitations of such an approach?

Class Activity 2:
In preparation for the final section of this module, remind students that the information may be distressing and have them share their strategies for looking after themselves with another student with whom they feel safe.

Allocate groups to note examples of the five types of harm, one type per group - physical, sexual, emotional abuse, neglect and cumulative harm. Each group should have a large piece of paper on which students can write the examples they hear.


Sources of violence, abuse, neglect and exploitation of children.
MOSD 2018 defines two sources of violence for children in Palestine:
1) conflict and occupation related violence, and
2) violence within families and communities, including domestic violence, harsh corporal punishment in homes and schools, sexual abuse, early marriage and child labour.

Conflict and occupation related violence
Many Palestinian households are directly exposed to violence by Israeli forces. A generation of children across the West Bank and Gaza live with:
the constant threat of violence and insecurity; as a result of the occupation:
- child deaths and injuries as a result of clashes between Palestinians and Israeli Forces, military operations, settler-violence and exposure to explosive remnants of war;
- family separation due to Israeli civil documentation1 conditions; the Israeli annexation of and the permit regime to access to Jerusalem;
- displacement, eviction and forcible transfer of children; harassment and attacks on school-going children, with concerns of recruitment and use of children in armed conflict;

Violence within Palestinian families and communities
Increased stress on parents means children experience high levels of physical violence within their families, reinforced by a cultural acceptance of corporal punishment. For children aged 12 to 17 years, 50% are exposed to violence by a member of the household, 69% exposed to psychological violence, 34.2% exposed to physical violence from their fathers and 34.5% physical violence from mothers (MICS, 2014).

A survey by Palestine Bureau of Statistics (PCBS) indicated that 91.5% of children aged 1 to 14 years had experienced violent discipline (psychological aggression or physical punishment) during the month prior to the survey, 73% of children had experienced physical punishment, including 23% experiencing ‘severe’ physical punishment (PCBS, 2015).

Other issues related to abuse in Palestine include high levels of unemployment, alcohol and drug use and family discord; increased reported ‘honour killings’ of women and girls (National Strategy to Combat Violence Against Women 2011-2019) plus:
Early marriage of girls (in UNICEF 2017).
- 36% of women were married before 18, and
- 5% before 15 (Palestine Central Bureau of Statistics 2010).
- 9.3% of young women currently aged 15 to 19 years were married (MICS, 2014),
- 2% of women aged 15-49 were first married before age fifteen
- 24.2% married before age eighteen (28.6% in Gaza and 21.4% in the West Bank)
- 22% of women 22 to 24 gave birth to at least one child before 18 (PCBS, 2015).

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1 Under the provision of Article 47 of the Fourth Geneva Convention of 1949, annexation of occupied territory is legally null and void.
In Gaza many marriages involving girls under the age of 18 were within the extended family:

- 55% of the women married a first or second degree relative,
- 44% of women didn’t have the chance to agree to their marriage but their father did (Women’s Centre 2015).

Violence in schools (UNICEF 2017)

- 34% subjected to physical violence in school in the previous year,
- 67% witnessed physical violence
- 29% admitted to using physical violence against others.
- 43.5% subjected to psychological abuse
- 73% witnessed psychological abuse being inflicted on other students.
- 12% subjected to sexual violence
- 23% had heard of others who had complained of such violence (MoEHE, 2011).
- 21.4% of students were exposed to physical violence from teachers
- 15% witnessed violence by schoolmates (PCBS Violence Survey, 2011)

Some teachers and parents consider violence a socially acceptable means to discipline students to improve their performance (Violence in Schools Policy, 2013).

- 1.6% of children between the ages of 10 and 14, dropping out of school due to poverty
- 7.5% of children between the ages of 15 and 17 were working (PCBS, 2011)
- 16% of children aged 10 to 14 (HRW, 2015).
- 30.8% aged 15-17 who were working did not attend school (PCBS, 2015a).

Sectors are commerce (24.3%) agriculture (22.1%) street vending (16.8%) (ILO, 2014).

- 62% working children performed dangerous work harmful to health - in tunnels, gravel collection, portering, construction, demolition of buildings, fishing, petrochemical sector.
- 19.3% of the children worked in agriculture at risk of exposure to pesticides (ILO, 2013).

In Gaza post 2014, 78% of respondents were aware of children in their neighbourhoods involved in harsh and dangerous types of labour, despite Israeli and Palestinian laws which set 15 years as minimum age of employment (MOSD, 2018).

To the tutor:

Class Activity - Feedback from earlier task:

Give students time in small groups to discuss these statistics and complete the task of writing examples of the five types of harm, one type per group - physical, sexual, emotional abuse, neglect and cumulative harm. Allow time for stories, shared grief and debriefing. When they have completed their ‘Examples of Type of Abuse’ page, they should silently pin it up on the wall then look at the other four categories. This is not about being right or wrong. The exercise aims for students to begin to identify examples of different types of abuse and neglect.

Channel grief and anger to the purpose of the modules – to address social problems, they must be identified as social problems. Write this question on the board for them to consider: How might social workers stop these forms of violence or respond to children and young people affected by them?

Before students leave this session, check that they are okay and have somewhere safe to go. Refer students to student support services if necessary.

References


Module 2:

Preventing Child Maltreatment

Module Description
As adults working with children, social workers need to challenge dominant discourses and prescriptions that put children at risk of abuse and neglect, seek justice and advocate for children and young people’s rights at family, community and government levels. This module will address theories, research and programmes that address prevention, the roles, principles and skills for social work with children. The module outlines practical steps, skill in engaging children and a framework that considers the developmental stages of children when looking at the social worker role and style.

Module Outline
Theory and research about preventing child maltreatment,
Programs for prevention of child abuse and neglect
Prevention of child maltreatment through individual work with children: principles, challenges and skills for working with children

Module Assessment
Child Observation Assignment: Choose a child aged 10 or under to observe, with the permission of their parent. Spend 20 minutes or more engaging the child, observing the child’s behaviour and development. Write a report of your observations. Describe what principles and skills you used to engage the child. Describe the challenges and how you surmounted them or not. Describe any actions you took that strengthened the child, the family or that might prevent harm to the child.

Assessment criteria:
Uses a developmental framework from the Child Development and Trauma Guide (DHHS, 2007) to describe child’s age and stage, or signs of trauma
Applies ideas creatively and appropriately from the lecture to the case

Social Work Curriculum Including Child Protection Modules

Lecture

1. Theory and research about preventing child maltreatment

‘Prevention’ typically means activities that stop an action or behaviour. It can also define activities that promote positive actions or behaviour. Successful child violence, abuse and neglect interventions must both reduce risk factors and promote protective factors to ensure the well-being of children and families. Stagner and Lansing (2009:19) articulate differences between traditional and contemporary responses to prevention of child maltreatment:

<table>
<thead>
<tr>
<th>Traditional responses</th>
<th>Contemporary responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent recurrence after abuse</td>
<td>Prevent maltreatment from occurring at all</td>
</tr>
<tr>
<td>Identify abuse risk factors and address the caretakers’ problems and deficiencies</td>
<td>Strengthen protective factors; build family and social networks to reinforce the ability of parents to care for their children</td>
</tr>
<tr>
<td>Legal and medical approach</td>
<td>Build child’s developmental strengths; enhance social context</td>
</tr>
<tr>
<td>Outside professionals decide family and children’s futures, including out of home care</td>
<td>Integrate professionals and paraprofessionals from the family’s community into their everyday life and ensure interconnected service systems.</td>
</tr>
<tr>
<td>Focus on minimising harm</td>
<td>Focus on strengthening the capacity of parents and communities to care for their children in ways that promote well-being.</td>
</tr>
</tbody>
</table>

Stagner and Lansing (2009)

Internationally, increasing evidence promote the importance of community wide efforts to prevent child violence, abuse and neglect before abuse or neglect by offering a three tier prevention model to promote the health of the population as a whole (Stagner & Lansing, 2009:11):

(i) Universal prevention efforts attempt to influence the attitudes and behaviours of the population at large, including universal preventive laws and services for all;
(ii) Selective or targeted programmes aimed at defined ‘at-risk’ populations and;
(iii) specific efforts to prevent further violence, abuse and neglect when violence, abuse and neglect has already been reported (UNICEF, Landers, 2013). This module will consider ii and iii.
2. Programs for prevention

UNICEF Landers (2013) summarizes selected targeted effective, evidence-based prevention programs for at risk populations that suggests ways to strengthen the capacity of child protection systems to respond to child victims and their families. Effective programs support parents and teach positive parenting skills, including:

a. Home visits
b. Parent education
c. Community-based Strengthening Family Resource Centres
d. Communications: Changing Social and Cultural Norms
e. Legal Reforms and the Promotion of Child Rights (Landers, 2013: 23)
f. Other prevention programmes (WHO, 2016).

a. Home visiting

Home visiting by social workers, counsellors and nurses to parents and children in their homes can provide support, education and information. It is a legitimate method for delivering services for families and a strategy for preventing child abuse and neglect. Preventative programs focus on early interventions with children in the first three years who are at greater risk for child abuse and neglect than older children.

Home visits provide one-to-one parent education and support and have been used as a way to serve hard-to-reach families, often in situations where parents are isolated or unlikely to participate in parent groups. Using home visiting as a strategy for reaching young children can prevent long-term costs and promote healthy social and emotional development in later years. Home visits can provide information, guidance and support directly to families in their home environments, eliminating many of the scheduling, employment and transportation barriers that might prevent families from using necessary services. Goals of home visiting include health care, parenting education, child abuse prevention and early intervention services for infants, toddlers and sometimes, older preschool-aged children. The most common model is for the home visit to focus on the child’s development and on the ways the parents can promote that development (Landers, 2013).

b. Parent Education

Parent education programs can be delivered in a wide variety of settings and are designed to develop positive child discipline approaches and promote positive parent child interactions. These programs have been implemented at community level where the program is available to all as well as a more targeted population identified to be at risk. Although some argue that parent education cannot succeed unless family problems are also addressed, much evidence suggests that first helping parents to be more effective with their children can address a range of individual and family risk factors (Landers, 2013).

Example Jordan: The Better Parenting Programme BPP

UNICEF and other key government and civil partners have supported a nationwide programme aimed at empowering parents and caregivers to provide a stimulating, loving and protective environment at home, through equipping parents and caregivers with skills and information to enable them to promote the psychosocial, cognitive, and physical development of their children aged 0–8 years. The BPP takes a holistic perspective on children’s growth and development, regarding children’s growth and development as being supported within the context of the family, the community, and the nation. The lessons are led by social workers, health workers, kindergarten teachers, and paraprofessionals who had been instructed in how to deliver the lessons by centralized trainers.

Evaluation found that over time, participants in the group experienced positive results including improved on parenting knowledge, spending time playing and reading books with their children, using more explanations during the course of disciplining their child and accurately perceiving behaviours that constitute child neglect (Landers, 2013: 18).

c. Community-based Strengthening Family Resource Centres (Landers, 2013:17)

provide opportunities for supporting and strengthening families. Evaluations of Family Resource Centres indicate that parents do gain new knowledge and improve parent child interaction skills. Strengthening Families approach, early childhood settings provide support to parents to help them develop positive relationships, increase knowledge of parenting and child development. The staff in early childhood care settings receives instruction in interacting with all families in ways that build protective factors. Services for parents include peer support groups, lending libraries, parent- information sessions, or volunteer projects. The focus is on protective factors but early childhood staff is also

To the tutor: Ask the students: What do you think are the advantages and disadvantages of working with families in their home as opposed to office based work?
trained to recognize risk and respond to early warning signs of abuse and neglect. The staff is prepared to carry out other strategies that strengthen parenting, link families to resources, respond to family crises, and value parents.

d. Communications: Changing Social and Cultural Norms (Landers, 2013: 22)
Public awareness and media campaigns can play an important role in highlighting the extent and nature of child violence, abuse and neglect. Research recommends that communication about prevention be linked to information about child development, including brain development and the impact of toxic stress as well as the importance of positive, reciprocal attachment and exchange between young children and adults.

e. Legal Reforms and the Promotion of Child Rights (Landers, 2013: 23)
Laws play a role in shaping social norms against violence, abuse and neglect of young children. Prohibiting harsh physical punishment and establishing legal requirements to report have been instrumental in countering the idea that child violence, abuse and neglect is a private matter only to be left to the family.

f. Other prevention programmes (WHO, 2016).
- Programmes to prevent abusive head trauma (also referred to as ‘shaken baby syndrome’, ‘shaken infant syndrome’ and ‘inflicted traumatic brain injury’). These are usually hospital-based programmes targeting new parents prior to discharge from the hospital, informing parent of the dangers of shaken baby syndrome and advising on how to deal with babies that cry inconstantly.
- Programmes to prevent child sexual abuse. These are usually delivered in schools and teach children about:
  - body ownership
  - the difference between good and bad touch
  - how to recognize abusive situations
  - how to say “no”
  - how to disclose abuse to a trusted adult.

Such programmes are effective at strengthening protective factors against child sexual abuse (e.g. knowledge of sexual abuse and protective behaviours), but evidence about whether such programmes reduce other kinds of abuse is lacking. The earlier such interventions occur in children’s lives, the greater the benefits to the child (e.g. cognitive development, behavioural and social competence, educational attainment) and to society (e.g. reduced delinquency and crime). Early recognition of risk to children coupled with ongoing care of child victims and families can help reduce reoccurrence of maltreatment and lessen its consequences (WHO, 2016).

3. Prevention through individual work with children
Preventative programs need trained staff to implement them (UNICEF Landers, 2013). Social workers should be equipped to explicitly address the developmental needs of young children beginning in the prenatal period and targeting parents, caregivers and professionals in direct contact with children. Efforts should be directed towards prevention factors that place the health and development of children at high risk including substance abuse, domestic violence, isolation and maternal depression. Preventing developmental impairments due to these complex factors requires proper identification, diagnosis and treatment of both caregivers and children. Social workers should have the capacity to provide young mothers and pregnant women with information about care and parenting as well as skills to work directly with children, particularly in the case of child abandonment where professional ward staff play a key role in prevention.

a. Principles for working with children (Geldard, Geldard and Yin Foo, 2013).
- The child’s safety is the priority;
- Someone in the family can provide safe, responsible and nurturing care for the child; family members can be encouraged to solve problems and be involved in decision-making about their children.
- Parents’ should give consent and be involved in planning for their child, unless there is a reason not to
- Conflict between family members can feel toxic to a child, so facilitate child/ren’s positive relationships with people in their lives
- Children have a right for their views to be heard and considered, for which social workers may have to advocate.
- Respect children’s, young people’s and families’ culture and religion;
- Identifying a child’s strengths and exceptions to problem-saturation descriptions can empower the child; encourage others to notice positive changes the child makes (Geldard, Geldard and Yin Foo, 2013).

b. Challenges in working with children
Social workers tend to avoid seeing young children for the following reasons:
- Some workplaces are not conducive to children
- They think it is too difficult or too time consuming
- Social worker can have inhibitions in playing with children
- Children are not seen as people in their own right who can express feelings and opinions
- Children may not feel safe to discuss issues (resistance) so you need to ‘give permission’ for them to not talk about some things, e.g., ‘it might be scary to talk about that. When I get scared I stop talking’.
• Children need help to discard un-useful and self-destructive beliefs such as ‘I’m unlovable, it’s my fault dad hurts mum, I’m naughty so mum doesn’t love me, my parents shouldn’t discipline me, I must not make mistakes’. To change the beliefs, check the validity and logic of the belief and where it came from, explore alternative beliefs, help the child accept unpalatable information eg your father has done the wrong thing
• Lack of knowledge of child development leaves the SW unsure of how to interact with the child (Scott, 1999).

The following address some of these difficulties:

c. Skills in Engaging and working with children

At the start, Scott (1999) suggests you should:
• Make the room safe room, with no sharp or swallowable objects
• Sit on the floor with the child on their level
• Explain why you are meeting and what you will share with others
• Define limits - how long you will meet what they can and cannot do. Keep meetings short for the child’s attention span,
• Give the child options e.g what would you like to play with next? (Scott, 1999).
• Use active listening to convey interest (Geldard, Geldard and Yin Foo, 2013).
• Help the child to tell their story through open questions. Find statements to help a child express an emotion eg ‘Adults do the wrong things too’, ‘It’s hard for you to decide which colour to use’ ‘That little mouse you drew looks like she’s scared of the big mouse’.
• Make observational comments, not praise eg ‘You’ve drawn your family!’ ‘Tell me about your picture’. Don’t ask ‘Why’ questions – too interrogative.
• Match the child’s body language – use same speed and tone of speech, work out how much eye contact is comfortable for that child
• Use play and art (age dependent, enabling the child’s creativity, imagination and themes) e.g. drawing, puppets or little characters to comment on what the child does and what you observe. Give minimal responses about your observations, eg ‘You’re drawing’, not ‘What a good picture’ ie observe rather than giving positive feedback.
• Help the child express emotions and unexplored issues, give the child affirmation (Geldard, Geldard and Yin Foo, 2013).

As you reflect on content and feeling, be clear about the difference eg ‘Sounds as if your mother and father (grandmother) aren’t around much’ rather than ‘you sound sad, scared, angry’, which may trigger the child’s emotions.

Observe the child in a non-intrusive way, without voicing judgement or giving interpretations.
• Observe the child’s appearance (nutrition, clothing, cleanliness, mannerisms)
• behaviour (quiet, boisterous, distractible, affectionate, anxious, risk taking),
• mood emotions (happy, sad, fear, no emotions, absorbed, aggressive),
• development – cognitive / intellectual functioning (age dependent – problem solving, conceptualisation, insight, sense of reality and organisation of thoughts, imagination and magical thinking?)
• speech and language (verbal non-verbal forms of communication, clarity of speech, stammers?),
• motor skills (gross and fine motor coordination, movement, sighing),
• relationships with parents, siblings, grandparents and other family, you - social work/ counsellor, friends, teachers (warm, friendly, mis/trustful?)
• indicators of trauma – see (DHHS, 2007).

At the end, let them know when you are about to end your time with them; link the child to their parent, caregiver or other supports; summarise to help the child clarify confusing situations or to end the session (Geldard, Geldard and Yin Foo, 2013).

References


Module 3: Ethical and Legal issues in Child Protection

(The tutor needs to plan more time for this module)

To the tutor: To teach this module, you need to

a. have studied the general social work modules Human Rights, Ethics and Values in Social Work as this module builds on that.
b. Invite a lawyer to give the lecture on the Palestinian Child and other relevant laws
c. Invite a Child Protection Officer to discuss the ways the Child Protection system works
d. Read the CRC principles, UNICEF 2017 on Child Protection systems and Lonne et al’s 2015 Ethical Decision making DECIDE model
e. Develop a case example to use in class and for assessment

Students should have studied and know how to do case management prior to this module.

Module Description

This module builds on earlier social work modules on human rights, social justice and ethical decision making. It reviews international social work and United Nations conventions, Palestinian laws and presents a model for ethical decision making for working with vulnerable children and young people.

Module Outline

2. Legislation
3. Ethical Decision making in Child Protection and Youth Justice

Assessment

a. Exam question

Q: Identify one international convention and one Palestinian law that pertains to violence and abuse to children and young people in Palestine and give an example of how each can be used to prevent or respond to child maltreatment.

Assessment Criteria:

- Accurate selection of convention and law with good example of application
- Should be familiar eg UN Convention on the Rights of the Child.

b. Essay assignment: (Provide a case example). Use the DECIDE model or Dolgoff et al’s hierarchy of principles to demonstrate how you would make ethical decisions to address the risks for the children and young people.

Assessment Criteria

- High level understanding of the inclusive model of ethical decision making
- Accurate demonstration and analysis of key concepts relevant to the scenario
- Attention to other ethical considerations in this scenario
- Written clearly and coherently; appropriately referenced throughout; required word length.

Lecture on Ethics and Legal issues in Child Protection


To the tutor: Make available the Convention on the Rights of the Child before class.

The Convention on the Rights of the Child was adopted by the United Nations in 1989 and is ratified by 191 countries. Although the Convention has the status of international law, it is not legally binding on public authorities or professionals unless state parties have incorporated its provisions into their domestic law.

CRC Definition of The Child (Article 1): The Convention is explicit about the definition of a child. A child is every person under 18 unless by law children attain majority at an earlier age. The IFSW covers civil, criminal, constitutional and employment law, the child’s rights to know biological parents, access to education, sexual consent and marriage, voluntary and forced conscription into the armed forces, religious freedom, use of alcohol, tobacco, drugs and other controlled substances (IFSW 2002 Social Work and the Rights of the Child).
The International Federation of Social Workers (IFSW) 2002 develop guidelines for social workers to respect and implement the CRC. They provide five building blocks to working from a children’s rights perspective (IFSW, 2002:8-9).

1. The acceptance that children are people now, not people-in-the-making. It is critical that social workers respect and value children as complete human beings from the moment they are born. This does not deny that children will change and develop over the years. However, it does accord them full human status from birth.

2. The acceptance that childhood is valuable in its own right and is not simply a stage towards adulthood. This has major implications for social programs and services, shifting the emphasis of work with children to the here-and-now of their experience. If this perspective were universally accepted education systems, for example, would be founded on children’s self-fulfilment and happiness as people today in addition to the need for them to acquire skills and qualifications for their future adult lives.

3. Working from a children’s human rights perspective acknowledges that children are active agents of their own lives. Every person can only live one life. Social workers must not underestimate children’s accumulated knowledge and insights into their own needs and life history. Although they may have access to information not shared with children, social workers must never assume they know more about a child’s life than the child.

4. Age discrimination needs to be identified and tackled, recognising that children across the globe are treated less seriously than adults simply because of their age.

5. A commitment to working from a children’s human rights perspective requires social workers to address the special vulnerability of infants and children, arising from their smaller size and physical strength and from their low status and dependency on adults. Children are vulnerable because they do not have the physical strength, experience or psychological capacity to withstand pressure from adults. This can easily lead to situations of exploitation and abuse (IFSW, 2002).

2. Legislation

To the tutor: A child protection lawyer could give this lecture, the contents of which are taken from UNICEF 2017, Child Protection Mapping. If a lawyer is not available, use this and UNICEF 2017: 17, Section 3.1 Legislative and Policy Framework as the basis for the lecture yourself.

