State of Palestine

Social Work Curriculum including Child Protection Modules

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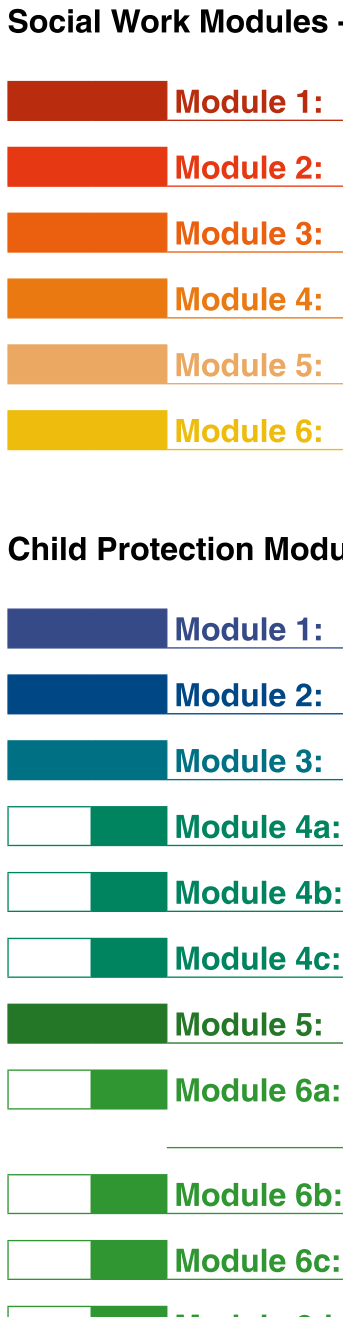
Social Work Modules -
Module 1:
Module 2:
Module 3:
Module 4:
Module 5:
Module 6:
Child Protection Modu
Module 1:
Module 2:
Module 3:
Module 4a:
Module 4b:
Module 4c:
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Module 6a:
Module 6b:
Module 6c:

Social Work Modules

Summary

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 Outline

1. Definition of Huma
2. Origin of Human R
3. Critique of the not
4. Why Social Worke
5. How to practice H
6. Morals, Ethics and
7. Inclusive Ethical D
8. The DECIDE mod

Module Assessmen

Assignment: Ethical lega

Task: Use one of the sc

a) your analysis of I Code of Ethics fo (PSW) Codes of I

OR

b) how you could a person/s in the ca in class and use Chenoweth, 2008 Harries, Feathers

Lecture

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

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3. Critique of the no

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4. Why Social Work

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Critical social workers
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- **Explore the historical context**. This means understanding the history of the problem the person presents with, in the context of the place, time, politics and discrimination, at the local national and international level.
- **Explore the organisational context**. This means knowing and having a good network of government, non-government, national and international organisations to whom you could advocate and seek assistance for the person.
- **Explore the theoretical context**. This means understanding the different forms of oppression the person may be experiencing, class, culture, gender, sexuality, dis/ability, age, place, citizenship, vulnerability, exclusion, internal oppression and exploring and naming the injustices in these situations to the person for example, 'What you're going through is not your fault and it is not fair'.
- **Explore the practice context.** This means taking an anti-oppressive stance such as anti-racist, culturally inclusive, feminist and anti-homophobic approach, knowing that human rights can be violated in many ways at personal, cultural and structural levels. This analysis can assist the person to identify goals at personal and community levels. The social worker can provide advocacy, information and refer the person to counselling, support services and community action groups. Being part of a community action group and campaign to challenge stereotypes, name injustices and call for social change reduces burn out and creates change at the wider societal level. Social workers can work for human rights through direct practice, social policy, research and education.

6. Morals, Ethics and Values in Social Work

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

Class Activity fo

Spend a few minutes

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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 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 decisions making process is completed. Afterwards, consult with the supervisor and other people who could give their opinion

8. The DECIDE mode

(Lonne, Harries, Feathe
for complex situations:

- **Define the ethica**
  Determine the fac
  stakeholders, suc
- **Ethical review**
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- **Consider Option**
  Consider the avai
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- **Investigate outc**
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- **Decide on actio**
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  and priorities
- **Evaluate results**
  Use reflective pra
  outcomes.

*After the lecture, allo
in the classroom. E
Palestinian people a
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References

AASW. (2010). Code of Ethics. Retrieved from Australian Association of Social Workers: http://www.aasw.asnau/document/item/1201

AHRC. (2017). Fact sheet 2: Human rights origins. Retrieved from Australian Human Rights Commission: https://www.humanrights.gov.au/our-work/education/human-rights-explained-fact-sheet-2-human-rights-origins

Banks, S. (. (2012). Ethics and Values in Social Work (4th ed.). UK: Palgrave Macmillan Basingstoke.

HRW. (2017). World Report. United States : Human Rights watch. Retrieved from Human Rights Watch: https://www.hrw.org/world-report/2017

IFSW. (2018, 2). Global Social Work Statement of Ethical Principles. Retrieved from International Federation of Social Workers: https://www.ifsw.org/global-social-work-statement-of-ethical-principles/

Lonne, B., Harries, M., Featherstone, B., & Gray, M. (2015). Working Ethically in Child Protection. UK: Taylor & Francis.

McAuliffe, D., & Chenoweth, L. (2008). Leave no Stone Unturned: the Inclusive Model of Ethical Decision Making. Ethics and Social Welfare, 2(1), 38-49.

Nipperess, S., & Briskman, L. (2009). Promoting a Human Rights Perspective on Critical Social Work. In J. Allan, L. Briskman, & B. Pease, Critical Social Work: Theories and Practices For A Socially Just World (pp. 58-69). Crows Nest: NSW: Allen& Unwin.

United Nations. (1948). United Nations Decleration of Human Rights. Retrieved from https://www.un.org/en/universal-declaration-human-rights/

United Nations. (2017). United Nationa Decleration of Human Rights:History of the Document. Retrieved from https://www.un.org/en/sections/universal-declaration/history-document/index.html

M2 Modu

Critical S
Reflective

Module Description

The aim of the module i
in social work theory an

Module Outline

a. What is Power?
b. Characteristics of
c. Language Discou
d. Empowerment
e. Critical Social Wo
f. Critical Reflection

Assessment: Critic

To the tutor:
asks student
theoretical le

To the tutor: See How to draw a Genogram in Open Dialogue (2017) and how to adapt it to different cultures and extended families in Yznaga 2008.

b. **Family Analysis** ***(30%)*** Analyse yourself and your family from a critical perspective e.g. describe how you experienced your social location in relation 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 exercised, not possessed, something people create and use, and we
- Power is both:
  - repressive (po
  - productive (po
  - productive (po
- Power comes fro have the potentia

Social workers may be acquiring knowledge an or referent power throug

Fook exposes some my away in binary oppositio

Powerful or powerless accounting for contradic

Types of Power

Power over: The powe to make decisions on b coercion, violence, inciti

Some forms of power *o* power, surveillance.

Power to: The power of make decisions for them or material resources, oppression or injustice.

Power with: The power and joint action. Social sharing their knowledge *2018 in* Foucault 1991).

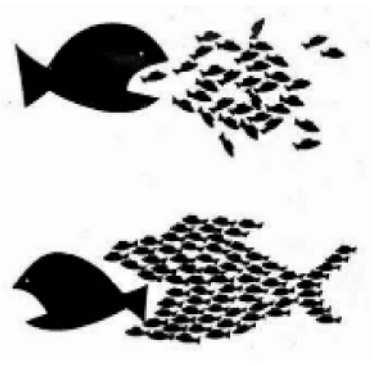
Lavalette (2015) gives e and Balata Youth Projec Jenin, the project was ab disability and develop so

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*)

Power over	Power to	Power with
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	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	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

b. Characteristics o

Thompson (2018) sugge

1. **Choice, intentio** enhance their pow
2. **Agency and des** relations so each consciously abou
3. **Resistance and** decision to use yo power over other efforts. Power is n domination by po
4. **Differences of in** between individua their goals.
5. **Negative restrict** experienced as agency can be re ability, age or sex the minority group embedded in soc

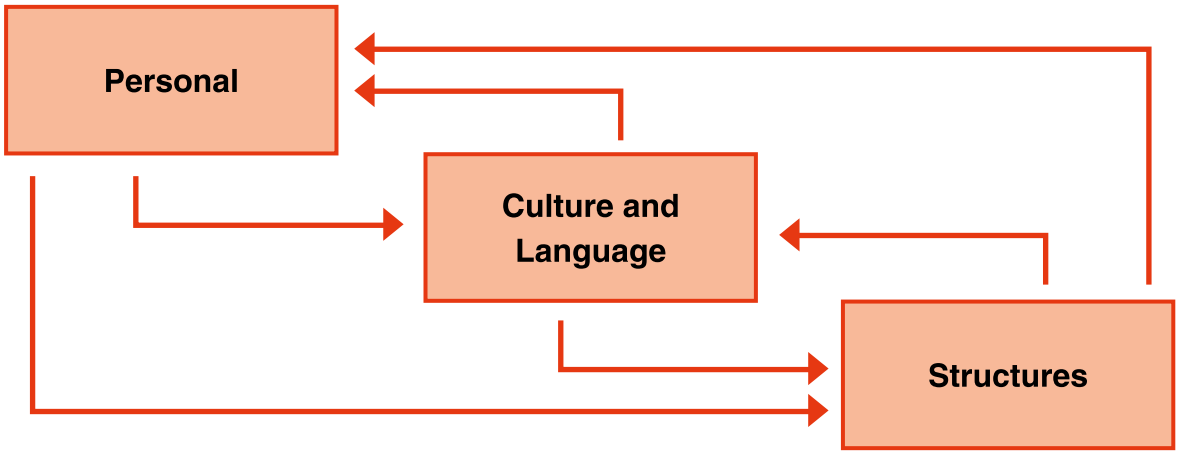
c. Language discou

Language is a vehicle of workers need to be se and problems in order n depersonalised and stig and dehumanise peopl rather than 'people who disability'.

Language reflects and t and maintaining them. F through discourses, the 2018).

- **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)



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?

