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Therapeutic approaches to social work in residential child care settings

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Therapeutic approaches to social work in residential child care settings

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Introduction

Children and young people in care are some of the most vulnerable in society. A small but significant proportion of looked-after children across the UK are cared for in residential settings such as children's homes.

Children in residential child care have some of the highest levels of need (Ward and Holmes 2008) – including increased emotional and behavioural difficulties– compared to the looked-after population in general. It is vital that staff have the right skills and support available to them.

Following a regional review of residential child care in 2007, the five Health and Social Care (HSC) Trusts in Northern Ireland introduced 'therapeutic approaches' in a number of children's homes and in the regional secure units. The aim was to improve staff skills and outcomes for young people.

This report gives the results of an evaluation of these approaches. The evaluation looked at the evidence for each of the chosen models and explored their similarities and differences. It also gathered the experiences of key stakeholders – including managers, staff and young people – of using the models and their effects. The report also gives the results of an analysis of the patterns in reporting untoward incidents.

Summary

- Following a regional review of residential child care in 2007, the five Health and Social Care (HSC) Trusts in Northern Ireland introduced 'therapeutic approaches' in a number of children's homes and in the regional secure units.
- The term 'therapeutic approaches' is used in this report to mean ways to help staff understand:
    - how trauma effects children and young people
    - how and why their ways of coping with this trauma might be maladaptive
    - how and why agencies and staff respond in the ways they do, how some of these ways are not adaptive, and how they might change.

  These approaches can help residential child care staff use a therapeutic perspective in their day-to-day social work with children and young people.
- Staff in Northern Ireland who are trained in a number of therapeutic approaches reported that this training had improved their practice, particularly in their relationships with young people and their consistent way of approaching this.
- Staff reported that as therapeutic approaches did have some limitations – for example in dealing with physical aggression – meaning that other models such as Therapeutic Crisis Intervention (TCI) were still an important part of practice.

- Young people in residential child care often noticed an improved ‘atmosphere’ and the use of fewer punishments to deal with poor behaviour, even if they did not notice that a new approach was being used.
- Some factors that helped put these approaches into practice included training staff, offering follow-up supporting materials, and developing wider systems of working that support the approaches – for example careful planning when a young person is first admitted to a home.
- Therapeutic approaches can complement specialist therapeutic interventions – such as trauma-focused and cognitive-behavioural therapy, counselling and so on – but do not replace them. These specialist services are a vital part of the support that looked-after children and young people should have access to.

Structure of the report

This report presents findings from each of the main phases of the study. An overview of the methodology is given in chapter 2.

A literature review was undertaken mainly to identify the ‘logic models’ and evidence supporting each of the models chosen, and to explore similarities and differences between the models. This is summarised in chapter 3.

Chapter 4 presents the evidence of key stakeholders on why each model was selected, their experiences of putting the model into practice, and issues that helped or got in the way of this.

Chapters 5 and 6 discuss the effects of introducing the models from the perspectives of staff and young people respectively.

Chapter 7 presents an analysis of the pattern of reporting events recorded in the monthly monitoring reports prepared for HSCB. This analysis focuses on issues that staff felt had changed as a result of introducing a therapeutic approach to their work, such as serious incidents involving young people.

The report concludes in chapter 8 with a discussion of how effective this strategic endeavour to improve the therapeutic environment of residential child care is.

1. Policy context and background to the study

This chapter gives a brief overview of the policy context in Northern Ireland. It also gives background information on how the five HSC trusts in Northern Ireland identified therapeutic approaches in residential child care and put them into practice. It concludes with an introduction to the study, and the structure and content of the rest of the report.

1.1 Residential child care in Northern Ireland

Health and Social Care in Northern Ireland is provided as an integrated service by five trusts responsible to the Department of Health, Social Services and Public Safety (DHSSPS). Each trust manages and administers a range of services, including social work and social care services. The Health and Social Care Board (HSCB), works closely with the trusts to commission health and social care services across Northern Ireland.

