Children's Resilience Research Project: Final Report

July 2017
Disclaimer

This report has been produced for beyondblue as part of the Children’s Resilience Research Project.

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1. Executive Summary

1.1 Background

Resilience means doing well in the face of adversity. Children who are resilient ‘bounce back’ from difficult experiences and are less likely to experience mental health problems.

Experts have differing views about the meaning of resilience, and how to measure and promote it. This lack of consensus poses challenges for professionals who want to promote resilience among children.

The Parenting Research Centre, in partnership with the Australian Research Alliance for Children and Youth (ARACY), was funded by beyondblue to develop a Practice Guide that will assist professionals to develop interventions that promote resilience in children (0-12 years of age). The project was also funded to carry out scoping work in relation to a new proposed intervention to be considered by beyondblue for further development and possible implementation.

The Children’s Resilience Research Project began on 2 June 2016. It involved seven key phases. This Final Report is one of the project deliverables.

1.2 Methods

Phase 1: Methods

Phase 1 of the project involved three key tasks: establish the Taskforce; develop a detailed research protocol; and obtain ethics approval.

Establish Taskforce

Establishing the Taskforce involved identifying nominees for Taskforce membership; developing criteria for membership; finalising membership; and inviting members to participate.

Research protocol

The research protocol was developed by PRC, reviewed by ARACY and approved by beyondblue.

Ethics approval

The research protocol was submitted to the PRC Human Research Ethics Committee in August 2016.

Phase 2: Methods

Phase 2 involved a research translation exercise comprising two tasks: identifying research; and summarising research. In total, we identified 16 publications for the research translation exercise including publications suggested by the Taskforce. After the relevant research was identified, we summarised the publications with a specific focus upon: definitions and dimensions of resilience; and characteristics of resilience interventions.

Phase 3: Methods

Phase 3 of the Children’s Resilience Research Project involved two key tasks: a consensus-building survey; and a parent survey.

Consensus-building survey

For the purposes of building consensus, we used the Delphi method; a multi-staged survey process designed to build consensus among the members of a carefully selected Expert Panel.

The first task was to develop the criteria for membership of the Expert Panel. Thirty people accepted the invitation to be on the Expert Panel.
The Expert Panel participated in three survey rounds. Responses were analysed by researchers and organised as statements or questions that were sent back to the experts for ratings. Consensus was defined as responding with (a) 70% of experts agreeing or strongly agreeing to a close-ended question, or (b) 70% of experts disagreeing or strongly disagreeing to a close-ended question.

For the quantitative data, we used the Statistical Package for Social Science (SPSS; Version 23.0) to identify the level of agreement and stability of experts’ responses. For the qualitative data, we undertook a thematic analysis.

Parent survey
A short survey was developed to seek parent views on childhood resilience. The survey was made available via the Raising Children Network and beyondblues’s blueVoices network. We used thematic analysis and an analysis of the frequency of responses to analyse the data.

Phase 4: Methods
The fourth phase in the project was Practice Guide development. This involved two tasks: a review of existing guidelines; and development of a draft Practice Guide.

Review of existing guidelines
For this aspect of the project, we sought to identify some of the common characteristics of practice guidelines. In order to identify relevant guidelines we undertook a search of relevant websites.

Development of draft Practice Guide
The content in the draft Practice Guide was based upon the findings of two of the three Delphi survey rounds, as well as the findings from the knowledge translation exercise (phase two) and the parent survey (phase three).

Phase 5: Methods
The fifth phase in this project involved real-world consultations with parents, children and professionals. All consultations were facilitated by staff members from ARACY and/or PRC.

Parent and child consultations
ARACY drew upon their existing relationships with schools to assist in the recruitment of parents and children for consultations. Champions in selected schools were asked to invite parents of children to a focus group.

Parent and child consultations were undertaken at the school the participating children attended. We undertook a thematic analysis to identify key themes from these consultations.

Professional consultations
Participants for professional consultations were recruited from PRC and ARACY networks. Taskforce members were also asked to nominate participants. Potential participants were emailed an invitation to participate.

During these consultations, participants were provided with information about the preliminary findings of the project, and provided with a copy of the draft Practice Guide to discuss. We undertook a thematic analysis to identify key themes from these consultations.

Phase 6: Methods
Phase 6 involved the consolidation of information collected and analysed during all previous phases of the project to develop a Practice Guide, sample program logic and scoping for a potential intervention.
**Practice Guide**

Developing the final Practice Guide involved the consolidation of information about resilience from experts connected to the project, professionals, parents and children. The process of developing the Practice Guide involved adding and revising content and responding to a number of iterations of feedback and comments.

**Program logic**

A ‘pipeline’ outcomes logic approach was taken, where proposed outcomes are associated with the identified activities and inputs. The Practice Design Lead at PRC worked with the Project Team to scope and develop a logic which reflected the recommendations contained in the Practice Guide.

**Potential intervention**

The development of a potential intervention involved a review of resilience interventions that the Project Team and beyondblue were aware of, and an examination of the characteristics of each of these and analysis of the alignment of interventions with the influences on resilience that we identified in the Practice Guide.

**Challenges: Methodology**

This was a multi-faceted project involving a range of stakeholders. The main challenges we experienced during the project were:

- coordinating the Taskforce and recruiting an Indigenous Taskforce member (Phase 1)
- undertaking a review of literature within a limited period (Phase 2)
- sustaining experts’ commitment, mastering an unfamiliar technological platform; and meeting the timelines for Delphi surveys (Phase 3)
- capturing the views and perspectives of multiple stakeholders; and developing user-friendly and practical Practice Guide that reflected the complex nature of resilience (Phase 4 & Phase 6)
- managing time; and managing children’s levels of engagement (Phase 5).

**1.3 Results**

**Phase 1: Results**

**Taskforce establishment**

Eleven people were invited to participate in the Taskforce and ten accepted. The Taskforce Terms of Reference were developed and reviewed by beyondblue. Professor Brett McDermott from beyondblue was appointed as the Chair of the Taskforce.

**Research protocol**

The research protocol was completed and submitted to the PRC Human Research Ethics Committee in August 2016.

**Ethics approval**

The ethics submission was approved by the Committee on 15 September 2016 (Ref: App37).
Phase 2 – Research Translation: Findings
A summary of the findings from our synthesis and translation of current research are included in Appendix B of this report.

Phase 3 – Consensus building: Findings
Based upon the findings of the three Delphi surveys, key findings regarding what we know (i.e. areas of agreement) and what we don’t know (i.e. areas of disagreement) about childhood resilience is provided below.

What we know
- Resilience is a state, a capacity or a process that is dynamic and involves doing well in the face of some type of adversity
- The sources of resilience are individual, environmental and the result of an interaction between individual and environmental factors
- Experiences of adversity may be important for developing resilience but resilience can be built in the absence of adversity
- Resilience measures should be: age appropriate; measured at multiple points over time; and multi-dimensional
- Measuring resilience depends very much upon context and the child’s situation
- Resilience may be evident in a child’s level of competence, level of physical and mental wellbeing, freedom from psychopathology, and freedom from poor mental health
- Resilience interventions should be: individualised; tailored to the child’s developmental stage; and continuous
- Factors that resilience interventions should address include: family relationships; peer relationships; and pro-social skills and empathy
- The best groups of people to target are: children themselves; parents/carers; and children’s families (i.e. including parents/carers, siblings and other family members).

What we don’t know
- The importance of adverse experiences in relation to the development of resilience is unclear
- There is uncertainty about determining resilience in a child based upon comparisons with other children
- Whether resilience interventions should occur before the adversity, after the adversity, or at any time
- There are some questions remaining about whether resilience can be taught.

Parent survey
A total of 341 people responded to the survey. Key findings from the parent survey were that parents believe resilience is something that occurs within the parameters of everyday life; and parents view themselves as a key influence on children’s resilience.

Phase 4 – Draft Practice Guide
Review of Existing Guidelines
The typical types of information presented in the guidelines we identified were: general information about the topic, practice-related material, policy-related material, and practical resources.

Draft Practice Guide
The draft Practice Guide included an introduction to the concept of resilience, a summary of related concepts, a description of what builds resilience, and information about measuring resilience.
Phase 5 – Translation into real-world practice: Findings

Parent and Child consultations
Parent (n=42) and child (n=44) consultations were undertaken in five different schools across three states. The age range of the participating children was 6 – 12 years.

Professional consultations
Seven professional (n=107) consultations were undertaken in six states/territories.

Phase 6 – Consolidation: Findings

Practice Guide
The Building Resilience in Children Practice Guide was submitted to beyondblue in June 2017. The Practice Guide includes information about why resilience is important; how to build resilience in children; and recommendations for practitioners supporting implementation of everyday strategies and resilience interventions.

Potential intervention scoping and program logic
Information about the potential intervention and an associated program logic was provided to beyondblue in June 2017.

1.4 Discussion

The Children’s Resilience Research Project confirmed that resilience is a complex concept. However, there are strategies and interventions that professionals can use to promote resilience among children (0-12 years).

Important findings from the project include that:

- there is a need for interventions that focus on promoting children’s resilience through the people and environments that surround them
- consensus agreement on key aspects of resilience provides a solid foundation for selecting or designing resilience interventions
- strategies that can be used opportunistically by professionals to promote resilience (i.e. everyday strategies) may be as important as structured interventions
- children will experience periods, such as significant transition points, when they need a ‘boost’ in resilient supports
- more long-term intensive and deliberate approaches to resilience may be required to support vulnerable and at-risk children.

1.5 Recommendations for Practice Guide dissemination and uptake

1. Present the Practice Guide in a visually engaging and accessible way
2. Promote the Practice Guide at events and conferences for professionals within relevant sectors (e.g. presentations, information in conference satchels)
3. Consult with relevant peak bodies, organisations and agencies, about how to ensure organisations and systems support the use of the Practice Guide in everyday practice
4. Develop a digital promotion strategy for the Practice Guide. This could include a webpage for practitioners and social media promotion
5. Explore the feasibility of establishing sector-based Working Groups that explore and provide advice to beyondblue on:
   a. ensuring the Practice Guide reaches the widest possible audience
   b. ensuring practitioners have the support they need to use the Practice Guide
c. addressing organisational and systems barriers to using the Practice Guide.

6. Explore the feasibility of developing a network of practitioner ‘Resilience Champions’ who are able to provide advice directly to other practitioners within their sector.
2. Background

Resilience means doing well in the face of adversity. Children who are resilient ‘bounce back’ from difficult experiences and, as a result, are less likely to experience mental health problems. The benefits of resilience extend to the broader community through a reduction in the costs of mental health treatment, and all the associated social benefits that go with good mental health (e.g. community participation).