- **Reconstruct an empowering** to players be inclu experiences be i created? (Fook, 2

Criticisms of the Empo

Although empowermen practice is not easy. Pe powerful groupings. Pe and oppression, highligh gender, but may have p may not be agreement v experience as empowe patronising. The end go For whom? What is equ conceived as a commo power from a powerful g

e. Critical Social W

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- A holistic approac
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- Consciousness ra
- Strengthening a s
- A heightened ser individual so that

To the tutor: Weiss-Gal et al (2012) provide a good example of critical social work in practice but you need to consider how to use this article, for example, critiquing the privileges of Israeli social workers vis-a-vis Palestinian social workers.

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

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To the tutor:

Class Activity - F

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References:

Fook, J. (2016). Social Work: A Critical Approach to Practice. London: Sage.

Foucault, M. (1991). Discipline and Punish: The Birth of a Prison. London: Penguin.

Freire, P. (1970). Pedagogy of the Opressed. New York : Herder & Herder.

Gray, M., & Webb, S. (2009). Critical Social Work. In M. Gray, & S. Webb, Social Work Theories (pp. 99-109). London: Sage.

Heron, B. (2005). Self-Reflection in Critical Social Work Practice: Subjectivity and the Possibilities of Resistance. Reflective Practice, 6(3), 341-351.

Lavalette, M. (2015). Once more on Popular social work in Palestine. Critical and Radical Social Work, 3(3), 425-431.

Lundy, C. (2004). Social work and social justice: A structural approach to practice. Peterborough: Broadview Press.

Open Dialogue. (2017). Family of Origin. Retrieved from http://open-dialogue.net/training/foundation/family-of-origin

Oxfam. (2017). Quick Guide to Power Analysis. Oxford: Oxfam. Retrieved from https://policy-practice.oxfam.org.uk/publications/quick-guide-to-power-analysis-313950

Pease, B. (2010). Undoing Privilege: Unlearned Advantage in a Divided World. NY: Zed Books.

Thompson, N. (2018). Promoting Equality: Working with Diversity and Difference. London: Palgrave.

Weiss-Gal, I., Levin, L., & Krumer-Nevo, M. (2012). Applying Critical Social Work in Direct Practice With Families. Child & Family Social Work.

Yznaga, S. (2008). Using the Genogram to Facilitate the Intercultural Competence of Mexican Immigrants. The Family Journal: Counselling and Therapy For Couples and Families, 16(2), 159-165.

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Strength-

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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.

To the tutor: When presenting the lecture, decide how to allocate time. You could give the whole lecture on strength-based practice, solution focused practice, narrative practice and

cognitive behavioral therapy (CBT), or divide the topics into sub lectures. The notes below are the same as the PowerPoint lecture, which has illustrations.

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:

Challenge oppression

To actively challenge inj

- name and expose
- raise awareness
- encourage social

Collaboration

To collaborate with and

- work in partnersh
- give maximum co
- reflect on and sha

Skills in Strength-base

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- listen to the perso
- show empathy fo
- define aspects of
- work with people
- build people's str
- use the worker as
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To the tutor:

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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

4. Ask Solution focuse

- **Coping Questio** the gravity of the each morning?' ' managed to keep
- **Influence quest** their behaviour: ' occurred?' 'What your children, pa have to do so tha
- **The Miracle que** you knowing it, a named) are solve things are better? phrase is 'What w and Berg, 2002). can change.
- **Scaling Questio**

Where would you rat kill yourself] and you like things to [from a 3 to a 4]?'

5. Give compliments surprised that you've be

6. Set observational a when you chose not to h 2000).

> To the tutor:
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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.

-1	2	3	4	5	6	7	8	9	10+
Ashraf lives on the street, no family contact, suffers violence and exploitation			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				Ashraf can assert himself with his father, attends school and plans to run a business in the market cleaning cars		Lives with his family safely, happily, attends school and believes in himself

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 Practic

To the tutor:
lecture.

Narrative practice is t
perspective in its focus
developed by Michael W

Principles of Narrat

- People's lives, re
develop or have i
- Meaning and ide
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- Dominant stories

Processes of Narra

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- **Externalize the**
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family?
- **Map the influenc**
Person on the pr
Doubt, Isolation)

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

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4. Cognitive Behav

The goal of CBT is to
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and operant conditionir
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teaches the person how
work, so they can disru
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Principles of CBT

The basis of CBT is Al
analyses the process by
to A, an Activating event
lead to C, Consequent p

Activating Event

Belief

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

Homework is given to
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them with alternatives. K

To the tutor:

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Critique and limitations

CBT is less effective wit
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Distribute th
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References:

Bitter, J. (2009). Therapy and Practice of Family Therapy and Counseling. Belmont: Brooks Cole.

Cousins, C. (2005). The Rule of Optimism: Dilemmas of Embracing a Strength Based Approach in Child Protection Work . Children Australia, 30(2), 28-32.

Dulwich Centre. (2014). Dulwich Centre. Retrieved from Responding to Trauma That is Not Past: https://dulwichcentre.com.au/product/when-the-trauma-is-not-past-or-post-palestinian-perspective-on-responding-to-trauma-and-torture-a-collection-of-articles/

Egan, R., & Papadopoulos, A. (2016). Critical Anti-Oppressive Strength based practice. In R. Egan, & J. Maidment, Practice Skills in Social Work and Welfare (3rd ed.). Sydney: A&U Academic.

Elliott, B., Mulroney, L., & O'Neil, D. (2000). Promoting Family Change: The optimism factor . St. Leonards: Allen&Unwin.

Ellis, A. (1957). Rational Psychotherapy and Individual Psychology. Journal of Individual Psychology, 13, 38-44.

Lowe, R., Axten, D., & Guy, G. (1998). Good Question! Solution-Oriented Counselling . Brisbane: Queensland University of Technology.

Michael, W. (2011). Narrative Practice: Continuing the Conversations. New York: W.W.Norton.

Payne, M. (2014). Modern Social Work Theory (4th ed.). London: Palgrave Macmillan.

Appendix

Strengths and Deficit Chart

Life experiences	Deficits and weaknesses	Strengths and resources
1. Roles		
2. Parents		
3. Money		
4. Relationships		
5. Control over life		

Strength-based pra

Narrative practice
1. Locate story in broader discourses
2. Externalise the problem
3. Map the influence of the Person on the Problem and the Influence of the Problem on the Person, over time
4. Develop alternate stories – replot the story
5. Respond to responses
6. Create an Audience and rituals

Challenges

All strength based appro

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:

- To mitigate an
  members.
- To advocate f
  relevant laws.

Assessment Criteria

Your case study should

1: identify the biolog
insights into the li

2: assess a comple
ethical dilemmas

3: create a rights-ba
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30%

4: communicate cle
evidenced argum
10%

Lecture

Case Management

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Case Management was
several service provide
coordinates case worker

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:

- Assisting with nav
  example during tr
- Pursuing professi
- Promoting quality
- Supporting and m

Principles for case ma

The key elements of the

- Engaging and bui
- Emphasis on sup
- Emphasis on buil
- Screening and ho
- Joint planning w
  management;
- Determining goal
  educational, socia
- Monitoring and r
  providers;
- Transition and clo
  2013).

Major Functions of

1. Engagement- ma

(Chenowith & McAuliffe

**Potential clients can h
following modes:**

1. Self-referral or W
2. Referrals from oth
3. Outreach or court

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)

To the tutor: You can provide information to the students about the National Referral and Networking System here.

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:

Depending on the natur
a report may include:

1. A biography and
2. Presenting Conce
3. Background

Housing and living a
Work, income and ec
Physical and Mental
Cultural considerati
Risks
Previous services
Strengths and suppo

4. Child's Developm
   impacting on risk
5. Summary and rec

3. Service or Case

To the tutor:

Together, the case mar
services involved. They
and with an agreed-on
centered work is empha
and client/s define the
reviews the client's stre
identified goals. The cas
Case Plan, including for

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

Preparing the referral

This involves sharing i
worker prepares a refer
participation for referral i
agency that can provid
that the social worker sh

Follow-up

The social worker make
with the referral agency
expected services and i

3. Mediator

A mediator is a person wh
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social worker often has t
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- the other person l
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sides a combine
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Mediation is not usually
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and if it is safe to do so,

Examples: a Forming

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).

- When the client th
  it is now possible
- When the agency
- When the system
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Termination should invo

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6. Review (Chenowith

The review phase invol
achieved, the new skills
way of reflecting on prac
with peers and meetings

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

Reviews and evaluation

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 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

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Strengths and limitatio	
Strengths	• An esse Wraparou particular
Limitations	• Lack of paramete • Difficulty effective • Difficulty particular

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Fernandez, E. (2013). Case Management in ¬Child Protection: Challenges, Complexities and Possibilities. In E. Moore, Case Management: Inclusive Community Practice (2nd ed.). South Melbourne: Oxford University Press.

Gursansky, D., Kennedy, R., & Camilleri, P. (2012). The Practice of Case Management: Effective Strategies for Positive Outcomes. Crows Nest NSW.: Allen & Unwin.

Treadwell, J., Perez, R., Stubbs, D., McAllister, J., Stern, S., & Buzi, R. (2015). Case Management and Care Coordination: Supporting Children and Families to Optimal Outcomes. Springer International Publishing.

Trotter, C. (2013). Collaborative Family Work: A practical guide for working with families in the human services. Crows Nest : Allen & Unwin .

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

CASE PLAN

Family or Individual's Na

Date Registered: . . . . .

Presenting Issues: . . . .

. . . . . .

Desired Outcome: . . . .

Goal or outcomes	Activ goal
1.	1. 2. 3.
2.	1. 2. 3.
3.	1. 2.

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.)

Case conference proc

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family member
- the workers are li
- If a child, young p
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that other worker
next to them and
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- If the client does n
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The chairperson facilitat

- welcomes everyo
role as worker in
- explains purpose
(note) taker to rec
- invites everyone t
to the family then
with the client if a
- summarizes wor

CASE CONFERENCE RECORD

FAMILY NAME: . . . . . FAMILY CODE: . . . . . .

Date of case conference: . . . . . .

Organization: . . . . . .

Contact information: . . . . . .

PRESENT:

Name: . . . . . .

Name: . . . . . .

Name: . . . . . .

Name: . . . . . .

Chairperson: . . . . . .

Issues discussed:

Case plan

Goal or outcomes	Activities to achieve goal	Who is responsible	Dates	Evidence
1.				
2.				