Background and context of the law

The legal system contains a myriad of laws adopted from various periods including the Ottoman Empire, the British Mandate period, Jordanian Laws (specifically relating to the West Bank), Egyptian Laws (specifically relating to Gaza), Israeli military orders, and Palestine National authority (PNA) laws that are still in effect. These outdated, mostly “non-rights” based laws undermine the ability to adjudicate children’s rights which leads to violations of some children’s rights when they come into contact with the judicial system. This is most notable regarding juvenile justice which is legislated through a 1954 Jordanian law. The current legal system is complicated by the presence of the Family Law/Personal Status Law which is under the jurisdiction of Islamic or Christian religious courts and handles some issues relevant to children (custody, inheritance, orphans). The Amended Palestinian Basic Law and the Palestinian Child Law of 2004 override all preceding laws. However, since the Child Law amendments were introduced, they are not fully recognised and enforced in Gaza. Hopefully, the political reconciliation process will bring unity to laws and their implementation in justice systems in West Bank and Gaza. Shariah courts are not required to apply the Child Law. However, in 2009, the Chief Islamic Justice Tamimi, disseminated an internal memorandum addressing all Islamic religious judges to review and take into consideration the Palestinian Child Law when dealing with children’s issues. Although this memorandum is not binding, it provides an indication that improved justiciability of children’s rights within religious courts is possible (UNICEF, 2017).

Legal definition of a child

According to the Palestinian Child Law No. 7 2004 and its amendments, the child is defined as any human being under the age of eighteen years, including the unborn.

The Palestinian Basic Law includes specific guarantees of children’s rights. Article 29 states that maternal and childhood welfare are national duties, and children have the right:

- to comprehensive protection and welfare;
- to be free from all forms of exploitation, including works which might damage their safety, health, or education; to protection from harm and cruel treatment;
- not to be subject to beating or cruel treatment by their relatives;
- and to be segregated from adults, in case they are sentenced, and to be treated in a manner which is appropriate to their age and aims at their rehabilitation.

The Child Law incorporates the principles of:

- non-discrimination (Article 3),
- child participation (Article 12)
- and the best interest of the child, stating that “considerations shall be given to the best interests of the child in all actions, whether undertaken by legislatures, courts of law, administrative authorities and/or public or private social welfare institutions” (Article 4).
• recognizes the fundamental role of parents and family in the care and upbringing of children (Article 5),

• obligates the State to support families in ensuring children’s needs and rights for growth, survival, and optimal development are met by guaranteeing health, education, and social services for children. In addition, the State must take all required legislative, administrative, social, educational and preventive measures to ensure children’s right to protection from all forms of physical, moral or sexual violence or abuse, neglect, inadequate care, vagrancy or any other form of abuse or exploitation (Article 42).

The Child Law is grounded in a rights-based approach, and includes a general guarantee of children’s rights in line with the CRC. The minimum age for criminal responsibility (12 years in the West Bank and 9 years in Gaza), for engaging in labour (15 years)\(^2\), and for military recruitment (18 years) all conform with international standards. However, some anomalies remain. The minimum age for marriage is different for boys and girls (15 for girls and 16 for boys), and whilst children are criminally liable from the age of 12 years in the West Bank and 9 years in Gaza, they are not considered competent witnesses to give evidence under oath until the age of 15 years. (The Status of the Rights of Palestinian Children, 2013).

**Notification of child abuse**

The 2012 amendments to the Child Law provided greater guidance on the role of child protection officers to intervene to protect children, and introduced a structured process for reporting and intervention. It states that every person should notify a child protection officer whenever s/he finds that something is threatening a child’s physical or mental wellbeing or health or subjects a child to the risk of delinquency. Notification is mandatory for educators, physicians, social workers and others assigned with child protection and care. Difficult circumstances that threaten a child’s physical or mental wellbeing or health and require mandatory reporting are defined quite broadly to include (Article 44):

- Loss of his/her parents and becoming without family support;
- Subjected to negligence and vagrancy;
- Evident and consistent default in his/her upbringing and care;
- Habitual ill-treatment and caregiver’s lack of knowledge of the basics of proper upbringing;
- Exploitation of the child sexually, economically, in organized crime or in begging
- Having the habit to leave his/her place of residence or being absent without prior notification;
- Being absent from school without reason; and

Where a child protection officer receives a notification that involves a child in imminent danger (defined as an act that threatens a child’s life, physical or mental wellbeing or health or subjects a child to the risk of delinquency in a way that cannot be avoided over time), the child protection officer must carry out an initial investigation to verify seriousness of the notification within 24 hours. In all other cases, the investigation must take place within 72 hours (Article 55). In carrying out investigations, child protection officers have been given authority to interview the child and his/her caretaker, to enter any place where the child might be (with an urgent warrant or police accompaniment where necessary), and to take appropriate preventive measures in regard to the child, including banning any contact between the child and persons (Article 56) and temporarily removing the child to a place of safety in the event of imminent risk (Article 65).

**Implementation/Response**

Where an investigation determines that a child’s physical or mental wellbeing or health is threatened, child protection officers may resolve the matter through agreement with the child’s parents or caregiver (“measures of a reconciliation nature”), or refer to the case to a competent judge for a child protection order (Article 58). Measures of a reconciliation nature are generally designed to remove the threat to the child’s well-being, and may include (Article 59):

- Keeping the child in his/her family, with periodic monitoring by the child protection officer and commitment from the parents to abide by certain measures, as well as a plan for social services and assistance to the child and family;
- Handing temporary care of the child to a guardian, family member, relative, alternative family or officially recognized agency specialized in child care;
- Banning the child from attending certain places or from practicing a certain work;
- Taking one or more measures of reform, including placing the child under “social control”; compelling the child to carry out certain duties, such as joining suitable vocational, cultural, sports or social training courses; and temporally placing the child with a suitable family or public or private social, educational or health agency or institution.

Where the matter is referred to a judge, the judge may, having regard to Article 59, take any necessary measure to protect the child (Article 63). The child’s parents or caregiver and the child have the right to attend before the judge, and if the child’s age and/or maturity do not allow him/her to participate directly, the judge must assign a suitable person to convey the child’s views (Article 66).
Palestinian and Shari’a laws should be compared and the differences discussed with guidance from human rights lawyers on how to prioritise decisions when the laws clash. Advanced students will attempt their own interpretation of how to ethically respond from a social work ethical point of view but most students will need your and lawyer’s interpretation and examples of precedents in practice. Use the NRC (2011) Shari’a Courts and Personal Status Laws in the Gaza Strip or another source that outlines Islamic laws in relation to children, to outline the basic rights of the child in Islam:

- The right of the child to health
- The right of the child to be protected
- The right of children to education.

The lawyer may be able to clarify any contradictions with the Palestinian laws. You will need to identify contradictions with the IFSW principles and help students discuss the controversies.

Care Planning

The law on Child Protection Procedures and Realisation of Children’s Rights provides more detailed guidance on the roles, responsibilities and authority of child protection officers in dealing with cases of children in need of protection. The law focuses exclusively on response to reported or identified incidents of child abuse, with limited guidance on a broader mandate with respect to prevention, family strengthening and early intervention. In addition, the proposed response process is oriented towards an investigative and enforcement approach, rather than working collaboratively with parents, extended family and community leaders to understand and address child protection concerns. Focus is primarily on investigation, evidence gathering and verification of notifications, with support of the police where necessary. Care plans are developed through coordination with network partners and the referral system, but there is no provision for active involvement of children, parents, extended family and community leaders in the care planning or decision-making process. The by-laws make provision for actions to be taken to protect the child through voluntary agreement with the parents, but conditions of the agreement are described as being explained to and affirmed by the child and parents, rather than developed together through a collaborative process between the child protection officer and family. The case must be referred to a judge if an agreement is not reached within twenty days after the child protection officer has assumed the case, or if any agreement is breached. Child protection officers must provide on-going monitoring, support and periodic review of the agreement and any remedial measures.

The By-laws also reinforce the importance of an inter-agency approach to child protection, and states that the role of all competent agencies should be defined through memorandum of understanding and through the national referral system.

The referral protocol is based largely on a formalised, multidisciplinary case management process, with standardised forms for registration, risk assessment, case planning and inter-agency referral. Under the protocol, as stipulated in law, all cases of violence against children must be referred to the child protection officer, who conducts a preliminary assessment, takes necessary protective action in partnership with the police and convenes a multi-agency case conference to develop a care plan. Based on the agreed plan, the child and family are then supported and followed-up over a period of time, guided by the individual needs of the child and family (UNICEF, 2017).

They are also based on a professionalised, multidisciplinary approach to case management, with a similar but more detailed process for identification and registration of cases, initial assessment and safety planning, comprehensive assessment and case plan development, following up and review, and case closure. They also include a set of standard registration, risk assessment and care planning forms, which are different from those in the National Child Protection Referral Protocol.

In complex cases, provision is made for an inter-agency case conference with a panel of experts, convened by case conference with a panel of experts, convened by MoSD case conference focal points and including representatives from the Child Protection Network members and relevant representatives from other sectors in the society, as it came in the National Referral System which encouraged the intervention of the community leaders and family conferencing as long as the Child Protection Officer is present and represents the best interest of the child. Decisions of the panel of experts are binding, and may be “endorsed” as necessary by a judge.

Non formal responses to child abuse and neglect are generally used instead of the formal child protection system.3 Extended family, neighbours or other community members who are influential and trusted by the family play a significant non-formal role in addressing child abuse and neglect. Tribal judges sometimes solve disputes based on tribal customs, mainly in Bedouin communities, Islah men settle disputes relying on customs and Shari’a law and Mukhtars will intervene in family and community matters including child abuse and neglect (UNICEF, 2017).

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3 According to national referral protocols there are provisions for social protection interventions including case confer-
ences and family group conferencing.

4 The tutor needs to know and bring to the attention of the students the difference between the tribal law and the restor-
ative justice which are two completely different concepts. In addition, the tutor needs to highlight the concept of Rights Based
Approach in dealing with matters related to children.
3. Ethical Decision making in Child Protection and Youth Justice

Ethics are important in child protection and youth justice because of the vulnerability of children and youth, unequal power relationships and the centrality of relationships in effective practice, all of which can be exploited. Young people, children and infants have less power than adults, but their parents can feel powerless, especially in the face of statutory bureaucratic powers. Families whose children come under the scrutiny of child protection and youth justice have usually experienced poverty, unemployment, mental illness, alcohol and drug addictions, disability and dislocation, demographics that rate highly in Gaza, where ongoing conflict and violence from the Occupation creates another layer of oppression for families (Lonne et al., 2015).

Legislation prescribes compliance for certain behaviours but the Social Work Code of Ethics (IFSW, 2012) provides guidance for addressing human rights, ethical relationships and for decision making to honour the rights of children and youth.

Some child welfare practices are morally and ethically indefensible. Many young people are harmed (physical and sexual abuse) in residential care, separated from parents, siblings, grandparents, caring neighbours, incarcerated in shocking conditions, exposure to crime, lack treatment for trauma and further abuses, and have poor access to education and employment opportunities.

Ethical practice includes how workers relate to children, youth and their families as well as how policies are made and implemented to promote respect, justice and care for children and youth. Injustice can be perpetrated in the guise of ‘protection’, for example removing a child from their family to live indefinitely in worse, unloving abusive conditions.

Ethical decision-making requires social workers’ and Child Protection Officers’ critical reflection about the contextual complexities in people’s lives to make sound decisions that do not harm the child or young person.

Principles for ethical relationships in Child Protection and Youth Justice

(Lonne et al., 2015)

1. **Respect and advocacy** for the Child or Young Person’s right to be heard, believed and safe. Children and youth find the processes of ‘care and protection’ to be intimidating, oppressive, uncaring and abusive. They are usually not included in decision making about their lives, because adults don’t invite them or trust their capacity to make good decisions and professional and parental voices override children’s and young people’s voices.

2. **Confidentiality** Young people expect that what they tell you will remain confidential, so inform them at the outset about the limits of confidentiality: ‘Be careful what you tell me as I’ll have to pass it on, for example if you threaten to harm anyone or yourself. Social workers have to balance the young person’s need for confidentiality and parents’ desires for information.

   - To the tutor: it is important to clarify the differences between the limits to confidentiality for a Child Protection worker and social workers in other roles.

3. **Role clarification and Limits:** Vulnerable children and young people are easy prey for friendship, closeness and romantic attachment so inform them of the obligations and limits of your role. Set boundaries, keep records safely, follow your mandate and report behaviours as transparently as possible with the child or young person’s awareness and input.

4. **Professional Obligation:** Schools and workplaces have a responsibility to report abuse and deal effectively with interpersonal and professional conflicts. Obtain child’s permission before sharing information with the family and other professionals, unless it is unsafe to do so, as long as this doesn’t contradict the law about the obligation of reporting abuse to child protection officers and the police. Inform and seek young person’s consent to referrals, work out what will be said to the other person, check the credentials and competence of the other service, facilitate the handover, and if they don’t want referral, continue to work with them with advice from a supervisor.

5. **Legal obligations:** Mandatory reporting of child abuse and neglect means that social workers can be held legally responsible for not reporting abuse, not warning someone of a threat to their life or property. Case notes can be subpoenaed so must be evidence based in case you have to give evidence in court. Be aware of privacy and confidentiality obligations and limitations.

6. **Counselling competence:** be aware of your limits, seek supervision and accredited training. Be aware of values and attitudes, explore how they affect your practice. Reflective practice: what did you do well? What could you have done better? What might have happened if you did X instead of Y?
7. **Supervision:** for another opinion of the situation and practice, address dependency and professional boundaries, upgrade skills and knowledge and work through own issues. Self-care is an ethical issue as you need to be well to be empathetic and tuned into the client’s issues rather than your own, which is hard if you’re burnt out, symptoms of which are compassion fatigue, uncharacteristic angry outbursts, emotional and physical exhaustion (Lonne et al., 2015).

To the tutor: As a child protection worker you will hear and see a lot of traumatic experiences. The impact of secondary trauma is psychologically similar to experiencing traumatic events. Supervision offers the opportunity to debrief and process some of the powerful emotions. This will be covered in the Module 4c on Trauma.

**The DECIDE model of ethical Decision making** (Lonne et al. 2015)

- Define the problem: what are the facts, who is involved, who has a stake in the decisions?
- Ethical Review: which principles are relevant, who holds power and responsibility?
- Consider options: legal, procedural and practical constraints, include child’s views.
- Investigate outcomes of all options against duty, justice and respect
- Decide on action: commit to a well-reasoned plan that does least harm to the child
- Evaluate results: reflective and reflexive practice to consider what has worked or no

To the tutor:

**Class Activity**

To bring together the challenges of ethical principles, legislation and ethical decision-making, ask students in small groups to discuss ethical decision making using either or Lonne et al’s (2015) DECIDE model or Dolgoff, Lowenberg and Harrington’s (2009)

Hierarchy of principles model (McAuliffe, 2014):  
1. Protection of Life  
2. Equality and inequality  
3. Autonomy and freedom  
4. Least harm; quality of life  
5. Privacy and confidentiality  
6. Truthfulness and full disclosure.

**References**


Module 4a: Theories and Principles for Child Protection

Module Description
The module provides an overview of theories and principles to inform social work with families affected by child abuse and neglect, including: systems theory, cultural sensitivity, development and trauma and gender awareness. Social workers should use these theories in analytical, dynamic, strength based, outcome-focused and relationship based responsive, professional judgement. The Best Interests Case Practice Model promotes these theories in child focused, family centred practice (DHHS, 2012).

Lecture

Systems theory
Systems theory underpins the model in its focus on the 'person-in-environment'. Child abuse is seen as a result of ‘multiple interacting factors’ including the child’s relationship with the family and community, the balance of external supports and stresses, both interpersonal and material and the living conditions of children’s lives.

Cultural sensitivity
Culture is central to the healthy development of children. It is therefore important that social workers ask the family for their definition of who should be involved in particular assessments, interventions and planning activities, rather than making assumptions about who is family or community for this child.

Developmentally and trauma informed practice
Social workers need to be informed about developmental trends and the detrimental impact of neglect, abuse and trauma on the developing child, including the impact of disrupted attachment and abuse on the neurological development of infants. The model draws on research and clinical literature from the child abuse, sexual abuse, family violence and offender literature as well as the trauma, attachment and child development evidence base. For a more thorough exploration of the relevant theoretical, research and evidence base, it is recommended that you read the Child development and trauma guide and papers on the Best Interests principles, cumulative harm and stability, which are available at DHHS (2007 and 2012).

Except where there are obvious signs, social workers assessing a child would need to see them a number of times to establish that there is something wrong. Children who are in a new or ‘artificial’ situation, unwell, stressed, interacting with someone they do not know, or if they need to be fed or changed, will be display behaviour that is not likely to be typical for that child. Premature babies, or those with low birth weights, or a chemical dependency, will generally take longer to reach developmental milestones.

Gender aware analysis
The dynamics of power, hierarchy and gender need to be assessed by practitioners who are mindful of the disproportionate nature of gender-based violence such as family violence on females, sexual assault on children, the differential responses to family violence by boys and girls and the need for a gender specific response to the needs of boys and girls by practitioners.

A gender analysis alerts us to the prevalence of ‘mother blaming’ within our culture. Mothers are more likely to be the major rehabilitative support figure, so they are more likely to be blamed for anything the professionals view as inappropriate.

Family violence affects one in two Palestinian women and is perpetrated largely by men (UNICEF, 2017). A gendered response means being aware of the likelihood of specific issues impacting differently on men, women, boys and girls. Children have gender differential responses to family violence: as a generalization, girls tend to internalize and boys act out. In terms of risk, girls are at higher risk of victimization as adults and boys at greater risk of perpetrating as adults. Witnessing parental violence is the strongest predictor of perpetrating violence in young people’s own relationships.

In responding to family violence, practitioners must:
- acknowledge violence as a violation of human rights and unacceptable in any form
- provide a strong justice response in dealing with family, physical or sexual violence
- act to increase the safety of women and children experiencing family violence
- recognise and address the power imbalance and gender inequality between those using violence (predominantly men) and those experiencing violence (predominantly women and children)
- hold men accountable for their violence and challenge them to take responsibility for their actions
- hear and represent the voices of women and children who have experienced violence

(Module 6b explores these issues further.)
Dynamic and responsive
Assessment and intervention with families are dynamic processes. Each stage informs the next. Reviewing the outcomes of practice often leads back to needing to know more and to alter the case plan in response to the feedback from the family and service system.

The processes of information gathering and analysis form the basis of good assessment, which in turn informs any planning and action. The model captures the circular nature of family work, the importance of reviewing the effectiveness of our work, and remaining attuned to the changing needs of the family. Good supervision and a commitment to collaboration are essential (more about supervision in Module 4c).

Professional judgement
Risk assessment within the Best Interest model relies on a professional judgement. All decisions should be based on significant historical and current information and shared analysis. The Best Interest Risk Framework focuses on evaluating the key areas of the:
- severity of the harm to the child
- vulnerability of the child
- strengths and protective factors within the family
- likelihood of further harm.

Consultation and shared decision making are essential aspects of good professional judgement.

Strength based
A strength based approach acknowledges the positive aspects of the family and looks for exceptions to the problem-saturated descriptions. A strength based approach looks for what parents and children do well despite problems, how they have tried to overcome their problems, and explores their aspirations and hopes. This approach is transparent and does not avoid difficult conversations about discrepancies in family members’ accounts of events. It is informed about child abuse and offending behaviour and is not naïve about the dangerous circumstances some children experience.

Practice needs to be both strength based and forensically astute, and be respectful and courteous at all times. The goals of the intervention should be developed with the immediate and extended family and it is critical that they are concrete, behavioural and measurable. Parents need to know when they have been successful. Practitioners need to engage them in meaningful ways that build confidence.

Professionals are in a powerful position in relation to children and families and the wise use of our authority requires expert listening skills to what is being said and keen observation of what is not being said. A strength based approach is solution focused and engages the family in providing a safe environment for the children.

‘Most families care deeply about their children’s development. Most parents make mistakes, often because they buckle under the stress of family life. Most parents believe it is a bad thing to hit children but nine in ten will do so at some point. Most parents resent being told how to bring up their children, but will welcome practical support when it is offered as a response to identified social needs’ (DHHS, 2012).

A relationship that seeks to understand, and invites responsibility rather than blame, will always yield a better assessment and case plan, and therefore better outcomes for children, young people and their families. It is possible to help people to face up to behaviour they are ashamed of and defensive about, if you have established a rapport that is respectful. This is possible if you:
- acknowledge their difficult context
- listen and explore the pressures they have been under
- validate their good intentions.

Where there is violence in the family, the perpetrator needs to be held accountable and engaged in taking responsibility for change. Children, young people and women should be supported and linked with services that will facilitate their recovery.

Outcome focused
The case practice model encourages a culture of reflective practice where the outcomes and process of our practice are regularly reviewed thorough such questions as: Is the child safe? What could or should we do differently in the light of what we know, or don’t know now, and what does this child need right now?

Assessment and planning are dynamic processes and need to be modified in the light of feedback about the effectiveness of our interventions.

The recovery process for children and young people who have been harmed is enhanced by the belief and support of protective family members, significant others and connection to their culture. Children and young people need to be made safe and given opportunities to grieve, and to make sense of the trauma they have experienced to maintain connection with their parents, siblings, extended family and or carer, school, community and culture. These children need calm, patient, safe and nurturing parenting in order to recover. Children who have experienced significant harm often need a range of professionals working together to deliver supports to assist their recovery.

Relationship based - child focused and family centered
Building good relationships with children, young people, their families, community members and other services, enables a more informed assessment to occur and provides the cornerstone for effective case work. Information from multiple sources and perspectives will always provide a stronger basis for effective practice. This practice model is based on the relationships that practitioners develop with children and families that engage them in a process of change. Purposeful engagement takes skill, empathy and emotional intelligence to manage often conflicting agendas. There is a clear link between better outcomes for children and greater involvement of parents.

Engagement is a consequence of relationship building with the family, that eventually develops shared goals, leading to purposeful change. This relies on there being some agreement and enough trust to begin to work together. Families have often experienced such pain, loss and violence that extraordinary courage and resilience is required to even begin to engage with a new service or practitioner. They may also be carrying the hurt and anger from previous experiences of the system. They often have very high needs and expectations but feel hopeless that this practitioner will be able to help. Asking families what they see as solutions and then responding in practical ways to their needs, usually expediates the engagement process.
Module 4b:

Child development and attachment theories

Module Description

Child development and attachment theories contribute important information when assessing what is best for children who are at risk. Identifying how children are developing, how they respond to the adults who look after them and what impact past experiences of abuse and neglect have had contribute to decisions about whether to remove or leave children with adult carers. This module covers child development and attachment theories in relation to children at risk of abuse and neglect.

Module Outline

1. Theories of Child Development
2. Attachment Theory

Module Assessment

Essay assignment: Provide a case study.

Q: Choose one of the following theories: developmental, attachment or trauma. Describe the theory and how you would use it to assess the situation and emotional wellbeing of one of the children in the case study and what the theory implies about their future.