Experts have differing views about the meaning of resilience, and how to measure and promote it. The differing views of experts can ‘muddy the waters’ for professionals who want to promote resilience among children, such as early childhood education and care professionals, teachers, allied health professionals, family support and child protection workers.

The Parenting Research Centre, in partnership with the Australian Research Alliance for Children and Youth (ARACY), were funded by beyondblue to develop a Practice Guide that will assist professionals to develop interventions that promote resilience in children (0-12 years of age). The aim of this project is to produce an evidence base to inform and guide the design and implementation of universal and targeted programs that promote children’s resilience.

The Children’s Resilience Research Project began on 2 June 2016 when the Project Team met with beyondblue to establish the focus and scope of the project. During this meeting, the project specifications, scope, milestones and deliverables of the project were discussed, as well as the process of obtaining ethics approval.

The deliverables for the Children’s Resilience Research Project are outlined in Table 1 below. This Final Report is one of the project deliverables (see Phase 6). Following the delivery of the Final Report, the final phase of the project involves the development of two manuscripts for peer publication.

Table 1: Project deliverables

<table>
<thead>
<tr>
<th>Project phases</th>
<th>Description</th>
<th>Deliverables (date delivered to beyondblue)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1: Project initiation</td>
<td>The project team met with beyondblue to discuss the scope of the project. The Taskforce was established and ethics approval was sought.</td>
<td>Research protocol (June 2016)</td>
</tr>
<tr>
<td>Phase 2: Existing research translated</td>
<td>Relevant research was identified and summarised. The summary of research was shared with the Taskforce to generate discussion and debate and inform the consensus-building survey.</td>
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</tr>
<tr>
<td>Phase 3: Consensus-building</td>
<td>An Expert Panel was established to undertake three rounds of a consensus-building survey. The findings from each round were shared with the Taskforce for comment and feedback. This process then informed the development of the next survey.</td>
<td>Progress Report 1 (November 2016)</td>
</tr>
<tr>
<td>Phase 4: Draft Practice Guide</td>
<td>A draft Practice Guide was developed based upon the findings of Phase 2 &amp; Phase 3. The draft Practice Guide was shared with the Taskforce for comments and feedback.</td>
<td></td>
</tr>
<tr>
<td>Phase 5: Real-world translation</td>
<td>Parents, children and professionals were recruited to participate in focus groups. Participants in these</td>
<td></td>
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</table>
focus groups provided feedback on key issues and concepts relevant to resilience, as well as the draft Practice Guide.

| Phase 6: Consolidation | The findings from Phases 1-5 were consolidated and used to update and review the draft Practice Guide. The Taskforce and beyondblue provided feedback and comments on the final Practice Guide. The program logic and scope for a potential resilience intervention were developed. | Practice Guide (June 2017)  
Pilot intervention and Program Logic (June 2017)  
Final Report (June 2017) |
<table>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 7: Manuscripts for peer publication</td>
<td>Development of two manuscripts for peer publication</td>
<td>Deliverable date for manuscripts (end July 2017)</td>
</tr>
</tbody>
</table>

In this report, we describe the methodology used to undertake this project, the project findings and a discussion of those findings.
3. Methods

The Children’s Resilience Research Project involved seven phases. Six of these phases have now been completed. Table 2 (below) outlines the main tasks involved in these six project phases. In this section of the report we describe the methods we used to undertake these tasks, organised by project phase.

**Table 2: Phases, tasks and products**

<table>
<thead>
<tr>
<th>Project phases</th>
<th>Main tasks</th>
<th>‘Products’ from each phase</th>
</tr>
</thead>
</table>
| Phase 1: Project initiation | • Establish Taskforce  
  • Ethics approval | • Ethics application  
  • Detailed research protocol |
| Phase 2: Existing research translated  | • Research translation | • Summary of research                                         |
| Phase 3: Consensus-building | • Establish Expert Panel  
  • Consensus building surveys (Expert Panel)  
  • Parent survey | • Summary of findings from rounds 1, 2 and 3 of Delphi survey  
  • Summary of findings from Parent survey |
| Phase 4: Draft Practice Guide  | • Review existing guidelines  
  • Develop draft Practice Guide | • Draft Practice Guide                                        |
| Phase 5: Real-world translation  | • Parent and child consultations  
  • Professional consultations | • Summary of consultation findings (parents and children and professionals) |
| Phase 6: Consolidation  | • Consolidate information collected and analysed during Phase 1 – 5 to produce:  
  The Practice Guide  
  Program logic and details of the potential intervention | • Practice Guide  
  • Program logic  
  • Information about potential intervention  
  • Final report (including a one-page summary) |

The final phase of the project (Phase 7) is outstanding. This phase involves the development of two manuscripts for publication.

3.1 Phase 1: Methods

Phase 1 of the project involved three key tasks:
1. **Establish Taskforce;** and
2. **Develop a research protocol**
3. **Obtain ethics approval.**

The methods used to undertake each of these tasks are described below.

3.1.1 Establish Taskforce

The purpose of the Taskforce was to steer the research process from inception through to completion, including the finalisation of the Practice Guide. In addition to providing advice on the Practice Guide, the Taskforce provided advice to the Project Team: during key stages (e.g. nominating members of the Expert Panel, consideration of stakeholder feedback); and about promoting the Practice Guide and identifying areas for further development.

Establishing the Taskforce involved the following key steps:
• **Identifying nominees for Taskforce membership.** The names of nominees were sought from PRC, ARACY and beyondblue. The list of subject matter experts who contribute to the Raising Children Network was also reviewed for potential Taskforce members.

A total of 30 nominees was identified. Short biographies for each nominee were compiled to assist with the process of refining the final list. Nominees included professionals from academic, not-for-profit and clinical sectors, and experts from a range of professional backgrounds including psychology, human services, child protection, medicine and public health.

• **Developing criteria for Taskforce membership.** To ensure Taskforce members’ knowledge and skills were appropriate to the project, we developed a set of criteria to assess the list of Taskforce nominees.

The criteria included the following credentials: *thought leadership* (regarding resilience); and *expertise and influence* (i.e. research, practice and/or policy). The criteria also reflected the need for: expertise across all age groups of interest to the project (i.e. infancy, early childhood, middle childhood and pre-adolescence); and Indigenous representation.

• **Finalising Taskforce membership:** The short-list was reviewed and refined by PRC’s CEO, Warren Cann, and Penny Dakin of ARACY – in consultation with executive-level colleagues of both organisations, as well as beyondblue. Eleven people from the short-list were identified as strongly meeting the criteria.

• **Taskforce members invited to participate:** The eleven people who were considered to most strongly meet the criteria were invited to participate in the Taskforce in June 2016. The names of the remaining nominees were kept on file so they could be considered for inclusion on the Expert Panel.

### 3.1.2 Research protocol

The research protocol was developed by PRC, reviewed by ARACY and approved by beyondblue.

### 3.1.3 Ethics approval

The research protocol was submitted to the PRC Human Research Ethics Committee (HREC) in August and approved by the Committee on 15 September 2016 (Ref: App37).

### 3.2 Phase 2: Methods

Knowledge translation is defined as, “the exchange, synthesis and application of knowledge within a complex system of interactions among researchers and users” (Canadian Institute of Health Research, 2011). In this project, the purpose of knowledge translation was to identify:

• commonly cited definitions of resilience, adversity and thresholds for establishing resilience (including key areas where there is a strong level of consensus or debate)

• commonly identified tools for effectively measuring resilience

• effective resilience enhancement strategies

• interventions for different settings (e.g. home, school, community) and age groups.

In undertaking this research translation exercise, we were not aiming to capture the entire body of knowledge about childhood resilience. Rather, we sought to produce a document that would provide a starting point for discussion and debate among the Taskforce, and thereby inform
subsequent phases in the Project (e.g. the development of questions for the consensus-building surveys).

The process of research translation involved two tasks:

- **Identifying research**; and
- **Summarising research**.

The methods used to undertake these tasks are described below.

### 3.2.1 Identifying research

In 2015, VicHealth commissioned three comprehensive reviews of publications relating to childhood resilience. The topics of these reviews were:

- interventions to build resilience among young people (Reavley et al, 2015)
- current theories relating to resilience and young people (Shean, 2015)
- epidemiological evidence relating to resilience and young people (Tollit et al, 2015).

The content of these reviews closely matched the information we sought about childhood resilience. As we did not want to replicate work that had already been undertaken, and due to the limited time available to complete this aspect of the project, a decision was made to do a limited additional search of existing literature.

An additional search was undertaken using PsychINFO and Google to identify literature reviews (including systematic reviews and meta-analyses) that included information about resilience interventions, measures or definitions. Through this search, we identified three relevant publications (CYP, 2014; Khanlou & Wray, 2014; LeMoine et al, 2014).

Taskforce members were also provided with an opportunity to suggest further research that would allow us to extrapolate specifically upon debates in the field about resilience (e.g. aspects of prominent debates not covered in the literature we identified), or any other recent developments in the field that would be important to include in our research summary. Through this process, a further seven relevant publications were identified.

In total, we identified 13 publications for the research translation exercise (see Table 3 below).

#### Table 3: Source of publications, number of publications and references

<table>
<thead>
<tr>
<th>Source of information</th>
<th>No. of publications</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>VicHealth reviews</td>
<td>3</td>
<td>Reavley et al, 2015</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shean, 2015</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tollit et al, 2015</td>
</tr>
<tr>
<td>Additional review of PsycINFO</td>
<td>3</td>
<td>CYP, 2014</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Khanlou &amp; Wray, 2014</td>
</tr>
<tr>
<td></td>
<td></td>
<td>LeMoine et al, 2014</td>
</tr>
<tr>
<td>Taskforce contributions</td>
<td>7</td>
<td>Collie et al, 2015</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Martin, 2013a</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Martin, 2014</td>
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<td></td>
<td></td>
<td>Martin &amp; Marsh, 2009</td>
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<td></td>
<td></td>
<td>Martin et al, 2010</td>
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<tr>
<td></td>
<td></td>
<td>Martin et al, 2013b</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
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</tbody>
</table>
3.2.2 Summarising research

After the relevant research was identified, we summarised the publications with a specific focus upon:

- **Definitions and dimensions of resilience**: including levels of agreement about key concepts pertaining to resilience, such as the influence of culture and context on resilience, sources of resilience, the relationship between mental health and resilience, and measuring resilience.