Residential child care is an important part of the looked-after children system in Northern Ireland. As of 31 March 2011, there were 2,401 looked-after children in Northern Ireland. Ten per cent of these children were in residential care (Children Order Statistical Tables 2010/2011), and many of these have troubled histories that present particular challenges for those caring for them (ref?). Considerable investment has been made to improve the skill set of residential care staff in Northern Ireland to tackle this issue.

Residential child care in Northern Ireland is primarily provided by the five HSC Trusts, although there are a small number of independent children's homes. Historically, the number of residential care staff in Northern Ireland with a social work qualification has been higher than in other parts of the UK (ranging between 47 per cent and 78 per cent in 2006[1], with an overall average of 64 per cent). Seventy-two per cent of unqualified staff either had a degree or A-levels (Campbell 2006).

Current legislation on residential child care in Northern Ireland is mainly contained in The Children (Northern Ireland) Order 1995, associated Regulations and Guidance Volume 4: Residential Care, and The Children's Homes Regulations (Northern Ireland) 2005.

[1] Draft of Regional Review of Residential Child Care 2007

1.2 Children's services in Northern Ireland

In 2006, the Office of the First Minister and Deputy First Minister (OFMDFM), published *Our Children and Young People – Our Pledge* – a 10 year strategy for children and young people in Northern Ireland (OFMDFM 2006). The Northern Ireland Executive endorsed this strategy and committed itself to making sure that the needs of children in Northern Ireland would be a policy priority across all government departments in the decade 2006-2016:

> *'We want all children and young people in Northern Ireland to fulfil their potential. We must help them get the best possible start in life and do as well as they can.' (OFMDFM 2006)*

The strategy's progress is assessed against six outcomes and associated indicators. These are that children should be:

1. healthy
2. enjoying, learning and achieving
3. living in safety and with stability
4. experiencing economic and environmental wellbeing
5. contributing positively to community and society
6. living in a society which respects their rights.

The 10 year strategy specifically refers to improving educational and health outcomes for children in care. Outcomes for looked-after children are fully outlined in a 20 year strategy published in 2004 by the DHSSPS – *A Healthier Future: A Twenty Year Vision for Health and Wellbeing in Northern Ireland 2005-2025*. As well as improving educational, training and employment outcomes for young care leavers, one of the long-term targets for looked-after children is that 95 per cent should experience 'no more than three placements during any one continuous period in care' (DHSSPS 2004).

In 2007 – in response to the Green Paper *Care Matters* (DfES 2006) – the DHSSPS published a strategy for young people in care that addressed the Northern Ireland context: *Care Matters in Northern Ireland: A Bridge to a Better Future* (DHSSPS 2007). The policy recognised that not all children have equal opportunities. It also recognised that additional support – offered in a whole-child approach – is necessary to help children in, or on the edge of care, fulfil their potential and improve their experiences and outcomes.

1.3 Policy developments in residential child care in Northern Ireland

The Social Services Inspectorate reviewed residential child care (DHSSPS 1998) following the implementation of The Children (Northern Ireland) Order 1995. The report – *Children Matter* – provided the basis for the resulting restructure of residential child care in Northern Ireland in the new millennium.

A Task Force was set up in July 2000 to take forward the recommendations of *Children Matter*. The Task Force's principles continue to influence developments in residential child care policy in Northern Ireland. They include the principles that:

- Residential care is an integral part of the child welfare system.
- Residential care is a valuable service in its own right, and one that some children choose.
- Placement choice is linked to quality of care and the safeguarding of children's wellbeing.
- Each home should have a statement of purpose and function – essential to the overall running of residential homes in Northern Ireland – that outlines the type and method of work they do and informs how they employ staff and admit children.

In 2006, the regional child protection report *Our Children and Young People – Our Shared Responsibility*, highlighted inconsistencies in practice across Northern Ireland, including those in the residential care sector (RQIA 2006).

In response to the challenges set out in the report, and others, the Children Matter Task Force commissioned a regional review of residential child care to consider the strategic direction of the sector. The review aimed to ensure that the wider reforms in children's services were reflected in residential care.