Assessment criteria: Theory described clearly with 5 identifying points applied to the case.
1. Theories of Child Development

Developmental theories focus on the changing physical, psychological, moral and/or social characteristics of children over time. Theories state that children progress through a succession of stages, each with certain developmental tasks to be completed. This takes place in the context of significant emotional relationships, by blood, adoption, marriage or commitment.

Family life cycle models identify stages for families, such as young people leaving home, coupling, child rearing, separation, divorce, re-partnering and retirement, each of which involves tasks and emotional challenges for individuals and the whole family. Used with an analysis of power, conflict, culture and diversity, knowledge of developmental stages can guide social workers’ assessment of infants, children’s, young people’s and families’ development and functioning.

The following child development and trauma guide is underpinned by a multi-theoretical perspective. It draws on research and clinical literature from the child abuse, sexual abuse, family violence and offender literature as well as the trauma, attachment and child development evidence base. For a more thorough exploration of the relevant theoretical, research and evidence base see Every Child Every Chance Child Development and Trauma Guide (DHHS, 2007).

Critique of developmental theories

If the guide to ages and stages is taken literally, professionals can over categorise children and blame parents or carers if their child does not appear to have reached age appropriate stages of development. Parents of children with a disability cannot experience discrimination and exclusion if their child is not at the developmental stage of their peers.

Child Development and Trauma Guide (DHHS, 2007)

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To the tutor: Whilst child development is universal, there may be aspects in social development in this guide that differ in the Palestinian context so the tutor needs to contextualise this to the Palestinian context where there is any deviation and difference.
### Child Development and Trauma Guide 1 - 3 years

#### Developmental Trends

<table>
<thead>
<tr>
<th>By 12 months</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Enjoying communicating with family and other familiar people</td>
<td>Does not like to be separated from familiar people</td>
<td>Picks up objects using thumb and finger</td>
</tr>
<tr>
<td>Seeks comfort and reassurance from familiar objects, family, carers, and</td>
<td>Moves away from things that upset or annoy</td>
<td>Pulls up to standing position</td>
</tr>
<tr>
<td>can be soothed by them</td>
<td>Can walk with assistance holding on to furniture or hands and</td>
<td>Gets into a sitting position</td>
</tr>
<tr>
<td>Begins to self-soothe when distressed</td>
<td>explores indicates wants in ways other than crying</td>
<td>Claps hands</td>
</tr>
<tr>
<td>Expresses feelings with gestures, sounds, and facial expressions</td>
<td>Doing things repeatedly</td>
<td>May even be able to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Understand that when you leave, you still exist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Crawl, stand, walk</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>By 2 years</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Takes off clothing</td>
<td>Plays alone but needs an adult nearby</td>
<td>May even be:</td>
</tr>
<tr>
<td>Likes to help</td>
<td>Plays and explores in complex ways</td>
<td>Able to string words together</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unable to share</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Having tantrums</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>By 3 years</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifies a friend by naming speaks and can be usually understood half the</td>
<td>Conversation of two or three sentences</td>
<td>Conscience is starting to develop; child thinks “I would take</td>
</tr>
<tr>
<td>time</td>
<td>May be toilet trained</td>
<td>it but my parents will be upset with me”</td>
</tr>
</tbody>
</table>

#### POSSIBLE INDICATORS OF TRAUMA

- Regression to behavior of a younger child
- Inability to relax
- Increased startle response
- Reduced eye contact
- Fight, flight, freeze
- Uncharacteristic, inconsolable, or rageful crying
- Neediness
- Withdrawal/lack of usual responsiveness
- Loss of self-confidence
- Sleep and eating disruption
- Loss of recently acquired motor skills
- Avoidance of eye contact
- Inability to be soothed
- Anxiety when separated from primary caregivers
- Indiscriminate attachment behavior
- Reduced capacity to feel emotions can appear “numb” apathetic or limp
- Uncharacteristic aggression avoids touching new surfaces eg. grass, sand
- And other tactile things avoids, or is alarmed by, trauma related reminders,
- E.g. sights, sounds, smells, textures, tastes and physical triggers
- Loss of acquired language skills
- Inappropriate sexualized behaviors
- Touching sexualized play with toys
- Genital pain, inflammation, bruising, bleeding
- Diagnosis of sexually transmitted disease

### Child Development and Trauma Guide 3 – 5 years

#### Developmental Trends Between 3-4 years

- Communicates freely with family members and familiar others
- Seeks comfort, and reassurance from familiar family and careers, and is able to be soothed by them
- Understands the cause of feelings and can table them

#### Between 4-5 years

- Knows own name and age
- Is asking lots of questions

#### POSSIBLE INDICATORS OF TRAUMA

- Behavioural change
- Regression to behavior of younger child
- Uncharacteristic aggression
- Reduced eye contact
- Lack of concentration and inattentiveness
- Complains of bodily aches, pains or illness with no explanation
- Loss of recently acquired skills (toileting, eating, self-care)
- Sleep disturbances, nightmares, night terrors, sleepwalking
- Fearfulness of going to sleep and being alone at night
- Inability to seek comfort or to be comforted
## Social Work Curriculum Including Child Protection Modules

### Child Development and Trauma Guide 5-7 years

<table>
<thead>
<tr>
<th>Social-emotional development</th>
<th>Physical skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>has strong relationships within the family and integral place in family dynamics</td>
<td>conscience is starting to be influenced by doing the right thing may become frustrated by failure</td>
</tr>
<tr>
<td>anxious to please and to gain adult approval, praise and reassurance</td>
<td>able to share, although not all the time</td>
</tr>
</tbody>
</table>

**Cognitive and creative characteristics**

<table>
<thead>
<tr>
<th>emerging literacy and numeracy abilities, gaining skills in reading and writing good communication skills, remembers</th>
<th>may require verbal, reminders to follow directions and obey rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>most valuable learning occurs through play rules more likely to be followed if he/she has contributed to them</td>
<td></td>
</tr>
</tbody>
</table>

**POSSIBLE INDICATORS OF TRAUMA**

<table>
<thead>
<tr>
<th>behavioural change inability to relax sleep disturbances, nightmares, night terrors, difficulty falling or staying asleep regression to behaviour of younger child anxiety, fearfulness and loss of self esteem fears</th>
<th>lack of eye contact toileting accidents/ smearing of faces eating disturbances repeated retelling of traumatic event withdrawal, depressed affect blanking out or loss of concentration</th>
</tr>
</thead>
<tbody>
<tr>
<td>bodily aches and pains-no apparent reason accident proneness absconding/truanting from school fire-lighting, hurting animals aggressive, exploitive, sexualized relating/ engagement with other children, older children or adults sexualized drawing excessive concern or preoccupation with private parts and adult sexual behavior running away from home</td>
<td></td>
</tr>
</tbody>
</table>

### Child Development and Trauma Guide 7-9 years

<table>
<thead>
<tr>
<th>Physical skills</th>
<th>Social-emotional development</th>
</tr>
</thead>
<tbody>
<tr>
<td>improved coordination, control and agility</td>
<td>conscience and moral values become internalized “I want it, but I don’t feel good about doing things like that”</td>
</tr>
<tr>
<td>often practices new physical skills over and over for mastery</td>
<td>increased confidence, more independent and takes greater responsibility</td>
</tr>
<tr>
<td>improved stamina and strength</td>
<td>peers seen as important friendships are based on common interests feelings of self-worth comes increasingly from peers begins to see situations from others perspective - empathy able to resolve conflicts verbally and knows when to seek adult</td>
</tr>
</tbody>
</table>

**Self Concept**

<table>
<thead>
<tr>
<th>influenced by media and peers learns to deal with success and failure</th>
<th>may compare self with others and find self wanting, not good enough can exercise self-control and stop desires to engage in undesirable behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>can manage own daily routines understands right from wrong</td>
<td></td>
</tr>
</tbody>
</table>

**POSSIBLE INDICATORS OF TRAUMA**

<table>
<thead>
<tr>
<th>behavioral change increased tension, irritability, reactivity and inability to relax sleep disturbances, nightmares, night terrors, difficulty falling or staying asleep obvious anxiety regression to behaviour of younger child</th>
<th>lack of eye contact toileting accidents/ enuresis, or smearing of faces eating disturbances blanking out/ loss of ability to concentrate hinting about sexual experience may appear “numb” or apathetic</th>
</tr>
</thead>
<tbody>
<tr>
<td>toileting accidents / enuresis, encopresis or smearing of bodily aches and pains-no reason accident proneness absconding/truanting from school fire-lighting, hurting animals sexualized drawing or written “stories” running away from home</td>
<td></td>
</tr>
</tbody>
</table>
**Child Development and Trauma Guide 9 – 12 years**

<table>
<thead>
<tr>
<th><strong>Physical</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>large and fine motor skills becoming highly coordinated</td>
<td>does well at games/sports requiring skill strength and agility</td>
</tr>
<tr>
<td>enjoys risk taking</td>
<td>may look more adult-like in body shape, height and weight</td>
</tr>
<tr>
<td></td>
<td>risk taking</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Social-emotional development</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>growing need desire for independence and separate identity may challenge parents and other family members</td>
<td>may experience embarrassment, guilt, curiosity and excitement because of sexual awareness</td>
</tr>
<tr>
<td>parents and home important, particularly for support and reassurance</td>
<td>girls may reach puberty during this time belonging to a group is extremely important:</td>
</tr>
<tr>
<td></td>
<td>gr oups generally one gender</td>
</tr>
<tr>
<td></td>
<td>strong desire to have, opinions sought and respected</td>
</tr>
<tr>
<td></td>
<td>growing sexual awareness and interest in the opposite gender</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Cognitive and creative characteristics</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>beginning to think and reason in a more logical adult-like way capable of abstract problem solving</td>
<td>concentrates for long periods of time if interested, but needs worries to be sorted popular culture of great interest</td>
</tr>
<tr>
<td></td>
<td>uses language in sophisticated ways; eg. Tells stories, argues, debates</td>
</tr>
<tr>
<td></td>
<td>knows the difference between fantasy and reality</td>
</tr>
<tr>
<td></td>
<td>has some appreciation of the value of money</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>POSSIBLE INDICATORS OF TRAUMA</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>increased tension, irritability, reactivity and inability to relax sleep disturbances, nightmares, night terrors, difficulty falling or staying asleep regression to behaviour of younger child may appear “numb” or apathetic repeated retelling of traumatic event</td>
<td>reduced eye contact toileting accidents/ enuresis, or smearing of faces eating disturbances</td>
</tr>
<tr>
<td></td>
<td>bodily aches and pains no reason accident proneness abscending or truanting from school fire lighting, hurting animals sexualized drawing or written “stories” running away from home verbally describes experiences of sexual abuse and tells stories about the ‘game’ they</td>
</tr>
</tbody>
</table>

**Child Development and Trauma Guide 12 - 18 years**

<table>
<thead>
<tr>
<th><strong>Physical development</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>significant physical growth and body changes develops greater expertise/ skills in sport</td>
<td>changing health needs for diet, rest, exercise, hygiene and dental care puberty, menstruation, sexuality and contraception</td>
</tr>
<tr>
<td></td>
<td>nutritious balanced diet including adequate calcium, protein and iron</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Self-concept</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>can be pre-occupied with self</td>
<td>dealing with own sexuality and that of peers</td>
</tr>
<tr>
<td></td>
<td>developing identity based on gender and culture</td>
</tr>
<tr>
<td></td>
<td>becoming an adult, including opportunities and challenges</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Social-emotional development</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>empathy for others</td>
<td>may explore sexuality by engaging in sexual behaviours and intimate relationship</td>
</tr>
<tr>
<td></td>
<td>seeks greater autonomy and intimate relationship</td>
</tr>
<tr>
<td></td>
<td>becomes firmer and affects views and opinions</td>
</tr>
<tr>
<td></td>
<td>beyond parents and family</td>
</tr>
<tr>
<td></td>
<td>peer assessment influences self-concept</td>
</tr>
<tr>
<td></td>
<td>focuses on the present</td>
</tr>
<tr>
<td></td>
<td>may take significant risks</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>POSSIBLE INDICATORS OF TRAUMA</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>inability to relax accident proneness reduced eye contact sleep disturbances, nightmares acute psychological distress personality changes in quality of important relationships evident</td>
<td>enuresis, encopresis eating disturbances/ disorders absconding or truanting and challenging behaviours substance abuse wish for revenge and action oriented responses trauma partial loss of memory and ability to concentrate</td>
</tr>
<tr>
<td></td>
<td>aggressive/violent behaviour fire-lighting, hurting animals suicidal ideation self-harming eg. Cutting, burning trauma flashbacks running away from home</td>
</tr>
</tbody>
</table>
2. Attachment Theory

Definition, origins, types of attachment, the impacts of disrupted attachment on children’s security, development and personality and how attachment theory can be used in child protection decision making processes.

What is Attachment?

Attachment theory is a psychological theory to explain how children interact with the adults looking after them. John Bowlby (1907 – 1990) was a psychiatrist who developed the ‘theory of attachment’, suggesting that infants are born with an innate need for proximity and attachments to others, as a means of survival. Children seek proximity to their primary attachment figure through crawling, smiling and crying. A child needs to have a strong attachment for at least the first two years of existence to form a secure base. The secure base provides a safe haven from which the child can explore, relate and learn, and return to in times of fear or stress.

Attachment can be understood as the enduring emotional closeness that binds families and to prepare children for independence and parenthood (Crittenden and Claussen, 2000). The child’s responsiveness is important in the process. Children display fear and insecurity at separation to elicit responses from the primary attachment figure. Long term separation from or loss of an attachment figure can lead to long-term problems such as difficulties forming friendships or a lack of caring about anyone else. Bowlby stressed the importance of attachment in the early years yet not all mothers feel bonded to their infants following the birth of their child (Atwool, 1997).

A healthy attachment is achieved through ‘attunement’, where the caregiver is sensitive to the child’s needs and responds warmly and empathetically. Attunement occurs through the adults reading and responding responsibly and consistently to the child’s non-verbal, social-emotional cues of another. Attunement can be taught (Perry, 2013). Though positive and responsive attunement, the child learns to regulate their own emotions with and without the significant other (Batmanghelidjh, 2006).

Class Activity: Show Still Face Experiment

Class Activity: Video

Attachment theory was further developed by Mary Ainsworth (1913 – 1999) who developed an attachment assessment technique called the Strange Situation Classification. Babies and toddlers cannot use words to tell us how they feel so Ainsworth found a way for them to show her. Children were observed through a one-way mirror and the researchers noted the children’s reactions in a range of different circumstances.

Parent and infant alone.
Stranger joins parent and infant.
Parent leaves infant and stranger alone.
Parent returns and stranger leaves.
Parent leaves; infant left completely alone.
Stranger returns.
Parent returns and stranger leaves.

Mary Ainsworth Strange Situation video

Suggest students watch for four different categories of behaviour:
Separation anxiety – what does the child do when the caregiver leaves?
Willingness to explore – was the child confident to explore theory environment?
Stranger anxiety – how did the child react to the stranger?
Reunion behaviour – how did the child react when the carer/parent came back?

From these experiments Ainsworth classified attachment into 3 different types, secure, avoidant and ambivalent. This classification was further developed in 1990 by Main and Solomon to include a fourth category, Disorganised Attachment style.
Table 1. Strange Situation Classification Groups

<table>
<thead>
<tr>
<th>Group</th>
<th>Brief description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure (B)</td>
<td>Uses mother as secure base for exploration. Separation: Signs of missing parent, especially during the second separation. Reunion: Actively greets parent with smile, vocalization, or gesture. If upset, signals or seeks contact with parent. Once comforted, returns to exploration.</td>
</tr>
<tr>
<td>Avoidant (A)</td>
<td>Explores readily, little display of affect or secure-base behavior. Separation: Responds minimally, little visible distress when left alone. Reunion: Looks away from, actively avoids parent; often focuses on toys. If picked up, may stiffen, lean away. Seeks distance from parent, often interested in toys.</td>
</tr>
<tr>
<td>Ambivalent or resistant (C)</td>
<td>Visibly distressed upon entering room, often fretful or passive; fails to engage in exploration. Separation: Unsettled, distressed. Reunion: May alternate bids for contact with signs of angry rejection, tantrums; or may appear passive or too upset to signal, make contact. Fails to find comfort in parent.</td>
</tr>
<tr>
<td>Disorganized/ disoriented (D)</td>
<td>Behavior appears to lack observable goal, intention, or explanation- for example, contradictory sequences or simultaneous behavioral displays; incomplete, interrupted movement; stereotypes; freezing/stilling; direct indications of fear/apprehension of parent; confusion, disorientation. Most character is lack of coherent attachment strategy, despite the fact that the baby may reveal the underlying patterns of organized attachment (A, B, C).</td>
</tr>
</tbody>
</table>

Note: Descriptions in Groups A, B, and C are based on Ainsworth et al. (1978). Descriptions in Group D are based on Main and Solomon (1990) (Solomon & George, as cited in Cassidy & Shaver, 1999).

Gauthier, Fortin and Jeliu 2004 applied attachment theory to children in out of home care. Their research demonstrated that that repeated ruptures of such attachment ties constitute severe trauma and children's best interests lie in the preservation of their attachment ties, which may be stronger with non-biological carers.

Relevance of attachment theory to child protection
Preserving children’s secure attachments is a priority. As part of assessing children at risk, social workers must assess whether their attachment is stronger within the family or with carers outside the family. Workers must know how to assess the quality, not just the existence of the attachment behaviours. Children often want to remain with their primary caregiver, despite their neglect, rejection, abuse or abandonment. Children who have been separated from their attachment figure(s) may have experienced the world as chaotic and dangerous and have internal working models and protective strategies based on dysfunctional attachment patterns (Atwool, 2005). Adult relationships are affected by early attachment experiences and parents who experienced a lack of nurturing or trauma may not know how to nurture their children.

Assessing attachment requires several observations over time of:

- Patterns of interaction between the child and caregivers – who does the child relate best to?
- The way the caregiver describes the child, especially when the child is distressed – are they empathetic?
- The caregiver’s beliefs about parenting and parental responsibility – are they attuned to and nurturing of the child?
- The reaction of the child to the parent – does the child appear safe to explore ideas, behaviours and the physical environment? Do they express fear, excessive pleasing or obedience?
- If the attachment does not appear secure, can it be developed or should the child be placed in another family? What are realistic timelines to find the strengths in the family without causing further damage to the child? (Watson, 2005).

Critique of Attachment Theory
Attachment theory can be misused by practitioners assuming that mothers are the only attachment figures, by making assessments too quickly without observations over time with the child and all attachment figures, or by assuming that poor attachment explains a child’s behaviour without considering other contextual issues such as domestic violence or peer relationships, physical or intellectual impairment, or genetics.
Module 4c: Trauma Theory and Practice

Module description

This module covers fundamental theory for social workers working with children and young people in child abuse and neglect and is core to child protection work. Child psychiatrist Bruce Perry’s research on the impact of trauma on a child’s brain development has changed the way people think about child abuse and neglect. You can read more of Perry’s research at www.childtraumacademy.com.

To the tutor: Most children and young people who are abused or neglected will be traumatised, as may their parents and family members given the circumstances under which people live in your country. Social workers are not expected to be trauma therapists; in fact, trauma therapy can be misused and trigger flashbacks and panic attacks if used at the wrong time or by insufficiently trained people. Instead, this module aims at providing social work students with a trauma informed approach. A trauma informed approach means workers understand:

- the processes and impacts of trauma;
- that people who have experienced or witnessed terrible things may not have control over their reactions because of the physiological and psychological impact of trauma;
- how to explain trauma to people affected by it;
- how to help trauma-affected children, young people and their carers to regulate their behaviour;
- that reflective supervision is necessary for workers to debrief and prevent vicarious trauma from witnessing others’ stories of trauma.

References


Module Outline

This module focuses on the relationship between the traumatic experiences of child abuse and neglect and the neurobiology of the developing brain including:

- Definitions of trauma
- Causes of trauma
- Physiology of trauma
- Trauma and memory
- Trauma and brain development in children
- Physiological impacts of trauma on social, cognitive and behavioural development
- How to help trauma affected children
- Vicarious or secondary trauma, and self-care

Assessment

Essay assignment or exam question:

Q: Choose an example of a child or young person discussed in the course. Describe how you would apply and use attachment, child development or trauma theories (choose one) to assess the child or young person, with reference to the Child Development and Trauma Guide, as if you were the social worker meeting with them and their family to assess their attachment, development and emotional well-being.

Assessment criteria:

a. Explanation and critique of theory
b. Effective application of theory to a case example, understanding the impact of trauma on the child or young person’s behaviour

1. Definitions of Trauma

Definition: Trauma occurs when an experience or a series of experiences so threaten the existence of the individual that all usual defences or responses are overwhelmed. Trauma is an experience that induces a sense of intense fear, terror, horror, disgust, panic, helplessness and an abnormally intense and prolonged stress response (Perry, 2009).

Trauma is a psychological and physiological theory. Freud first identified the impact of shocking events on people’s psyche and behaviour when he observed ‘shell shocked’ soldiers returning from European World War 1 who were unable to function. The symptoms he described were observed in holocaust victims and refugees in post war migration. Similarly, people in Palestine experience current and past trauma under the prolonged conflict (Dulwich, 2014). ‘Complex Trauma’ describes trauma that occurs as result of abuse within dependent care relationships such as sexual abuse, domestic violence and childhood abuse and neglect (Perry, 2009; Herman, 1992). Since complex trauma occurs in the context of a relationship, it needs to be repaired within the context of the same relationship.

2. Causes of Trauma

Trauma can result from experiencing or witnessing any form of violence, abuse, bullying, assault, death, serious accidents, early rejection, neglect, divorce, loss, being diagnosed with a life-threatening disease, sexual assault, threats of violence (Greenwald, 2005) or through witnessing something shocking such as a parent or sibling being injured, a ‘natural’ disasters such as an earthquake, flood or fire or events such as street violence, a murder or a car crash. Trauma can be an outcome of a single occurrence or a series of interactions which in total are traumatic (Downey, 2009). Trauma can be passed from one generation to the next when whole communities have been affected.

3. Physiology of Trauma

Lecture on trauma

To the tutor: Be aware that many students, and perhaps you, will have experienced trauma and the material may trigger emotional responses that frighten them. Spend time preparing students for the material and have counsellors available for debriefing if students are feeling stress. Give permission for people to leave the room and arrange for someone to go with and check on them. You may prefer to start with point 7: Vicarious trauma and self care and to put some self and other care principles in place before you start.