- **Characteristics of resilience interventions**: the most common characteristics of resilience interventions trialled among children (e.g. age range of participants, setting of interventions).

The tasks involved in summarising this information is described further below.

**Definitions and dimensions of resilience**

The summary of definitions and dimensions of resilience involved ‘mapping the contours’ of contemporary debates about resilience. This involved identifying key issues pertaining to resilience reported upon within these publications, and categorising these according to levels of agreement and disagreement.

Levels of agreement and disagreement were either reported upon in the reviews (e.g. the author stated that the concept was highly contentious), or evident when comparing the information in the reviews (e.g. one review stated one opinion, and another review stated a different opinion). For example, this involved identifying all the definitions of resilience in multiple publications (including how it is defined by the authors of that publication, as well as other definitions noted within that publication by other authors), and then determining the extent to which these definitions align with each other.

Mapping the contours of the debate in this way relied upon a classification system. Levels of agreement were determined according to the following assessment:

- a **high level of agreement** is where all theorists appear to hold the same (or a very similar) views about the concept, or no theorist is identified as strongly opposing the concept;

- a **moderate level of agreement** is where one theorist overtly disagrees with multiple theorists about a concept, or where there appears to be some uncertainty regarding the concept;

- a **low level of agreement** is where multiple theorists have multiple viewpoints on the issue, or theorists identify this as an issue which is highly contested; and

- an unknown level of agreement is where a concept has been put forward by a key theorist but, as yet, does not appear to be a topic of debate among key theorists.

**Characteristics of resilience interventions**

The summary of the characteristics of resilience interventions involved drawing out specific information about the interventions described in 147 studies cited in the VicHealth publications and the three other systematic reviews and meta-analyses identified in the subsequent search. The information that was drawn out included:

- the age of participants

- the setting of the intervention (e.g. school, home, clinic, kindergarten)

- the type of intervention (universal and/or targeted)

- the population (e.g. school students, at-risk children, young children in foster care)

- family involvement

- mode of delivery (individual, group)
• dose
• method of delivery (e.g. discussion, art therapy, social learning).

This information was then used to identify the common characteristics of resilience interventions among children aged 0-12 years.

We analysed the characteristics of 147 studies cited in six reviews of evidence regarding resilience (CYP, 2014; Khanlou & Wray, 2014; LeMoine et al, 2014; Reavley et al, 2015; Shean, 2015; Tollit et al, 2015). Our analysis identified:

• 32 primary studies specifically focusing upon resilience
• 14 systematic reviews and meta-analyses specifically focusing upon resilience
• 13 other primary studies not focusing specifically upon resilience but addressing a concept relevant to resilience (e.g. depression and anxiety, behaviour problems)
• 88 other systematic reviews and meta-analyses not focusing specifically upon resilience but addressing a concept relevant to resilience.

We then summarised the characteristics of the 32 primary studies specifically focusing upon resilience. In doing so, we identified the key characteristics of interventions focusing upon resilience among children aged 0-12 years.

3.3 Phase 3: Methods

Phase 3 of the Children’s Resilience Research Project involved two key tasks:

• a consensus-building survey among experts which examined the relevance, appropriateness and feasibility of resilience definitions, assessment instruments and interventions
• a parent survey which examined parent views on childhood resilience. This survey was not part of the formal research protocol and the findings are not to be published but instead used internally to inform the following phases of the project.

The methods used for both of these tasks are described below.

3.3.1 Consensus-building survey

For the purposes of building consensus about childhood resilience among experts, we used the Delphi method. The Delphi method is a multi-staged survey process that is designed to encourage consensus among anonymous participants about a specific issue (Kalaian & Kasim, 2012; McKenna, 1994). The aim of the Delphi method in this project was to establish a shared view on definitions, measures and interventions related to resilience among children.

The first round of the Delphi method typically involves using an open-ended question(s) to generate the experts’ opinion on a certain topic. The responses are analysed by researchers and organised as statements or questions that are sent back to the experts for ratings. Rounds usually continue until a pre-determined consensus level is reached, with most studies finding that three rounds are sufficient to achieve consensus among the panel members (Keeney, Hasson, & McKenna 2010).

There are several advantages to the Delphi method over a face-to-face single-method qualitative data collection process based on thematic or content analysis (Hsu & Sandford, 2007a, 2007b; Kalaian & Kasim, 2012). Specifically, the Delphi method:

• provides in-depth information about the problem or issue that is being investigated
• enables an anonymous and confidential process that enhances consensus-based decisions
allows for collection of data of a larger group of participants that are also based at various geographical locations

is time efficient

assists in reducing the effects of dominant individuals in a group setting and thus elicit the true beliefs of participants on the topic

reduces the effect of ‘noise’, which refers to communication and sharing that occurs in a group process which can distort the data. This noise may represent personal interests or strong positions emerging as part of the group’s interaction (Hsu & Sandford, 2007a).

The process of data collection and data analysis for this survey are described below.

Data collection

The Delphi method involves two or more rounds of surveys administered to a carefully selected group of experts with relevant knowledge and expertise about a particular topic (Keeney, Hasson, & McKenna 2010). Therefore, the first task for this aspect of the project was to develop the criteria for membership of the Expert Panel (i.e. the group of experts with relevant knowledge and expertise about childhood resilience).

In consultation with the Taskforce, the criteria for membership of the Expert Panel were:

- diversity
- coverage (match between expertise and key areas of enquiry for Delphi)
- independence and decentralisation
- availability
- expertise
- stakeholder expectations (panellists from all jurisdictions)
- number required to have a complete panel (in this case 20-30 members were required).¹

Potential participants were contacted via phone or email to ascertain their interest to be a member of the Expert Panel. The invitation provided information about the aim of the study, the Delphi method, expected commitment and a formal invitation to become a member of the Expert Panel.

Thirty people accepted the invitation to be on the Expert Panel. This group comprised professionals with a vast range of expertise including: clinical research, paediatrics, primary and community health, psychology and social psychology, and education (including early childhood education and care). Each member was provided with an information sheet and consent form (via email).

For the purposes of this project, Expert Panellists participated in three survey rounds (see Table 4, p.22, for the dates when the survey rounds were undertaken). All survey links were emailed to Expert Panellists with instructions for completion. Expert Panellists were given two weeks to respond.² To monitor and increase the response rate, an email reminder was sent after one week. Another reminder was sent two weeks later to Expert Panellists that had not completed the survey.

¹ According to the Delphi methodology, the ideal number of panel members required to reach consensus is 20-30 people. (Keeney et al., 2010)

² The two-week deadline for completion was based upon the findings of research which suggests that a period of less than a week might not provide enough time to complete a Delphi survey, while providing more than two weeks poses a risk of the task becoming a low priority and not being completed (Keeney, Hasson, & McKenna, H. 2011). For two of three rounds, a one-day extension of the 2 week deadline was allowed in order to ensure as many participants was possible were able to contribute to the survey.
The original schedule for completion of all three Delphi surveys was October 2016 (see Challenges section).

All three surveys included close-ended and open-ended questions. For close-ended questions, participants were required to identify their response according to five options, from 1 = ‘strongly disagree’ to 5 = ‘strongly agree’. For these questions, only one response could be selected per question. For open-ended questions, participants were required to type in a free text response. Consensus was defined as responding with (a) 70% of participants agreeing or strongly agreeing to a close-ended question, or (b) 70% of participants disagreeing or strongly disagreeing to a close-ended question.¹

The process for each round of the survey was as follows:

- **Round 1**: the questions for this round were based upon the findings of the research translation (see section 3.2.2 above), as well as input from the Taskforce. The survey included closed- and open-ended questions about the relevance, appropriateness and feasibility of resilience definitions, assessment instruments and interventions. The draft survey was disseminated to the Taskforce for feedback before it was emailed to the Expert Panel. The Taskforce also reviewed the findings from the survey for the purposes of assisting with the development of the Round 2 survey.

- **Round 2**: the questions for this round were based upon the findings of the first round, incorporating feedback from the Taskforce. Specifically, members of the Expert Panel were asked in this round to: rate any new statements generated from the open-ended responses in the first round; re-rate the statements that did not reach the consensus level of 70% in the first round; and confirm the ratings for previous statements for those that did reach consensus. The results were then analysed and the statements not reaching consensus were collated. The Round 3 survey was developed in consultation with the Taskforce.

- **Round 3**: the results from Round 2 were presented to the Expert Panel. The panel members were asked to re-rate the statements that did not reach the consensus level of 70% and to confirm the rating for previous statements for those that did reach consensus. As in the previous rounds the results were then analysed and presented to the Taskforce for feedback and discussion.

**Data analysis**

According to the Delphi method, responses are analysed by researchers and organised as statements or questions that are sent back to the experts for rating. Rounds usually continue until a predetermined consensus level is reached, with most studies finding that three rounds are sufficient to achieve consensus among the panel members (Keeney, Hasson, & McKenna 2010). However, the amount of time available, reductions in the amount of new information gained in each round, and participant fatigue (resulting in reduced response rate) should also be considered in determining the number of rounds conducted (Keeney et al., 2010).

For this project, the Delphi surveys allowed us to collect both quantitative and qualitative data. For the quantitative data, we used the Statistical Package for Social Science (SPSS; Version 23.0) to identify the level of agreement and stability of participants’ responses. Consensus was defined as a 70% positive (agree and strongly agree) or negative (disagree and strongly disagree) response to an item among respondents.

To determine the stability of participants’ responses, we used a statistical indicator known as Kappa to measure inter-rater agreement, and the McNemar’s change test which told us if there was a statistically significant change in responses (i.e. how much have responses changed from disagree to agree).
For the qualitative data, we undertook a thematic analysis to identify key themes. This involved identifying, examining and documenting thematic patterns in the data that were relevant to the issues we sought to extrapolate upon.

As noted previously, after the analysis of data from each survey round was completed, we provided the Taskforce with a summary of the findings. The findings were discussed in the Taskforce meetings in order to determine what conclusions could be drawn from the data, and to provide the Taskforce with an opportunity to provide suggestions for refining or including new questions in the following survey round.

3.3.2 Parent survey
A survey was developed by PRC, ARACY and beyondblue, to seek out parent views on childhood resilience. The survey comprised six questions – three of which were open ended (e.g. What does a resilient child mean to you?).

The purpose of the Parent survey was to develop an understanding of parents’ views and priorities relating to resilience, in order that these could be incorporated into the Practice Guide. It was also expected that the findings from this survey would help to ensure that the language and concepts in the Practice Guide – which would be designed for practitioners working with children and parents – would be relevant and appropriate to Australian families.