Modu

Crisis Int

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Module Description

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Module outline

Definition and critique
intervention, crisis with
for working with angry,
protocols for work with p

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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 iplies the pressure of time. *Trauma* may follow a crisis.

Crisis intervention may
and social issues. As c
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2. Crisis Interventio

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Crisis interve
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These are the steps for

Stage I: Rapid Psycho
Case Management)

In a crisis, the social
assessment. At a minim
supports and stressors
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indication you are thinki

Stage 2: Rapidly Estab

Rapport is facilitated by
client. This is the stage
and confidence in the c
creativity, flexibility, war

require modification if the present crisis is to be resolved and future crises prevented. It involves focussing on the present rather than exploring the problems in detail and gaining a detailed history (Payne, 2014).

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;

Stage 7: Follow-Up:

Crisis workers should pla
to ensure that the crisis
status of the client. This

- physical condition
- cognitive master
understanding of
- an assessment o
and academic;
- satisfaction and p
- any current stress

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

4. Crisis Interventio

Children who experienc
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4. Working with Inv

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community (Trotter, 200

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care of their family. Wha

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Practice Strategies for

Trotter (2015) suggests
the contradiction in soci

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 definitions 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 traumatised 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 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

may come from their fe
and helpless. Identifyin
clients, for example, 'I ir
you to accept our serv
understanding with the

5. Safety Protocols

Workers are entitled to
threatening situations.
emotionally challenging
protocols for safety and
as establishing rules fo
for example, Don't go a
be there, take a mobile
address and time due b
manage violent behavio
a safety protocols for s
inform police if threaten
or report to police violer

What challenges the pr
threat?

At the personal level:
Currently, a law is bein
Palestinian Legislative
vulnerable to threats an
their lives.

At the National level:
service delivery due to
procedures at checkpoi
affect adults and childre
the needs of children at

At the Organizational le
strategic planning; fundi
or unsustainable; there
coordination and coope
programs and commun

References

De Jong, P., & Berg, I. (2002). Interviewing for Solutions. Pacific Grove: Brooks/Cole.

Greenstone, J., & Leviton, S. (2002). Elements of Crisis Intervention. Pacific Grove: Brooks/Cole.

James, R., & Gilliland, B. (2006). Crisis Intervention Strategies (5th ed.). Belmont, CA.: Brooks/Cole.

Kagan, R., & Schlosberg, S. (1989). Families in Perpetual Crisis . New York: WW Norton & Co.

O'Donohue, D. (2016). Using Constructive Challenge During Crisis Intervention. In J. Maidment, & R. Egan, Practice Skills in Social Work and Welfare: more Than Just Common Sense. Crows Nest, NSW.: Allen & Unwin.

O'Leary, P., Hutchinson, A., & Squire, J. (2015). Community-Based Child Protection with Palestinian Refugees in South Lebanon: Engendering Hope and Safety. International Social Work, 58(5), 717-731.

Payne, M. (2014). Modern Social Work Theory (4th ed.). London: Palgrave Macmillan.

Qassis-Jaraysay, M., & Daqaq, N. (2017, March 7). Social Work and Child Protection in Palestine. Melbourne.

Roberts, A. (2005). Bridging the Past and Present to the Future of Crisis Intervention and Crisis Management. In A. Roberts, Crisis Intervention Handbook: Assessment, Treatment, and Research (3rd ed., pp. 3-34). Oxford: Oxford University Press.

Thompson, N. (2011). Crisis Intervention: A Brief Account of Crisis Intervention Ideas. Lynne Regis: Russell House.

Trotter, C. (2015). Working with Involuntary Clients: A Guide to Practice (3rd ed.). Crows Nest: Allen and Unwin.

Appendix:

Case study f*rom* O'Lea
child protection with Pa
safety International Soc
hommes Lausanne (Td
strengths-based child pr

Nadia (13 years old) wa
(TdH) service because
her at home where Nad
there was too much to d
hair had been falling out
Lufti 8 were finding it ha
to gain enough income
old is severely disabled

Over several home vis
Neighbours who gather
missed Salah who died
extreme poverty, poor li
exposed electricity wire
revealed that Nadia is o

Tdh Response

The TdH social worker d
help to improve the livir
safe electric wiring. Th
worker persisted, callin
relationship was establis
resources for their studi

Nadia, however, remaine
Nadia said she felt resp
examined ways to enco
training. This required w
to encourage Nadia to
Nesma is shared. Relat
rest of the family are ou

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
7. Baine's 6 principles for activist practice (2007)
8. Key Ethical Principles of Case Management Advocacy

Assessment

Assessment criteria:

Demonstration of unders
and how to be an adv
Tahan's (2016) and Mcl

Lecture:

1. What is Advocac

'Advocacy entails the p
resource allocation de
institutions – that directl
established strategy for
a professional social w
work bodies entrench p
through their codes of et
Federation of Social Wo
Canadian Association o
and social justice:

> Social workers advo
> benefits. Social work
> law and challenge in
> disadvantaged. (CAS

To the tutor
strategy mo
Gray, 2007).
involved in r
cultural, mec
assess and i
advocacy rol
(Hoefer, 200

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

Author, Year	Primary Focus
Cesta & Tahan, 2016	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
Daniels, 2009	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
Hawkins et all, 1998	Client's empowerment, independence, and autonomy
Hellwig et all, 2003	Ethical and legal practice as a philosophy foundation Moral commitment for client's autonomy Protection of client's freedom of self-determination
Pinch, 1996	Bridging ethical and legal practices Client's informed decision making

3. A Framework for Ad

McLaughlin identified th
a driving value underpin
that they carry out in the
instrumental, education
individual, marginalized
below:

Table 1: Advocacy Stra

	I
Instrumental Holding systems accountable	• • a • s
Educational Educating individuals, families, colleagues, society	• ir ri c • a s
Practical engaged in action	• fo • to ir •

(McLaughlin 2009)

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 2 Four Basic Perspectives on Advocacy in Case Management Practice

Perspective/Framework	Main Characteristics
Paternalistic	Traditional Assumes the client is powerless, passive, and lacks knowledge Assumes the case manager as the 'boss' Case manager is directive
Empowering	Contemporary Assumes that clients are able to be their own advocate and voice own opinions Clients are empowered participants in their own care Case managers are client supporter and educator
Shared Responsibility	Contemporary Objectivity is relative Assumes a joint decision-making process between the client and the case manager Respects the contributions made by both the client and the case manager Case managers have a moral obligation to share their professional opinions with the clients
Engaging	Contemporary Thought to influence individual and population health Protection of client's freedom of self-determination

5. Roles of an advo

1. Educator for clie
   when the system
2. Power broker: red
3. Representative w
   stands alongside
4. A watchdog – a
   identifies and pro

6. Skills required fo

- Confidence and s
- The ability to de
  verbally or in writi
- Skills in the strate
- Challenging or inf
- Making a request
- Persuasion, using
- Being assertive, c
- Brokering, referra
- Developing open
  truthfulness and t

7. Baine's (2007) Si

- Be likeable, charr
- Be good at your j
- Use your privilege
- You are an instru
- Build your allies a
- You are not 'The

6. Processes of Ad

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 ad 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 5 Key Ethical Pr	
Principle	**Hig**
Demonstrated in behav	
Objectivity	Ma tru int per
Goal orientation	Act rea the
Confidentiality	Pro a r div
Altruism	Act sal
Accountability	Ob int
Obligation	A s It i cli situ
Full Disclosure	Tel wit inf
Influence behaviors of	
Informed decision	Tak ava
Shared decision making	A c cas wh cor
Empowerment	Fa cha to t

References

Baines, D. (2007). Doing Anti-Oppressive Practice . Canada: Fernwood Publishing .

BASW. (2002). The Ethics of Social Work:Priciples amd Standards. Retrieved from British Association of Social Workers : http://www.basw.co.uk/portals/0/CODE%20OF%20ETHICS.pdf

Bateman, N. (1995). Advocacy Skills: A Handbook for Human Service Professionals. Ashgate Publishing Limited.

Faust, J. (2007). Clinical Social Worker as Patient Advocate in a Community Mental Health Center. Clinical Social Work Journal, 36(3), 293-300.

Gehart, D., & Lucas, B. (2007). Client Advocacy in Marriage and Family Therapy: A Qualitative Case Study. Journal of Family Psychotherapy, 18(1).

Hoefer, R. (2006). Advocacy practice for social justice. Chicago: Lyceum Books Inc.

International Federation of Social Workers. (2012). Ethics in Social Work, Statement of Principles. .

McLaughlin, A. (2009). Clinical Social Work: Advocates for Social Justice. Advances in Social Work, 10(1).

NASWDC. (2018). Code of ethics of the National association of Social Workers. Retrieved from National Australian Association of Social Workers: http://naswdc.org/pubs/code/code.asp

Sheafor, B., & Horejsi, C. R. (2008). Techniques and guidelines for social work practice (8th ed.). Boston: Allyn & Bacon.

Tahan, H. (2016). Essentials of Advocacy in Case Management: Ethical Underpinnings of Advocacy-Theories, Principles, and Concepts. Professional Case Management., 21(4), 163-179.

Wolfer, T., & Gray, K. (2007). Using the decision case method to teach policy advocacy. Journal of Teaching in Social Work, 27((1-2)), 37-59.

Child Protection modules

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

Module Description

This module defines typ
abuse and neglect, and
of international child pr
violence, abuse and neg

Outline of the modu

1. Child maltreatme
   abuse, neglect ar
2. Child protection de
3. Situation for childr

Assessment for the m

1. Essay or exam qu

Student task: Describe a
are exposed to and iden
rationale for selecting th

Assessment criteria

Physical, sexual, emo
accurately.