To the tutor: You can lighten this section up by drawing an outline of a human body on the board and asking students to identify what happens to the body under stress. The following section then affirms and theorises their knowledge.

Stress is the body’s primitive mechanism to survive danger via the fight, flight or fright responses. The body’s automatically releases short term stress hormones (adrenalin, cortisol and norepinephrine) to activate the sympathetic nervous system to react to perceived danger (hyperarousal or FFF panic):

Fight – the body is ready to protect self and others through aggression or self-harming behaviours
Flight – hyper arousal, ready to run.

Bodily reactions to fear include:

- Blood is diverted to the muscles from other parts of the body eg hands and feet go cold, pale face
- Increased blood pressure, heart rate, blood sugars and fats to supply the body with extra energy
- The body’s blood clotting function speeds up to prevent excessive blood loss in the event of injury
- Muscle tension increases to provide the body with extra speed and strength.

Fright/ Freeze is a sense of numbness, feeling scared stiff, not feeling anything. The other automatic survival response is the ‘freeze’ response. It can occur when we’re terrified and feel helpless, as if there is no chance for our survival or escape. It happens in car accidents, to rape victims and to people who are arrested at gunpoint. Some people pass out, freeze or mentally remove themselves from their bodies, and don’t feel the pain of the attack, and sometimes have no (explicit) memory of it afterwards.

4. Trauma and memory

Conscious or explicit memory

Information from the senses (smells, sounds, tastes, touch, emotions, vision) goes through a pathway in the brain which makes sense of it through developmentally available language and thought. Children cannot make sense of information in the same was as adults. The memory is stored in the conscious or explicit memory, the Hippocampus.

Implicit Memory or unconscious memory

When the brain receives information about a threatening event, the information goes straight to the Amygdala for storage to prepare the body for survival eg Fight Flight Fright, without being processed for meaning.

Afterwards, under supportive circumstances, the information will be processed and stored in the Hippocampus. If the danger remains, the person does not feel safe or does not have the language capacity or opportunity to make sense of what happened, the memory remains as raw emotion in the Amygdala. From then on, things that stimulate that memory will evoke the FFF response - eg smell smoke and fear the terror of the fire. Babies are born with the capacity for implicit memory, which means they can perceive and recall things unconsciously (Batmanghelidjh, 2006).

Traumatic implicit memories

Traumatic implicit memories stay ‘stuck’ in the subcortical regions (amygdala, thalamus, hippocampus, hypothalamus and brain stem) where they are not accessible to the Cortex in frontal lobes where understanding, thinking, reasoning takes place. The paradox at the heart of trauma is that people see and feel only their emotional trauma, or they see and feel nothing at all.

5. Trauma and brain development in infants and children

The raw material of the brain is the nerve cell, called the neuron. During foetal development, neurons are created and migrate to form parts of the brain. As neurons migrate, they differentiate, or specialize, to govern specific functions in the body in response to chemical signals. This process of development occurs sequentially from the ‘bottom up’ that is, from areas of the brain controlling the most primitive functions of the body (e.g., heart rate, body temperature, breathing) to the most sophisticated functions (e.g., abstract, complex thought) (Perry, 2000) [see diagram]

Brain architecture and skills are built in a hierarchical ‘bottom up’ sequence.
Neuroscientists are able to study the composition, activity, chemicals and response of the brain. Evidence indicates that early experiences influence brain architecture, function and capacities by:

- affecting gene expression and neural pathways
- shaping emotion, regulating temperament, coping and social development
- shaping perceptual and cognitive ability
- shaping physical and mental health, activity, performance, skills and behaviour in adult life, language and literacy capability (Mustard, 2008).

Social, emotional and cognitive development are interrelated. Brain plasticity and the ability to change behaviour decreases over time. Relationships are the active ingredients of early experience. Early childhood adversity increases the risk of a range of poor outcomes. Stress is harmful to children and inhibits a child’s optimal development particularly when the onset is in the early years (Shonkoff, 2010).

The greater and earlier a child is exposed to trauma, the greater and more enduring and pervasive are the changes in brain structure. The earlier the intervention, the better the prognosis (Perry, 2002).

Some of the changes to the brain associated with trauma include:

- Reduced volume of the hemispheres (associated with PTSD (DeBellis et al., 2002).
- Fluid filled cavities in the (DeBellis et al., 2002).
- Thinner cortex (responsible for language and complex thought)
- Reduced corpus callosum, which connects the 2 brain hemispheres and is responsible for inter-brain communication and other processes (e.g., arousal, emotion, higher cognitive abilities). Reduction means impaired connections, cognitive and emotional ability (McCrory et al., 2011).
- Limbic system abnormalities. The limbic system includes the thalamus, hypothalamus, amygdala and hippocampus. It regulates emotions and motivations, learning and memory.
- Reduced hippocampus, central to learning and memory (McCrory et. Al., 2010; Wilson et al., 2011). Toxic stress can reduce the hippocampus’s capacity to bring cortisol levels back to normal after a stressful event has occurred (Shonkoff, 2010).

Some studies on adolescents and adults who were severely neglected as children indicate they have a smaller prefrontal cortex, which is critical to cognition, behaviour and emotion regulation (National Scientific Council on the Developing Child, 2012). Other studies show no differences (McCrory et al, 2010; Physically abused children may have reduced volume in the orbitofrontal cortex, a part of the prefrontal cortex that is central to emotion and social regulation (Batmanghelidjh, 2006).

6. Physiological impacts of trauma on social, cognitive and behavioural development

Hyperarousal – The traumatic experience severely harms the victim’s belief that the world is a good, safe place’ After the traumatic experience, the victim feels that world is full of threats so they must be alert to react immediately to any renewed attack on them. This constant state of readiness to respond immediately to danger causes victims to experience heightened physiological arousal and psychological tension, which they did not have previously and which can damage their ability to concentrate. Hyperarousal is expressed by the following ways:

- **Difficulty sleeping**: trouble falling asleep and remaining asleep.
- **Anger, irritability and/or outbursts of anger**.
- **Difficulty concentrating**: Hypersensitivity to loud or unexpected noises terrify victims, make them jump.
- **Intrusions or Triggers**: where they re-experience the trauma: feeling, smelling, thinking and seeing in their mind’s eye what they felt, smelled, thought and saw then. The sense of danger that overwhelmed them at the time, overwhelms them again and they might feel panic, setting off the fight/flight/fright response.
- **Dissociation**: The person feels cut off and detached from day-to-day activities, friends and family, or feels emotionally flat and numb.
- **Avoidance**: Victims take steps to protect themselves from additional experiences of trauma. Victims become more suspicious and react angrily towards people whom they experience as threatening.
- **Increased Internalising Symptoms**: Child maltreatment permanently alter the brain’s ability to use serotonin, a hormone that helps produce feelings of well-being and emotional stability (Healy, 2004).
- **Delayed Developmental Milestones**: Neglected children may not show the normal rapid growth in language development at 18–24 months, which may extend to all types of normal development for neglected children, including their cognitive-behavioural, socio-emotional and physical development (USDHHS, 2015).
- **Complicated Social Interactions**: Children or youth with toxic stress may find it challenging to navigate social situations and adapt to changing social contexts. They may perceive and react to threats in save situations and have difficulty interacting with others (National Scientific Council on the Developing Child, 2010b). For example, a maltreated child may misinterpret a peer’s neutral facial expression as anger, which may cause the maltreated child to become aggressive or overly defensive toward the peer (USDHHS, 2015).
Children who have experienced or witnessed violence, abuse and neglect can feel:

- **Fear and mistrust** of those who are meant to care and protect them because they
  - have lived with the fear of being hurt, killed, starved or physically or sexually exploited
  - fear they have caused harm for their family if they were punished for the abuse
  - may have frozen fear - paralysis, muteness, trauma

- **Doubt, shame and guilt**: Abused children
  - distrust themselves, doubt their own worth or capabilities
  - feel ashamed of being ‘bad’ and that they deserve punishment
  - feel the shame of having been sexually abused, and may lose control of bowels and bladder because of stress

- **Despair**: Abused children feel
  - inferior - can’t get a parent’s love
  - role confusion - role of family scapegoat, over-responsible parent role, isolated and different- can’t make friends

- **Learned Helplessness** – children give up from despair, because no-one listened to or believed them (Doyle, 2006).

**7. How to help trauma affected children who disclose abuse**

Throughout the case management process, further information will be gathered as the child develops more trust. At any point, a child may disclose information that requires a social worker to be receptive to their needs. Some skills required to respond to a child who discloses are:

- Listen attentively to what the child tells you.
- Sit level with the child; provide drawing materials or toys and a safe and comfortable space
- Control your expressions of panic or shock
- Express your belief that the child is telling the truth
- Use the child’s language or vocabulary
- Tell the child that this has happened to other children, and that they are not the only one
- Reassure the child that to disclose is the right thing to do
- Emphasise that whatever happened was not the child’s fault, and that the child is not bad
- Tell the child that you know some adults do wrong things
- Tell the child you will do your best to support and protect them
- Indicate what you will do, such as reporting it to the Child Protection who will help stop the abuse recurring and that it is necessary for Child Protection to be told
- Report to Child Protection.

There are five important messages to give to a child who has disclosed abuse:

- I believe you
- I am glad you told me
- I am sorry this happened to you
- It is NOT your fault
- I need to speak to other adults in order to help you and to try and make sure this does not happen to you again (AMWCHR, 2013).

**Responding to children exposed to trauma**

As well as safety and security for the child, the goal is to support the child to recover from their traumatic experience and to lead a dignified, self-valued and self-determined life in the future. The process of recovery and healing can be a long complex journey. The child’s psychological, emotional and physiological adjustment is disrupted though abuse. Survivors must cope with the trauma of abuse again and again in each succeeding development stage of their life. Depending on the specific personal circumstances of the victim, he or she may require long-lasting economic, psychological and emotional assistance, practical life skills training and further education about the impact of trauma (Patel, 2003 in CBM, 2008).

Depending on their age, disposition and recovery, survivors of child abuse can act as advocates for other children being abused and can provide effective front-line support. Being involved as an advocate to stand up against abuse can contribute to young people’s personal recovery and rebuild self-esteem. Invoking a former victim of abuse to contribute to awareness raising campaigns may serve young person’s recovery as well as preventing other children being victims of abuse. The social worker should invite the young person’s participation and work with them to prepare their activities for this cause (Patel 2003 in CBM, 2008).

To the tutor: Take some time with the class to discuss this last point about the potential of the former victim of child abuse as advocate against abuse.
Individual and family work with abused children and their families. The social worker should:

- Provide a safe space for children and parents to express negative and painful emotions.
- Build safe connections between children/parents and or their carers.
- Provide therapeutic work, when and if the child or young person wants it.
- Educate parents on the impact of their violence on their children.
- Challenge control, power and gender issues inherent in all violent relationships.
- Teach the young person about communication – how to delineate and express complex feelings.
- Help the young person explore their understanding and sort out what happened to them.
- Teach and explain the physiology of the traumatizing experiences to children young people and families.
- Keep a balanced perspective – the experience should be accepted as something that has happened without minimization or exaggeration of its impact.
- Let child victims participate as far as possible in decision-making and planning for their future.
- Inform and include people close to the victim about decisions e.g. his / her family, as far as possible.
- Answer all questions of children patiently so children’s insecurity and / or anxiety can be reduced;
- Inform children about the purpose of any activity related to them, and always tell them what will happen next (Jenkins, 2004).

Residential Therapeutic Program for children

Jenkins (2004) described a residential therapeutic program for children who have been so harmed by abuse and neglect that they cannot live with a family. She advocates strategies to calm and make the child feel safe:

- Teaching the child about communication so they learn how to delineate and express complex feelings.
- Sorting out – exploring their understanding of what has happened to them.
- Education – understand the specific elements of the traumatizing experience.
- Perspective – the experience is accepted as something that has happened without the need for minimization or exaggeration of its impact.
- Provide a safe space for children and parents to express negative and painful emotions.
- Build safe connections between children/mothers and or their carers.
- Provide therapeutic work, when and if wanted.
- Educate parents on the impact of violence on children.
- Challenge control, power and gender issues inherent in violent relationships.
- Minimise shame (Jenkins, 2004).

Jenkins (2004) strategies in response to the outcomes of trauma in children and young people are summarised below:

<table>
<thead>
<tr>
<th>Impact Issues</th>
<th>Goals of Therapy</th>
<th>Therapeutic Techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fears and associated behaviours, eg, bed-wetting/nightmares</td>
<td>To build the child’s strengths to overcome their fears by helping them develop strategies to achieve mastery. To assist caregivers to develop strategies to help the child manage their fear.</td>
<td>Dream-catchers, Nightmare Box, Relaxation and Drawing, Guided Fantasy. Use of Metaphor. Art and Drama.</td>
</tr>
<tr>
<td>Anxiety</td>
<td>To reduce anxiety levels and facilitate statements of support, belief and safety from caregivers and others.</td>
<td>Worry Trees, Recacation, Scaling, Visualisations of Safe Places, Drawing, Art and Drama.</td>
</tr>
<tr>
<td>Anger</td>
<td>To externalise/express appropriately feelings of anger in a safe, non-abusive environment.</td>
<td>Body work. Empty Chair Exercise, Interviewing the Perpetrator, Angry Letter, Puppets. Art and Drama.</td>
</tr>
<tr>
<td>Depression, sadness, loss and other negative feelings.</td>
<td>To identify, name and understand the myriad feelings caused by abuse and to work towards resolution with the support of carers and others.</td>
<td>Body Charts, Identifying Feelings in Body, Externalising Feelings. Having a conversation with the feeling and giving it a name. Art and Drama.</td>
</tr>
<tr>
<td>Sense of belonging</td>
<td>To resource and empower the child to feel a sense of purpose, place and belonging.</td>
<td>Eco Maps, PCH Life Story Book CD, Pictorial Record</td>
</tr>
<tr>
<td>Sense of future</td>
<td>To resource and empower the child to integrate their experience of abuse by enhancing and building on their constructive survival skills.</td>
<td>Life Story Book CD, Journal/Diary, Rubbish Bin Exercise, Life Train Exercise. Hopes and Wishes Exercise</td>
</tr>
</tbody>
</table>
8. Vicarious or secondary trauma and its effects

Secondary or vicarious trauma is the transmission of the effects of trauma from the traumatised person to the caregiver. It occurs when we witness or listen to the traumatic events experienced by others and become overwhelmed by their experience, particularly when it hooks into our own traumas. We need to deal with our own traumas before we can shift the effects of secondary trauma. When we visualise the other person’s trauma with a high level of empathy with the traumatized person, we can ignore our own distress until it affects us as trauma (Perlesz, 1999).

Taking care of yourself

• Establish systems of warning and response with staff and ensure all are familiar with safety policy and procedures; create a safe office environment: sit near an exit, install alarms, security on call.
• Consider safety of home visits, find about clients before you see them, assess likelihood of violence; don’t visit potentially threatening places outside hours, don’t go alone to a car park.
• Learn how to defuse a situation – see crisis intervention: Clarify your role and don’t make promises to clients that you can’t keep dialogue or EXIT
• Arrange debriefing and reflective supervision. Talk regularly with your supervisor. The more un-answered questions you have, the higher your anxiety
• Pass on positive feedback to fellow workers; channel your rage at injustice through collective action with teams of workers to enact justice (Reynolds, 2011).

References


Class Activity:

Use the story of Tarek to analyse his trauma and how the social worker helped him through re-membering conversations, (Dulwich, 2014: 21-25).

Cse the Kite of Life approach from Dulwich (2014: 44-47) to work out how to listen to and co-construct Asraf's story.

Module 5:

Risk Assessment in Child Protection

To the tutor: This module is core to the child protection in that it brings together previous modules: strength based approaches, theories for assessment (developmental, attachment and trauma) and requires professional ethical decision making. Delivering this module will work most effectively if you use a case example, or draw on students’ own examples so you can apply the ideas in the classroom. Warn and prepare students for the emotions ahead.

Module Description

This module provides a framework and tools for assessing risks for children and their families where children or young people are at risk of child abuse and neglect, using the Best Interests of the Child Case Practice Model (DHHS, 2012) from the Victorian Government Department of Human Services with the Australian Institute of Family Studies.

Module Outline

a. Case Management in Child Protection
b. Tools for Risk Assessment
c. When to Report to Child Protection

Module Assessment

Take home test: Provide a case example of a child or young person at risk. Students to write an assessment of the child and family identifying the risks and protective factors for the child and the processes by which they would assess the risks.

Assessment criteria: A balanced assessment of the risks for the child and family, written from a strength based perspective.
**Lecture:**

1. Case Management in Child Protection

To the tutor: Provide a copy of the circular risk assessment diagram or draw it on the board, so students can follow the process.

Assessing risks is an ongoing process of gathering information, analysing the context and risks, planning for children’s safety and reviewing the progress. While the stages in the assessment process can be specified, in practice, ‘assessment’, ‘planning’ and ‘responding’ overlap as the case is monitored and interventions are evaluated.

a. Assessment is the first two steps in the circular case management cycle:
   - Information Gathering
   - Analysis of risks and strengths
   - Planning responses
   - Action to implement plan
   - Review Outcomes

The first two of these steps will be covered here, the others will be covered in Module 6: ‘Responding’ to vulnerable children.

**Information Gathering**

The child is viewed and assessed in the context of their family and community so assessing a child at risk means finding out about the challenges for the family, their strengths and their protective capacity.

Narrative approaches can be used to gather the family’s perspectives.

Examples of evidence of abuse or neglect:

- Disclosures of harm by the child or young person – direct or indirect, for example, a child might say they ‘know someone who has been abused’ while referring to themselves to ‘test’ your reaction
- Physical Signs – look for injuries not consistent with explanation. Children may cover their bruises even in hot weather to avoid injuries being sighted
- Behavioural Signs – signs of fear, abuse and trauma, or children who are wary of physical contact with adults, frightened of parent, show little or no emotion when hurt, are unduly compliant, withdrawn, regressive or demonstrate aggressive, self-injurious or show high risk behaviours, or are attention seeking or indiscriminate with affection.

Developmental Stage and milestones. The Child Development and Trauma guide (DHHS, 2007) provides ways of assessing children and young people’s development and trauma.

(2) Analysis of risks and strengths

Given all the information you have gathered, how do you make sense of it? The analysis should:

- assess whether, and to what extent, a child is in immediate danger of serious harm;
- Identify the type, source, frequency, duration, severity, impact and likelihood of harm continuing;
- Evaluate the protective capacity of the immediate and extended family to care for the child in the short and long term;
- Involve the child or young person in decisions about their living arrangements;
- Use ethical decision making to determine what interventions should be initiated or maintained to provide ongoing protection for the child;
- Establish and communicate the criteria for the child’s immediate removal or return from out of home care if the family cannot provide sufficient protection which in Palestine needs a court decision.
The Best Interests of the Child case practice model (DHHS, 2012) is underpinned by a strengths based approach that assesses the risks whilst building on protective factors to increase the child’s safety and maintain family connections. Attention to safety factors within the risk analysis recognises that:

- Both the potential for harm and for safety must be considered to achieve balanced risk assessment and risk management.
- Strengths that increase the potential for safety are evident in even the worst case scenarios. These are fundamental building blocks for change. Building safety is different from efforts to minimise harm.
- A strengths perspective can be actively (and safely) incorporated into what may otherwise become a ‘problem saturated’ approach to risk assessment and risk management if the family or others are willing to make changes.

**How to analyse harm for the child**

Consider the vulnerability of the child, the severity and likelihood of continuation of the harm: Assess: Is this child/young person at risk of being harmed now?

- **Type of harm:** Identify the forms of harm. Are there signs that child has experienced other types of abuse or neglect in addition to those reported? [refer to context module for types]
- **Source of harm:** Who is harming the child? Does current situation make child vulnerable to other perpetrators?
- **Frequency:** How often does the harm occur? Have there been previous allegations for similar issues? Is it episodic or cumulative or both?
- **Duration:** How long have the problems that led to current harm been present?
- **Severity:** Has or is the abuse or neglect likely to cause significant harm if repeated over a prolonged period?
- **Likelihood:** What is the likelihood of the child being harmed in the future if nothing changes?
- **Impact:** What is the impact on this child’s safety and development, of the harm that has occurred, or is likely to occur? (Bromfield & Miller, 2012).

**2. Tools for Risk and Safety Assessment**

- **Note to the Tutor:** The following tools are useful in preparation for Child Centred Family Focused and ‘Resolutions’ Approach used in work with children, young people, families and communities, including Family Group Conferences to find ways to make them safe. These tools are based on a collaborative way of working with families approach and requires permission from parents to work with them and the children. It is challenging to use when families are defensive or do not want a social worker involved.

The Signs of Safety (Turnell and Essex, 2011) is a visual assessment tool that can be used with children to assess their concerns, safety factors, multiple views and to form a plan. The Three Houses Assessment Tool can be used to express children’s and parents’ view, can be used in a review, can be used to represent children’s view in court and can be used in a signs of safety assessment. It assesses children’s strengths, vulnerabilities and fears, and their hope and dreams.

The social worker is required to write a comprehensive assessment and referral. The Signs of Safety is an assessment and planning tool developed by child protection practitioners in Australia. Signs of Safety is useful in collaborative risk assessment, based on strength based solution focused theories (Bunn, 2013). The Signs of Safety assessment and planning protocol maps the harm, danger, complicating factors, strengths, existing and required safety, and a safety judgement in situations where children are vulnerable or have been maltreated (Turnell, 2011:14).

The table below describes a basic assessment and planning Signs of Safety template. The social worker can work with the family through each step starting at step 1 and finishing with step 7. Step 1 draws a genogram with the family. Step 2 explores the safety for the child. Step 3 explores the concerns for the child. It is important that details and descriptions are included in both step 2 and 3. Complicating factors such as death in family or a terminal illness are explored in step 4. Step 5 explores multiple views of the situation and step 6 uses scaling questions to estimate the levels of risk. Step 6 starts the planning process by determining what needs to happen to address the concerns (Turnell, 1999).

**Signs of Safety template (Turnell, 1999)**

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Genogram</td>
</tr>
<tr>
<td>2</td>
<td>Wellbeing/Safety</td>
</tr>
<tr>
<td>3</td>
<td>Concerns/Danger</td>
</tr>
<tr>
<td>4</td>
<td>Complicating factors</td>
</tr>
<tr>
<td>5</td>
<td>Multiple views, Family’s views, Mum’s views, Dad’s view, Child’s view, Prof’s view Eco-maps</td>
</tr>
<tr>
<td>6</td>
<td>Scaling</td>
</tr>
<tr>
<td>7</td>
<td>Next Step Plan</td>
</tr>
</tbody>
</table>

A more simplified Signs of Safety assessment and planning protocol considers the following questions: What are we worried about? What is working well? What needs to happen? And scales the safety of the children (Turnell, 2011).
Three Houses Tool

The Three Houses tool was created by Nicki Weld and Maggie Greening in New Zealand. It is a practical method of undertaking child protection assessments and case planning with children and young people (Weld, 2015). The Three Houses method takes the three key assessment questions of Signs of Safety assessment and planning - what are we worried about; what’s working well and what needs to happen - and locates them in three houses to make the issues more accessible for children (DCPWA, 2011). Social workers can use the three houses tools to gather information from children for completing the FGC referral and to seek children’s’ views for presentation in the FGC.