Data collection
The survey was made available via the Raising Children Network and blueVoices, and promoted by beyondblue, PRC and ARACY.

Data analysis
A thematic analysis was undertaken on the qualitative data collected from the Parent survey. To analyse the quantitative data, we undertook an analysis of the frequency of responses.

3.4 Phase 4: Methods
The fourth phase in the project was Practice Guide development. This involved two tasks:

- a review of existing guidelines; and
- development of a draft Practice Guide

The methods used to undertake these two tasks are described below.

Review of existing guidelines
For this aspect of the project, we sought to identify some of the common characteristics of guidelines, in order to inform the structure, style and tone of the Building Resilience in Children Practice Guide. We were interested in guidelines that presented information to professionals who work directly with clients in a concise and engaging way. We focused upon guidelines that targeted practitioners in relevant sectors (i.e. health, welfare, education and community services) working in Australia.

In order to identify relevant guidelines we undertook a search of Google using terms such as ‘practice guideline’, ‘professional guideline’, ‘practice guide’, ‘practice framework’, and ‘practice strategies’. Our searches were neither exhaustive nor systematic. Rather, we were seeking out practice guidelines that would give us some ideas about how to present the information in concise and engaging way.
Development of draft Practice Guide

A brief for the Practice Guide was provided to beyondblue for comment on 15 November 2016. The Brief outlined the proposed audience, aims, structure and format of the Practice Guide. The brief was approved by beyondblue as the basis for the draft Practice Guide.

The content in the draft Practice Guide was based upon the findings of two of the three Delphi survey rounds, as well as the findings from the knowledge translation exercise and the parent survey. We used placeholders and text boxes to indicate where additional information could be presented. This draft was provided to beyondblue and the Taskforce for feedback and comment in March 2017.

3.5 Phase 5: Methods

The fifth phase in this project involved ‘real-world’ consultations with parents, children and professionals. The purpose of these consultations was to ensure the Practice Guide reflected the experiences and perspectives of Australian parents and children; as well as the reality of the ‘on the ground’ practice of professionals who work with children and families.

The real-world consultations involved two key tasks:

- Parent and child consultations; and
- Professional consultations.

All consultations were facilitated by two appropriately qualified staff members from ARACY and/or PRC who had a current Working with Children Check.

Facilitators were trained in the consultation procedures prior to undertaking the consultations. This training took place face-to-face or on the phone in a group of one-on-one format (depending upon the needs and preferences of the facilitators).

A moderation guide was also developed for facilitators undertaking the consultations. The moderation guide provided a basic structure for the consultations – setting out what takes place, in what order and how much time would be allocated to each task, as well as more detailed guidance for facilitators such as what to say when and prompts that can be used to generate discussion or activity. Facilitators were able to make adaptations to the timing, order and nature of the tasks depending upon the preferences and needs of the participants.

In line with the ethical requirements of the project, every parent was required to complete a consent form for themselves, and for their child (or children). Parents also completed a brief anonymous demographic survey, and professionals completed an anonymous survey about their professional background.

For the purposes of analysis, an audio recording was made of all consultations. Photographs were also taken of materials produced during the consultations (e.g. children’s drawings).

In the following sections we describe the process of data collection and data analysis for the parent and child consultations, and the professional consultations.

3.5.1 Parent and child consultations

Data collection

ARACY drew upon their existing relationships with ‘Parent Engagement Champions’ at a number of schools across Australia to assist in the recruitment of parents and children for consultations.

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3 The findings from the third Delphi survey were not included in the draft Practice Guide due to the amendment to the schedule of Delphi surveys (see ‘Challenges: Methodology’ section, p. 7).
Champions in the selected schools were asked to invite parents of children (aged 6-12 years and currently attending that school) to a focus group. The invitation – in a letter format – was given to parents and included the date and time of the focus group.

The invitation letter included the contact details of an ARACY staff member should parents have any questions about the focus group. Potential participants were also informed that the consultations would be audio recorded and that photographs from the consultations may be used in the Guide.

Parent and child consultations were scheduled for 90 minutes and were undertaken at the school the participating children attended. The consultations comprised three parts:

1. ice-breaking activity and a general discussion about the concept of resilience (parents)
2. children’s views and perceptions of resilience (with activities such as drawing and word association) (parents and children)
3. group reflection and discussion about what could be done to enhance children’s resilience (parents).

Although some parts of the consultation were intended for parents, children were occasionally present for those sections of the consultation.

Data analysis

For the qualitative data, we undertook a thematic analysis to identify key themes. This involved a number of steps:

• listening to the recordings from all of the consultations
• noting important quotes, statements and reflections in a spreadsheet according to one of the following categories:
  o resilience concept
  o nature of resilience
  o source of resilience
  o what builds resilience
  o how to build resilience (professionals)
  o how to build resilience (families)
  o how to build resilience (community)
  o specific interventions
  o other relevant quotes/statements
• using the data in the spreadsheet to identify common themes according to parents and children, and professionals.

Throughout the Practice Guide, we also used the children’s drawings and quotes to reflect their unique perspectives on resilience.

3.5.2 Professional consultations

For the professional consultations, we were seeking the participation of professionals from a range of sectors including maternal and child health, early childhood education and care, mental health, and primary schools.

Participants for professional consultations were recruited from PRC and ARACY networks and from key stakeholder groups such as the Raising Children Network professional subscription list. Taskforce members were also asked to nominate participants for the professional consultations.
Potential participants were emailed an invitation to participate, which included information about the consultation. They were also asked to nominate the most convenient location for their participation (from a list of potential locations). ARACY followed up by phone or email to confirm workshop participation. Confirmation of the consultation details were emailed to every participant who indicated their interest.

The professional consultations were scheduled for 2.5 hours. They were undertaken at community facilities that were convenient to participants. During the consultation, participants were provided with detailed information about the preliminary findings of the project, and were also provided with a copy of the draft Practice Guide to discuss in small groups. Participants were asked to comment upon the content of the draft Practice Guide, and to discuss their views about the best type of resilience intervention, the ideal timing and location of resilience interventions. They were also asked to share case studies of resilience from their own professional practice.

Data analysis

We used the same approach to analysing the data from the professional consultations as we did for the parent and child consultations.

3.6 Phase 6: Methods

Phase 6 involved the consolidation of information collected and analysed during all of the previous five phases of the project. In doing so we sought to finalise the:

- Practice Guide
- Program logic and the details of the potential pilot intervention.

The methods used to create each of these products are described below.

3.6.1 Practice Guide

The aim of the Building Resilience in Children Practice Guide was to provide professionals with information and guidance to develop and implement universal and targeted interventions that promote resilience in children (0-12 years of age). The Practice Guide needed to cater to all developmental ages and stages within the target age group, and be useable within a range of diverse family, service and community settings.

Developing the final Practice Guide involved the consolidation of information about resilience from:

- **Experts** through the knowledge translation exercise, the consensus-building survey and the guidance and advice of the Taskforce
- **Professionals** working in relevant sectors through the professional consultations
- **Parents and children** through the parent and child consultations.

The process of developing the final Practice Guide involved:

- adding content to the Practice Guide to ensure it reflected the findings from the third Delphi survey and the consultations
- revising the content in the Practice Guide to make it more accessible to the target audience
- inserting diagrams and visual information to make the Practice Guide more accessible and engaging to the target audience
- including quotes from the consultations to ensure the views of professionals, parents and children were emphasised in the Practice Guide
- responding to the feedback and comments on the Practice Guide provided by the Taskforce and Project Team.
3.6.2 Program logic
The development of one or more program logics was planned in order to clarify and visually represent the potential pilot intervention designed by the Project Team. Outcomes logic diagrams assist in the design, implementation and evaluation of any new intervention as they visually depict the relationships between intended outcomes, intermediate outcomes, activities and inputs or resources.

For this work, a ‘pipeline’ outcomes logic approach was taken, where proposed outcomes are associated with the identified activities and inputs to reflect what is essentially a set of ‘if-then’ statements underlying the proposed theory of change.

The Practice Design Lead at PRC worked with the Project Team to scope and develop a logic which reflected the recommendations contained in the Practice Guide, incorporating key principles of effective intervention design and focusing on key modifiers for resilience supported by the findings of our consensus-building and consultation work.

The Project Team developed more than one logic, in order to describe both universal and targeted elements of the potential pilot intervention. This approach aimed to assist beyondblue and its selected collaborators with the future development and refinement of the intervention.

3.6.2 Potential intervention
The proposed intervention aimed to:

- add value to what is already available, especially via beyondblue (e.g. SenseAbility and Healthy Families website)
- complement existing interventions
- fill the gaps that other major initiatives are not currently targeting (e.g. a more targeted focus on the role of parents and relational factors between children and members of the wider community)
- incorporate a universal approach to building resilience, whilst also offering a more targeted intervention for those at risk, with one building upon the other.

This involved a review of resilience interventions that the Project Team and beyondblue were aware of, and an:

- examination of the characteristics of each of these (e.g. target age group, platform, delivery)
- analysis of the alignment of interventions with the influences on resilience that we identified in the Practice Guide (e.g. child coping skills, positive family relationships).

3.7 Challenges: Methodology
The Children’s Resilience Research Project was a multi-faceted project with a number of different steps and involving a range of stakeholders (e.g. high-level resilience experts, managers of agencies and services, practitioners, parents and children). As with all projects of this kind, we experienced some challenges during the process of collecting, analysing and consolidating the information we collected.

In the following section, we outline the key challenges faced in each phase of the project, and discuss the lessons learned from these challenges.

3.7.1 Phase 1: Challenges
The challenges during Phase 1 of this project pertained to establishing the Taskforce. They were:
• **Taskforce coordination**: all members of the Taskforce – including the Chair – were required to meet regularly as a group to provide advice and guidance to the Project Team. As high-level experts, however, Taskforce members had competing demands. Finding a time when all members were available proved challenging.

The main lessons learned were that when working with a group of high-level experts: reduce the time of teleconferences; allow for meetings with a smaller ‘core’ group; and appoint a Deputy Chair (for when the Chair is unable to attend).

• **Indigenous membership**: because of the competing demands on the high-level Indigenous professionals we approached to join the Taskforce, securing participation proved challenging. One of the alternative options pursued was a small Indigenous advisory group comprising mid-level Indigenous professionals who would provide culturally specific advice and guidance via teleconference.

The main lessons learned were that when seeking to involve Indigenous members on a Taskforce: contact potential members as soon as the project begins, and consider alternatives that allow for targeted culturally specific advice and guidance.