The report of the regional review of residential child care (DHSSPS 2009) states that trauma can add to the emotional and mental health problems of looked-after children and highlights the effect this can have on a range of other outcomes. It also highlights the effect of working with traumatised children on residential care staff, and the need for this to be recognised with 'appropriate support from the whole organisation, accompanied by good levels of specialised training and high quality and regular supervision' (DHSSPS 2009).

One of the proposals in the report was to adopt and promote 'therapeutic approaches' to social work residential child care, to tackle the range of emotional and mental health needs of looked-after children more effectively. The report does not define what is meant by the term 'therapeutic' in this context, nor does it state any particular approach (or model) of working. However, it does mention developments already taking place across the five trusts in Northern Ireland.

This need for a specific definition or agreement of the term 'therapeutic' is complicated even more by the use of different terms such as 'therapeutic approach' or 'therapeutic

model'. However, it is clear from the report that the therapeutic role of residential care staff is not 'stand alone', but part of the wider range of therapeutic services currently on offer, including specialist Child and Adolescent Mental Health Services (CAMHS), specialist therapeutic support teams, and specialist residential services such as Intensive Support Units.

The report goes on to suggest that staff will 'need to be provided with training and regular consultation with other related professionals to develop this role' (DHSSPS 2007) to give a therapeutic context that will help to address the complex needs of children and young people. Therefore, in this context, the term 'therapeutic approach' describes any approach to training generic residential care staff in a model of care that:

- recognises that children in residential care have suffered trauma and disadvantage
- encourages staff to understand and address the needs and emotions that cause challenging behaviour, rather than just responding to the behaviour
- provides staff and children with techniques to help them understand and control their responses to stressful situations.

Although the report talked about therapeutic 'approaches', front-line staff talked about the 'model' being used in their trusts. For that reason, the two terms are used to mean the same thing throughout this report. However, we will return to this issue of terminology in the final chapter.

1.4 The development of therapeutic approaches

The *Regional review of residential child care* (DHSSPS 2007b) proposed the adoption and promotion of 'therapeutic approaches' to social work residential child care. By the time the review was completed, each of the five trusts had identified a particular therapeutic model that they intended to use, and some were ready to put this model into practice.

The DHSSPS gave £360,000 to the five trusts to support the development of therapeutic work for children in residential care. This was divided proportionately between the trusts according to the numbers of young people in residential care. Not all trusts used this money to introduce therapeutic approaches in their residential units. Some used the funding to develop other support services for looked-after children. The amount of money used to support the development of their adopted model varied in each trust.

Perhaps because these were 'ground up' developments, each trust chose a different model or approach. Whilst recognising the difficulties that might arise from this, the DHSSPS did not want to force the trusts to use one model because:

i. this would risk undoing positive progress that had already been made
ii. there was an opportunity to learn from the experiences across the trusts.

The models used by each trust are listed in Table 1.

Table 1: Models used in the five Health and Social Care trusts

	Name of Model / Approach
Belfast HSC Trust	Social Pedagogy
Northern HSC Trust	Children and Residential Experiences (CARE)
South Eastern HSC Trust	Sanctuary
Western HSC Trust	Model of Attachment Practice (MAP)
Southern HSC Trust	Attachment, Regulation and Competency (ARC)[2]

A brief description of each of these therapeutic approaches is given in Appendix 1.

[2] The Intensive Support Unit had already begun to develop a model for delivering therapeutic practice (known as 'Scaffold') in the Southern Trust. Earlier in the project, the Southern Trust took part in an action research project around a model of building resilience in young people in another home (Houston 2010). However, this was not rolled out more widely.The model evaluated in this study was ARC – the model that was rolled out to the whole trust.

2. Evaluation of therapeutic approaches

The regional review of residential child care also emphasised the importance of evaluating initiatives that aimed to improve outcomes. In April 2010 DHSSPS asked SCIE to commission an evaluation of therapeutic approaches as part of the service-level agreement between the two organisations. SCIE commissioned the Institute of Child Care Research at Queen's University, Belfast, to undertake this evaluation of the models and has remained involved throughout the process.

2.1 Evaluation aims

This evaluation focused the five therapeutic approaches developed in response to the recommendations of the Regional Review – social pedagogy, CARE, Sanctuary, MAP and ARC.