Rationalised response t

Lecture on the co

1. What is Child Ma

Definition: Child maltre
18 years of age. It includ
sexual abuse, neglect, r
labour and harmful tra
and child marriage, or c
the child's health, survi

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,

brain development. Ext
immune systems. Cons
for behavioural, physica

- perpetrating or be
- depression
- smoking
- obesity
- high-risk sexual b
- unintended pregn
- alcohol and drug

Via these behavioural a
to heart disease, cancer

Beyond the health and s
impact, including costs
longer-term health costs
and physical problems
of abuse are likely to re
and distrust of adults. Th
Abused and neglected c
or aggressive, to abuse
kids'. In some situations
In the longer term, adu
to abuse their own chil
relationships with other
one acts to stop the abu

What is Child Protecti

UNICEF (2006) uses th
to violence, exploitation
trafficking, child labour
mutilation cutting and ch
the Child provides for th

The goal of Child Prote

violence and witnessing

2. International Approaches to Child Protection Responses

To the tutor: Using Price-Robertson, Bromfield and Lamont's 2014 article (p9-10), present the three approaches of child protection services to respond to parental maltreatment:

- the 'child protection' orientation evident in Australia, the United States, the United Kingdom, Canada and New Zealand;
- the 'family service' orientation evident in many European countries, such as Denmark, Belgium, and Sweden and
- community-based child protection responses in emergency, transitional and developmental contexts around the world, most notably in Africa, Asia and Gaza.

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

Strengths and limit

In an unpublished UN
influencing the effective

- community owne
- building on existi
- support from lead
  leaders or respec
- child participation
- diversity and inclu
  groups;
- adequate array of
  and
- linkages with for
  referrals for forma

Child-focused communi
of a national child prote
However, effective syst
is therefore difficult to d
systematic review of ch
that in the seven areas
areas was an exceptio
evidence base analysing
(Wessells, 2009).2 The
and encourage policyma

Case study: Gaza S

In the Gaza Strip, where
are refugees), Save the
Committees. Typically t
community members, r
organisations, schools,
session, the committees

and other organisations 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. On-going 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.

3. Situation for children in Palestine (From MOSD 2018 Review of the Child

Conflict and occupatio

Many Palestinian hous
generation of children a

the constant threat of vi

- child deaths and i
  Forces, military o
  of war;
- family separation
  annexation of an
- displacement, evi
  on school-going
  armed conflict;
- arrest, detention
  2018 Review of th

Violence within Palest

Increased stress on pare
within their families, rei
children aged 12 to 17
household, 69 % expo
violence from their fathe

A survey by Palestine Bu
1 to 14 years had exper
punishment) during the
physical punishment, inc
2015).

Other issues related to a
and drug use and famil
girls (National Strategy

Early marriage of girls (

- 36% of women w
- 5% before 15 (Pa
- 9.3% of young wo

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 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 do 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 Activi

Give studen
complete the
per group - p
harm. Allow
have comple
silently pin it
not about be
to identify ex

Channel grie
social proble
question on
stop these fo
affected by t

Before stude
somewhere
necessary.

References

MOSD . (2018). Review of th
Social Development.

AIFS. (2016). Australian lega
Family Studies. Retri
when-child-need-pro

Robertson, P., Bromfield, R.,
to Child Protection: h
paper23.pdf

UNICEF. (2006). Child Prote

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

Lecture

1. Theory and resea

'Prevention' typically m
define activities that pro
abuse and neglect inter
factors to ensure the wel
articulate differences be
of child maltreatment:

Traditional response
Prevent recurrence af abuse
Identify abuse risk fac and address the caret problems and deficien
Legal and medical app
Outside professionals decide family and chil futures, including out o home care
Focus on minimising h

Stagner and Lansing (2

Internationally, increasin
to prevent child violenc
three tier prevention mo

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).

To the tutor: Ask the students: What do you think are the advantages

b. Parent Education

Parent education progr
designed to develop po
child interactions. These
the program is available
at risk. Although some
problems are also addr
be more effective with t
factors (Landers, 2013).

Example Jordan: The

UNICEF and other key
programme aimed at e
loving and protective en
with skills and informa
and physical developme
perspective on children
development as being
and the nation. The les
teachers, and paraprofe
by centralized trainers.

Evaluation found that ov
including improved on p
with their children, using
and accurately perceivi

To the tutor:
forms, for ex
feel less isol
their collectiv
worker meet
and parentin
through writt

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 inconsolably.
- 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.

3. Prevention throu

Preventative programs r
Social workers should
of young children begin
and professionals in di
preventing factors that pl
substance abuse, dome
developmental impairme
diagnosis and treatmen
the capacity to provide
care and parenting as
case of child abandonm

a. Principles for working

- The child's safety
- Someone in the f
child; family mem
decision-making a
- Parents' should g
there is a reason
- Conflict between
positive relationsh
- Children have a ri
workers may hav
- Respect children'
- Identifying a child
can empower the
makes (Geldard,

b. Challenges in workin

Social workers tend to a

- Some workplaces

- 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).

Observe the child in
interpretations.

- O bserve the chil
- behaviour (quiet,
- mood emotions (h
- development – c
  solving, conceptu
  imagination and r
- speech and lang
  speech, stammer
- motor skills (gross
- relationships with
  work/ counsellor,
- indicators of traur

At the end, let them kn
child to their parent, ca
confusing situations or t

References

DHHS. (2007). Child Develo
ChildProtection/Child

Geldard, K., Geldard, D., & Y
London: Sage.

Scott, E. (1999). Are the Chi
Therapy Australian a

Stagner, M., & Lansing, J. (2
19(2), 19-38. Retriev

UNICEF. (2017). Preventing
of Change. Retrieved
WEB_271117.pdf

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 Chid 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

Assessment

a. Exam question

Q: Identify one inter
violence and abu
example of how e

Assessment Criteria

- Accurate selectio
should be familia
- Norwegian Refug
Laws in the Gaza

OR

b. Essay assignment: (
et al's hierarchy of princ
address the risks for the

Assessment Criteria

- High level unders
- Accurate demons
- Attention to other
- Written clearly a
word length.

Lecture on Ethics

1. United Nations C

To the tutor:
before class.

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

Background and conte

The legal system contai
Ottoman Empire, the Br
the West Bank), Egypti
and Palestine National
mostly "non-rights" base
leads to violations of s
judicial system. This is
through a 1954 Jordania
of the Family Law/Pers
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Law of 2004 override al
were introduced, they a
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justice systems in Wes
the Child Law. Howeve
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consideration the Palest
this memorandum is not
children's rights within r

Legal definition of a ch

According to the Palest
defined as any human b

The Palestinian Basic
29 states that maternal
the right:

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- to be free from a
their safety, healt
- not to be subject
- and to be segrega
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The Child Law incorpora

- 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;

Investigation

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Implementation/Respo

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is threatened, child prot
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case to a competent ju
reconciliation nature are
being, and may include

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as a plan for soci
- Handing tempora
alternative family
- Banning the child
- Taking one or mo
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the child with a s

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 tutor needs here to invite a Child Protection Officer to explain this section to the students. If that is not possible, highlight the role and mandate of the Child Protection Networks and their role in implementing the community based child protection.

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

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from those in the Nation

In complex cases, provi
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are binding, and may be

Non formal responses t
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on tribal customs, mainl
customs and Shari'a law
including child abuse ar

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

2. Confidentiality Youn
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To the tutor:
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3. Role clarification an
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of reporting abuse to ch
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The social worker's acti
Networking system,

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 traumatisation 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

References

Children Youth and Families
Retrieved from http://
interest-principles-a-

GPC. (2013). Global Protecti
https://www.refworld.

Harrington , D., & Dolgoff, R.
Social Work. Ethics a

IFSW. (2002). Social Work a
International Federat
ifsw_124952-4.pdf

Lonne, B., Harries, M., Feath
Taylor & Francis.

McAuliffe, D. (2014). Ethical
health and human se

NRC . (2011). Shari'a Courts
Council.

PCBS. (2014). The Status of
Retrieved from http://

United Nations. (1989). Unite
Retrieved from http://

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

of disrupted attachment
model draws on resear
family violence and offe
development evidence b
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and trauma guide and p
stability, which are avail

Except where there are
see them a number of ti
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Gender aware analysis

The dynamics of power
who are mindful of the di
violence on females, se
violence by boys and gir
boys and girls by practit

A gender analysis alerts
Mothers are more likely
likely to be blamed for a

Family violence affects
men (UNICEF, 2017). A
specific issues impactin
gender differential resp
internalize and boys act
adults and boys at great
is the strongest predicto

In responding to family v

- acknowledge viol
  form
- provide a strong
  violence

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 naive 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

A relationship that seeks
always yield a better asse
young people and their f
are ashamed of and defe
This is possible if you:

- acknowledge thei
- listen and explore
- validate their good

Where there is violence
engaged in taking respo
be supported and linked

Outcome focused

The case practice model
and process of our prac
child safe? What could c
know now, and what doe

Assessment and plannin
feedback about the effec

The recovery process for
by the belief and support
to their culture. Children
to grieve, and to make se
with their parents, sibling
These children need ca
Children who have exp
working together to deliv

Relationship based - cl

Building good relations
members and other se
provides the cornerstor
and perspectives will a
practice model is based
and families that engag

References

MOSD . (2018). Review of the Child Protection System in the State of Palestine. Ramallah: Ministry of Social Development.

DHHS. (2007). Child Development and Trauma Guide. Retrieved from https://www.dcp.wa.gov.au/ChildProtection/ChildAbuseAndNeglect/Documents/ChildDevelopmentAndTraumaGuide.pdf

DHHS. (2012). Best Interests Case Practice Model. Retrieved from Australian Institute of Family Studies: https://providers.dhhs.vic.gov.au/sites/dhhsproviders/files/2017-08/the-best-interests-framework-for-vulnerable-children-and-youth.pdf

Modu

Child dev attachme

Module Description

Child development and assessing what is bes developing, how they re experiences of abuse a remove or leave childre attachment theories in r

Module Outline

1. Theories of Child
2. Attachment Theo

Module Assessmer

Pssay assignment: Prov

Q: Choose one of the Describe the theory and wellbeing of one of the

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 can experience discrimination and exclusion if their child is not at the developmental stage of their peers.

Child Development and Trauma Guide (DHHS, 2007)

> To the tutor: Whilst child development is universal, there may be aspects in social development in this guide that differs in the Palestinian context so the tutor needs to contextualise this to the Palestinian context where there is any deviation and difference.