3.7.2 Phase 2: Challenges

The primary challenges during Phase 2 was balancing the need for a review of literature that captured key concepts and debates about resilience, whilst at the same time keeping the review narrow enough to enable its completion within a limited period. The main lessons learned was that when undertaking a time-limited review of research it is important to: rely as much as possible upon existing reviews of literature; develop a very targeted strategy for identifying relevant literature; and relying upon the knowledge of expert stakeholders (e.g. the Taskforce) to fill any major gaps in the final product.

3.7.3 Phase 3: Challenges

The challenges during Phase 3 of this project pertained to the consensus-building surveys. They were:

• **Sustaining experts’ commitment** to the Delphi was at times challenging.

  The main lessons learned were that to sustain experts’ commitment to a Delphi process: provide individualised email reminders to participants to encourage their participation, and provide phone support to experts to assist them with any concerns they have about the survey (e.g. technical difficulties).

• **Mastering an unfamiliar technological platform**. The platform used to develop and distribute the survey was unfamiliar to the staff involved.

  The main lesson learned was that when working with an unfamiliar technological platform it is important to collaborate closely with the technical supplier.

• **Meeting the timelines for Delphi surveys**. The challenges associated with Taskforce coordination (see section 3.7.1), as well as the amount of time required to develop the first Delphi survey, led to a delay in the Delphi survey schedule. Amendments to the schedule were negotiated with *beyondblue* (see Table 4 below).

  Although this delay did not affect the deadlines for project deliverables, it is important to note that sufficient time needs to be put aside in the project timeline for developing and
disseminating the survey, especially when the schedule depends upon the input of a group of high-level professionals that is being established specifically for that project.

### Table 4: Original and amended schedules for Delphi surveys

<table>
<thead>
<tr>
<th>Survey</th>
<th>Original schedule (to be completed by)</th>
<th>Amended schedule (to be completed by)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delphi survey 1</td>
<td>October 2016</td>
<td>November 2016</td>
</tr>
<tr>
<td>Delphi survey 2</td>
<td>October 2016</td>
<td>January 2017</td>
</tr>
<tr>
<td>Delphi survey 3</td>
<td>October 2016</td>
<td>March 2017</td>
</tr>
</tbody>
</table>

3.7.4 Phase 4: Lessons learned
When developing the draft Practice Guide (Phase 4) the challenges were:

- **capturing the views and perspectives of multiple stakeholders**: because we were attempting to build consensus among multiple stakeholders, capturing the range of views and perspectives was, at times, challenging.
  
The main lesson learned was to allow sufficient time to review and consolidate the views and perspectives of stakeholders.

- **Developing a user-friendly and practical Practice Guide that reflected the complex nature of resilience**: we needed to find a balance between communicating a complex concept (i.e. resilience) and appealing to an audience focused on practice.
  
The main lesson learned was the importance of ‘testing’ the language, style and tone of documents with a practice audience (i.e. Phase 5).

3.7.5 Phase 5: Lessons learned
The primary challenges associated with this task were managing time within sessions; and managing children’s level of engagement.

- **Managing time**: resilience is a topic of great interest among parents and professionals. Participants in our consultations were keen to discuss resilience, and share their own views and experiences on the issue. At the same time, however, we needed to focus upon specific tasks in a relatively limited period of time.
  
The main lesson learned was the importance of keeping to time limits as strictly as possible in order to ensure participants undertake all the tasks.

- **Managing children’s levels of engagement**: During the parent and child consultations, some groups of children were initially reluctant to participate in activities, whereas others were extremely enthusiastic.
  
The main lesson learned regarding this challenge was the importance of balancing flexibility (to account for the group style and dynamic) with encouragement to undertake the tasks at hand by either directing the energy of the enthusiastic groups, or gently emboldening those that were more reserved.

3.7.6 Phase 6: Lessons learned
The challenges during this phase were similar to those described for Phase 4. At this point in the project, we had comments and feedback on the Practice Guide from the Taskforce, as well as the
information in each of the ‘products’ developed throughout the project (see Table 2 above). Again, as with Phase 4, we needed to communicate a complex concept, incorporate the findings of multiple sources of data, and ensure that the Practice Guide reflected the lessons learned during the consultations with parents, children and practitioners.

The main lessons learned were the importance of: developing products at each phase of the project that could be used during the process of developing the final product (e.g. summaries of findings); and ensuring all these products are maintained in a single convenient location that is easily accessible to all members of the Project Team involved in developing the Practice Guide.
4. Results

4.1 Phase 1: Results

The results of the two tasks involved in Phase 1 are summarised below.

4.1.1 Taskforce establishment

Eleven people were invited to participate in the Taskforce and ten accepted. The Taskforce Terms of Reference were then developed and reviewed by beyondblue. These Terms clearly set out the objectives and responsibilities of the Taskforce, as well as:

- Taskforce authority
- internal decision-making
- membership
- time commitment and meetings
- confidentiality
- conflict of interest
- costs
- Secretariat information.

The Chair was appointed in collaboration with beyondblue. Professor Brett McDermott from beyondblue was chosen because of his high level research expertise in the area, and his advanced understanding of beyondblue’s perspective on the project. Another member, Professor Ann Sanson, was appointed to be the Taskforce Deputy Chair, should the need arise.

The first Taskforce meeting (the ‘orientation meeting’) was hosted by beyondblue on 23 August 2016 at the beyondblue office in Hawthorn, Melbourne. Subsequent Taskforce meetings were held in October 2016, December 2016, February 2017 and May 2017 via teleconference.

Over the course of the project, the Taskforce:

- advised on project scope and purpose
- provided input on the development of Delphi survey material
- provided feedback on all Delphi findings and separate drafts of the Practice Guide
- provided feedback on early findings for real-world consultations
- provided input on early design of intervention to be scoped.

4.1.2 Ethics approval

The ethics submission was approved by the Committee on 15 September 2016 (Ref: App37).

4.2 Phase 2 – Research Translation: Findings

The results of the research translation tasks are summarised below according to the two key areas of focus (i.e. dimensions and definitions; and characteristics of interventions).

4.2.1 Dimensions and definitions: Findings

After identifying and summarising the literature, it appeared that there was in fact a high level of agreement about a number of concepts relating to resilience. Perhaps not surprisingly, the issue of measuring resilience emerged as one of the issues for which there was a low level of agreement.

A summary of levels of agreement for key concepts related to resilience is provided below.
High levels of agreement

- **Basic definition**: resilience involves a person experiencing serious adversity and demonstrating positive functioning.
- **Influence of culture and context**: resilience is influenced by culture and context.
- **Resilience trait**: resilience is not an inherent trait or quality that some people are born with but the result of interactions between the child and their environment.
- **Cumulative versus individual risks**: cumulative risks (i.e. a greater number of risks over a long period of time) are worse than individual risks.
- **Multi-level protective factors**: protective factors exist at three levels: the child, the family and the community.
- **Social relationships & resilience**: high-quality social relationships (including family relationships) are important for building resilience.
- **Turning points**: there are turning points in people’s lives when there are opportunities for constructive change (e.g. entering a drug rehabilitation program).
- **Testing theories of resilience**: there is a need for interventions to test theories of resilience, for example testing that resilience can be learned with support.

Moderate levels of agreement

- **Multi-level interventions**: many say there should be interventions at multiple levels (i.e. children, parents, schools, communities), but when the researchers identified suggested interventions, many of these focus on altering the individual characteristics of children.
- **Universality of factors**: research undertaken in middle-class Western suburban contexts suggests that risk and protective factors are universal. However, it has been argued that it is misguided to assume that all risk and protective factors have similar effects in all conditions in all people.
- **Voices of research subjects** (children & young people): one prominent resilience researcher (Ungar) consistently incorporates the voices of young people in his research, but most other theorists rely solely upon parent and teacher reports.
- **The relationship between risk & protective factors**: most theorists argue that a factor can be a risk in some circumstances, but protective in others. However, one prominent resilience theorist (Masten) views risk and protective factors as bipolar opposites.

Low levels of agreement

- **Mental illness & resilience**: absence of mental illness is one of the most frequently used indicators of resilience. However, an absence of mental illness may not be enough to indicate good outcomes.
- **Competence & resilience**: competence can be measured within numerous domains; it is difficult to determine whether some domains are more important than others and at what level competence is indicated; signs of competence within each domain can be measured via different methods; it is unrealistic to expect children to be successful in all domains consistently.

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4 A concept for which there was a high level of agreement was defined as one where all theorists appeared to hold the same (or a very similar) views about the concept, or no theorist was identified as strongly opposing the concept.
5 A concept for which there was a moderate level of agreement was one where one theorist overtly disagrees with multiple theorists about that concept, or where there appeared to be some uncertainty regarding the concept.
6 A concept for which there was a low level of agreement is where multiple theorists have multiple viewpoints on the issue, or theorists identify this as an issue which is highly contested.
• **Timing of measures**: some studies measure resilience immediately after the adverse event or circumstance while other studies measure resilience many years after the event or circumstance.

• **Stability of factors**: some theorists focus on risk and protective factors that have historically strong relationships with outcomes, which suggests that risk and protective factors are stable (e.g., high intelligence as a protective factor). Others focus on the risk and protective factors within the context where the child is based. This is founded upon the idea that risk and protective factors are not stable; in some contexts, for example, high intelligence can be a risk factor.

4.2.2 Characteristics of interventions: Findings

For this aspect of the project, our analysis of 147 studies pertaining to resilience and cited in six reviews of evidence led to the identification of 32 primary studies specifically focusing upon interventions designed to enhance the resilience of children aged 0-12.

The findings from the analysis of the characteristics of the interventions described in these 32 studies are summarised in Table 5 below.