Steps for using the Three Houses tool include:

1. Wherever possible, inform the parents or carers of the need to interview the children, explain the three houses process to them and obtain permission to interview the children.
2. Make a decision whether to work with the child with/without parents or carers present.
3. Explain the three houses to the child using one sheet of paper per house.
4. Use words and drawings as appropriate and anything else useful to engage child in the process.
5. Often start with ‘house of good things’ particularly where the child is anxious or uncertain.
6. Once finished, obtain permission of the child to show to others - parents, extended family, professionals. Address any safety issues for the child in presenting to others.
7. Present the finished three houses assessment to the parents/caregivers, usually beginning with the ‘house of good things’ (DCPWA, 2011).

[Show the YouTube video. Students can practise using the tools in roleplays]

How to analyse parents or carers’ capacity to protect and care the child

A Risk Assessment only provides a snapshot of current risks and predicted likely risks so it will need constant review as further information comes to light. It should address these questions about the family: What are the risks, strengths and protective factors for the child in this family? Can the parents prioritise the child’s safety and developmental needs over their own wants and constraints? Do the parents or carers provide responsible, responsive ongoing trustworthy care? Are the parents affected by untreated mental health problems, substance abuse, poverty, violence or trauma? With appropriate support, are the parents likely to be able to provide an adequate level of care to their children? From the point of view of each child and family member, what needs to change to enable safety, stability and healthy development of the children? If circumstances are improved within the family, what will you notice that is different – what would there be more/less of? Can family members do what they need to achieve this? (Bromfield & Miller, 2012).

3. When to Report to Child Protection

To the tutor: This section would be best conveyed by a Child Protection social worker who can refer to the National Referral and Networking system practised in Palestine. In lieu of that content, what follows are ideas from the Australian child protection system (DHHS, 2012 Best Interests Case Practice model), which can be used as a comparison, or discarded for local content.

If sufficient protection cannot be provided, establish a safe process for the child’s removal from the family home.
A report to Child protection should be made by a professional, family member or the community when there is indication of:

- Serious physical abuse
- Disclosure of sexual abuse or signs of likely sexual abuse
- Serious emotional abuse or ill treatment impacting on healthy development
- Serious or persistent family violence, parental substance misuse, mental illness, disability where there is likelihood of significant harm to child
- Child/young person’s actions place them at risk and parents unwilling or unable to protect
- Child appears abandoned, parents dead or incapacitated and no other person caring

The concerns have a serious impact on the child’s immediate safety are persistent and entrenched and likely to have a serious impact on the child’s development.

The child has experienced ‘harm accumulated through a series of continuing acts, omissions or circumstances’ – cumulative harm (DHHS, 2012).

References


Turnell, A. (2014) What is Signs of Safety Video https://www.youtube.com/watch?v=x6WYm4F9nik


Module 6a: Responding to vulnerable children and young people at risk of abuse and neglect

To the tutor: Modules 6. Responding to vulnerable children and young people at risk of abuse and neglect follow Module 5 Risk Assessment in presenting a case management approach to assessing and responding to child maltreatment. 6a outlines the case management approach to follow once a child is assessed at being at risk of or having experienced harm and outlines the steps of planning, implementation and monitoring.

We have separated the Responding modules into responding to different types of child abuse, but in practice they overlap. You might select some of these forms of vulnerability rather than all of them. The specific types of abuse that follow this general module are children living with domestic violence, sexual abuse, children with disabilities and children living in conflict zones.

Module Description
This module provides a family focused child centered approach for social workers to respond to abused maltreated children and young people. It describes the 3 steps in the case management process following the Information Gathering and Analysis steps described in Module 5: Risk Assessment.

Module Outline
A. Theoretical Framework- Child Centred Family Focused Approach and ‘Resolutions’ Approach
B. Case management steps following assessment of child maltreatment

Module Assessment
Exam question: Explain the steps social workers should take in responding when a child is assessed as abused or at risk of harm or abuse and neglect. Using an example, describe how you would respond to stop the risks to and provide for the child if you were the social worker. Explain your rationale.

Assessment Criteria: Identifies and applies the 3 steps to the case example with a relational, child centred, family focused approach that provides safety to the child in terms of safe accommodation and trauma informed care.

Lecture
A. Theoretical Framework- Adopting a Child Centred Family Focused Approach

The following principles are essential to effective child-centred practice:

• Thorough assessments of children and young people need to take account of their developmental level across a range of spectrums.
• Linking children, particularly very young children and their families with services and supports strengthens their physical, cognitive and social functioning.
• Children and young people should be informed of legal and administrative decisions that affect them and be provided with opportunities to express, clarify and communicate their feelings and wishes, considering their age and capacity to understand.
• All interventions should try to create and strengthen children’s networks and provide appropriate information to enable the child’s networks to increase protection and support.
• Interventions involving young people should recognise the importance of the young person developing a sense of self and that it may not always be appropriate for the family to be involved in the resolution of adolescent issues.
• Adopting a family-focused approach aims to ensure the worker assesses and responds to issues affecting a family’s capacity to care for and protect their children. It also aims to ensure that the child’s needs are considered within the context of their family.

Being family focused means recognising the important role of the family and responding to the parent’s needs to enhance the safety, wellbeing and best interests of their children. Adopting a family focused practice means:

• being inclusive and involving parents, extended family, kin and friends (where appropriate and relevant) and recognising and considering the role of the broader community
• understanding the child’s position in the family in relation to other family members
• ensuring where possible that there is two-way communication between the family and worker, especially regarding decision-making
• developing knowledge and understanding of the family's past experiences, current situation, concerns and strengths to inform case plans based on an assessment of the child and parent's strengths and needs (DFCSNSW, 2012)
• case plans that reflect ongoing input from the family and are specific, measurable, achievable, realistic and timely (SMART)
• understanding that the combination of institutional mistrust with the complex issues that families face, for example, substance use, health issues and violence, is a serious impediment to the engagement process for birth families
• recognising that engaging fathers in the child protection context may require different considerations and approaches from those adopted when working with mothers (Casey Families, 2012)
• providing or facilitating the provision of concrete services meet immediate needs for food, housing, child care, transportation and other costs, and help communicate to families a sincere desire to help (Child Welfare Information Gateway, 2016).

A ‘Resolutions Approach’ to intervention.

To the tutor: Out of family care occurs too often in situations of child abuse because social workers and child protection workers do not try hard enough to find positive people in the child’s life or dismiss the abusive parents as totally incapable of remorse and responsibility in caring for their child. The Resolutions Approach aims to find and work with positive people in the family or community who can commit to keeping the child safe. In some circumstances, however, no such person can be found or the family has been so abusive that the children need to be placed with non-family members. Social work professional and ethical decision making from Module 3 should be used in making decisions about how to respond to the families of abused children and the children themselves.

The Resolutions approach is a risk management program for responding to families where children have been abused or neglected. The focus of Resolutions is not on investigating who committed the abuse (which may be done by the legal system). Instead the Resolutions approach concentrates on finding strengths and supportive networks so that children can return safely to the care of their family (immediate or extended) with ongoing assessment to ensure their safely. Resolutions can be used in situations where family, or family members deny the children’s risk, abuse or neglect. It recognises that in some situations, there may never be clear answers about child injuries or abuse. Parents of injured or abused children have many reasons for not wishing to recognize or admit their culpability, which could involve them in adversarial systems with severe consequences, both legal and social, if they are judged culpable of abuse. Child protection professionals often attempt to define how the child has been injured. Parental denial can become part of the family's narrative around the allegations, evoking an equally strong reaction from the professionals involved.

B. Case management steps following assessment of child maltreatment

To the tutor: When introducing this framework to students it is important to emphasise that it is a set of guiding principles that will help them work through the dilemmas of ‘multiple agendas’ and needs that make it hard to prioritise which needs to work on.

Module 5 provided a Case management framework and tools for assessing vulnerable children and young people
• Information Gathering
• Analysis of risks and strengths
• Planning responses
• Action to implement plan
• Monitor and Review Outcomes

[Steps 3, 4 and 5 will be covered here in this module]

As described in Module 4c, the psychological, emotional or physical effects of child abuse are devastating for the victim. Direct consequences may include shame, feelings of guilt, of defilement and amnesia. Victims of abuse may suffer physical shocks, frequent nightmares, flashbacks, depression, grief and the inability to maintain close relationships. Severe cases of abuse can lead to complex post-traumatic stress disorder (CPTSD). CPTSD describes a psychological alteration of self-perception, consciousness and the ability to build up relationships with others. Although the extent of the trauma depends on the resilience of the individual, the experience of abuse has dramatic influence on a persons’ life, regardless of whether it is a child or an adult. As trauma within child abuse is caused by damaging relationships, it can only be repaired by positive relationships.
(3) Planning responses

Once a child is assessed as having been harmed and at risk of further harm, these five steps can provide holistic support for survivors of child abuse (Patel, 2003).

i. Immediate help to address children’s safety (a crisis response): Immediate intervention to end the abuse and make the child safe. This might include placing the child safely with non-abusing extended family members, psychological and medical assistance and involving authorities such Child Protection councillors and police (see the Palestine National Referral and Networking system).

ii. Assist Recovery from abuse: Refer children to professionals such as doctors, psychotherapists or other therapists who can treat their physical, psychological or mental injuries.

iii. Continued analysis: In planning responses to redress the trauma of a child having suffered abuse and keep the child safe from further abuse, the social worker needs to continually analyse the factors and circumstances that caused the child to suffer abuse, such as the environment (that is, context, situation) in which the child lives, family-relationships and child related factors such as age, gender, disposition, development stage and severity of the abuse (see Risk assessment module).

iv. Decision making and Case Planning: Through ethical decision making (Module 3) and child centred, family focused work, a case plan is developed and documented. The case plan should address the child’s specific needs for future safe accommodation and care, professional support and activities based on a medical assessment, a comprehensive factor analysis and the specific individual requirements.

In the written case plan:

• State the child’s, young person’s and family’s goals and how they will know when these have been achieved, in their own words.

• Plan with the family, not for the family, while prioritising the child’s needs.

Make decisions with the child, young person, family and other stakeholders about appropriate goals:

• Include the family and community in defining how to break the goals down into manageable steps.

• What goals should be prioritised? Make goals specific, measurable, achievable, related to the concerns and timely (SMART). Who will do what, to whom, by when? How?

• What resources are needed? How can they be provided?

• Document agreed roles, actions and responsibilities.

• Document timelines and build in frequent review of what is working and not working.

• Be solution focused and identify indicators of change.

• Give positive feedback to the family members and to your co-workers.

• Celebrate successful outcomes. If you start to feel overwhelmed, seek support and consultation from others (DHHS, 2012). [Show example of a family inclusive case plan].

(4) Action – implement case plan

Once the plan is documented and roles, responsibilities and timelines are allocated, the plan is implemented (See Social Work Module 4: Case management). If the family is capable and motivated to keep the child safe, the case plan should:

• Build partnerships with families against the abuse, using strength based support.

• Work with children and extended families. Expect parents to feel overwhelmed, suffer shock, feel blamed, anger, severe grief, sleep disturbances and other trauma responses.

• Work in partnership with other services (Bromfield & Miller, 2012).

(5) Monitor, review and evaluate outcomes

Routine and regular reassessment of the circumstances for the child and family should occur to ensure significant changes are not overlooked (Bromfield & Miller, 2007). Ongoing review and updating of the case plan should be conducted in collaboration with the child, family and carers to assess what goals have been met, what constraints may prevent goal achievement and if new goals and priorities should be set and monitored. Critical reflection should be used to monitor children’s safety and that the family and implementation team follow-up on allocated tasks and responsibilities. Documentation and records of progress or problems should be written in the file (Patel, 2003).

References


Module Description

This module explores gender differences, definitions of family and domestic violence; impacts of domestic violence on women; impacts of witnessing domestic violence on the social, emotional and cognitive development of children and young people and how to work with children exposed to violence.

Module Outline

Lecture:
1. Gender role differences
2. Definition of Domestic Violence
3. Effects of male violence against women
4. Developmental impacts of witnessing violence on children’s cognitive, emotional, social and psychological development
5. Neurobiological changes of witnessing domestic violence
6. How to work with children exposed to violence
7. Class Activity: Class discussion on facilitating stopping violence

Module Assessment

Essay or exam question 1500 words

Read UN Women Palestine (2017), Islam Opposes Violence (AMWCHR, 2013) (and or AMWCHR, 2011, available in Arabic) and the section on men and women talking about male violence against women in Dulwich (2014), then write a job description for a social worker to support women from male violence, protect children who witness domestic violence or work with men who are violent to women, to challenge them to take responsibility for and stop their violent behaviour.

Assessment criteria
Evidence of having read and understood the prescribed references
Realistic job description
Evidence of gender role differences and their impact on women and children in male violence against women.

To the tutor: As part of preparing students for this assignment, discuss the relative merits within your culture and elsewhere of the roles of female and male social workers working with women victims of male violence and male perpetrators of violence against women. Pease (2010) would be useful background reading for this issue.
1. Gender role differences

Gender role differences often become apparent from a young age. In some families, this manifests as boys being allowed more independence and less supervision than girls as they get older. In others, with this independence comes greater responsibility and parental discipline and control. Girls, on the other hand, are often expected to take on greater responsibility within the home, such as helping with the housework, caring for younger siblings, etc. Their outdoor activities may become more and more restricted as they approach puberty, and varying degrees of modest dressing may be expected of them. In some families, this is reflected by the headscarf or ‘hijab’.

Academic achievement may be encouraged in both girls and boys; however, men are expected to go on to develop skills and a professional career, while women may or may not. While for some women this is a choice to make while for others the decision to work may be needs-based. For other women, the option to pursue higher studies and/or have a career can face limitations due to familial and/or community disapproval. Even in cases where women work outside the home, career choices are sometimes limited to socially-approved professions such as doctors, nurses, teachers, childcare workers, dress-makers, etc. Otherwise, the goal of marriage continues to be the general expectation for women. The notion of women as nurturers and homemakers means that many women’s and girls’ mobility may also be limited; at times this is due to limited exposure and opportunities, but in some cases mobility may be actively curtailed.

Financial responsibility for maintaining the family falls on the men of the family, sometimes irrespective of whether or not their wives are earning money. Times of financial difficulty, such as during unemployment, then, can affect the sense of self-worth and well-being of the heads of family. Psychological morbidity in such situations may be high, with implications for the whole family.

Family wellbeing is affected by gender discrimination and the challenges that women and young girls face in areas such as education, community participation and freedom of movement (AMWCHR, 2013:18).

The right to live in safety is one of the most fundamental of our human rights (UN 1993). It is also one of the most actively violated of human rights all over the world. Crucial to understanding the context of violence against children is violence directed against women as they are the principal carers of children. Additionally, both women and children generally witness violence targeted at the other, especially when it is in the home. It is not uncommon for women and children to experience violence from the same perpetrator, particularly in cases of domestic violence. Intimate partner violence, also commonly termed domestic violence, is one of the most common forms of violence against women and may be physical, emotional or sexual in nature (AMWCHR, 2013:3).

2. Definition of Domestic Violence

Domestic violence is behaviour that causes physical, sexual or emotional damage to another, or causes her/him to live in fear. Domestic violence is the hurtful misuse of power and the desire or choice to control a partner, spouse, child or situation (AMWCHR, 2011:8).

Victims of domestic violence are usually women and children and the perpetrators are usually men. In most situations, domestic violence is aimed at women by men to physically or psychologically abuse, harm or control them. This includes spouses and ex-spouses. It can also occur in wider family relationships and includes the abuse or neglect of children by adults, the violent behaviour of a child against a parent, and abuse by a child towards his/her sibling/s. Many terms are used to refer to domestic violence when it occurs between partners, such as family violence, partner violence, intimate violence, spouse abuse and wife beating (AMWCHR, 2011:8).

The definition of violence against women (VAW) adopted in the MoWA (2011) Strategy to Combat Violence Against Women in the occupied Palestinian Territory is

All forms of physical, mental, sexual and verbal violence and social and economic deprivation; threats of such acts; coercion and other deprivations of liberty that are directed against a woman because she is a woman, whether directly or indirectly, inflicting physical, psychological, sexual, mental, social or economic harm or suffering, and whether occurring in public or in private life. Violence is a very broad term that encompasses all forms of discrimination against women, including being deprived of the right to work, health, education, political participation, as well as family and civil rights in both public and private life.

Forms of violence within the family and domestic violence against women in the Palestinian society may include:

- Physical abuse by one’s husband, father, brother or a male in-law.
- Early marriage
- Threat of killing.
- Rape by one’s brother, father, uncle, father-in-law or husband.
- Fleeing home because of exposure to physical or sexual violence.
- Sexual harassment.
- Emotional apathy.
- Verbal violence.
- Neglect.
- Social division of roles in the family that favours males over females (MoWA, 2011:15).

For further information, please refer to the Standard Operating Procedures for Mihwar and the Ministry of Social Development. You can also refer to the booklets and published material by Al Muntada – the coalition to combat violence against women.
3. Effects of male violence on women

Male violence against women and girls occurs in every continent, country and culture. It takes a devastating toll on women's lives, on their families, and on society as a whole. Most societies prohibit such violence — yet it is often covered up or tacitly condoned. Women are at higher risk of physical injuries from domestic violence, as well as higher risk of:

- reproductive problems - still births, miscarriages, infant deaths, health problems in new born babies
- poor relationships with children and other loved ones
- being cut off and isolated from family or friends
- lack of trust in others
- feelings of abandonment
- inability to work
- an inability to adequately respond to the needs of children (AMWCHR, 2011:38).

4. Developmental impacts of witnessing domestic violence on children

Children, even when not direct victims, are affected by witnessing domestic violence. This has been shown to apply even when children are not in the same room where violence occurs. Depending on their age, they are likely to react in different ways. They may try to intervene to stop the violence, or they may withdraw and feel overwhelmed and helpless. As a result of what they witness within the family, children can develop a range of emotional, behavioural, developmental, or academic problems, some of which may continue into adulthood (AMWCHR, 2013).

Domestic violence leads to changes in the development of the brain, both anatomically and physiologically, and subsequently impairs affected individuals’ ability to respond appropriately to social situations and impairs their ability to deal with even minor challenges throughout their lifetime. It is critical to understand that child-witnessed domestic violence is a form of child abuse and neglect (Tsavoussis et al., 2014).

A child witness of domestic violence, where no intervention occurs, may develop Post Traumatic Stress Disorder (PTSD) that results in permanent changes to their personality as well as their ability to interact effectively in society as an adult (Tsavoussis et al., 2014). Depending on their age, they are likely to react to witnessing domestic violence in different ways. They may try to intervene to stop the violence, or they may withdraw and feel overwhelmed and helpless. As a result of what they witness within the family, children can develop a range of emotional, behavioural, developmental, or academic problems, some of which may continue into adulthood (AMWCHR, 2013).

As described in the Child Development and Trauma Guide (DHHS, 2010), the range of effects of witnessing domestic violence can be categorised according to children’s age groups:

To the tutor: These check lists need more clarification and explanation through consultation with Maternal and Child Health nurses or by using the Child Development and Trauma Guide Ages and Stages.

Infants
- sleep and feeding disturbances
- continual fussing and crying
- an inability to be comforted
- being easily irritated or easily startled

Toddlers/pre-schoolers
- frequent physical complaints
- difficulty going to sleep or frequent nightmares
- frequent tantrums
- clingy behaviour
- not knowing how or when to play
- general sadness
- acting cruelly towards other children and adults (AMWCHR, 2013).

School-aged children
(in addition to symptoms experienced by toddlers/pre-schoolers)
- difficulty concentrating or following instructions
- consistent inability to complete homework tasks, a drop in school performance, extreme shyness or fear of adults
- regressive behaviours such as thumb sucking, crawling, inability to control urination
- bullying, general ‘acting out’ behaviour, aggression, violence
- trying to please others and trying avoid any conflict in the house
- depression and/or withdrawal (AMWCHR, 2013)

5 DCI Palestine had been working with clergy and Imams opposing violence and corporal punishment against children. It is advisable to check the curriculum they had used.
Adolescents

- frustration, rage, anger
- self-destructive or suicidal behaviour
- frequent physical complaints
- drug and/or alcohol abuse
- delinquent behaviour, such as destroying property, stealing, etc.
- cruelty to animals, small children, peers of the opposite gender
- running away
- aggressive/abusive/violent behaviour, use of weapons
- depression, anxiety, sleep disorders, eating disorders,
- withdrawal from social involvement with peers or family
- low self-esteem
- lack of respect for one (either the victim or perpetrator) or both parents
- accepting of violence in a relationship

5. Neurobiological changes of witnessing domestic violence

To the tutor: For this section, remind students of Module 4c. Trauma Theories and the diagram of the brain.

Neurobiological changes seen among children witnessing domestic violence include abnormalities in the midbrain, the limbic system, cortex, corpus callosum, and cerebellum. Their importance can be outlined as follows. The midbrain is the “relay point” for changes or messaging in sight and hearing.

The limbic system (amygdala, hippocampus, hypothalamus) houses the centres for emotion, survival, fear, anger, and pleasure, including sex. It is also important for memory information and storage, as well as being involved in the weight of the individual’s response. The cortex houses executive functions, and the comprehension of consequences, and the corpus callosum allows both sides of brain to communicate in regard to hearing, sight, and cognition. The corpus callosum is the largest concentrated collection of white matter in the brain and connects both cerebral hemispheres thereby facilitating intra-cerebral communication. Finally, the cerebellum is involved in balance, emotion and cognitive development. These structures and the resultant pathways of response are altered following child-witnessed domestic violence (Carrion, Wong & Kletter, 2013; Delima & Vimpani, 2011).

6. How to work with children exposed to violence

What do children need? (from UNICEF 2006)

As we know from attachment theory, children need a secure environment that is relationally enriched, safe, predictable and nurturing (Perry, 2006). They need to know that there are adults who will listen to them, believe them and shelter them.