STAGE 0-12 months

By 3-4 months
Increasing imitation of interaction with caregive
Begins to regulate emotions and self sooth through attachment to primary carer
Can lie on tummy with head held up to 90 degrees, looking around
Starts to play with own fingers and toes
By 9 months
Strongly participates in, and initiates interactions with, caregivers
Lets you know when help is wanted and communicates with facia expressions, gestures
Watches reactions to emotions and by seeing you express your feeling starts
POSSIBLE INDICATOR
Increase startle respons
Lack of eye contact
Sleep and eating disrupt
Fight, flight, freeze response
Uncharacteristic, inconsolable or rageful crying, and neediness
Withdrawal/lack of usua

Child Development and Trauma Guide 1 -3 years

Developmental Trends		
By 12 months		
Enjoys communicating with family and other familiar people Seeks comfort and reassurance from familiar objects, family, carers, and can be soothed by them Begins to self soothe when distressed Expresses feelings with gestures sounds and facial expressions	Does not like to be separated from familiar people Moves away from things that upset or annoy Can walk with assistance holding on to furniture or hands and explores Indicates wants in ways other than crying Doing things repeatedly	Picks up objects using thumb and finger Pulls up to standing position Gets into a sitting position Claps hands May even be able to: Understand that when you leave, you still exist Crawl, stand, walk
By 2 years		
Takes off clothing Likes to help	Plays alone but needs an adult nearby Plays and explores in complex ways	May even be: Able to string words together Unable to share Having tantrums
By 3 years		
identifies a friend by naming speaks and can be usually understood half the time	conversation of two or three sentences may be toilet trained	conscience is starting to develop; child thinks “I would take it but my parents will be upset with me”
POSSIBLE INDICATORS OF TRAUMA		
regression to behavior of a younger child inability to relax increased startle response reduced eye contact fight, flight, freeze	sleep and eating disruption loss of eating skills loss of recently acquired motor skills avoidance of eye contact inability to be soothed	uncharacteristic aggression avoids touching new surfaces eg, grass, sand and other tactile things avoids, or is alarmed by, trauma related reminders,

Child Development an

Developmental Trends
communicates freely with family members an familiar others seeks comfort, and reassurance from famili family and careers, and able to be soothed by th understands the cause of feelings and can table them
Between 4-5 years
knows own name and a is asking lots of questio
POSSIBLE INDICATOR
behavioural change regression to behavior o younger child uncharacteristic aggression Reduced eye contact

Child Development and Trauma Guide 5-7 years

Social-emotional development		Physical skills
has strong relationships within the family and integral place in family dynamics anxious to please and to gain adult approval, praise and reassurance	cconscience is starting to be influenced by doing the fight thing may become frustrated by failure friendships very important, although they may change regularly	aable to share, although not all the time
Cognitive and creative characteristics		
emerging literacy and numeracy abilities, gaining skills in reading and writing good communication skills, remembers	may require verbal, reminders to follow directions and obey rules	most valuable learning occurs through play rules more likely to be followed if he/she has contributed to them
POSSIBLE INDICATORS OF TRAUMA		
behavioural change inability to relax sleep disturbances, nightmares, night terrors, difficulty falling of staying asleep regression to behaviour of younger child anxiety, fearfulness and loss of self esteem fears	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	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

Child Development an

Physical skills
improved coordination, control and agility
Social-emotional deve
strong need to belong to, and be and be a part of, family and peer relationship increasingly able to regulate emotions increasingly independen of parents; still needs th comfort and security
Self Concept
influenced by media and peers learns to deal with succe and failure
POSSIBLE INDICATOR
behavioral change increased tension, irritability, reactivity and inability to relax sleep disturbances, nightmares, night terrors difficulty falling or stayin asleep obvious anxiety regressi

Child Development and Trauma Guide 9 – 12 years

Physical		
large and fine motor skills becoming highly coordinated enjoys risk taking	does well at games/sports requiring skill strength and agility	may look more adult-like in body shape, height and weight risk taking
Social-emotional development		
growing need desire for independence and separate identity may challenge parents and other family members parents and home important, particularly for support and reassurance	may experience embarrassment, guilt, curiosity and excitement because of sexual awareness girls may reach puberty during this time belonging to a group is extremely important:	gr oups generally one gender strong desire to have opinions sought and respected growing sexual awareness and interest in the opposite gender
Cognitive and creative characteristics		
beginning to think and reason in a more logical adult-like way capable of abstract problem solving	concentrates for long periods of time if interested, but needs worries to be sorted popular culture of great interest	uses language in sophisticated ways; eg. Tells stories, argues, debates knows the difference between fantasy and reality has some appreciation of the value of money
POSSIBLE INDICATORS OF TRAUMA		
increased tension, irritability, reactivity and inability to relax sleep disturbances, nightmares, night terrors, difficulty falling or staying asleep	reduced eye contact toileting accidents/ enuresis, or smearing of faces eating disturbances	bbodily aches and pains- no reason accident proneness absconding or truanting from school fire lighting, hurting animals

Child Development an

Physical development
significant physical grow and body changes develops greater experti skills in sport
Self-concept
can be pre-occupied wit self
Social-emotional deve
empathy for others ability to make decisions (moral) values and moral systen become firmer and affec views and opinions spends time with peer fo social and emotional ne beyond parents and fam peer assessment influences self-concept
POSSIBLE INDICATOR
inability to relax accident proneness reduced eye contact sleep disturbances, nightmares acute psychological distress

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: Sh

Class Activity: Vide

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Stranger returns.

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Mary Ainsworth Str

Suggest students

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Stranger anxiety

Reunion behavio
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avoidant and ambivaler

Table 1. Strange Situation Classification Groups	
Group	**Brief description**
Secure (B)	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.
Avoidant (A)	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.
Ambivalent or resistant (C)	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.
Disorganized/ disoriented (D)	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).

Note. Descriptions in Groups A, B, and C arc 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.

Assessing attachment r

- Patterns of intera relate best to?
- The way the careg – are they empatl
- The caregiver's b attuned to and nu
- The reaction of th ideas, behaviours pleasing or obedi
- If the attachment be placed in anot the family without

Critique of Attachmen

Attachment theory can b attachment figures, by m with the child and all atta a child's behaviour wit violence or peer relatio

References

Ainsworth, M., Bell, S., & Stayton, D. (1991). Infant-Mother Attachment and Social Development: 'Socialisation' as a Product of Reciprocal Responsiveness to Signals. In M. Woodhead, R. Carr, & P. Light, Becoming a Person. London: Routledge.

Aldgate, J., Jones, D., Rose, W., & Jeffery, C. (2006). The Developing World of the Child. London: Jessica Kingsley.

Atwool, N. (1997). Attachment as a Context for Development: Challenges and Issues . Children's Issues Seminar. Invercargill: University of Otago. Retrieved from http://www.thelizlibrary.org/liz/attachment.html

Batmanghelidjh, C. (2006). Shattered Lives: Children Who Live With Courage and Dignity. London: Jessica Kingsley .

Bowlby, J. (1988). A Secure Base: Parent-Child Attachment and Healthy Human Development. New York: Basic Books .

Crittenden, P., & Claussen, A. (2000). The Organisation of Attachment Relationships: Maturation, Culture and Context. Cambridge: Cambridge University Press.

DHHS. (2007). Child Development and Trauma Guide. Retrieved from https://www.dcp.wa.gov.au/ChildProtection/ChildAbuseAndNeglect/Documents/ChildDevelopmentAndTraumaGuide.pdf

Gauthier, Y., Fortin, G., & Jeliu, G. (2004). Clinical Application of Attachment Theory in Permanency Planning for Children in Foster Care: The importance of continuity of Care . Infant Mental Health Journal, 25(4), 379–396.

Perry, B. (2013). Bonding and Attachment in Maltreated Children: Consequences of Emotional Neglect . The Child Trauma Academy. Retrieved from www.ChildTrauma.org

Watson, S. (2005). Attachment Theory and Social Work. In M. Nash, R. Munford, & K. O' Donoghue, Social Work Theories in Action . London: Jessica Kingsley.

Modu

Trauma T

Module description

This module covers fu
and young people in cl
Child psychiatrist Bruce
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To the tutor
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trauma infor

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- that p
may
physic
- how to

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
- *Kite of Life Exercise*

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(chose 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

Lecture on trauma

To the tutor: Be aware that many students, and perhaps you, will have

1. Definitions of Tra

Definition: Trauma occ
the existence of the indi
Trauma is an experienc
panic, helplessness and
2009).

Trauma is a psychologic
shocking events on peo
soldiers returning from
symptoms he described
migration. Similarly, peo
prolonged conflict (Dulw
result of abuse within d
violence and childhood a
trauma occurs in the cor
of the same relationship

2. Causes of Traum

Trauma can result fro
bullying, assault, death
being diagnosed with a
(Greenwald, 2005) or t
sibling being injured, a 'n
such as street violence,
occurrence or a series
Trauma can be passed f
been affected.

3. Physiology of Tra

To the tutor:
of a human
happens to t
and theorise

Flight – hyper arousal, ready to run.

Bodily reactions to fear include:

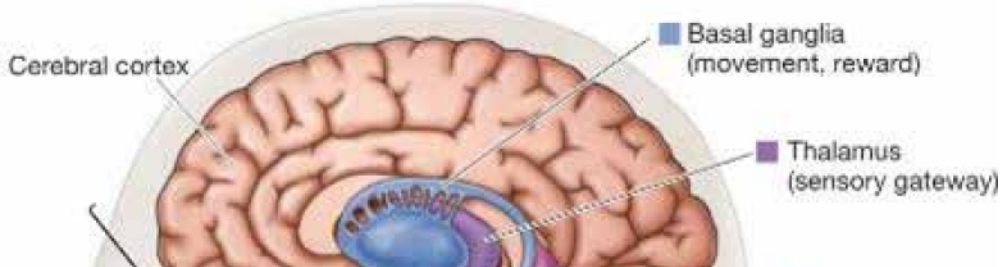
- Blood is diverted to the muscles from other parts of the body eg hands and feet go cold, pale face
- Increased blood pressure, heart rate, blood sugars and fats to supply the body with extra energy
- The body's blood clotting function speeds up to prevent excessive blood loss in the event of injury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

When the brain receive straight to the **Amygda** Fright, without being pro

Afterwards, under supp stored in the Hippocamp not have the language memory remains as raw that memory will evoke fire. Babies are born w perceive and recall thing

Traumatic implicit mer

Traumatic implicit memo hippocampus, hypothal Cortex in frontal lobes paradox at the heart of t or they see and feel not

5. Trauma and brai

The raw material of th development, neurons a migrate, they differentia response to chemical si the 'bottom up' that is, f of the body (e.g., heart functions (e.g., abstract