When the research was commissioned, DHSSPS thought it would be possible for each trust to continue using its different local approaches, as long as each approach showed evidence of working. It also thought there might be similarities between the approaches that could form the basis of a 'core' regional training programme.

The evaluation aimed to provide:

- a description of each approach and the reason for selecting it
- details of how each approach works in practice and the resources needed to make it happen
- views of different stakeholders (including managers, practitioners, and children and young people) on how the approach works in practice and its effect on them
- early indications of whether the approaches are effective and why
- early indications of whether any approaches are likely to be ineffective and why
- evidence of organisational/contextual factors that help the approach or get in the way of its successful implementation
- evidence of what is needed to continue the approach.

In particular, the research focused on the following:

i. What the 'logic model' underlying each approach is and what evidence exists for each.
ii. What factors led each trust to choose its particular therapeutic approach.
iii. How closely the practice of each approach follows the features of that approach as identified by relevant programme developers or theorists, and what reasons there are for any departures from, or tailoring of, the approach.
iv. What key stakeholders think about the acceptability and contribution of each approach, both to changes in practice and perceived impact on children and staff.
v. What organisational / contextual factors help or get in the way of the successful implementation of each approach.
vi. What is needed to continue and/or improve implementation.

In all five trusts, the approaches form one part of a wider set of therapeutic provision and services available to young people in residential child care. Arrangements across the trusts vary. They include a multi-disciplinary consultation and support service that provides assessment, intervention and consultation for emotional and psychological wellbeing (Southern Trust), and the availability of multi-disciplinary 'therapeutic wraparound' services (Belfast Trust). This study has not evaluated these wider arrangements. Further research could explain the contribution of each model depending on the extent of other therapeutic support available.

2.2 Methods

The evaluation was completed in three phases, described briefly below. The methodology is described in more detail in Appendix 2.

I. Scoping literature review

The research team carried out scoping literature review of the six approaches deployed within the trusts at the start of the project[3] (Macdonald and Millen 2011). The 'inclusion criteria' for the review included papers and other publications that described:

i. The therapeutic models, their theoretical and empirical origins, and their development.
ii. The 'logic model' (or theory of change) supporting each model

[3] The sixth model – the resilience model – which was initiated in one home in the Southern Trust was not rolled out more widely

iii. Outcome studies giving evidence of the effect of each model, irrespective of study design (other than single case designs).

It was agreed that the effectiveness of each model would be judged based on studies with comparison groups, where these existed. In the original literature review we looked all six models in use at the time. As part of this 'scoping review', we searched a wide range of databases and examined over 25,000 records, before identifying 63 that related directly to the six models. This report focuses on the five models that have been formally adopted by the trusts[4].

II. Qualitative research on experiences of implementation

Interviews with managers and staff

Qualitative interview research was conducted with 18 home managers and 38 residential child care workers in 18 homes already implementing a therapeutic approach. The chosen homes represented the training of staff and implementation of the model at various stages. They include homes where staff have received training and have put the model into practice for some time, as well as homes that have been trained more recently so have not had as much experience of working with the model. The homes selected included a Secure Unit. The staff selected for interview were representative of professional/career bands, gender and length of experiences.

The purpose of using this sample was to record any 'live' issues of putting the models into practice. It also allowed us to record the lessons that had already been learned about the general aim of improving services in residential care by adopting a specific therapeutic approach, as well as those particular to each model.

The interviews explored reasons for selection of the model, experiences and challenges of implementation, perceived impact on practice and on the young people, and sustainability issues (addresses research questions 1, 3, 4, 5 & 6).

Interviews with young people

We also conducted qualitative research with 29 young people from a sample of the same homes about their perceptions of the approaches (addresses research question 4). At the start of the study we had hoped to interview young people who had lived through the introduction of a therapeutic approach, and to look at the differences they had seen, for example in the way the home was run, how staff behaved, and so on. However, by the time the interviews took place in the first half of 2011, most young people would only have known the home under its new regime, so there were few opportunities to compare young people's experiences before and after the introduction of a therapeutic model.