**Table 5: Characteristics of resilience interventions**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Characteristics most often reported in selected interventions</th>
<th>% of total no. of studies where characteristic is reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age range</td>
<td>10 years +</td>
<td>66%</td>
</tr>
<tr>
<td>Setting</td>
<td>School</td>
<td>71%</td>
</tr>
<tr>
<td>Universal/targeted</td>
<td>Targeted</td>
<td>59%</td>
</tr>
<tr>
<td>Intervention level*</td>
<td>School</td>
<td>83%</td>
</tr>
<tr>
<td>Participants</td>
<td>Students (universal)</td>
<td>41%</td>
</tr>
<tr>
<td>Mode of delivery</td>
<td>Group</td>
<td>83%</td>
</tr>
<tr>
<td>Intervention</td>
<td>• Penn Resiliency Program</td>
<td>21%</td>
</tr>
<tr>
<td></td>
<td>• CBT</td>
<td>19%</td>
</tr>
<tr>
<td></td>
<td>• FRIENDS</td>
<td>9.5%</td>
</tr>
<tr>
<td>Method of delivery</td>
<td>• CBT</td>
<td>46%</td>
</tr>
<tr>
<td></td>
<td>• Traditional educational approach (e.g. didactic learning, lectures, homework activities)</td>
<td>46%</td>
</tr>
<tr>
<td></td>
<td>• Therapeutic techniques/theories</td>
<td>28.5%</td>
</tr>
<tr>
<td>Content</td>
<td>• Social skills and building relationships</td>
<td>45%</td>
</tr>
<tr>
<td></td>
<td>• Problem solving and decision-making</td>
<td>42%</td>
</tr>
<tr>
<td></td>
<td>• Stress management and relaxation</td>
<td>32%</td>
</tr>
<tr>
<td>Desired outcomes</td>
<td>• Resilience</td>
<td>37.5%</td>
</tr>
<tr>
<td></td>
<td>• Social/prosocial outcomes</td>
<td>37.5%</td>
</tr>
<tr>
<td></td>
<td>• Depression-related outcomes (e.g. depression symptoms, prevalence of depressive disorder, risk of depressive disorder onset)</td>
<td>34%</td>
</tr>
<tr>
<td>Measures</td>
<td>• Connor-Davidson Resilience Scale</td>
<td>15%</td>
</tr>
<tr>
<td></td>
<td>• Prince-Embry Resilience Scale</td>
<td>15%</td>
</tr>
</tbody>
</table>

* The levels (formats) of interventions include the: individual level (e.g., a professional delivering an intervention to children on a one-on-one basis); a family (i.e., the family receives the intervention); a school (i.e., the school receives the intervention); and a community (i.e., the community receives the intervention).

Other important findings include:

• Where reported, of all age groups within the 0-12 period (i.e., early childhood, middle childhood and pre-adolescence/adolescence) interventions most often incorporated the pre-adolescent and adolescent years (i.e. 10-12 years) (59%), followed by interventions that incorporated middle childhood (6-9 years) (22%), then those that incorporated the early childhood period (0-5 years)
(18.5%). Of these interventions focusing on 0-5, one was prenatal, and only one was specifically 0-5, the others incorporated early years but were not limited to early years. The settings of the interventions were varied and included schools (for kids aged 4+), home and community settings.

- In schools, interventions were more often universal than targeted. Interventions not in a school setting were more often targeted than universal.
- Due to a lack of information, it was difficult to determine the extent to which resilience interventions involved families. Most primary resilience studies (69%) did not indicate whether families were involved. This is a limitation of the research.
- Only a very small number of those interventions, where the level of intervention was reported, were undertaken at the family or individual level (n=3, 12.5% and n=1, 4% respectively), and none were undertaken at the community level. Community level interventions is a gap. One other factor influencing this is potential under-reporting.

4.3 Phase 3 – Consensus building: Findings

The number of Expert Panellists in all three rounds of the consensus-building survey are outlined in Table 6 (below), along with the number of questions included in each round of the survey. The average number of Panellists across all three rounds was 24.

<table>
<thead>
<tr>
<th>Survey</th>
<th>No. of questions</th>
<th>No. of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delphi survey 1</td>
<td>67</td>
<td>25</td>
</tr>
<tr>
<td>Delphi survey 2</td>
<td>57</td>
<td>25</td>
</tr>
<tr>
<td>Delphi survey 3</td>
<td>8</td>
<td>22</td>
</tr>
</tbody>
</table>

Based upon the findings of the three Delphi survey rounds, a summary of what we know (i.e. areas of agreement) and what we don’t know (i.e. areas of disagreement) about childhood resilience is provided below.

4.3.1 What we know (i.e. areas of consensus)

The concept of resilience

- Resilience is:
  - a state, a capacity or a process that is dynamic
  - doing well in the face of some type of adversity (the definition of ‘doing well’ and ‘adversity’ depends upon context)
  - more than just good mental health or personal competence
  - something that can be learnt
  - not the same as adaptability
  - not a rare quality.
- The sources of resilience are individual factors (e.g. biological, temperament, psychosocial), environmental factors (e.g. family, community, society); and the result of an interaction between individual and environmental factors
- Experiences of adversity may be important for developing resilience, but resilience can be built in the absence of adversity
- It is easier to build resilience than to prevent adversity.

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7 These figures included interventions that crossed over more than one age category (e.g. 0-9; 6-12 etc).
Resilience measures

- Resilience measures should include:
  - Information about interactions between the child and their environment (e.g. connections with social groups)
  - Assessment or consideration of the child’s characteristics, their level of support, as well as information about the child’s family and the child’s context
  - Perceptions of the child themselves about their situation, as well the perceptions of other people about the child and their situation (e.g. teachers)

- Resilience measures should be:
  - Age appropriate
  - Measured at multiple points over time
  - Multi-dimensional

- Resilience is evident in a child’s level of competence, level of physical and mental wellbeing and freedom from psychopathology and/or poor mental health.

Resilience interventions

- Resilience interventions should be:
  - Individualised (tailored to the specific circumstances of the child)
  - Tailored to the child’s developmental stage
  - Continuous (over the life course)

- The goals of resilience interventions should be to: introduce or enhance protective factors; provide resources/experiences that build resilience; reduce risk factors; and/or build attributes in the child

- Factors that resilience interventions should address include: family relationships; peer relationships; pro-social skills and empathy; positive coping skills; and self-regulation

- The best groups of people to target are: children themselves; children’s families; and parents/carers

- The best relational factors (around the child) to target are: parenting; attachment; and warmth

4.3.2 What we don’t know (i.e. areas without consensus)

- It is clear that resilience can be taught in the absence of adversity, however there are still some questions remaining about the importance of adverse experiences in relation to the development of resilience. Experts were unable to come to a consensus about whether adversity is necessary to build resilience.

- While we know how a child will demonstrate resilience, there is some uncertainty about determining resilience in a child based upon comparisons. For example, we do not know whether a child who is resilient should show the same or an improved level of functioning after adversity when compared to before the adversity. Similarly, we do know whether a child who is resilient should show a normal level of functioning compared with all other children, or whether they should show a higher level of functioning than children in similar adverse circumstances.

- Another area where there is uncertainty relates to the timing of intervention. While continuous interventions are well supported, we do not know if non-continuous interventions should occur before the adversity, after the adversity, or at any time.

- There are some questions remaining about how resilience can be taught. It is unclear whether it can be, for example, self-taught. It is also unclear whether some children could display a natural

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8 Top 3 responses identified by Expert Panellists.
9 Top 3 responses identified by Expert Panellists.
disposition towards resilience, in the same way they might display talent in another area (e.g. musical talent).

- There is strong support for resilience interventions that target families and family relationships, however the breadth of the intervention within the family (e.g. should siblings and grandparents be included) is unclear.

4.3.4 Parent/carer survey
A total of 341 people responded to the survey. Key findings from the survey were that parents/carers:

- believe resilience is something that occurs within the parameters of everyday life. This belief contrasts with the view shared by experts; that resilience occurs within the context of serious adversity
- view themselves, and families, as a key influence on children’s resilience – and a key target group for resilience interventions.

There was also a notable absence of responses referring to community and societal sources of and supports for child resilience. It is unclear whether parents view community and societal factors as irrelevant to child resilience, or whether they have never considered what role those factors might play in child resilience.

4.4 Phase 4 – Draft Practice Guide
The results of Phase 4 are summarised below.

4.4.1 Review of Guidelines
We identified a number of practice guidelines by undertaking a search of relevant websites. PRC and ARACY staff also provided the Project Team with guidelines they believed were potentially useful. Through this process, we identified six relevant practice guides. Some of these included:

- a practice guide for General Practitioners pertaining to best practice in collaborative care
- guideline statements for the general public about eating and physical activity
- a guide for sexual assault and alcohol and other drug sectors to support shared clients who have both sexual assault trauma and substance use issues.10

Our analysis of these guides and guidelines led us to conclude that the typical types of information presented was:

- general information about the topic, such as definitions of concepts, key messages, case studies
- practice-related material, such as descriptions of stages of practice, diagrams of models of practice
- policy-related material, such as information about the policy context
- practical resources for practitioners, such as templates and checklists.

4.4.2 Draft Practice Guide
The draft Practice Guide was organised according to the outline in the brief submitted to beyondblue. This included an introduction to the concept of resilience, a summary of related

10 All of the guides and guidelines we identified were developed in Australia except for the guideline statements about eating and physical activity, which were developed in New Zealand. Given the similarities between the Australian and New Zealand context, these guideline statements were considered relevant.
concepts, a description of what builds resilience, and information about measuring resilience. Textboxes were used as placeholders for subsequent information. The draft Practice Guide was submitted to beyondblue and the Taskforce for comment and feedback in March 2017.

4.5 Phase 5 – Translation into real-world practice: Findings

4.5.1 Parent and child consultations

Parent and child consultations were undertaken in five different schools (four public and one independent) in NSW (n=2), Victoria (n=2) and Western Australia (1). All consultations were undertaken in March 2017.

The age range of the children participating in the consultations was 6 – 12 years. The number of parent-and-child dyads (i.e. one parent and their child) ranged from 6-8 per consultation.

Of those children whose parents completed a demographic survey, 13% were Aboriginal or Torres Strait Islander. Almost half (49%) were between the ages of 6 – 9, a smaller proportion were aged 10 and over (40%) and 6% were 5 years or younger.

Of those parents who completed the demographic survey, the primary activities they were involved in was full time home duties and parenting (52%) (see Figure 1 below).

![Figure 1: Parent primary activity](image)

4.5.2 Professional consultations

Seven professional consultations were undertaken in six states/territories: ACT (1), NSW (1), Queensland (1), South Australia (1), Victoria (2) and Western Australia (1). All professional consultations were undertaken in March – April 2017.

The most common role of participants was ‘practitioner’ (e.g. psychologist, physiotherapists, nurse, social worker, midwife, therapist, counsellor) (24%), followed by educator/early childhood educator (21%), and manager/director (20%) (see Figure 2 below).

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11 Some consultations included the younger siblings of participating children. These children were not excluded from the activities their siblings were participating in, however because of their young age they could choose for themselves whether and how they wanted to participate.
The vast majority of participants had more than five years of relevant professional experience (84%), and more than one-quarter had more than 20 years of experience (27%).