Children who are exposed to violence in the home need to know that they are not alone and that the violence is not their fault. They need support services to meet their needs. To avoid the terror of witnessing domestic violence or of being hurt themselves, children must have places to go that are safe and supportive, whether it be with extended family or at a domestic violence shelter.

Children need to learn that domestic violence is wrong and learn non-violent methods of resolving conflicts. Children need adults to speak out and break the silence and to re-affirm that domestic violence is wrong. Children who are exposed to violence in the home need to know that things can change and that violence in the home can end. Children need hope for the future (UNICEF, 2006).

How social workers can work with children exposed to violence

Social workers cannot usually stop men being violent to women but can try to help families to speak about these issues and to keep speaking about them. Dulwich (2014) identifies ways of doing that:

- Listen carefully as people are talking. We know they might not speak directly about violence so we listen for possibilities of violence between people’s words. We listen for words like ‘my husband does not understand me’ or ‘my children are suffering’. These might be signs of violence.
- Talk with families about what is likely to happen to the family, the children, if violence in the home continues. ‘How will your future be?’
- Facilitate interventions where men choose to stop violence, facilitating discussions with extended family and community supports.
- Become involved in raising community awareness about these issues. We could run workshops for men and for women to increase understanding of the impact that witnessing domestic violence has on children.
- Seek out ways that people in other Arabic countries are trying to respond to violence against women. We could explore our own Palestinian ways for men to take some action about men’s violence.
- If it is hard to work together with the woman and the man, sometimes two social workers can work separately with the man and the woman.
- When violence occurring, make a home visit with a male social worker and a female social worker. The man sits with the man while the woman sits with the woman and then come together to talk about it.
Always try to find safety in the family for the women, the men and the children (Dulwich, 2014)

Social workers can create safety plans with families, to establish ground rules, containment, or with children or young people to help them find safe spaces, privacy, build protective rituals to deal with crises – phone list for hard times, suicide prevention plan, asking for help when I start to panic. Social workers can help children build a support system within the extended family and community.

- Note to tutor: Provide some context before introducing the class activity. In severe cases of domestic violence a child may be temporarily or permanently removed from the home to protect them from further harm. However, ideally, in the child’s best interests, the role of the social worker is to address the domestic violence and help men to choose to stop violence, so the child can remain in the home.

Class Discussion:

Use the case example of Fadi. As a social worker working with children and young people to reduce risk, our first intervention is to assess and facilitate stopping domestic violence. How could we facilitate that? Which family members, extended family members, leaders in the community might we bring in help facilitate this change and hold Fadi accountable for his violence?

There is a recorded roleplay in Arabic of an example of a meeting where the male social worker facilitates a discussion challenging Fadi about his violence that you could listen to for ideas.

References


Module 6c: Children with Disabilities

Module Description
As an often overlooked group, Children with Disabilities (CWD) are highly vulnerable to child abuse and neglect. This module aims to alert social work students to their roles in advocacy and non-discriminatory practice with CWD and their families. This module introduces Lecture

Outline of the module
The module explores definitions and the rights of children with disabilities (CWD), factors that affect child development and disability, the vulnerability of CWD to child abuse and neglect and how to work with children with disabilities and their families.

Assessment: Essay question:
Q: Read the UNICEF ODI MoSD (2016) Report Executive Summary online and summarise allocated sections to one sentence. In what ways does a child’s disability make them more susceptible to risk? What are the rates of CWD in the State of Palestine and to what do you attribute the high proportion? Identify 3 goals in working with a child with a disability.

A. from UNICEF ODI MoSD (2016) Every child counts: understanding the needs and perspectives of children with disabilities in the State of Palestine.

OR

What else could O’Leary et al do to improve Nesma’s life circumstances?

Lecture

Introduction and definition

Defining Disability

‘Disability’ is a contested concept, and how professionals understand disability influences their responses to the abuse of disabled children. Three professional perceptions of disability are

1. an individual or medical problem caused by illness or functional limitations. The professional tasks are to cure, ameliorate and/or rehabilitate. This model can view disability as a personal tragedy, so individuals are given a passive ‘sick’ role while practitioners act in the role of experts who ‘know best’. The focus is on needs rather than rights.

2. The social model of disability, developed by disabled academics and activists, distinguishes between ‘impairment’, meaning a physical, sensory or cognitive limitation, and ‘disability’, referring to the social, material and cultural barriers which exclude people with impairments from mainstream life. Using this frame, disability is caused by social oppression: it is neither natural nor inevitable. The social model has influenced anti-discrimination legislation and accessible public services in some countries.

3. A ‘social relational understanding’ of disability adds the concepts of ‘impairment effects’ which denote restrictions of activity on a person’s day-to-day life resulting from impairments, and ‘psycho-emotional disablism’ which refers to hurtful, hostile or inappropriate behaviour from others which have negative effect on a disabled person’s sense of self, affecting what they feel they can be or become. Psycho-emotional disablism operates at both one-to-one and institutional levels.

The Convention on the Rights of the Child (CRC) (UN 1989) and the Convention on the Rights of Persons with Disabilities (CRPD) (UN2006) highlight how children with disabilities have the same rights as other children—for example to health care, nutrition, education, social inclusion and protection from violence, abuse and neglect. The CRPD formalised a shift in thinking about what disability is and is grounded in the social model of disability. An important element of the social model is to distinguish between an impairment (a medical condition leading to disability) and disability (the...
result of the interaction between people with impairments and barriers in the social, physical, attitudinal etc environment). Ensuring access to appropriate support, such as early childhood intervention (ECI) and education, can fulfil the rights of children with disabilities, promoting rich and fulfilling childhoods and preparing them for full and meaningful participation in adulthood (WHO, 2012).

The International Classification of Functioning, Disability and Health: Children and Youth Version (ICF-CY) regards disability as neither purely biological nor social but instead the interaction between health conditions and environmental and personal factors (8). Environmental factors include built and physical structures, nature, social and community attitudes, social mores, institutions and structures including discriminatory legislation, policies, and practices, or context.

Disability can occur at three levels:

- an impairment in body function or structure, such as a cataract which prevents the passage of light and sensing of form, shape, and size of visual stimuli;
- a limitation in activity, such as the inability to read or move around;
- a restriction in participation, such as exclusion from school.

The CRPD states that ‘persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others’ (WHO, 2012). It also usefully offers practical examples of what to do to better support PWDs e.g. schools to offer braille books, and other forms of access. The term children with disabilities (CWD) will be used throughout this paper. Some children are born with a disabling health condition or impairment, while others may experience disability as a result of illness, injury or poor nutrition. Children with disabilities include those with health conditions such as cerebral palsy, spina bifida, muscular dystrophy, traumatic spinal cord injury, Down syndrome, and children with hearing, visual, physical, communication and intellectual impairments. Some children have a single impairment while others may experience multiple impairments. For example, a child with cerebral palsy may have mobility, communication and intellectual impairments. The complex interaction between a health condition or impairment and environmental and personal factors means that each child’s experience of disability is different (WHO, 2012).

**Class Activity:**

Students in groups to identify social perceptions of children with a disability. Compile their list of perceptions on the white board then go through and discuss the evidence or myths of each one. Finish with a discussion of prejudice and its origins in fear and ignorance.

Children with disabilities rarely think of themselves as disabled. Labelling a child solely in terms of their health condition should be avoided. They are children first and aspire to participate in normal family and peer-group activities.

Children with disabilities are more vulnerable to physical, sexual and psychological abuse and exploitation than non-disabled children. Social isolation, powerlessness and stigma faced by children with disabilities make them vulnerable to violence and exploitation in their own homes and in other environments such as care centres or institutions. Research shows that children with disabilities are three to four times more likely to experience violence than their non-disabled peers. Parents of children with disabilities are significantly more likely to report hitting them for a number of reasons including cultural prejudices and the increased demands that disability may place on their families. Children with disabilities are often perceived to be easy targets: powerlessness and social isolation may make it difficult for them to defend themselves and report abuse. Exposure to violence, neglect or abuse can lead to developmental delays and behaviour problems in childhood and later life (WHO, 2012).

**Why social workers should focus on children with disabilities?**

**Human rights rationale:** All children with disabilities have the right to develop ‘to the maximum extent possible’. It is important to focus not only on the child’s health condition or impairment but also on the influence of the environment as the cause of underdevelopment and exclusion.

**Economic rationale:** Children with disabilities who receive good care and developmental opportunities during early childhood are more likely to become healthy and productive adults. This can potentially reduce the future costs of education, medical care and other social spending.

**Scientific rationale:** The first three years of a child’s life are a critical period. They are characterized by rapid development particularly of the brain and thus provide the essential building blocks for future growth, development and progress. If children with disabilities are to survive, flourish, learn, be empowered and participate, attention to Early Childhood Development is essential (WHO, 2012).

**What factors affect child development and disability?**

**Poverty:** Although disability can occur in any family, poverty and disability are strongly interlinked: poverty may increase the likelihood of disability and may also be a consequence of disability.

**Stigma and discrimination:** Children with disabilities are among the world’s most stigmatized and excluded children. Limited knowledge about disability and related negative attitudes can result in the marginalization of children with disabilities within their families, schools and communities.
Child-Parent/Caregiver interaction: Stimulating home environments and relationships are vital for nurturing the growth, learning and development of children. The quality of child-caregiver interaction may be compromised when a child has a disability.

The World Health Organization’s research (WHO, 2012) shows that there are differences in parent-child interaction when a child is disabled as well as parental issues of carer exhaustion, social exclusion (including from work) and broader impacts on families.

Institutionalization: isolates children from their families and communities and places them at increased risk of neglect, social isolation and abuse.

Violence, abuse, exploitation and neglect: Children with disabilities are more vulnerable to physical, sexual and psychological abuse and exploitation than non-disabled children.

Humanitarian situations: There is a bidirectional link between humanitarian situations—such as conflict and natural disasters—and disability. While all children are vulnerable during humanitarian situations, children with disabilities are particularly at risk and disproportionately affected (WHO, 2012).

Child protection concerns about disabled children

To the tutor: See the Qader manual especially the section on children with disabilities.

Stalker et. al’s (2015) research identified professionals’ variable awareness of the prevalence, nature and heightened vulnerability of disabled children to abuse. Examples of a professionals’ lack of awareness include: attributing physical and behavioural signs of abuse to a child’s impairment and not noticing abuse because of disabled children’s social isolation, which means that the child has no-one to listen to help them deal with or stop abusive situations.

Failure to Act on child abuse concerns

Factors that prevent practitioners from taking prompt and effective action for disabled children at risk or being harmed include: empathising with parents and overlooking the child; not identifying or speaking out early enough; insufficient training in child protection with disabled children; not considering disabled children as their responsibility, the perception that developing relationships with a disabled child is too difficult and time consuming; and fewer resources for children with disabilities.

Stalker et. al’s (2015) suggest a child focused approach. The approach places the child at the centre of practice by using good communication, ie finding a way to adapt the level, nature and format of communication to suit individual children; using observation to gauge children’s feelings and well-being, focusing on behavioural changes and, in non-verbal children, noticing subtle signs like the meaning of different noises a child might make. Communication is enhanced by seeking support from a professional who knows the child well, is trusted and attuned to her communication style.

Class Activity:

A sk students for examples of difficulties in communication with children with a disability, and how they might overcome them in forming a warm engagement with the child.

When there are clear child protection concerns, social workers should seek disabled children’s views separately from the parents and involve or seeking the advice of colleagues who know the child well, before deciding whether to raise concerns with the child or during the investigation. Careful planning and preparation is needed to establish a child-friendly venue, the best time of the day to suit individual children’s needs, and finding communication aids and facilitators. The social worker should help the child identify their worries or special needs and explain the process, be honest about the concerns, adopt an informal approach and use simple language to seek children’s feelings about leaving or returning home, their care and place of residence, their understanding of the current situation, its impact on them and their wishes for the future.

Professionals framed disabled children as:

a. ‘different or other’ because of their impairments, which were unfamiliar and because of their (real or perceived) communication difficulties. Communication aids were seen as difficult to use. The prospect of child protection work with disabled children aroused discomfort, anxiety or even fear.

b. the ‘same as any other child’. Disabled children were thought to face the same level of risk as others whereas disabled children receive less protection than others.

c. ‘equal and different’. This child-first view takes account of the impairment effects and psycho-emotional disablism. There was awareness of disabled children’s heightened vulnerability, risk factors, the under detection of abuse and widespread negative attitudes towards disabled people. Professionals have responsibility to spend time and effort to build rapport with individual children and address such barriers (Stalker et al., 2015).

A community response to working with children with disabilities

To the tutor: in this section, you need to contextualize these points with examples from Palestine.
Identify and register children with disabilities and their families, noting where they live, their needs during humanitarian situations, and a plan for addressing these needs;

Include children with disabilities and their families in planning and preparedness activities which take place in their communities;

Ensuring that transport, emergency shelters, and alert and warning systems are accessible for children with different types of impairments, such as visual, hearing and mobility impairments;

Provide training for people who may work with children with disabilities so they are aware of the needs of children with disabilities and their families, and can address these needs (WHO, 2012)

Include fathers, siblings and other extended family members who often play a significant role in caring for and supporting children with disabilities

Provide therapeutic activities based around play and other activities; functional training to work on skills required for independence in everyday activities;

Educate parents to help them better understand their child’s disability and their role;

Prescribe and provide assistive devices including user training and modifications to the home and school environments (WHO, 2012).

Offer interventions that allow the acquisition of even basic skills, such as helping a child with a disability learn to feed or dress himself or herself, can lead to a growing sense of independence and competency and reduce the burden on other family members.

Combine centre based and home-based services

How to work with children with disabilities in emergency/crisis situations

Provide equal access to essential supplies, which may require specific strategies such as “fast track” queues and delivery of goods directly to children and their families;

Organize for replacement of lost or damaged assistive devices and providing new ones for children who have newly acquired injuries or impairments;

Ensure that temporary shelters, water distribution points, and latrine and toilet facilities are physically accessible to children with disabilities and their families;

identify child-friendly spaces and other child protection measures, and facilitate the inclusion of children with disabilities;


References


Module 6d:

Responding to vulnerable children facing dangers and injuries including in conflict zones

To the tutor: This module presents four projects responses to children who live in danger or conflict zones, as children in Palestine do. There is an emphasis on research so you could ask students to identify the methodologies used by the different projects to gather and analyse their data. The dangers and conflict may evoke memories and fear in students so prepare them to look after themselves and each other emotionally whilst discussing this topic.

Module Description

Children in Palestine face more danger than children in non-conflict areas. This module proposes community development approaches to work with children and young people vulnerable to danger and injuries in Palestine.

Outline of the module

4. Social workers engendering hope and safety (O’Leary et al., 2015).

Assessment

Group work task for community project:

Each of the projects involves research to gather ideas from children and young people. When you have explained the four projects, students form groups to plan a response with a group of children affected by conflict. These can include children of parents imprisoned in Israeli military detention, children who fear Israeli forces at check points, on way to school, displaced children, those with houses demolished, unable to access Mosques safely (as described in PCC, 2017) or are in poverty, have no electricity, limited fresh water and at risk of poison from polluted sea water. What are their obligations according to Interagency Child Protection Minimum Standards? How can they engage children’s ideas and contributions as the PCC and Dulwich did? How might they create safety and hope? (O’Leary et al., 2015).

A second assessment task might be for students to write a reflection on their and other group presentations to the class.

Lecture


UNICEF led the Child Protection Area of Responsibility (CPAoR) within the Global Protection Cluster and developed the Minimum Standards for Child Protection in Humanitarian Action, which evolved to The Alliance for Child Protection in Humanitarian Action, co-led by UNICEF and Save the Children. Excerpts follow:

STANDARD 7 Dangers and injuries

After the age of one, unintentional injuries are a leading cause of death among children and adolescents, accounting for over 30% of deaths among 10- to 14 year olds and almost 50% in 15-19 year olds. Road traffic injuries, drowning and fire related injuries are responsible for almost 50% of child deaths across the world. In an emergency, in addition to these “ordinary risks”, children are at greater risk of injury and disability. Children with existing disabilities can be children are particularly at risk from explosive remnants of war (ERW) and landmines. Displacement as a result of emergencies can also put children unstable debris and ERW. If injuries to children are not treated quickly and appropriately, there is a greater chance of long-term or permanent injury. Children who have been injured in emergencies, especially those left with disabilities, have different physical rehabilitation needs to adults, and in situations where resources are limited, they are less likely to receive age-appropriate assistance.

Standard: Girls and boys are protected against harm; injury and disability caused by physical dangers in their environment, and the physical and psychosocial needs of injured children are responded to in a timely and efficient way (UNICEF, 2013).
KEY ACTIONS:

Preparedness

• Assess, identify and analyse existing and possible physical dangers to children;
• implement community-based messaging, awareness, and public education campaigns on risks to children to prevent injury (see Standard 3); include risk reduction in formal and non-formal education curriculum and activities (schools, childcare centres, child-friendly spaces (CFSs), youth clubs, and so on) as a mandatory subject for educators, caregivers, and children;
• actively involve children, especially those with disabilities, in activities to prevent risks; protected
• ensure that children are included in disaster risk reduction processes at community level;
• include physical dangers for children when creating contingency plans;
• train brigades and rescue groups on dangerous situations for children; and
• train community members in life saving in the water, and in first aid (UNICEF, 2016:80).

Response

• Collect information, with all relevant actors, on physical dangers to children;
• create safe community spaces, playgrounds, and recreation areas for children and youth (see Standard 17);
• include risk-reduction and risk-education messages in formal and non-formal education, recreation activities for children, and community messaging activities (Standard 3);
• involve children and youth in mapping and assessing risks and spread messages on the physical safety of children;
• make sure there are procedures for case management and referrals in place, and that quality programmes for children who are injured or left with an impairment are available, accessible and used (see standard 15);
• advocate for increased safety of children with the most important stakeholders;
• make sure that child-related risks are taken into account in camp design/ construction/management; and
• advocate for making clearing of landmines and ERW a priority in places where children go often (for example, schools, hospitals, etc.) and carry out mine risk education in contaminated areas (UNICEF, 2013).

Guidance notes (UNICEF 2016:81)

Physical dangers and risks for children and young people:

Unintentional injury may include drowning (rivers, lakes, ocean, wells, pit latrines), falling (cliffs, trees, pits, trenches), burning (fire, cooking oil, boiling water, electrocution), road traffic, wild animals (snake bites), sharp objects (knives, barbed wire), exposure to garbage containing infectious waste, etc.

In disaster zones, risks can include damaged infrastructure (roofs and walls collapsing, exposed electrical and barbed wire, rubble) and drowning (floods, landslides). In conflict areas, risks can include using explosive weapons and containment by explosive remnants of war (for example, landmines, cluster munitions, mortars, shells, grenades, cartridges, ammunition and so on), collapsed infrastructure, and the widespread availability of guns and other weapons.

Data collection:

Use the information from assessments and child protection monitoring to develop targeted age-, gender- and risk-specific education messages.

Assessments must involve children of different sexes, ages and disabilities, as children’s views of risks often vary greatly from those of adults. One good example of how this can be done is by drawing a map of the community and getting children and adolescents to mark areas on the map where there are risks, and then discuss these with them. Discussion should include:

• The main physical risks of unintentional injury to children
• The risk ranking of unintentional injuries for children (for example, most frequent to least frequent)
• Risks specific to particular groups of children (younger children, adolescent boys, adolescent girls, children with disabilities, etc.)
• Where the dangerous areas are where these risks are found
• What knowledge children in the community have about these dangers
• What skills and capacities children have to deal with such risks
• What the preventive and responsive mechanisms are that are already in place
• What hospitals, primary health-care centres and programmes exist for children who are injured (UNICEF, 2013: 82).

Specific groups:

Younger children, who have less experience of danger, may easily put themselves in harm’s way if they are not sufficiently well supervised. Adolescents often see themselves as unaffected by danger and harm, and are specially at risk of taking part in hazardous behaviour. Adolescent boys may be the most likely group to play with or use guns and weapons, to approach explosive remnants of war, or to take part in dangerous vehicle-related activities. Children with intellectual or sensory impairments (for example, impairments to eyesight and hearing) might be less aware of the risks around them, whereas children with physical impairments may have less mobility with which to protect themselves from danger (UNICEF, 2016).
Key elements of survivor assistance, which must be age and gender appropriate, include:

- Emergency and continued medical care
- Physical rehabilitation (including ortho-prosthetic services)
- Psychosocial support
- Legal support

Involving boys, girls and youth as leaders in designing and implementing these activities builds their self-esteem and gives them a sense of control in these situations of insecurity (UNICEF, 2016: Standards 3 and 16).

Schools:

Schools and after-school activities provide opportunities to discuss and share self-protection information with a large number of children. Risk education and information activities can be most effective if designed and delivered by children and youth themselves. Developing special methods to reach out-of-school children and those who attend informal schools, religious schools, or schools specifically for children with disabilities may be needed. The need to reach these children poses a serious challenge, as they are often more at risk than those who go to formal schools (UNICEF, 2016: 83 Standards 3 and 20).

Case management and referral:

Include serious physical injury and disability among the criteria for case-management services (see Standard 15). Pay special attention to the specific protection risks faced by girls and boys with disabilities. Develop referral mechanisms to:

- Spreading community and public awareness messages on risks and prevention measures
- Running community safety drills for children
- Community clean-up programmes
- Building fences and bridges
- Making sure that wells and pits have safety mechanisms
- Making sure there is enough lighting at night
- Raising awareness of and marking out areas known to be contaminated with ERW.

Survivor assistance:

Key elements of survivor assistance, which must be age and gender appropriate, include:

- Economic inclusion (including the right to work and employment, and the right to an adequate standard of living)
- Social inclusion (including rights to involvement, accessibility, education and cultural life and sports).

Laws and policies and public education campaigns, accessible to everyone and which promote the rights of people with disabilities, should also form part of assistance to survivors. When providing assistance, make sure to strengthen and not to undermine existing national child protection systems, including community-based systems. The Convention on the Rights of Persons with Disabilities, the Mine Ban Treaty, the Convention on Certain Conventional Weapons, the Convention on Cluster Munitions, and relevant national laws and policies provide a legal framework to address the use and effect of explosive weapons, including providing survivor assistance to those injured, including those with disabilities (UNICEF, 2016).


When someone begins to speak about their losses, the values that have survived the human rights violations, social workers can guide the conversation to discussing special people and the special relationships they had in the person’s life. These can be relationships with people who are still alive, or with people who have passed away. Remembering conversations can be called ‘saying hullo again’ conversations, as the person gets a chance to ‘say hullo again’ to lost loved ones. It is useful to help the child choose a supportive person apart from the social worker who can be an outside audience to their grief and recovery. Dulwich 2014 provides examples of talking with children who have lost people as well as group work with children in preparation to manage the effects of a military attack: ‘Tips for children from the children of the Aidini family’.