We interviewed 29 young people across the five Health and Social Care Trusts. Although we did ask about their awareness of any particular model or approach being used in the home, the main focus of the interview with young people was on their

[4] The sixth model – resilience – was tested as part of an action learning project in one home only in the Southern Trust.

experiences of living in the home more generally. We asked how they felt about staff, what they liked and didn't like about the home and what they would like to change. The rationale for this approach was to look at the level of change in young people's experiences as a result of using a therapeutic approach and how this matched staff descriptions of these changes.

All interviews were conducted between January and May 2011. Interviews were tape recorded and transcribed, and analysed by the interviewer.

III. Investigation of impact

Survey

An online survey of staff was conducted with the aim of testing whether the themes from the interviews were more widely 'generalisable', and of comparing the responses of trained and untrained staff.

The survey was sent out between August and November 2011 to a random sample of 205 workers out of a total population of 392 staff. Seventy-three were from homes that had not yet been trained (see Appendix 1). Of these, 116 (30 per cent of the total residential child care workforce) completed the questionnaire; only nine were untrained in any of the five models. The response rate was significantly lower for untrained staff (12 per cent) than for those who had received training (81 per cent). This meant that we were unable to compare trained and untrained staff as we had hoped. It is worth noting that untrained staff (n=9) did not have to answer all parts of the survey. The software used to analyse the surveys records all unanswered questions as 'missing data', and this has inflated the number of unanswered model-specific data items by nine.

The survey explored what training people had received, how they rated the quality and usefulness of the training, and their perception of the impact of the training on their practice.

Analysis of administrative data

Qualitative data from interviews showed that staff believed introducing a therapeutic approach had had a positive effect on the amount and serious nature of incidents in homes. We therefore planned to analyse monitoring data to see if this was the case. Data on the number of Untoward Events and Notifications – per schedule 5 – was gathered from monthly monitoring reports completed by the trusts. This records data on (amongst other things) untoward incidents and how they have been dealt with. This data has its own problems (see below), but it less subjective than the views of staff who have invested their time and energy in a particular approach.

Of the 33 residential children's homes across the region, administrative data was collected from a sample of 18 homes (55 per cent). A sample was selected because the data in the monthly monitoring reports was not created electronically, and the research team had to source the reports from each trust and manually extract the data.

Data was collected at both a trust and 'study home' level. A stratified random sampling strategy was used to select homes that equally represented each trust. Trained homes were randomly sampled from each trust, along with untrained homes, where these were available. We compared the performance of trained versus untrained homes in those trusts where it was possible to get data from untrained homes for some of the 18 month

period September 2009–March 2011 (Belfast, Western and Southern). For trusts where there were no untrained homes (South Eastern and Northern) we compared performance before and after training over a longer period (24 months, March 2009–March 2011). Appendix 2 provides detailed information on the sampling frame.

The sample of data collected was relatively small and of variable quality. We have therefore been cautious in our analysis and interpretation of these data, and these findings should be treated as indicative only.

2.3 Governance and stakeholder participation in the evaluation

The evaluation was designed to inform future policy and practice. The research was carried out with the guidance of the regional Therapeutic Approaches Steering Group – made up of Heads of Service, training leads from each of the trusts, and a representative of the looked-after children psychologists who provide a service across the region – given the role of this group in supporting and providing therapeutic support in residential care. The group helped to shape the research and questions, and the research team fed back findings as they became known. A young person's advisory group from Voices of Young People in Care (VOYPIC) also gave feedback on the interview materials, procedures and protocols that were designed for young people as part of the evaluation.

3. The models, their origins, features and evidence base

This chapter gives an overview of each model, based on the literature review (Macdonald and Millen 2011), with particular attention to their similarities and differences.

3.1 Models, frameworks or approaches?

The language used by the trusts to describe the approaches is not precise. They use ‘model’, ‘framework’ and ‘approach’ to mean the same things in different contexts. Some trusts use all three terms. Some describe themselves as a model, but the approach and content vary across settings and countries (Social Pedagogy). Some use both framework and model (e.g. Sanctuary) and others use framework and approach. In the following sections, we use the term ‘model’ in the looser sense of ‘approach’ or ‘programme’.