4.6 Phase 6 – Consolidation: Findings

The results of Phase 6 are summarised below.

Practice Guide

The Practice Guide was submitted to beyondblue on 2 June 2017, exactly one year after the start date of the project.

The Guide includes information about:

- why resilience is important
- the meaning of resilience
- concepts related to resilience (e.g. adversity, buoyancy, mental health)
- ideas for professionals to build resilience in children including:
  - everyday strategies; and
  - specific interventions;
- recommendations for practitioners including:
  - overall recommendations; and
  - recommendations for interventions (universal and targeted);
- considerations when choosing an intervention; and
- measuring resilience.

The Practice Guide also includes a list of additional resources, a resource sheet for families about how to build children’s resilience and a resource that outlines a useful metaphor for resilience that practitioners could use to describe resilience to children and parents. More information about the Practice Guide can be found in Appendix A.

Program logic and potential intervention

The program logic and information about the potential intervention was provided to beyondblue on 2 June 2017. This piece of work was done to inform and contextualise the scoping of the potential intervention for consideration and further design.

![Figure 2: Practitioner roles](image-url)
Through collaboration with *beyondblue*, we paid attention to modifiers for resilience identified during our consensus building research, gaps in current interventions offered and practical implementability of new interventions. As a result, the proposed intervention considers both universal and targeted approaches to building resilience at particular ages and in particular settings.
5. Discussion

The Children’s Resilience Research Project confirmed that resilience is a complex concept. Even so, the project showed that despite the complexity of the concept, there are strategies and interventions that practitioners can use to promote resilience among children.

One of the most important findings from the project is that resilience is a process that is influenced by multiple factors within a child (e.g. skills and capacities) and a child’s environment (especially the ‘environment’ of parenting and the family). This finding is strongly supported by resilience experts, practitioners, parents and children. However, resilience interventions appear to more commonly focus upon bringing about a change within the child, rather than bringing about a change in their environment.

This is an important finding because it is important not to focus solely on the child as their locus of control is limited. For this reason, while we support the removal of adversity wherever possible, we also support interventions that focus on promoting children’s resilience through the people and environments that surround them.

Another important finding from the project is that in some respects resilience is not a contested concept. The Delphi method used in the project made a unique contribution in this respect. In the first survey we identified numerous issues relating to resilience that Expert Panellists agreed upon. The basic definition of resilience, influences on resilience, and the multiple levels of protective factors are issues that the Expert Panellists typically agreed upon – and this aligned with the points of consensus among international child resilience experts (as identified through the review of literature).

Notably, parents, children and practitioners also confer with many of these issues. The real-world consultations demonstrated, for example, that parents and practitioners agree that resilience is not an inherent trait within a child. Children in our consultations indicated that they also viewed resilience as something that is intimately linked to the people and environments around them.

The methodologies we used in this project – including the Delphi method and the consultations with professionals, parents and children – led to the finding that there are, in fact, numerous points of consensus about resilience among a broad range of stakeholders. This makes an important contribution to the field of resilience as it indicates that resilience is not as contested as often assumed.

This widespread consensus provides a solid foundation for resilience interventions. For example, if we can agree about the factors that promote resilience, then we can also agree on the importance of interventions that address those factors. Nevertheless, most resilience interventions target the skills, knowledge and capacities of children. This suggests that it is not always the concept of resilience that makes resilience promotion challenging, but also the realities of delivering and evaluating programs. That is, the focus on resilience interventions that target children is probably not a reflection of an ideological leaning, but a reflection of the difficulties of changing children’s environments.

The other notable finding from the project was that structured resilience interventions (e.g. manualised programs) have a very important role to play in promoting children’s resilience, but also that strategies that can be used opportunistically (by practitioners) to promote resilience are perhaps equally important. Since we found resilience to be a dynamic process, it makes sense to promote resilience in a dynamic way – that is, by making the most of everyday opportunities.
Similarly, if resilience changes over time, as we found in this project, it makes sense to embed strategies for promoting resilience across the multiple settings that children engage with during their first 12 years of life (e.g. child and maternal health services, early childhood education and care, primary schools).

Where children need ‘boosted’ resilient supports, such as during significant transitions, it makes sense to have a more intensive, structured approach to promoting resilience. Similarly, for vulnerable and at-risk children – who are likely to encounter more adversities compared with other children – it again makes sense to have a more long-term intensive, structured and targeted approach to resilience promotion.

In the following section, we outline our recommendations for the Building Resilience in Children Practice Guide.

5.1 Recommendations for Practice Guide dissemination and uptake

1. Present the Practice Guide in a visually engaging and accessible way. Some design elements that could be used for this purpose include:
   a. visual design elements to separate and highlight key messages
   b. theme appropriate photographs
   c. infographics
   d. clean colour badging (for sections 1-5)
   e. practice-friendly format (e.g. the type of paper used, the size of the product).

2. Promote the Practice Guide at events and conferences for practitioners within relevant sectors (e.g. presentations, information in conference satchels) with the aim of:
   a. increasing awareness of the Practice Guide
   b. enhancing practitioner readiness to use the Practice Guide.

3. Consult with relevant national, state- and territory-based peak bodies, as well as relevant organisations and agencies, about how to ensure organisations and systems support the use of the Practice Guide in everyday practice

4. Develop a digital promotion strategy for the Practice Guide. This could include:
   a. a webpage for practitioners to access the Practice Guide, information about the Practice Guide and links to other relevant resilience frameworks
   b. social media (e.g. LinkedIn, Facebook, Twitter).

5. Explore the feasibility of establishing sector-based Working Groups (or linking in to existing formal or informal Working Groups) that explore and provide advice to beyondblue on:
   a. ensuring the Practice Guide reaches the widest possible audience
   b. ensuring practitioners have the support they need to use the Practice Guide
   c. addressing organisational and systems barriers to using the Practice Guide.

6. Explore the feasibility of developing a network of practitioner ‘Resilience Champions’ who are able to provide advice directly to other practitioners within their sector about how to:
   a. use the Practice Guide
   b. address barriers and obstacles to using the Practice Guide (e.g. organisational and systems barriers).  

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12 The Project Team would be able to provide beyondblue with information about potential Resilience Champions.
6. Conclusions

The Parenting Research Centre, in partnership with the Australian Research Alliance for Children and Youth (ARACY), was funded by beyondblue to develop a Practice Guide to assist practitioners to develop interventions that promote resilience in children (0-12 years of age). As part of this project, we also developed a program logic and outlined the details of a potential intervention to promote children’s resilience in Australia.

*The Building Resilience in Children Practice Guide* has been designed to inform and guide the design and implementation of universal and targeted programs that promote children’s resilience.

The Practice Guide is designed for use by practitioners working in early childhood education and care settings and primary schools, clinicians, government stakeholders, researchers and other key stakeholders connected to welfare and community-based health and mental health settings. It also includes strategies for promoting resilience among children, and strategies for encouraging families and the broader community to promote children’s resilience.

The Practice Guide was informed by the findings of existing international research about childhood resilience, and new research including: the expert views of a Taskforce, the findings of a consensus-building survey with Australian-based resilience experts (separate to the Taskforce), as well as the experiences and perspectives of practitioners who work with children and families, and parents and children themselves. The *Building Resilience in Children Practice Guide* is a valuable resource for Australian practitioners who work with children, parents and families.

Over the course of undertaking this project it was clear that there were a range of perspectives on the meaning of resilience and its characteristics. However, there was also a large degree of consensus. We believe that it is important that practitioners supporting children adopt a shared and common language for resilience. It is anticipated the products developed as part of this project will assist with:

- contributing to this common language
- raising community awareness about resilience
- providing clear recommendations on how to build resilience in children
- providing clear direction for those seeking to develop or implement resilience interventions
- providing a foundation for promoting resilience among children the benefits of building resilience.

Finally, for the potential pilot intervention, we developed a set of specific intervention characteristics designed to ‘fill the gap’ in the service system. Two major gaps in existing interventions are interventions that help younger children build resilience skills, and interventions targeting parents as key change agents in their children’s lives. Thus, the intervention we proposed focuses upon: 3-5 year-old children; parents and parenting; healthy thinking habits, and relational skills.
7. References


Appendix A - The Children’s Resilience Research Project (one-page summary)

The Children’s Resilience Research Project has led to the development of a new Practice Guide for Building Resilience in Children. The Practice Guide provides an important foundation for promoting resilience in young children, and offers practical strategies for how this can be achieved.

The concept of resilience is commonly understood as ‘doing well or thriving in the face of adversity’. However, people who work with and care for children often have differing views about what resilience means.

To better understand resilience in children, beyondblue commissioned the Parenting Research Centre and the Australian Research Alliance for Children and Youth to develop the Practice Guide to help professionals understand how to promote resilience in children aged 0-12 years.

The Practice Guide is informed by the findings of existing international research and new research including consensus-building among Australian experts, in-depth consultation with practitioners working with children and families, and incorporating the lived experiences, perceptions and voices of parents13 and children themselves.

The Practice Guide reports that resilience is:

- a dynamic process, rather than a fixed trait, that can change over time
- supported by a range of conditions including factors within the child (e.g. child’s skills), their family (e.g. positive family relationships) and community (e.g. positive educational settings)
- something that can be learned.

The Practice Guide includes everyday strategies that professionals can use to promote resilience – as well as information about how to design structured interventions to promote children’s resilience. The research found that practitioners can promote children’s resilience by:

- using everyday teaching opportunities to discuss resilience and teach skills relevant to building resilience
- implementing or designing interventions and strategies that build and enhance supportive relationships between children and significant people in their lives (e.g. parents, peers, educators)
- implementing or designing interventions and strategies that enhance family cohesion or create a positive family atmosphere and environment
- enhancing resilience during significant universal transitions (e.g. primary to high school) and other significant transition points (e.g. parental separation)
- implementing existing age-appropriate interventions that have been shown to produce positive change.

The Practice Guide is a valuable resource for professionals across Australia who work with children, parents and families. It provides a shared and common language of resilience and is an important foundation for promoting resilience among children and the benefits of doing so.

13 The term ‘parent’ is used inclusively and also incorporates carers – that is, adults who are not the biological parents of the child but have taken on a primary caregiving role (e.g. grandparents, foster carers, kinship carers).
Appendix B – Summary of synthesis and Translation of research

Dimensions and definitions of resilience
A summary of levels of agreement for key concepts related to resilience is provided below.