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,

To the tutor:
groups abou
students will

6. Physiological im
behavioural develo

Hyperarousal – The tra
world is a good, safe pl
is full of threats so the
on them. This constant
victims to experience h
which they did not have
Hyperarousal is express

- **Difficulty sleepi**
- **Anger, irritability**
- **Difficulty concen**
victims, make the
- **Intrusions or Tri**
thinking and seei
then. The sense
them again and th
- **Dissociation:** Th
friends and family
- **Avoidance:** Victi
of trauma. Victim
whom they exper
- **Increased Intern**
brain's ability to u
being and emotio
- **Delayed Develo**
normal rapid gro

Children who have experienced or witnessed violence, abuse and neglect can feel:

- **Fear and mistrust** oof 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

There are five important

- I believe you
- I am glad you told
- I am sorry this ha
- It is NOT your fau
- I need to speak to does not happen

Responding to children

- Note to the are working sensitive to aware that vu let down if so long they wil example of goals and int

As well as safety and s from their traumatic expe life in the future. The pr The child's psychologic though abuse. Survivo each succeeding develo circumstances of the vict and emotional assistanc impact of trauma (Patel,

Depending on their age advocates for other child Being involved as an a people's personal recov contribute to awareness as preventing other chil the young person's part

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

Jenkins (2004) strategie
people are summarised

Impact Issues	**Goals**
Guilt/ responsibility/ self-blame	To vali of abu mispla respon
Fears and associated behaviours, eg, bed-wetting/ nightmares	To bui overc them achiev To ass strateg manag
Anxiety	To red facilita belief and ot
Anger	To ext aoprop a safe
Depression, sadness. loss and other negative feelings.	To ide the my abuse resolu carers
Self esteem	To rec and en
Sense of belonging	To res child t

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

AMWCHR. (2013). Working w
on Children . The Aus
ausmuslimwomensce

Batmanghelidjh, C. (2006). Sh
Kingsley .

CBM. (2008). Guidelines on C
np/documents/Guideli

DeBellis, M., Kesharan, M., Sl
Pediatric Maltreatmen
Biological Psychiatry,

Downey, L. (2009). From Isola
Children and Young P
earlytraumagrief.anu.

Dulwich Centre. (2014). Dulwi
dulwichcentre.com.au
responding-to-trauma

Greenwald, R. (2005). Child T
Adolescents. New Yo

Herman, J. (1992). Trauma ar

Jenkins, S. (2004). Developin
Behaviours. Children

Landers, C. (2013). Preventin
techical Background D
www.unicef.org/protec
childhood_2013_Cass

McCrory, E., De Brito, S. A., &
Maltreatment and Adv

Mustard, J. F & South Australi
We Know and What W
TIR_Reports_2007_M

Perlesz, A. (1999). Complex P

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.

The Kite of Life

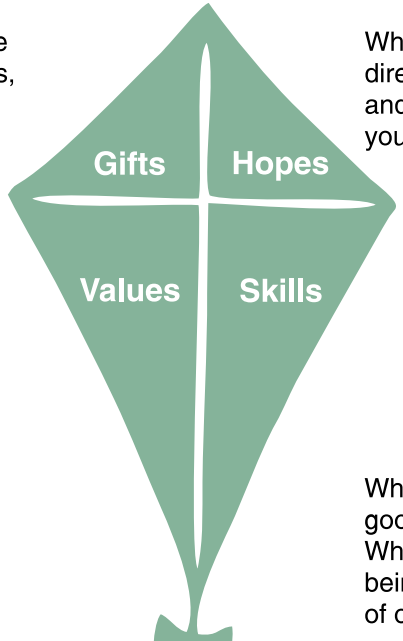
Because Palestinian children often love to make and fly kites, we also use the metaphor of the kite in our work. As Dr Akram Othman explains.

'For the Palestinian people, kites represent hope and freedom.
Here, we face strong winds and kites represent our hopes and dreams'.

Different parts of the kite can be used to represent different parts of life:

What are some gifts you have been given? Not material gifts, but things like the gift of love or friendship.

What are some hopes for the direction of your life? What dreams and wishes do you have for yourself, family, friends, or the world?



Backbone
What is your most important value?

What are some values that you have in your life?

What are some things you are good at? What are you talents? What are your special skills like being kind to others, taking care of others?

Modu

Risk Asse
Protectio

To the tutor:
together pre
assessment
professional
most effectiv
examples so
prepare stud

Module Description

This module provides a
families where children
the *Best Interests of the*
Government Department

Module Outline

a. Case Manageme

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:
b. Information Gathering
c. Analysis of risks and strengths
d. Planning responses
e. Action to implement plan
f. 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.

[Provide an example here for students to think about in relation to the headings]

Family and social relat
carer provide stimulatin

Parent/carer capabilit
warmth and responsiver

Family history, comp
family's involvement wit

Examples of evidence c

- Disclosures of ha
a child might say
themselves to 'te
- Physical Signs –
cover their bruise
- Behavioural Sign
of physical conta
when hurt, are
aggressive, self-i
or indiscriminate

Developmental Stage a
(DHHS, 2007) provides
and trauma.

(2) Analysis of risks a

Given all the informatio
analysis should

- assess whether,
harm;
- Identify the type,
harm continuing;
- Evaluate the prot
for the child in the
- Involve the child
- Use ethical decisi
or maintained to

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).

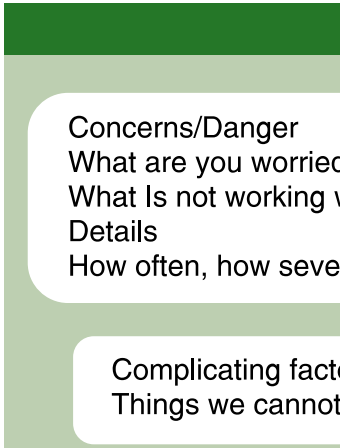
2. Tools for Risk and Safety Assessment

The Signs of Safety (T
be used with children to
form a plan. The Three
and parents' view, can b
court and can be used in
vulnerabilities and fears

The social worker is rec
Signs of Safety is an a
practitioners in Australia
based on strength base
assessment and plann
strengths, existing and
children are vulnerable

The table below describ
The social worker can w
finishing with step 7. St
safety for the child. Ste
details and descriptions
as death in family or a te
views of the situation ar
Step 6 starts the planni
the concerns (Turnell, 1

Signs of Safety templa

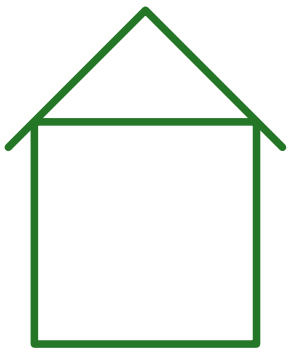


Three Houses Tool

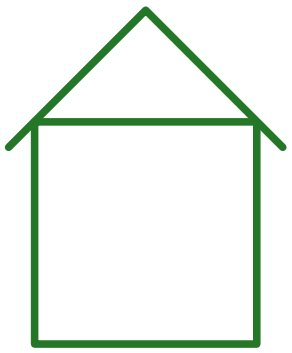
TThe Three Houses tool was created by Nicki Weld and Maggie Greening in New Zealand. It is a practical method of undertaking child protection assessments and case planning with children and young people (Weld, 2015). The Three Houses method takes the three key assessment questions of Signs of Safety 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.

- *Note to the tutor:* Show the Signs of Safety (Turnell, 2014) and Three Houses (Weld, 2015) YouTube videos. Students can practise using the tools in role plays

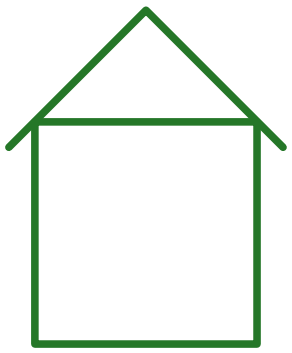
'Three Houses' Child Protection Risk Assessment Tool to use with Children and Young People



House of Worries



House of Good Things



House of breams

4. Use words and dra
in the process.

5. Often start with 'h
uncertain.

6. Once finished, obta
family, professior
others.

7. Present the finish
beginning with th

[Show the YouTube vide

How to analyse parent

A Risk Assessment or
risks so it will need cor
address these questions
factors for the child in
developmental needs ov
provide responsible, res
by untreated mental hea
With appropriate suppor
of care to their children?
needs to change to ena
If circumstances are imp
what would there be mo
this? (Bromfield & Miller

3. When to Report t

To the tutor:
social worke
system prac
ideas from t
Interests Cas

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

Bunn, A. (2013). Signs of Sa
model in child protec

Bromfield, L. and Miller, R. (2
Victorian Governmer
Victorian Governmer
http://www.dhs.vic.go
practice-resource-20

DCPWA (2011) The Signs of
of Child Protection W
Policies%20and%20

DHHS (2012) Best Interests
Services with the Aus
assets/pdf_file/0011/

DHHS (2007) Child Develop
https://providers.dhhs
framework-for-vulner

Miller, R. 2007, Cumulative h
Department of Huma
pdf_file/0012/589665

Turnell, A. (2014) What is Sig

Turnell, A. and Essex, S. (20
au/Resources/Docun

Turnell, A. & Essex, S. (2006
3 in Working with de
Maidenhead.

Turnell, A. and Edwards, S. (
protection casework,

Weld, N. (2015) The Three H
https://www.youtube.

M6 a **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

Module Assessmer

Exam question: Explain
child is assessed as abu
describe how you woul
were the social worker.

Assessment Criteria:
relational, child centred
terms of safe accommo

Lecture

A. Theoretical Framew

The following principles

- Thorough assess
their developmen
- Linking children,
and supports stre
- Children and yo
decisions that aff
and communicate
to understand
- All interventions
provide appropri
protection and su
- Interventions inv
the young perso
appropriate for th
- Adopting a family
responds to issu
children. It also a
context of their fa

Being *family focused* me

- 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, measureable, 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).

The Resolutions approa
exceptions within the all
safety guidelines. Reso
and others around as
experience. Resolution
progress, not past deni
(Turnell & Essex, 2006)

B. Case managemen

To the tutor:
to emphasise
through the c
to prioritise w

Module 5 provided a
framework and tools for a
children and young peo

- *Information Gath*
- *Analysis of risks a*
- Planning respons
- Action to impleme
- Monitor and Revi

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

As described in Module
abuse are devastating
feelings of guilt, of def
shocks, frequent nightm

(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?