Table 2 gives an ‘at a glance’ overview of the models, where they originated, their main components and theory of change.

Only one model (CARE) shows a clear ‘theory of change’. The other four models do not specifically say how their ‘ingredients’ combine to bring about changes in outcomes for young people, other than through changes in staff behaviour and practice. However, there is an implicit theory of change in each model. Each ‘principle’ or ‘building block’ shows a clear rationale and often an established evidence base, although this might not always relate to work with children in residential care.

All five models tackled the challenges of working with traumatised children in residential care, who have a range of difficulties in their social, emotional and intellectual development as a result of their pasts.

Each model has a framework that incorporates a number of theories that, together, help staff to understand:

i. how trauma affects children and young people
ii. how and why their ways of coping with this trauma might be maladaptive
iii. how and why agencies and staff respond in the ways they do, and how some of these ways are not adaptive
iv. how they might change.

Each model also emphasises the importance of developing the knowledge, skills and techniques of staff to help them look after the children and young people in their care.

Table 2: Overview of therapeutic approaches or models used in Northern Ireland

	Sanctuary	Care	Social Pedagogy	ARC	MAP
Origins	**USA**	**USA**	**Europe**	**USA**	**NI / Canada**
Core components	Highlights the effect of trauma on children. Recognises that organisations and their staff can produce dysfunctional (defensive) ways of behaving, so change has to be at a systems level. Incorporates a trauma-informed, shared language – SELF: • Safety • Emotion management • Loss • Future.	Aims to develop a competency-based curriculum to help residential care staff establish practices to improve outcomes for children. Focuses on two core areas of competence: 1. Improving leadership and organisational support for change. 2. Enhancing consistency in and across teams in how they think about, and respond to, the needs of the children in their care.	Based on values reflecting different approaches to children and different cultural histories of social interventions. The relationship between child and pedagogue is important and good communication essential. 'Ordinary tasks or events' provide opportunities for development.	A flexible framework that allows practitioners to choose from a 'menu' of sample interventions organised around three areas: attachment, self-regulation and competency. Traumatised children are helped to (re)build healthy attachments by helping carers to: • better understand children's behaviour and emotional responses • manage their own affect • provide a consistent response.	Draws on attachment theory and research on neurodevelopment to help staff understand children's behaviour and what it means. Encourages staff to think of themselves as 'actors' rather than 'observers' and to recognise the effects of the emotional demands placed on them in their work with children. The importance of authoritative parenting and attunement is also a core component.

3.2 Similarities between the models

The models share many features (see table 3). For example, with the exception of Social Pedagogy, all share theories of the importance of attachment and trauma in the lives of children. However, each has a more prominent place in some models than others (e.g. the theory of attachment is particularly strong in Sanctuary, CARE, ARC and MAP models). Both theories are used to help staff better understand why children (and staff) behave the way the do. The theories give a conceptual framework that can help staff think about the best way to intervene or support children and young people. Their absence from Social Pedagogy is mainly because of the way the model is described. It does not mean that these concepts are not part of the training for staff using this approach, or in the expectations of practice. In fact, the background papers given in staff training packs for Social Pedagogy include information on resilience and attachment.

Table 3: Features of the models

	Sanctuary	Social pedagogy	ARC	CARE	MAP
Attachment theory	✓		✓	✓	✓
Trauma theory	✓		✓	✓	✓
Competencies		✓	✓	✓	
Neurodevelopmental/ bio-psychosocial	✓	✓		✓	✓

Another similarity between the Sanctuary, CARE, ARC and MAP models is the emphasis on creating an environment that is trauma-informed. This setting aims to be therapeutic, supportive and attentive to the individual needs of children, to maximise their chance of healing and growth. The Sanctuary and CARE models in particular take a full-systems approach to creating a setting that is therapeutically beneficial. Both these models focus on giving training to all staff at every level in the organisation, with the help of a guiding set of principles (see above). All models recognise the bio-psycho-social nature of development, however, Sanctuary, CARE, MAP and Social Pedagogy explicitly address this in descriptions of their approach.