High levels of agreement
- Basic definition
- Influence of culture and context
- Resilience trait
- Cumulative versus individual risks
- Multi-level protective factors
- Social relationships & resilience
- Turning points
- Testing theories of resilience

Moderate levels of agreement
- Multi-level interventions
- Universality of factors
- Voices of research subjects
- The relationship between risk & protective factors

Low levels of agreement
- Mental illness & resilience
- Competence & resilience
- Timing of measures
- Stability of factors

Characteristics of interventions: Findings
Our analysis led to the identification of 32 primary studies specifically focusing upon interventions designed to enhance the resilience of children aged 0-12. The findings from the analysis of the characteristics of the interventions described in these 32 studies are summarised in Table 7 below.

Table 7: Characteristics of resilience interventions

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Most often reported in selected interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age range</td>
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<tr>
<td>Setting</td>
<td>School</td>
</tr>
<tr>
<td>Universal/targeted</td>
<td>Targeted</td>
</tr>
<tr>
<td>Intervention level</td>
<td>School</td>
</tr>
<tr>
<td>Participants</td>
<td>Students (universal)</td>
</tr>
<tr>
<td>Mode of delivery</td>
<td>Group</td>
</tr>
<tr>
<td>Intervention (most common)</td>
<td>Penn Resiliency Program</td>
</tr>
<tr>
<td>Method of delivery</td>
<td>CBT</td>
</tr>
<tr>
<td>Content</td>
<td>Social skills and building relationships</td>
</tr>
<tr>
<td>Desired outcomes</td>
<td>Resilience</td>
</tr>
<tr>
<td>Measures</td>
<td>Connor-Davidson Resilience Scale</td>
</tr>
</tbody>
</table>
Appendix C – Summary of real world consultation findings

Summary of Thematic Data

Resilience concept

Child Perspective

- Resiliency means to bounce back, problem solve, and keep trying. Such situations were identified as when things are hard (e.g. school, exams) and when experiencing strong emotions (e.g. sadness, anger/annoyance, depressed etc.).

Parent Perspective

- Resiliency was described as thriving under any circumstance and not letting things affect you. Specifically, they noted that importance of being able to let go and move on. Further, taking things in one’s stride, not catastrophizing, and being able to self-regulate (e.g. not crumbling, having meltdowns or freaking out).
- As parents, resiliency was noted as being firm and not giving in to their children – ‘saying yes to everything’.

Professional Perspective

- Similar to what children and parents noted, professionals described resilience as one’s ability to self-regulate and return to normal (understanding that everyone’s ‘normal’ is different) (emotional fortitude), being well adjusted and flexible, and being interested and willing to try different thing new things.
- Something not mentioned by parents is the ability to articulate feelings.
- Two different streams of resiliency were noted:
  1. A child’s resourcefulness in the face of few challenges (e.g. setbacks, disappointment, difficult situations/conversations)
  2. Resiliency in the face of something life challenging (e.g. death of a parent)
- Resiliency is not just about functioning in hardship, but also the presence of positive functioning. That is, building on things that are going to prepare you for life’s difficulties.

Nature of Resilience

Parent Perspective

- One’s upbringing and culture greatly defines what resiliency is to them. For example, not showing emotion vs. being able to express/manage it.
- Resiliency is not just about coping but also how you respond to unfavourable situations. For example, adjusting expectations, managing emotions appropriately, articulating self.

Professional Perspective

- Resiliency is on a continuum (think bell curve). There are extremes – hypoactive down one end and dissociative on the other. Both seen as a negative.
- Resiliency is not static, it’s an ever developing process. It ebbs and flows. Process of building resilience through the protective factors for mental health and wellbeing
- Linked to attachment and is multi-player. Development requires the child to feel loved and safe (doesn’t necessarily have to be by a parent).
• In agreement with parents, professional reported the importance of community connectedness and sense of belonging. For example, how you see yourself in your culture, your values. Resiliency is not just about ability but about one’s perception.
• Linked with sense of control – modelling and increasing ones capacity to deal with things not going their way - flexibility.

Sources of Resilience

Parent Perspective
• Parents identified themselves as children’s primary source of resilience, namely via modelling. They highlighted the importance of self-awareness and the need to consciously display adaptive coping strategies. Normalising and validating children’s feelings was also reported as pivotal in this process.
• Children’s environment was reported to impact on how they displayed resilience. For example, cultural and or societal norms (e.g. expectations of females vs. males), within family expectations (e.g. internalising emotions is seen as a strength), and the extent of children’s support network. Greater resiliency was attributed to a high sense of safety and belonging.
• Children’s personality and temperament influences children’s responses, and ultimately their level of resilience. For example, parents described their more sensitive child as being hyperarousal and less able to self sooth than their siblings.
• Teacher’s response to incidences was noted as a huge impact in children’s resiliency. Empathy, acknowledging children’s viewpoints and feelings, and working with children’s strengths were noted as important. Punishment (e.g. labelling a child as ‘bad’) and being dismissive (e.g. not guiding children to problem solve) were described as counter-productive.

Professional Perspective
• In agreement with parents, professionals noted the important role of caregivers in children’s development of resiliency, particularly in ‘re-wiring [children’s] brains’ and changing behaviour. Realistic expectations of children (e.g. how they should or should not behave) was identified as a positive influencer.
• Similar to parents, professionals noted the importance of children’s sense of belonging. They stressed the importance of children having someone in their life that they know fundamentally loves them and believes in this.
• The distinction between guidance and ‘telling children what they think and feel’ was important. For teachers, this meant hearing what children have to say rather than telling them that they are okay or coming to resolutions for them without input.
• Siblings and children’s extended networks were identified as potential role models for children.

What builds resilience

Child Perspective
• Children reported the following strategies as helpful in building their resilience:
  o Time out to be on their own and to calm down. Self-soothing techniques included mindfulness – be present and grounded; deep breathing, washing your face, playing games, playing with a pet, eating, and saying positive affirmations in your head (e.g. ‘I’m not scared’; ‘I’m my own person and I can do it’; ‘I did my best’).
  o Not overthinking or ruminating on the situation (e.g. the person who is hurting your feelings)
  o Getting someone to help you (e.g. problem solve or get advice)
To keep trying and never give up
To be confident and believe in one self

Parent Perspective
- Routine – Knowing what is planned and therefore allowed time to adjust to changes through repeated exposure.
- As caregivers, setting boundaries and rules will help children deal with disappointment and coping to difficult or uncomfortable conversations.
- Normalising and validating children’s feelings, accomplished through encouragement of children to identify and talk about their emotions. Important in this process is being empathetic and understanding the child’s context and asking what would be helpful to them when they are feeling that way. Parents stressed the importance of balancing being supporting and helping children learn when they are not around.
- Expanding children’s self-concept through questioning such as ‘what did you do well today?’ and when things are difficult, ‘what did you learn?’.

Professional Perspective
- Exposure to adversity or everyday challenges. Here, empathises was placed on providing children with the opportunity to develop positive attitudes and feel optimistic as well as practice adaptive skills in a safe environment where they can make mistakes.
- Like parents, professionals stressed the importance of boundary setting, noting its role in children’s sense of safety. For example, stability and predictability was attributed to increasing children’s sense of meaningfulness in what they have to say and who will listen.
- Unlike children who identified time out a means of self-soothing, professionals noted this as an opportunity for reflection and problem solving.
- Activities focused on strengths and perseverance.
- Like parents, the concept of connectedness and belonging was also highlighted by professionals. This achieved through engagement in community activities.

Action statements - ‘What to do’
Participants were asked about what practical things can be done to build children’s resilience from a professional, family, and community standpoint.

What to do – professional
As a professional support to families and children, a focus on the following were noted:
- Providing education with parents about the impact of healthy attachments on children prior to birth.
- Supporting parents to navigate conversation around adversity and challenges with their children.
- Providing services with a focus on emotional coaching in a ‘fun’ way such as camps.
- Making the most of ‘teachable moments’. For example, ‘unpacking the moment’ when incidences arise in school rather than jumping straight to problem solving.
- Encouraging parents or early childhood workers to move away from structured and goal directed activities to those more naturally occurring. This in turn allowing opportunity for greater mental flexibility and in the moment problem solving.
- Teaching appropriate language like avoiding ‘are you okay’ and short ended questions. Teaching children to talk about what’s happening to them. Strategies of useful language tools.
Comments about the barriers to service delivery, information dissemination and limitations of current resiliency measures were also placed here. Such limitations included:

- The need for a measure to account of behaviour over time
- Making provisions whereby observations need to be taken from different viewpoints (e.g. from a parent and teacher) in varying contexts (e.g. school vs. home)

What to do – family
Examples of children’s demonstration of resilience was predominately placed within this field. In terms of practical skills, showing ‘tough love’, encouraging healthy routines, and setting aside time to talk to children about their day was noted as useful. Avoiding ‘yes’ and ‘no’ questions and focusing on learnings and strengths were noted as most important when having conversations with children around resiliency.

What to do – community
Most comments related to what schools can do to help build children’s resiliency and overall wellbeing. This included:

- Having allocated home to discuss how children’s days have been. Questions include:
  - What was the best things that happened today?
  - What was most horrible or how did you fail today? What did you do to feel better?
  - What’s been challenging?
  - What are you looking forward to?
  - Finishing the end of a school day with something relaxing (e.g. yoga or mindfulness). This helps children to be in a better mindset at home.

- Having a school culture where teachers are accountable for their behaviour. For example, taking an empathetic approach to understanding and managing inappropriate child behaviour.

The importance of creating a supportive community was also highlighted, namely, through advocacy.

Specific interventions
Mention of interventions or approaches specific to building children’s resiliency was noted in this section. This also included supports for families experiencing vulnerability (e.g. trauma, financial strain etc.)

Approaches

- Positive psychology – Looking at strengths and teaching children to identify innate strength and perseverance characteristics in themselves and others
- Child centred approach - Knowing what the children need, listening to what they need and helping them communicate it.
- Family centred approach – Working with strengths within a family to support one another.

Programs/Models

- Berry Street Education Model (whole school trauma approach)
- Tuning into Kids - Parent education for communicating through adversity
- Pre-school programs incorporating social welfare/intervention
• Australian Curriculum for Parent friendly resources
• Good bye Mr. Scary program: For child fears
• BMA program 'Circles' - If you are looking for a friend to play with you stand in the 'circle'. The goal is that when other children see you in the ‘circle’ they’ll invite you to play.
• Bounce back
• Ben Soc Resilient families program - An intensive program - wraparound support in a case management style, linking in with existing services
• ‘Tune in not out’ website - playlists that young people use to communicate with other young people