(4) Action – implem

Once the plan is docum
the plan is implemented
is capable and motivate

- Build partnerships
- Work with childre
  suffer shock, fee
  trauma responses
- Work in partnersh

(5) Monitor, review

Routine and regular rea
occur to ensure signific
Ongoing review and upd
the child, family and car
prevent goal achieveme
Critical reflection should
implementation team fol
and records of progress

References

Bromfield, L., & Miller, R. (20
Government, Departm
file/0010/665902/cum

Casey Families Program. (20
Leadership in the Ch
Resources/Publicatio

Child Welfare Information Ga
Improve Child Welfar
engagement

DFCSNSW . (2012). Child W
Department of Family

M6 b **Module 6b:**

Responding to Children living with Domestic Violence

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

As background to the theory in the lecture, read the following on how religions oppose violence against women and children:

Islam and Muslims oppose violence against women: A Guide for Muslim Women (AMWCHR, 2011, available in Arabic)

"Disciplining Children with Kindness: A shiite Sharia's Perspective"

"No Longer a Secret": The church and violence against women a WCC publications)

Dulwich (2014, available in Arabic) for the assignment for this module.

Adapt the ideas here 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 The AMWCHR documents were written for Islamic communities in Australia and although some sections are not relevant to the Palestinian context, the booklets are useful in the sensitivity to and respect of culture. AMWCHR 2013 is highly relevant to Child Protection but is not available in Arabic, as is AMWCHR 2011 which provides the background theory.

Many students may not have spoken about violence against women

Module Description

This module explores g
impacts of domestic vio
the social, emotional a
how to work with childre

Module Outline

Lecture:

1. Gender role differe
2. Definition of Dome
3. Effects of male vio
4. Developmental im
   social and psycho
5. Neurobiological ch
6. How to work with
7. Class Activity: Cla

Module Assessmen

Essay or exam questio

Read UN Women Pales
or AMWCHR, 2011, ava
about male violence aga
a social worker to supp
domestic violence or wo
take responsibility for a

Assessment criteria

Evidence of having read

Realistic job description

Lecture

1. Gender role differences

Geender 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 head scarf 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

2. Definition of Dom

Domestic violence is b
to another, or causes h
of power and the desi
(AMWCHR, 2011:8).

Victims of domestic vio
are usually men. In mos
physically or psychologi
ex-spouses. It can also
neglect of children by a
abuse by a child toward
violence when it occurs
intimate violence, spous

The definition of violenc
to Combat Violence Aga

> All forms of physcal, r
> deprivation; threats o
> are directed against
> indirectly, inflicting ph
> harm or suffering, ar
> is a very broad terr
> women, including bei
> participation, as well a

Forms of violence with
Palestinian society may

- Physical abuse by
- Early marriage
- Threat of killing.
- Rape by one's br
- Fleeing home bec
- Sexual harassme
- Emotional apathy
- Verbal violence

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).

> To the tutor: Since this document is in Arabic, you may choose to include more information on the impact of male violence against women. The AMWCH recommends that you invite an Imam and priests to clarify the religion's message about male violence against women, and discuss how social workers can work with clergy[5] and Mokhtars to stop violence against women and children

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, 2013:38).

A child witness of dome
Traumatic Stress Disord
as well as their ability t
2014). Depending on th
in different ways. They
and feel overwhelmed a
children can develop a
problems, some of whic

As described in the Chi
of effects of witnessing
age groups:

> To the tutor:
> through cons
> the Child De

Infants

- sleep and feeding
- continual fussing
- an inability to be
- being easily irritat

Toddlers/pre-schooler

- frequent physical
- difficulty going to
- frequent tantrums
- clingy behaviour
- not knowing how
- general sadness
- acting cruelly tow

School-aged children

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

6. How to work with

What do children need?

As we know from atta
relationally enriched, sa
that there are adults wh

Children who are expos
and that the violence is
To avoid the terror of wit
must have places to go t
or at a domestic violenc

Children need to learn t
of resolving conflicts. C
re-affirm that domestic v
home need to know tha
Children need hope for

How social workers ca

Social workers cannot
families to speak about t
identifies ways of doing

Listen carefully as peop
violence so we listen for
words like 'my husband
might be signs of violen

Talk with families about
the home continues. 'Ho

Facilitate interventions
with extended family an

Become involved in ra
run workshops for men
witnessing domestic vio

Seek out ways that peo

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

AMWCHR . (2011). Islam an
Women. Retrieved fr
ausmuslimwomensce

AMWCHR. (2013). Working
Abuse on Children .
www.ausmuslimwom

Carrion, V., Wong, S., & Klet
Maltreatment-Relate
53–61.

Delima, J., & Vimpani, G. (20
Matters, 89, 42–52.

DHHS. (2007). Child Develo
ChildProtection/Child

Dulwich Centre. (2014). Dulw
https://dulwichcentre
perspective-on-respo

MoWA. (2011). National Stra
Territory 2011-2019.
aspx?ATT_ID=5501

Pease, B. (2010). Undoing P

Perry, B. (2006). Fear and Le
Directions for Adult a

Tsavoussis, A., Stawicki, S.,
and its Adverse Effe
Awareness. Frontiers

UN Women. (2017). Islam op
and-events/stories/20

UNICEF. (2006). Behind Clo
https://www.unicef.or

United Nations. (1993). Decl
http://www.un.org/do

M6 C **Module 6c:**

Children with Disabilities

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

Basam Abu Hamad et al's UNICEF (2016) report

Basam Abu Hamad et al's UNICEF (2016) PowerPoint lecture PowerPoint lecture

O'Leary et al's (2015) article and case study of Nadia, or create a case study yourself

Adapt the 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

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

A. from UNICEF OD
and perspectives

OR

What else could O'L

To the tutor:

Lecture

Introduction and de

Defining Disability

'Disability' is a contes
influences their respon
perceptions of disability

1. an individual or m
professional task
view disability as
role while practitio
needs rather than
2. The social model
distinguishes bet
limitation, and 'di
which exclude pe
disability is cause
social model has
services in some
3. A 'social relationa
effects' which den
from impairments

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).

Children with disabilitie
abuse and exploitation
and stigma faced by ch
exploitation in their own
institutions. Research sh
likely to experience viol
disabilities are significan
including cultural preju
on their families. Childr
powerlessness and soci
and report abuse. Expo
delays and behaviour pr

To the tutor:
PowerPoint
disability, ho

Why social workers

Human rights rationa
the maximum extent po
condition or impairment
underdevelopment and

Economic rationale: Ch
opportunities during ear
adults. This can potent
other social spending.

Scientific rationale: Th
are characterized by rap
essential building blocks
disabilities are to surviv
Early Childhood Develo

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

Class Activity:

A sk students for exa
disability, and how th
with the child.

When there are clear cl
children's views separa
colleagues who know th
the child or during the
establish a child-friendly
needs, and finding comm
the child identify their w
about the concerns, ac
children's feelings abou
their understanding of th
future.

Professionals framed di

a. 'different or othe
because of their
aids were seen a
disabled children

b. the 'same as any
level of risk as o
others.

c. 'equal and differ
effects and psyc
children's heighte
and widespread r
responsibility to s
and address such

A community respo

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

Include, collaborate with and support parents (WHO, 2012).

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;

References

CBM. (2008). Guidelines on

Hammad, B., & Odeh, K. (20

O'Leary, P., Hutchinson, A., &
Refugees in South L
717-731.

Stalker, K., Taylor, J., Fry, D.
Scotland- A hidden G

UNICEF. (2016). Every Child
Disabilities in the Sta

United Nationa. (2006). Con

United Nations. (1989). Unite
Retrieved from http://

WHO. (2012). Early Childhoo

M6 d **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.

Assessment

Group work task for con

Each of the projects invo
When you have explain
with a group of childre
imprisoned in Israeli mili
on way to school, displa
Mosques safely (as desc
fresh water and at risk
according to Interagency
children's ideas and con
safety and hope? (O'Lea

A second assessment ta
group presentations to t

Lecture

1. Analysis of dang
from UNICEF (2016
Humanitarian Actio

UNICEF led the Child
Protection Cluster and
Humanitarian Action, wh
Action, co-led by UNICE

STANDARD 7 Dangers

After the age of one, uni
and adolescents, accou
almost 50% in 15-19 ye
are responsible for almo
addition to these "ordin
Children with existing di
remnants of war (ERW)

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

In disaster zones, risks c
exposed electrical and
conflict areas, risks can i
remnants of war (for exa
cartridges, ammunition
availability of guns and

Data collection:

Use the information fro
targeted age-, gender- a

Assessments must inv
children's' views of risks
how this can be done is
adolescents to mark are
with them. Discussion s

- The main physica
- The risk ranking c
to least frequent)
- Risks specific to
boys, adolescent
- Where the dange
- What knowledge
- What skills and ca
- What the prevent
- What hospitals, p
who are injured (U

Specific groups:

Younger children, who
in harm's way if they
themselves as unaffecte
in hazardous behaviour
or use guns and weapo
dangerous vehicle-relat
(for example, impairmo

Community activities

Strengthen existing community-based protection mechanisms to identify and address physical risks to children. Activities that can be carried out at the community level to prevent physical injury can include (but are not limited 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.

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:

- Identify and refer injury survivors, including children with disabilities, to accessible mainstream integrated child protection and other relevant programmes for both

- Economic inclusio
  an adequate stan
- Social inclusion
  cultural life and sp

Laws and policies and p
promote the rights of p
survivors. When providi
existing national child
The Convention on the
Convention on Certain
and relevant national la
and effect of explosive
injured, including those

2. Engendering chil of a military attack:

When someone begins
the human rights violati
special people and the
be relationships with pe
Remembering conversa
person gets a chance t
child choose a supporti
audience to their grief a
children who have lost
manage the effects of a
family'.

3. Research on vio Jerusalem (PCC, 20

Use Palestine Counselin
Palestinian Families in J
to demonstrate that ever
Students in Gaza can m

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 blind-folded, 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 care- givers 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 Issawiyah

The daily incursions and raids experienced by children living in Issawiyah 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 teargas and sound bombs near students to intimidate them (PCC, 2017).