Use Palestine Counseling Centre’s (PCC, 2016) research ‘Violence and its Impact on Palestinian Families in Jerusalem: A Study By and About Jerusalem’s Children Center’ to demonstrate that even children can participate in and contribute to research projects. Students in Gaza can make their own lists of the violence that children experience that is different from those in Jerusalem. The research aspect of this project is strong so ask students to read and present their views on the types of methodology. These are four areas of violence and abuse experienced by children and their families in Jerusalem:

- Children Who Experienced House Demolitions in Jebel Al-Mukkaber

Most of the children who experienced house demolitions were exposed to several traumatic events successively, some without long-term resolution.

Social support in the period surrounding the demolition of private homes, from the extended family, through neighborhood events and community institutions, can play a
role in reducing the series of shocks. Children who have been exposed to demolition face difficulties in adapting to their new circumstances as they are forced into new surroundings (to live with their relatives or neighbours, or into a house in another neighbourhood, for example).

As stress increases within the family, violence is increasingly used as punishment by parents and aggression is used by children. It has magnifying impact for the community in Jebel al-Mukkaber (PCC, 2017).

Detention and House Arrest of Children in Silwan

The experience of arrest and home confinement is one of the most difficult endured by children, and in Silwan it has left its marks on their mental health, with children expressing a constant sense of fear and experiencing challenging relationships with family and friends. Night arrest operations are especially traumatic to children and their families, with documented incidents of ill-treatment of children including being blindfolded, painful hand ties, and verbal and physical abuse. Children continue to be subjected to ill-treatment including violence and physical and psychological pressure during interrogation and imprisonment. Children leave detention suffering from health problems and physical pain as a result of ill-treatment during the period of detention and interrogation. Children in Silwan who were arrested avoided talking with their parents about their feelings and experiences in prison. Parents were challenged in interacting with their children after they had completed a period of detention. They said that their children’s behavior changed, they became unable to cope with their anger and they experienced bouts of rebellion. House arrest transforms the home into a prison for these children, imposing on their caregivers the threat of legal prosecution, actual imprisonment for children if they do not keep their children at home. The situation increases the psychosocial challenges for children, especially adolescents.

Impact on Children of Daily Raids in Issawiya

The daily incursions and raids experienced by children living in Issawiya take a toll on them through a constant sense of fear and insecurity, permanent tension, instability in daily routines, a deprivation of play and exercise, and a loss of childhood. Families show negative outcomes from this instability, such as anxiety and difficulties sleeping. Parents experience daily fear for their children due to the ongoing arrests and raids, military presence around schools, and the use of tear gas and sound bombs near students to intimidate them (PCC, 2017).

Restrictions on Play and Worship for Children in the Old City

Children experience psychosocial challenges due to exposure to constant violence, confinement at home, denial of entry to the al-Aqsa Mosque and its courtyard, and restrictions on accessing the mosque and schools inside the mosque. Children witness attacks during physical inspections by the military, prevention of entry into the Al-Aqsa Mosque, and the use of tear gas and rubber-coated metal bullets, which create in them a sense of fear and result in social isolation. There are not enough children’s clubs and designated areas to play in the Old City, which negatively affects children, who are confined to their houses due to the presence of military and armed settlers.

Parents are anxious and worried about their children, reporting that their children are becoming angry towards the occupation and feeling the desire for revenge. Parents in the Old City reported psychosocial problems in their children ranging from problems eating and using the bathroom to behavioral problems. After the age of one, unintentional injuries are a leading cause of death among children and adolescents, accounting for over 30% of deaths among 10-14 years and almost 50% in 15-19 years old. Road traffic injuries (the leading cause of death among those aged 15-19), drowning and fire related burns are responsible for almost 50% of child deaths across the world. In an emergency, in addition to these “ordinary risks”, children are at greater risk of injury and disability. Children with existing disabilities can be children are particularly at risk from explosive remnants of war (ERW) and landmines. Displacement as a result of emergencies can also put children unstable debris and ERW (PCC, 2017). If injuries to children are not treated quickly appropriately, there is a greater chance of long-term or permanent injury. Children who have been injured in emergencies, especially those left with disabilities, have different physical rehabilitation needs to adults, and in situations where resources are limited, they are less likely to receive age-appropriate assistance.

4. Social workers engendering hope and safety (O’Leary et al., 2015)

Read O’Leary et al’s research and project (distribute to students if available in Arabic). Make available the Hope Tool for students to measure their own resilience and hope privately then share what they want to with each other. End the session with how can we create hope and safety for children in Palestine?

References


Module 6e: Responding to children and young people experiencing sexual abuse

Module description
In this module we will explore the definition of sexual abuse of children and young people. Myths and truths around sexual abuse are explored. An overview of the impact and indicators of sexual abuse will be covered. The next part of the session identifies how social workers can best intervene with children and young people who have been sexually abused.

Module Outline
1. Definition: What is sexual abuse?
2. Myths and truths about sexual abuse of children
3. Impact of sexual abuse on children
4. Indicators of Child sexual abuse
5. Principles of intervention
6. Practical steps for dealing with disclosure of child sexual abuse

Module Assessment
Select 2 myths about sexual abuse of children (from AMWCHR, 2013) and explain why people might hold the myth as truth, how it may cause harm to a child who is being or has been sexually abused and how social workers can work to rectify the myth and respond to affected children.

Assessment Criteria:
1. Demonstrates critical thinking to evaluate and critique the myth
2. Identifies problems arising from the myth
3. Describes a realistic ethical and creative response to the problems of the myth

Lecture:
1. What is sexual abuse?
A child or young person is sexually abused when any person uses their power over the child to involve that child in sexual activity. When parents or caregivers are unwilling or unable to protect a child from further abuse, it becomes a child protection concern requiring statutory intervention.

Child sexual abuse involves a wide range of sexual activity. It may include fondling of the child’s genitals (or getting the child to fondle the perpetrator’s genitals); masturbation (with the child as either observer or participant); oral sex (either fellatio or cunnilingus); vaginal or anal penetration by a penis, finger, or any other object; fondling of breasts; voyeurism (regular observation of the child) or exhibitionism. It can also include exposing the child to pornography or using the child for the purposes of pornography or prostitution.

Abuse occurs when a person uses their authority, either by using force or not, to get a child to participate in activities that are for the adult’s or older person’s sexual gratification. Children always have less power than adults. The closer the relationship between the child and the adult, the greater the dependency and therefore the greater the power that the adult has over the child.

Children lack the necessary information and maturity to make an ‘informed’ decision about sexual activities with an older person. They do not have adult knowledge of sex and sexual relationships, or the social meaning of sexuality and its potential consequences.

Sexual activity between a child and older person is inappropriate because children are never in a position to give informed consent to such activities. (DHHS 2013).
To the tutor: The information presented in this part of the lecture is from the Australian Muslim Women’s Centre for Human Rights (AMWCHR, 2013). This is an organisation of Muslim women working to advance the rights and status of Muslim women in Australia. As an organisation committed to human rights, they aim to work with communities when Islam is used to undermine the status of Muslim women and intervene in these instances with facts and informed analysis through the development of publications, advocacy with government, workshops with women, individual support.

2. Myths and truths about sexual abuse of children (from AMWCHR, 2013)

Because of the taboos in discussing child sexual abuse, many myths exist in the community about it. Discussing and debating the myths enables students to address their biases and knowledge gaps.

- Myth: Child sexual abuse occurs mostly in the uneducated class and poor areas.
- Truth: Child sexual abuse can happen to any child, irrespective of how literate, educated, rich or poor they are. In lower socio-economic areas, an incidence may have occurred due to the community set-up, however that does not mean there is a higher occurrence. Children are children and are vulnerable anywhere.
- Myth: The abuser is usually a stranger.
- Truth: Studies indicate that in the majority of cases the abuser is known to the victim, which include neighbours, teachers, community members and family members.
- Myth: Boys are rarely sexually abused.
- Truth: Boys are as vulnerable to sexual abuse as girls. Cases of boys being sexually abused are usually underreported. Boys are given much more freedom of mobility and therefore become more vulnerable to being sexually abused by persons outside the home. There is also greater stigma for boys to disclose sexual abuse because of perceptions and ideas of masculinity and there is greater shame associated with being sexually abused by another male.
- Myth: A person sexually abuses children because he/she cannot control his/her sexual urges.
- Truth: An abuser does not sexually abuse children out of sexual frustration. Sexual abuse is about power and control, not sex. Sex is the tool that is used to attain feelings of power. People that are married can sexually abuse children, as can people who have open access to sexual relations with other adults. Sexual abuse of children is also a planned, thought-out process which involves grooming the child slowly with gifts and sweets to build trust and does not happen out of the blue to relive sexual frustration. (AMWCHR, 2014).
- Myth: Children often make up stories about being abused.
- Truth: Children rarely lie about sexual abuse. Children do not imagine or make up traumatic occurrences or sexual events unless it has happened or they have witnessed it. Remember, children may lie to get out of trouble, but they rarely lie to get into trouble.
- Myth: Children who seem fine after sexual abuse do not need counselling.
- Truth: All sexually abused children need to be assessed and treated by professionals. If they are not attended to, there may be major problems later on in the child’s life.
- Myth: Sometimes it can also be the child’s fault if he/she is sexually abused and exploited.
- Truth: Sexual abuse is NEVER the child’s fault. Children are often scared, threatened, coerced, blackmailed, enticed and groomed into sexual abuse. It is always the responsibility of the adult to have the best interest of the child in mind and to never exploit children. Our bodies respond to touch and children are not sexually and emotionally mature enough to understand what that touch, attention or affection might mean. Sexual abuse is an exploitation of their innocence and needs.

3. Impact of Sexual Abuse on children

Short term effects

- Feelings of powerlessness
- Shame
- Anger
- Fear
- Increased anxiety
- Phobias (fears of specific objects, places, or people)
- Nightmares
- Difficulty concentrating
- Flashbacks of the event
- Frequent vigilance of one’s environment for fear of confronting the perpetrator.

Long term effects

Psychological problems (depression and anxiety) • Psychosomatic problems (continuous unexplained illnesses) • Difficulties with trust and intimacy in relationships • Re-victimization (e.g. becoming a victim of domestic violence or further sexual abuse as a child or adult) • Suicide or suicide attempts • Substance abuse (alcohol/ drugs) • Delinquency (stealing, breaking the law, etc) • Sexually transmitted infections and HIV/AIDS (AMWCHR, 2013)
4. Indicators of child sexual abuse

Behavioral indicators

Physical Indicators • Excessive crying • An increase in irritability or temper tantrums • Fears of a particular person or object • Disrespectful behaviours • Aggression towards others • Poor school performance • Bedwetting or soiling of pants • Age-inappropriate sexual knowledge • Sexualized play (e.g. trying to have sex with other children) • Unexpected change in a child’s behaviour (e.g. a lively, outgoing child suddenly becoming withdrawn or quiet) • Unexplained pain, swelling, bleeding or irritation of the mouth, genital or anal area • Sexually transmitted infections (sores, discharge, frequent itching of the genitals) • Pregnancy • Unexplained difficulty walking • Increase in headaches or stomach aches (AMWCHR, 2014).

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5. Principles of intervention when helping children and young people who have been sexually abused

Sexually abused children and their families may require assistance from child protection services, the criminal justice system and counselling and support services. No one group can totally meet the needs of the sexually abused child. Effective intervention must be child-centred, involve multi-disciplinary teamwork and be guided by the following principles:

• Child sexual abuse is unacceptable
• All children have a right to be safe and protected from sexual abuse
• Child sexual abuse is a criminal act
• A child should always be taken seriously if they allege sexual abuse
• Intervention should aim to promote the relationship between the child and the non-abusing parent(s)
• Children who have been sexually abused have the right and need to be in a safe supportive environment. They also have the right to legal and protective intervention and to counselling and treatment services
• The first priority of intervention should always be to protect the child and to promote their recovery (DHHS, 2013).

6. Practical steps for dealing with disclosure of child sexual abuse

<table>
<thead>
<tr>
<th>Do</th>
<th>DON’T</th>
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<tr>
<td>Listen and show empathy</td>
<td>Overreact or look shocked</td>
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<tr>
<td>Acknowledge the child’s statement</td>
<td>Push for details</td>
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<tr>
<td>Speak to the child quietly and privately</td>
<td>Put words in the child’s mouth</td>
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<tr>
<td>Stay calm, reassuring and non-judgmental</td>
<td>Question why it took so long for the child to disclose the abuse (if this is the case)</td>
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<tr>
<td>Give the child your full attention</td>
<td>Make promises you can’t keep (“this can be our secret if you tell me”)</td>
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<tr>
<td>Believe what the child tells you</td>
<td>Ask many “why” questions (AMWCHR, 2013).</td>
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<tr>
<td>Let the child do the talking</td>
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<tr>
<td>Take down the facts</td>
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<td>Give direct answers to the child’s questions</td>
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<tr>
<td>Tell the child that he or she is not responsible for the abuse, whatever the circumstances</td>
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<td>Discuss a course of action with the child be realistic, but try not to frighten the child</td>
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<tr>
<td>Tell the child who else you will need to tell</td>
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What a child or young person may believe:

• That it is their fault
• That they could have stopped the abuse;
• That they are a bad person so deserve to be sexually abused;
• That they are better off dead;
• That no one will believe them (CASA, 2017).

What might children/young person fear?

• That those who they love will reject them;
• That they will be removed from their home;
• That their father/other perpetrator will go to jail;
• That they have destroyed their family;
• That they will lose their family home;
• That they will have to move schools (CASA, 2017).
Module 7:

Family Group Conferences (FGC)

Module Description
Family Group Conferencing (FGC) puts the child, parents and their extended family at the heart of the decision-making process about the care of their children. In this module the historical development, principles and process of family group conferencing will be explored. The Signs of Safety and Three Houses assessment and planning tools will be introduced, and students will have an opportunity to familiarise themselves on how to apply this technique.

Module Outline
- What is a family group conference?
- Child Protection FGC
- Youth Justice Conferencing
- FGC Historical view
- Theories that inform the FGC
- Principles of FGC
- Cases for FGC
- The conference process
- Class Activity: watch Katie’s family group conference
- The Family Group Conference Plan
- Professional Roles
- Preparation for FGC – Signs of Safety and Three Houses tools

Module Assessment
Watch the two FGC videos and answer the following questions:
1. Discuss the principles of the FGC that are evident in Katie’s FGC
2. Drawing from Katie’s FGC, discuss the pros and cons of bottom lines
3. Discuss a tool that you could use to prepare children for a FGC
4. Review Katie’s FGC plan and discuss how it addresses Katie’s care and protection needs
5. What are the differences between the role of a child protection social worker and the role of a FGC coordinator in a FGC?
1. Introduction to Family Group Conferences: What is a FGC?

Family group conferencing (FGC) is a method of resolving, or attempting to resolve, family issues in relation to child protection. It involves bringing together three sets of people – the child or young person, members of their immediate and extended family and child protection professionals – to air issues, come to a resolution and develop a plan for future action.

FGC puts the child, their parents and the extended family at the heart of the decision-making process. A central aim is family empowerment, shifting decision-making power back to families (Doolan, 2003). The child protection system retains responsibility for ensuring the safety of the children whose fate is the primary concern of the FGC. The FGC approach has been adapted to work with adult victims and perpetrators of domestic violence, adult offenders and their victims, powerless and dependent communities, schools where children face school failure and school exclusion, older persons facing loss of independence, and persons with a mental illness (Doolan, 2003; Mirsky, 2003).

The FGC model is based on the following assumptions:

• Families have a right to participate in decisions that affect them
• Families are competent to make decisions if properly engaged, prepared and provided with
• necessary information
• Decisions made within families are more likely to succeed than those imposed by outsiders.

2. Child protection FGC

The child protection system retains responsibility for ensuring the safety of the children whose fate is the primary concern of the FGC. FGC puts the child, their parents and the extended family at the heart of the decision-making process. A central aim is family empowerment, shifting decision-making power back to families (Doolan, 2003). A FGC aims at addressing care and protection concerns and to strengthen families. It involves the family in decision making and formulates a plan to address the care and protection concerns about the child.

3. Youth Justice Conference (YJC)

Based on restorative justice, the purpose of a Youth Justice conference is to make young offenders accountable for their offence that are not punishable by imprisonment. The YJC plan may include apology, reparation, reimbursement to the victim, donation to the community or counselling.

4. FGC historical view

Developed in New Zealand following an inquiry about over-representation of Maori children in care, FGC is based on the notion that families and communities have strengths and capabilities which can be mobilised to create safety for children at risk of harm.

5. Theories that inform the FGC

Based on the Maori cultural practice Maatua Whangai (Kinship carers)

The FGC approach has been adapted to work with adult victims and perpetrators of domestic violence, adult offenders and their victims, powerless and dependent communities, schools where children face school failure and school exclusion, older persons facing loss of independence, and people with a mental illness (Doolan, 2003; Mirsky, 2003).

Over 20 countries have adopted the Family Group Conferences, including Australia, Belgium, Brazil, Canada, Denmark, Germany, Ireland, Israel, Netherlands, Norway, Puerto Rico, Saudi Arabia, Scandinavia, South Africa, Sweden, Thailand, UK, and with Anglo, African American and Hispanic families in the USA.

While requiring an initial high investment in time and money, the outcomes are seen to be more sustainable and more cost effective in the long term.

6. Principles of FGC

Based on the Maori cultural practice Maatua Whangai (Kinship carers)

The FGC approach has been adapted to work with adult victims and perpetrators of domestic violence, adult offenders and their victims, powerless and dependent communities, schools where children face school failure and school exclusion, older persons facing loss of independence, and people with a mental illness (Doolan, 2003; Mirsky, 2003).

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While requiring an initial high investment in time and money, the outcomes are seen to be more sustainable and more cost effective in the long term.

5. Theories that inform the FGC

- Strength based,
- Empowerment,
- Anti-racist,
- Community development,
- Group work,
- Conflict resolution,
- Narrative theory,
- Task and solution focused models

6. Principles of FGC

- The safety of the child is paramount
- Children have rights and can participate in decision making and planning on matters that relate to their safety.
- Children can attend if age appropriate or can be represented, for example, using Three Houses
- The source of a child’s wellbeing is within the family
- Working in partnership with families has better outcome for children
- Families have the capacity to make decisions for their children
- With the right resources, families can provide safety for their children

7. Cases for FGC

The research is inconclusive about whether FGC is appropriate for cases with different problems of domestic violence and sexual abuse. Jones and Finnegan (2003) found that participants came largely from families with multi-problems. Sexual abuse cases and domestic violence cases were less likely than other cases to be invited to a meeting. However, the outcome variables used in this study suggests FGC worked as well for these families as it did for other families without those specific problems. Social workers and coordinators must ensure that the process is conducted in ways that ensure the safety of participants where these factors are present (Huntsman, 2006).
Cases that are suggested as inappropriate for FGC
• Families with limited networks
• Families with many conflicts
• Transient families
• Sexual abuse or domestic violence cases (where perpetrator insists on being part of the meeting) (Jones and Finnegan, 2003).

8. The conference process
The process is convened by the FGC coordinator. The actual conference can be held in a formal or informal venue. It has three stages: Information sharing, family time and agreement and planning
• Introductions and information sharing from professionals
• The SW and other professional share information
• Family asks questions/seek clarifications
• Social work explains the bottom-line
• The coordinator asks whether the family is in agreement that the child has care and protection concerns
• The coordinator and the social worker provides the family with the resources they need during family time, for example, a list of the concerns, a template of the plan, a white board.
• All the professionals leave the room, the family is left to discuss the concerns and work out a plan to address the concerns.
• Family private time – to reach a plan. The family inform the coordinator when the family is ready for professionals to re-join the conference
• Discussion of family’s plan with professionals
• Social worker submits plan to authorities
• Three monthly reviews of plan by social worker

If the plan is not followed or the desired outcome is not achieved, the FGC is reconvened or the social worker might take the matter directly to Court as the child’s safety is paramount.

9. Class Activity: watch Katie’s family group conference
Show the video examples (below) of a family group conference and afterwards students reflect on: ‘What did you notice in the process? In what ways did the process demonstrate collaboration, participation and partnership? In what ways does the process need to be adapted to your context?’
Family Group Conference video 1
https://www.youtube.com/watch?v=kTbWy3oHFaw
Family Group Conference 2
https://www.youtube.com/watch?v=aB4ON_6m95Q

Tutor: Refer to transcripts of Katie’s conference

10. The Family Group Plan
• SMART plan
• Must address the care and protection concerns
• Must be written in a language that the child and the family understand
• Strength based
• Includes a monitoring process and review time

Agreement and planning
The family presents their plan
The coordinator asks the social worker whether the plan meets the bottom line. If the social worker is not satisfied with the plan, changes can be discussed and agreed upon and if this is not possible the outcome of the conference becomes non agreement and the matter is taken to court
The plan could also include seeking court orders and is therefore included in court order application documents
If the conference reaches an agreement, all professionals participate in ensuring that the resources for the plan are available.

11. Roles of professionals
The role of social workers is to:
• Investigate and assess the risks and concerns to determine whether a FGC referral is appropriate.
• Put a safety plan in place for cases with immediate safety concerns
• Define rules for safety for the child or children
• Inform the child (if appropriate) and the family about the option of a FGC and if they agree, refer the child and selected family members to the FGC Coordinator
• Social worker decides with family who will attend FGC and liaises with coordinator
• Write a comprehensive referral
• Ensure the child’s voice is heard in the conference- can represent the child, for example, using the Three Houses tool
• Attend the conference and present information
• Approve the family plan to be presented to the authorities
• Ensure the family have the resources they need to implement the plan
The role of the coordinator:

Pre conference
• Meets with immediate family members, including the child or children if age appropriate. The child and family choose the venue and who should be invited to FGC and send invitations.
• Seeks children, family and community members' views to identify family members and strategies to keep the children safe
• Coordinator informs them about FGC, and informs family and community members about the situation, the laws and resources available
• Explores and address any conflict that may arise during the conference
• Ensure that the family has all the resources they need to attend the conference, for example, transport, childcare
• Explores and address any cultural considerations prior to the conference

During the conference, the coordinator
• Facilitates Introductions
• Addresses cultural protocols
• Ensures safety for all participants
• Invites the social worker and other professionals to share information.
• Ensures the family has the resources they need during the conference including catering
• Leaves the room so family can make their decision

Post conference
• The coordinator compiles the plan and sends it to all the participants
• The social worker works with the child and the family and the professionals involved to implement the plan
• The social worker monitors the plan

Review of plan
• The plan is reviewed after 3 months
• The FGC can be reconvened anytime if it becomes evident that the plan is not working – the goals are not being achieved
• The social worker discusses the upcoming review with the family
• The coordinator reconvenes the FGC using the same process used to convene
• The review follows the same process as the conference

References


Transcript of FGC Video 1. What is a family group conference? (FGC)

The film contains scenes from a fictional family group conference featuring family members and practitioners who have previously been involved in a family group conference. [https://www.youtube.com/watch?v=kTbWy3oHfaw]

Reuben: From time to time some families may have difficulties caring for their children for a whole variety of reasons from a bereavement, to mental ill health or stress. Parents can’t always cope with the pressure of looking after a child. When this happens local authorities may have to carry out child protection enquiries to ensure the child is protected from harm and is given the right support and care.