Children in residential care often have lower levels of competencies due to the high levels of trauma they have experienced. These models specifically aim to look at these shortfalls according to the needs of each individual child. ARC, CARE and Social Pedagogy in particular refer to the concepts of competency. The aim of building competency in ‘executive functions’ and ‘social skills’ is a key similarity between the ARC and CARE models. More generally, the importance of helping children develop a range of competencies is recognised (more or less explicitly) in each of the models. Even though resilience only features explicitly in Social Pedagogy, it is clearly implicit across all models.

3.3 Key differences between the models

While the CARE, ARC and MAP models were designed specifically for use with traumatised children, mainly in residential settings, the Sanctuary model was originally designed for use with adult psychiatric patients. Since then it has been used in a range of settings such as schools, domestic violence shelter and substance abuse centres, as well as children's residential settings. This is not a key difference as the model lends itself to a range of settings where trauma is a central issue.

Both MAP and Sanctuary emphasise the importance of working with families, but CARE is the only model that includes the involvement of a young person's family in their care, planning and treatment as a core principle. There is evidence that contact with family is an important driver to securing positive outcomes for children in residential care (Kilpatrick et al. 2008).

3.4 Just a different way with words?

Given the clear similarities between the five models, does it matter which one is used? This is a question we return to in Chapter 8. There is value in the argument that the principal value of a model lies in giving staff a coherent 'conceptual framework' to think about the work that matters. After all, staff who can:

- think clearly and logically about their work
- use a set of strategies to understand children's behaviour and critically evaluate their own actions and those of others
- use their understanding to act in the best interests of children

are likely to be better at their job than those who have no framework.

They are also likely to have more job satisfaction and – particularly when whole staff teams are trained in that framework – likely to behave consistently, which is something we know that children value. Unfortunately, the literature review found little evidence of this to investigate further.

3.5 Evidence of effectiveness

Despite a broad search strategy and generous inclusion criteria, we were unable to identify more than a handful of studies that had tried to assess the effectiveness of any of the models currently being used (see Macdonald and Millen 2011). One was a pilot study of ARC (Blaustein and Kinniburgh 2007), and another was a pre-post survey of changes in staff knowledge and intentions to practice after being trained in CARE (Holden 2010).

Rivard (2005) reported preliminary findings of an evaluation of Sanctuary that used a comparison group design, with measures at baseline, three and six months after staff training. This study did not show any differences for the children cared for by staff who were trained in the model at the three month follow up. There were small differences at six months on two subscales of one of the many measures they used to assess change. However, there are reasons to believe that these results were not genuine (see Macdonald and Millen 2011). This study was one of a small number of studies that gave

data on the process and practice of introducing a particular model (see Bloom 2003 and Cameron 2010). At the time of writing, a study of the impact of Social Pedagogy was nearly complete in England.

Looking at the ‘good evidence’, the current evidence supporting all of the models used in Northern Ireland is, at best, sparse. If we looked deeper into particular aspects of the models, such as their use of social learning theory or cognitive behavioural therapy, we could provide strong evidence to support individual components. But this would not be true of all components, and – importantly – these models are more than the sum of their parts. They are complex social interventions designed to change organisational culture, and the ways that staff think and act. Their ultimate goal is to improve outcomes for children who spend time in residential children’s homes – whether long-term or short-term – and in whatever circumstances that bring them into care. Although little evidence of effectiveness is not the same as evidence of ineffectiveness, the fact remains that the effectiveness of doing any or all of these things is unknown. Furthermore, there is a discrepancy between the enthusiasm for these approaches on paper, and the available evidence.

4. Implementing the models

This chapter looks at staff views and experiences of selecting and implementing the therapeutic model in use in their trust. It draws primarily on the interviews with home managers and residential child care staff conducted in phase 2 of the research (see Section 1.6).

4.1 Understanding of how the models were selected

As a whole, home managers tended to be more knowledgeable than residential child care workers about how the decision was made to opt for a particular model/approach within the trusts and whether any alternatives were considered.