Restrictions on Play and Worship for Children in the Old City

Parents are anxious an
becoming angry towards
the Old City reported ps
eating and using the bath
injuries are a leading ca
over 30% of deaths am
traffic injuries (the leadir
related burns are respo
emergency, in addition
and disability. Children
from explosive remnant
emergencies can also p
children are not treated
permanent injury. Childr
with disabilities, have di
where resources are lim

4. Social workers e

Read O'Leary et al's res
Make available the Hop
privately then share wha
we create hope and saf

References

Dulwich Centre. (2014). Dulw
https://dulwichcentre
perspective-respo

O'Leary, P., Hutchinson, A., &
Refugees in South L
717-731.

PCC. (2017). Violence and it
Centre.

UNICEF. (2013). Minimum S
Cluster: Child Protec

M6 e **Module 6e:**

Responding to children and young people experiencing sexual abuse

To the tutor: when presenting this information to students be aware that some students may be survivors of sexual abuse themselves who may or may not have disclosed this information to another person.

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?

Module Assessmer

Select 2 myths about se
people might hold the m
has been sexually abus
respond to affected chil

Assessment Criteria:

1. Demonstrates cri
2. Identifies problem
3. Describes a realis

Lecture:

1. What is sexual a

A child or young person
child to involve that chil
or unable to protect a c
requiring statutory interv

Child sexual abuse invol
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vaginal or anal penetrat
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or prostitution.

Abuse occurs when a
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the power that the adult

Children lack the neces
about sexual activities

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
- Truth: An abuser
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- Myth: Children of
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- Truth: Sexual ab
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  sexually and emo
  or affection might
  needs

3. Impact of Sexual

Short term effects

• Feelings of powerless
(fears of specific object
Flashbacks of the event
the perpetrator.

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).

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 fo

Do
• Listen and show emp
• Acknowledge the chi
• Speak to the child qu
• Stay calm, reassuring
• Give the child your fu
• Believe what the chi
• Let the child do the f
• Take down the facts
• Give direct answers t
• Tell the child that responsible for the circumstances
• Discuss a course of be realistic, but try n
• Tell the child who els

What a child or young

- That it is their fau
- That they could h
- That they are a ba
- That they are bett
- That no one will b

What might children/y

- That those who th

References:

AMWCHR . (2011). Islam and Muslims oppose violence against women: A Guide for Muslim Women. Retrieved from The Australian Muslim Women's Centre for Human Rights : www.ausmuslimwomenscentre.org.au

AMWCHR. (2013). Working with Muslim Women on the Effects of Family Violence and Child Sexual Abuse on Children . The Australian Muslim Women's Centre for Human Rights. Retrieved from www.ausmuslimwomenscentre.org.au

DHHS. (2013). Child Sexual Abuse: Understanding and responding for Professionals working with Children who Have Experienced Sexual Abuse. Melbourne: Victorian Government Department of Human Services .

Victorian Centres Against Sexual Assault (CASA). (2017). Responding to SExual Abuse, Fact Sheet: Responding to Children Talking About Sexual Abus.

Modu

Family G

Module Description

Family Group Conferen
the heart of the decision-
the historical developme
explored. The Signs of
be introduced, and stud
to apply this technique.

Module Outline

- What is a family g
- Child Protection F
- Youth Justice Co
- FGC Historical vi
- Theories that info
- Principles of FGC
- Cases for FGC
- The conference p
- Class Activity: wa
- The Family Group
- Professional Role
- Preparation for F

Lecture

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

Based on the Maori cultu

The FGC approach ha
of domestic violence, a
communities, schools w
persons facing loss of ir
Mirsky, 2003).

Over 20 countries have
Belgium, Brazil, Canad
Puerto Rico, Saudi Arab
Anglo, African American

While requiring an initial
be more sustainable and

5. Theories that info

- Strength based,
- Empowerment,
- Anti-racist,
- Community devel
- Group work,
- Conflict resolution
- Narrative theory,
- Task and solution

6. Principles of FGC

- The safety of the
- Children have rig
matters that relate
- Children can atter
Three Houses
- The source of a cl
- Working in partne
- Families have the
- With the right reso

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

Tutor: Refer

10. The Family Gro

- SMART plan
- Must address the
- Must be written in
- Strength based
- Includes a monito

Agreement and planni

The family presents thei

The coordinator asks th
social worker is not satis
and if this is not possible
the matter is taken to co

The plan could also inc
order application docum

If the conference reache
the resources for the pla

11. Roles of profes

The role of social worl

- Investigate and a
  referral is appropr
- Put a safety plan
- Define rules for s
- Inform the child (i

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

References

Doolan, M. (. (2001). Youth ju
University Press.

Huntsman, L. (2006). Family
Centre for Parenting

Jones, L., & Fennegan, D. (2
Journal Of Family So

Ministry of Social Developme
Group Conferencing
documents/resources

Mirsky, L. (n.d.). Family Grou
Practices. Retrieved

Pennel, J., & Burford, G. (20
Women Child Welfar

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

Reuban: 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.

Reuban: 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

Brian (family member) got a visit from an FGC individual separately to that situation. I immediat

(Pat knocks in door of coordinator will visit all f them for the family grou and place are suitable fo

Pat: Susan and Carl are I think is really positive a essential part of Katie's couple and looking after group conference. How

Susan: We feel we nee

Any children involved in It is also good practice will meet with the child encouraged to get involv on the food.

The FGC meets at a ne with the family.at a time the evening. Food shou

Transcript of FGC V

https://www.youtube.co

Reuban: There is often FGC but through dialogu with structure and help f

Brian (family member starting the process be about blame. It's about n done things differently. C

FGC Coordinator: Hull

The Coordinator chairs t

SW: In summary, Katie has been living with Susan's brother Paul and Christine for the first 6 month 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 terms 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 lie addressed in the FGC including contact between Carl and Susan, and Carls' 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.

Liz: I don't see why. We

Susan: But it's hard for
far away.

Paul: We can help with
Katie if we don't work t
drugs as the social work

Eileen FGC coordinato
the first opportunity fam
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families developing the
During the FGC private
and make sure that eve

Paul: Come on we've g
to show social services
stay with us.

Susan: Yes, but I miss

Paul: We can work at t
you've got to talk to her.

Carl: Susan I agree wit
we're not to get her bac

Paul: If you don't follow

Susan: Yes, that's the
get off it

Paul: If you go through
the system, you've got t

Carl: I'm determined to

Melanie (Carl's sister)

Carl: Rea and Jack will

Melanie: We need to d
you've had it hard but s

Carl: If Susan doesn't m

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 cant 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

Modu

Youth Jus Conferen

Module description

he Youth Justice Fami diversion to resolve you conviction. This module systems. The Module p run a YJFGC and socia maximise learning and u

Acknowledgement to Te

Module outline

- Introduction to the
- YJFGC Historical
- Theories that info
- The aim and func
- Preparation for th
- Professional roles
- Stages of the YJ

Module Assessments

Assessment one: (1000 words)

Watch Penny's YJFGC and answer the following questions:

https://practice.mvcot.govt.nz/knowledge-base-practice-frameworks/better-family-group-conferencing/fgcs-check-out-how-we-worked-in-the-past.html#null

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.

Lecture

Responding to Youth Offending

- *Note to the tutor:* Compare with laws and processes in local context and consider how these processes could work in your context.

When a young person (14-17 years) is alleged to have committed an offence, the police office may:

- Issue a warning
- Refer the young person to Police Youth Aid Section

Introduction to the

There are two types of
meetings for families w
convicted of committing
making process about th
Protection FGC focuses
their children. The Youth
to a young person who
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the YJFGC coordinator

YJFGC Historical o

The YJFGC was deve
legislation which noted
Based on the principles
YJFGC developed partn
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Theories underpinn

Rather than punishing
responses to youth crim
custodial diversion and
families, victims and th
Kingi, Robertson, Morris
not because they are ba
live in situations of oppre
young offenders account
in making amends, the
and community cohesio
express remorse withou

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.

Preparation for the

- The referral is re
  youth court
- As a well prepa
  coordinator consu
  conference
- The Coordinator e
  access to the res
  Such resources in
- Children between
  their wellbeing an
  and risks prior to
- A social worker
  for young offende
  assessment by th
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  dealing with the
  custody is require
  required for child
  might be address
- The coordinator t
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  social workers ab
- The venue, date a
  the young offende
- Social work asse
  prior to the YJFG
- The Coordinator
  the conferences a

Professional roles

YJFGC coordinator/co

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

important to get a share
solutions so the coordina
back to that when we've

Hearing what happene

a. The coordinator s
on the day of th
happened?"; "and
…?" and "What w

b. the police officer
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c. the victim is asked
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others.

d. the offender's fam

e. anyone else gives

The coordinator asks e
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Generating ideas abou
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It is important to deple
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after the story, second, a
happen.

What should happen?

The coordinator is more
done and ideas about w
The coordinator asks the
What were you hoping

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

Doolan, M. (. (2001). Youth justice services in child welfare in M., Connolly (Ed.). Auckland: Oxford University Press.

Family Group Conferencing. (n.d.). Retrieved from https://practice.mvcot.govt.nz/knowledge-base-practice-frameworks/better-family-group-conferencing/fgcs-check-out-how-we-worked-in-the-past.html#null

Kokiri, T. P. (2001). Whanake Rangatahi Programs and Services to Address Maori Youth Offending. Wellington, New Zealand: Minsitry of Maori Development.

Maxwell, G., Kinigi, V., Robertson, J., Morris, A., Cunningham, C., & Lash, B. (2004). Achieving Effective Outcomes in Youth Justice. Wellington: Ministry of Social Development, New Zealand.

Youth Justice Community Practice Manual. (n.d.). Retrieved from https://www.yjcommunitypracticemanual.vic.gov.au/youth-justice-court-advice-service/pre-sentence/recommending-a-youth-justice-group-conference-in-a

Youth justice family group conferences. (n.d.). Retrieved from http://communitylaw.org.nz/community-law-manual/chapter-9-youth-justice/youth-justice-family-group-conferences-chapter-9/

Youth Justice in New Zealand: Principles and Procedures. (n.d.). Retrieved from https://www.parliament.nz/resource/ennz/00PLLawRP09061/20e5da80b9771698ef168956f6679636d6813557