This can often be a difficult time for family members who may feel they don’t get a chance to put their views across and that the local authority is making all the decisions. But there is a different way of working with families to help them.

Some local authorities are offering families the opportunity to have a family group conference, which enables the whole family to come together to work through the problems to find a solution.

A family group conference is organised by a local service who is independent of the social worker making decisions about the child. With guidance and supervision from an independent coordinator the family can be supported in organising a family group conference where a plan for the care of a child can be drawn up by the family and approved by the local authority if it is safe.

To show you how this might work we’ve been following one particular case in the North of England.

Pat (Social Worker): It’s about a baby who was born in January this year called Katie. Both her parents have parental responsibility but both are heroin users. We are before court procedures are issued because Katie’s currently living with maternal aunt and uncle and although that is working well we need more permanent placement.

Ruth (FGC Coordinator): Yes that sounds absolutely fine for a FGC referral.

Reuben: The local authority has been concerned about Katie’s care for some time and she is currently the subject of a cp plan. This plan involved her staying with her aunt and uncle while her CP concerns are addressed, and this has been agreed with her mum and dad.

Pat talking to Carl and Susan (Katie’s parents) After the referral has been made, it’s the family’s decision whether to have a family group conference, no-one can be forced to have one, and the coordinator is there to help set up the FGC, the family can invite whoever they want from both sides of the family as well as friends, supporters community and religious leaders.

Pat: The next thing is for you to decide who you think you’d like to be there, who you think will be supportive in your family and friends.

Susan: I’d like my mum and my sister, and my brother will have to be there cos he’s got care of Katie.

Carl: I’d like my sister to be there is possible.

Namrata (FGC Coordinator): My role as a family group conference coordinator is to facilitate the FGC meeting. I go and meet with the family and explain the process to them and provide advocacy services when necessary.

Brian (family member): Once we’d agreed we’d have a family group conference we got a visit from an FGC coordinator. Basically what happened was she met with each individual separately to get a true picture of their situation what they understood from that situation. I immediately found her very approachable, open honest and transparent.

(Pat knocks in door of Paul and Christine’s home who are caring for Katie). The coordinator will visit all family members identified as participants to invite and prepare them for the family group conference, answering questions and ensuring that the time and place are suitable for all.

Pat: Susan and Carl are both very keen for a family group conference to happen which I think is really positive and when I met with them I asked them who they thought were essential part of Katie’s family network and obviously they both said yourselves as a couple and looking after Katie is an essential role and they’d like you to be at the family group conference. How do you feel about that?

Susan: We feel we need to get it sorted out as we want the best for Katie. Any children involved in the family group conference should be offered an advocate. It is also good practice for vulnerable adults to be offered this support. The advocate will meet with the child and find out how they want to be participate. The child will be encouraged to get involved in planning including designing the invitation and deciding on the food.

The FGC meets at a neutral venue arranged by the coordinator following discussion with the family at a time that suits family members. This may be on the weekend or in the evening. Food should always be available with the family deciding the menu.

Transcript of FGC Video interview 2: The Family Group Conference [https://www.youtube.com/watch?v=aB4ON_6m95Q]

Reuben: There is often initial reluctance by some family members to be involved in the FGC but through dialogue and debate, the family can begin to work through the issues with structure and help from the coordinator.

Brian (family member): I found that some of my extended family were fearful of starting the process because they were fearful of being blamed. I explained it’s not about blame. It’s about moving forward and admitting to each other that we could have done things differently. Once that was explained, they agreed to take part.

FGC Coordinator: Hullo everyone. I’d like to welcome you all to Katie’s FGC.

The Coordinator chairs the first part of the FGC to ensure the family has clear information so they are enabled to participate fully. Ground rules are normally negotiated before the meeting but the coordinator will remind the family of the rules. The meeting sometimes gets heated so the family is encouraged to take breaks or call on the coordinator when needed.

Coordinator: If you have questions that come up in your discussion you can call the coordinator or the SW back into your private family time and we would hopefully provide the answers. There’s no time limit so take as long or as short as you like. Now that you’re here together it’s a great opportunity to discuss Katie’s future.

The referrer, the social worker, is there to clearly outline the concerns and to give the family the bottom line.
SW: In summary, Katie has been living with Susan’s brother Paul and Christine for the first 6 months of her life because Carl and Susan have been using drugs and have been unable to care for Katie. Carl and Susan have worked really hard with Children’s Protection Services and had regular supervised contact with Katie and are keen to continue that. I know this is a difficult meeting for everyone but we need to be looking at making short and long term plans for who cares for Katie.

The social worker makes it clear that the bottom line is that Child Protection (the local authority) believe that Katie would be at risk if she went home to live with her parents at the moment. She tells the family that if they propose that Katie goes back to Susan and Carl, the local authority would immediately apply to the court for an order to stop that from happening.

The SW will have already have set out in writing the key concerns that the FGC should address as well as available support such as drug rehabilitation, information about legal options, what financial help may be available if Katie remains living with her uncle and aunt and where to get independent legal advice.

Claire Drug counsellor is in the group.

The family has already identified additional issues they would like addressed in the FGC including contact between Carl and Susan, and Carl’s older children Rea and Jack from a previous relationship.

Once the family are clear about the key decisions the FGC must address, the professionals leave the room to allow the family private time.

The private Family Time (3.30 on film)

Liz (Katie’s maternal grandmother). All she wants is to have Katie back living with her.

Christine: She can’t because she’s on drugs.

Liz: But she’s trying her best aren’t you Susan.

Christine: She’s stopped before, started again, stopped and started. Katie can’t go back to that. We’ve worked hard to get Katie into a routine.

Paul: There’s no proof she’s not taking drugs. Has she taken any urine tests?

Susan: Have I ever turned up to your place high as a kite? Isn’t that proof that I’m prepared to give up drugs to look after my daughter?

Paul: Were not saying that. If you turned up on drugs you wouldn’t get in.

Christine: You’re not reliable.

Susan: You live too far away. How can I get there? Why can’t mum have her a couple of days a week?

Christine: She’s got a bad back.

Liz: Yes I have a bad back but I can manage.

Paul: It’s not feasible. She’s in a routine at home with us.

Christine: We can’t take her out of her routine. If she comes to you it’ll mess it all up.

Paul: She needs stability she feels secure. We’re not shifting her from one house to another one. It can’t happen.

Liz: I don’t see why. We’re not saying all the time. I am her Gran.

Susan: But it’s hard for me to get to your place to see her all the time cos you live too far away.

Paul: We can help with this. We’ve got to work together for Katie. We’re going to lose Katie if we don’t work together. It says here you cannot have her while you’re taking drugs as the social worker says.

Eileen FGC coordinator: The time set aside for families within a conference is often the first opportunity family members and the wider network have had to sit down and look together for a solution for the difficulties they have been experiencing. It empowers the family and transfers the decision making power to the family. It’s crucial in terms of families developing the confidence and feeling they’ve had a say in decision making. During the FGC private time, the family is encouraged to develop a plan, write it down and make sure that everyone is happy with it.

Paul: Come on we’ve got to sort this out. We’ve got to get something down on paper to show social services we’ve got to make a decision and move forward. Katie’s got to stay with us.

Susan: Yes, but I miss Katie and I don’t get to see her much.

Paul: We can work at that afterwards. We’ve got to make a decision. Come on Carl you’ve got to talk to her. You’ve got to see reason.

Carl: Susan I agree with Paul. We’ve got to go to detox and go into Rehab. Otherwise we’re not to get her back.

Paul: If you don’t follow this through, you will lose Katie.

Susan: Yes, that’s the only thing I can do isn’t it? I’m going have to try my hardest to get off it

Paul: If you go through detox you can have Katie back, but you’ve got to go through the system, you’ve got to prove it.

Carl: I’m determined to help myself get over drugs cos I want to see Katie.

Melanie (Carl’s sister): So do Rea and Jack.

Carl: Rea and Jack will I see Katie. I’ve not been well. I’ve let you all down.

Melanie: We need to do something now, it needs to be sorted. It’s not fair. We know you’ve had it hard but so have they.

Carl: If Susan doesn’t mind Rea and Jack coming down on weekends ...

Susan: I don’t think that’s a good idea. The two kids need to get to know you before I’m stepping in.

Rea and Jack: Yeah, yeah (agreeing).

Melanie: Maybe they can come around to my place and you come and visit until it’s better.

Carl: We will do that, we’ll make that arrangement.

Rea: It’s not as if we see you enough anyway.

Jack: We’ve hardly ever met you. We barely know you.

Rea: We’ve never met Katie.
Carl: I will make up for that and you will see Katie.
Melanie: You’ve got a lot of making up to do.
Carl: Yeah, I have.

Once the family have agreed on a plan, they call the coordinator and others back into the meeting to discuss and agree to the plan. The family’s plan must be approved by the referrer and must take all family members into account.

FGC Coordinator: How was your private time? Was it okay? Yes? Okay Kelly tell us your decisions and I’ll take notes
Kelly (Susan’s sister): Susan and Carl have agreed to go to detox as soon as possible and could Claire sort that out please?
SW: Claire is that feasible?
Claire: Yes, I can arrange the referral in the next couple of days.

Coordinator: Susan and Carl is that okay with you?
Kelly: They also said they would cooperate with the local authority to get Katie home.
The plan also addresses what childcare support from the local authority Paul and Christine need to be able to continue to care for Katie. Although the family’s plan A is for Katie to eventually be returned to Carl and Susan, their contingency plan is that of Carl and Susan can’t demonstrate that Katie will be safe in their care, then Katie’s uncle and aunt will raise Katie permanently. The plan also addresses contact with Carl’s older children

The FGC has now led to a structured plan and the family members know what needs to be done and who needs to do it.

FGC Coordinator: Thanks for the details Kelly. It looks like you’ve reached a good plan. (Asks Social worker, local authority) Does this look like a plan that you can agree to?

SW: Yes, I think it’s a good plan!

FGC Coordinator: Okay the next stage for me is for me to type up the notes that I’ve made today and from Kelly’s notes and send a copy of the FGC plan to everyone who’s here today.

Since the local authority has approved the plan, the coordinator will send the plan to all members of Katie’s FGC meeting, including the social worker and professionals involved. It is then the social worker’s responsibility to ensure the FGC decision becomes the core plan to safeguard Katie.

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Module 8:

Youth Justice Family Group Conference (YJFGC)

Module description

The Youth Justice Family Group Conference (YJFGC) is an intervention that uses diversion to resolve youth offending without the young offender receiving a criminal conviction. This module is based on the New Zealand and Australian youth justice systems. The Module provides a historical overview, explains how prepare for and run a YJFGC and social work and coordinators’ roles. YJFGC videos are included to maximise learning and understanding of the YJFGC process and stages.

Acknowledgement to Teresia Kanyi who created much of this module.

Module outline

- Introduction to the YJFGC
- YJFGC Historical view
- Theories that inform the YJFGC
- The aim and functions of the YJFGC
- Preparation for the YJFGC
- Professional roles in the YJFGC
- Stages of the YJFGC

To the tutor: As YJFGC is an Australasian intervention, you will need to adapt it to your context by including relevant laws and policies from your community.
Module Assessments

Assessment one: (1000 words)
Watch Penny’s YJFGC and answer the following questions:
How does the YJFGC help Penny address the identified concerns and reduce the likely hood of her reoffending?
Discuss how systems theory and strength based theories are reflected in Penny’s YJFGC.

Assessment two (1500 words)
Outline the stages of the Youth Justice Family Group conference and discuss the roles of the coordinator and the social worker in each of the stages

Assessment Three (1500 words)
Review the concept of restorative justice in the Youth Justice Family Group Conference and discuss its role in reducing re-offending for young people.

Introduction to the YJFGC

There are two types of Family Group Conferences (FGC). FGCS are decision making meetings for families where a child has been deemed at risk or a young person convicted of committing a crime. The conference involves families in the decision-making process about their children through participation and empowerment. The Child Protection FGC focuses on involving extended families in the care and protection of their children. The Youth Justice FGC determines what needs to be done in response to a young person who is proved to have offended. The meeting is attended by the young person, the young person’s family, the victims, the young person’s social worker, the YJFGC coordinator and other support people.

YJFGC Historical overview

The YJFGC was developed in New Zealand in 1989 following a review of youth legislation which noted over-representation of Maori (indigenous) children in care. Based on the principles of Maori restorative justice and collective responsibility, the YJFGC developed partnerships between the state and the families in managing youth crime. In the New Zealand collective context, an offence by a young person is viewed as an offence by his or her family towards the victim’s family. Offenders are not treated as outcasts; they are supported and nurtured by the community, and the wider family is involved in restoring justice. Reconciliation with the crime’s victim and his or her family is initiated by the offender’s family (Te Puni Kokiri, 2000), hence the YJFGC was designed.

Theories underpinning the YJFGC

Rather than punishing young offenders to teach them a lesson, contemporary responses to youth crime aim to stop young people re-offending through court and custodial diversion and community-based interventions (Stewart, 1996) that include families, victims and the young person in the process of decision making (Maxwell, Kingi, Robertson, Morris, Cunningham, & Lash, 2004). Young people commit crimes not because they are bad, but because they are young, make mistakes and sometimes live in situations of oppression that make them more vulnerable to mistakes. By holding young offenders accountable for their offending and expecting them to take responsibility in making amends, the YJFGC can restore young people and their families’ honour and community cohesion. Restorative justice helps young offenders experience and express remorse without carrying ongoing shame for their family (Doolan, 2001). The meeting of the victim, the victim’s family and offender’s families in the YJFGC promotes the idea of forgiveness, reparation and social harmony. The young offender’s sense of belonging is supported, nurtured and strengthened in the conference. The YJFGC has positive impact on reducing youth crime by facilitating remorse, responsibility and reparation for the young person and healing and compensation for the victim.
The YJFGC is informed by theories, including:

- Strength based theory: the conference seeks the strengths in the family and community
- Systems theory: involves people involved at all levels of the system
- Empowerment theory: victims are empowered by being heard and involved in deciding the offender’s future; offenders are empowered by taking responsibility and making reparation
- Narrative theory: the conference enables multiple versions of the incidents to be told, heard and made sense of
- Task centred and solution focused models: tasks are devised for the young offender to make some reparation as a step towards resolving the issues

The aim of the Youth Justice FGC is to:

- Hold the young person accountable for his/her offending and to prevent further offending
- Support the young person in taking responsibility for his/her action and make lasting changes
- Give the young person, his/her family, the police the victims and other stake holders a chance to develop helpful solution when a young person has offended.
- Encourage collaborative decision making by all affected parties
- Make recommendations for youth court in both pre and post judging
- Make right the wrong and improve the young person’s life situation and wellbeing

The functions of a YJFGC are to:

- make decisions and plans for a young offender who has admitted to committing an offence. The plan aims to hold the young offender accountable, reduce reoffending and address care and protection needs that might have contributed to the offending.
- consider whether a young offender will be prosecuted in the Youth Court and whether the offender has care and protection needs that need to be addressed in a FGC
- make recommendation to the Youth Court for a young offender who has been brought before the Youth Court, has denied the charges and is in the custody of child protection services. The recommendation is on whether the young offender continues to be held in custody or whether alternative options should be sought.
- consider and recommend to the Youth Court how to deal with a young offender in a defended hearing when a young person has admitted to an offence or charges have been proved against the young person. The judge may or may not accept some or all the recommendations (New Zealand community law, 2018).

Preparation for the YJFGC

- The referral is received by the coordinator either from the police or from the youth court
- As a well prepared YJFGC is more likely to achieve better outcomes, the coordinator consults the family about social-cultural protocols to be used in the conference
- The Coordinator ensures that the young person, their family and the victim have access to the resources they need to attend and participate in the conference. Such resources include: transport cost, childcare, refreshments etc.
- Children between 10-14 years old who have committed an offence that threatens their wellbeing are allocated a social worker to assess their needs, strengths and risks prior to the FGC.
- A social worker is allocated to complete an assessment prior to a YJFGC for young offenders in custody and for cases that are considered to need an assessment by the pre FGC case consultations
- Consultations between the coordinator, the police and other stakeholders are held to discuss how to avoid criminal proceeding as much as possible when dealing with the young offender. Consultations considers: whether ongoing custody is required for children in residential care, whether full investigation is required for children with care and protection concerns and how the concerns might be addressed.
- The coordinator takes all relevant information about the young offender that is known by child protection and youth justice services to the consultation meeting. It is expected that the coordinator will consult child protection and youth justice social workers about their involvement with the young offender
- The venue, date and time for the conference are discussed and agreed upon by the young offender, his/her family and the victim
- Social work assessments are shared with the young person and their family prior to the YJFGC to avoid ‘surprises’ during the conference
- The Coordinator and the social worker assist the young person to prepare for the conferences as needed (New Zealand Ministry of children, 2017).

Professional roles

YJFGC coordinator/convenor

The YJFGC coordinator/convenor runs the FGC, they accept the referral and attend the pre-conference consultation meetings to discuss the FGC. The coordinator explores the family networks, prepares the young person, family members and the victims for the conference, discusses attendees with the young offender, the families and the social worker, clarifies the role of each participants and facilitate access to financial resources, support people and advocate for the young person and the family as needed. In the conference, the coordinator chairs all stages of the conference apart from the family private time. The coordinator ensures that cultural protocols and safety for all participants are maintained throughout the conference. Once a plan is agreed upon, the coordinator writes up the plan and distributes it to all the participants. In
addition, the coordinator checks in with the social worker post-conference to ensure that the plan is implemented and monitored. The coordinator also arranges review of the conference as needed (New Zealand Ministry of Children, 2017).

**Youth Justice social worker**
A youth justice social worker is allocated prior to a YJFGC for all people who have care and protection involvement, children and young persons who require pre FGC case consultation or children with complex cases and those who have committed serious offences. The social worker undertakes a comprehensive assessment with a focus on the needs, strengths and risks of the young person and their family. The social worker may be required to write a social work report or plan for the formal youth court.

The social worker assesses the child by exploring his/her attachment, identity, culture, social and emotional well-being, behaviour, friendships, education and learning skills. They assess the young offender’s parents and caregivers, explore factors impacting on safe parenting, parents’ ability to protect young people and to meet their children’s basic needs, relationship with their children including how well they attune to their children’s needs, and their willingness to address concerns impacting on their parenting. The social work report includes assessment of social, cultural and environmental influences such as social network supports, access to resources and social-cultural relationships. A social worker can also be appointed post the YJFGC to implement and monitor the plan in cases that do not require a pre-conference assessment (New Zealand Ministry of Children, 2017).

**Stages of the YJFGC**

**Opening the conference**
The coordinator opens the conference using the family’s cultural protocols. Having met with everyone beforehand, the convenor invites all participants to introduce themselves, explains the situation and who is in the room and defines the purpose: “We’re here to hear what happened and to work out together how the crime can be resolved”.

**Information sharing stage**
- The police officer reads the report, the social worker reads the assessment and any other reports are read
- All professionals involved with the young offender share information
- The coordinator finds out if the young person agrees with the police report.
- If the young person does not admit to the offence, the FGC ends and the matter is left to the police and the court to address

**The conference**
The coordinator conducts a process where everyone in the room describes their experiences of the offence and its impact on them, the victim and the offending young person. The coordinator is neutral in asking questions to elicit information (i.e. takes no sides, makes no interpretation, offers no minimal encouragers, no reframing, comment or inference from convenor but conveys strong attention, including taking notes). It is important to get a shared understanding of what happened and impact before going for solutions so the coordinator will shut down early solution offers by saying: “Yes, we’ll go back to that when we’ve heard everyone’s versions of what happened”.

**Hearing what happened:**
- a. The coordinator starts by asking the offender to tell the group what happened on the day of the incident/s, encouraging detail by asking: ‘and then what happened?’; “and after that?” and asks: “What do you remember about when …?” and “What was going through your head at the time?”
- b. the police officer describes the events that led to the criminal charge (and has been informed that s/he will be asked to speak personally about the impact of the incident on them later in the conference).
- c. the victim is asked to tell the group from their perspective what they recall on the day, their experiences and the impacts of the offence on them, their family and others.
- d. the offender’s family members describe their experiences of the incident.
- e. anyone else gives their input

The coordinator asks each person: What’s your understanding of how people have been affected? eg emotions, damages, costs…?

**Generating ideas about what the young person and anyone else can do to make things right**
It is important to deplete the anger by ensuring everyone is fully heard before the solution generating phase, so the coordinator contains the solutions phase with a final statement: “We’ll move onto what the response should be soon but before we hear from each of you, is there anything further you want to say? The story should be told in the sequence that it happened. The coordinator goes around the room twice, once after the story, second, after the plan so time for the SHIFT from anger to resolution to happen.

**What should happen? Generating solutions**
The coordinator is more instructive in this phase, asking for recognition of the harm done and ideas about what it will take to put things back into place, for accountability. The coordinator asks the most angry person first: “What would you like to see happen? What were you hoping to get out of the Group Conference?”; clarifying the damage, noting suggestions, using note taking to veer away from eye contact so people in the room look and talk to each other. The coordinator may prompt the victim to suggest actions the offender could take to make reparation.

**Final planning**
The coordinator works with the victim, the young person, their family and others to clarify the identified issues and develop an outcome plan which sets out what the young person needs to do to make amends for the offence/s and prevent further offending. When the issues include care and protection concerns, two plans are developed; a youth justice one and a care and protection one, the latter requiring a review date. The plan can include supports from service providers such as counselling and mentoring.
Adopting the plan

- Once an agreement is reached, the plan is adopted
- If there is not agreement on the plan, the matter is taken to the Youth Court
- The coordinator and the social worker ensure that the family have the resources they need to implement the plan.

Closing the FGC

The coordinator closes the conference and acknowledges the contributions of all participants. Social cultural protocols are performed in the closing process. The coordinator ensures that all participants are emotionally and physically safe to leave the conference.

References