In all trusts, information days were held during which alternatives were considered. A decision about which model to adopt was subsequently taken by senior management. In a significant number of cases, models were thought to be chosen because of already existing knowledge and enthusiasm for the approach within a trust.

4.2 First reactions

The first reaction of most staff was one of doubt and concern at the prospect of more change. Responses fell into one or more of the following categories:

- Apprehension (from the majority) at the prospect of unnecessary change to practice and increased workloads.
- Concerns that the training was going to be similar to other recent training.
- A general feeling that the models/approaches basically represented good social work practice and that the skills had been conveniently packaged into a single model.
- Resistance towards a change in practice from longer serving members of staff.

'I think amongst managers there was a fairly significant buy-in ... there was more of a reluctance and in that suspicion – wondering if this is a little bit of pie in the sky – from ground level practitioners'. Home manager-6 (Sanctuary)

'I heard comments like "teach people to suck eggs" and it was too basic and this sort of stuff. But, when you look at it [in] a wee bit more depth, then people started coming round and thinking yes I can see the benefits involved in this.' Home manager-7 (CARE)

Despite these early reactions, the staff interviewed said that taking part in training had triggered their enthusiasm. This enthusiasm increased as they learned more about the models and began to see the value in what they had to offer. It was generally felt that the models gave staff additional tools to improve their practice, and the consistency in practice within and across different homes.

> *'I think people are definitely coming round to it. I still see ... people struggling with their own value base and about being a bit more open-minded about stuff … But I do feel that … we have come to a really good place, definitely do.' RCCW-23 (MAP)*

4.3 Training

Change is difficult. There is a large amount of literature on the challenges facing anyone looking to change the way staff work, particularly when it requires new ways of thinking and behaving and, often, new attitudes. Training is an important part of any change programme. For new models of practice to work effectively, staff normally need additional knowledge and skills, as well as an organisational context that supports change. Training was therefore a key aspect of each trust's plan for putting the models into practice.

Trusts took different approaches to 'rolling out' training in the models. Most trusts started implementation in one or two pilot homes, and then started to roll out more widely. The number of homes in each trust in which a therapeutic model had been introduced are shown in Appendix x. It should be noted that more widespread implementation is not necessarily an indication of success – trusts have simply taken different approaches to introduction.

Each trust took a different approach to training staff in the model. Three of the trusts (South Eastern, Northern and Belfast) used formal training sessions, with at least some sessions delivered by the programme developers. Two trusts (Western and Southern) used a 'consultancy' model, where clinical psychology staff within the trust provided ongoing advice and support. They also had some dedicated training sessions.

There were also differences between trusts in who was trained. To help effect organisational change, the CARE and Sanctuary approaches insist that training is done with 'whole teams' – including senior managers, support staff and 'core' care staff, most of whom hold some professional or academic qualification. Social Pedagogy and ARC focus on care staff and their line managers, and MAP initially focused on care staff and line managers, then extended this to whole teams.

The training given in each trust is summarised in Table 5 below.

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Table 5: Overview of training experiences of residential care staff

Model (trust)	Training format	Number of days	Staff trained	Method of training	Follow-up and supporting materials
Sanctuary (SE)	• Initial training by programme developers • Training by Sanctuary facilitator • In-house training	• Initial training – 5 • Sanctuary facilitator – 2.5 • 17 sessions over 2 years	• 3 staff from each team • All staff from Senior Managers to domestic staff	• Mixed staff groups/teams • Whole units	• Manual • Follow-up/developmental training by Sanctuary facilitator and core team members
CARE (N)	Small number of staff attended a conference followed by: • Training course to prepare conference attendees for their role as CARE trainers or 'champions' • Introductory training – all staff	• Conference – 5 • Preparation for CARE trainers – 2 • Introductory training by internal 'champions' – 5	• Senior managers plus 2 staff from each team • Residential care staff	• Half of a staff group at a time	• Manual • Follow-up training by programme developers and CARE champions
Social Pedagogy (B)	• Provided by ThemPra Social Pedagogy Community Interest Company	• Pilot homes – 8 days over four months (2 days per month) • Other 2 homes – 6 days	• All staff from 4 homes	• Pilot homes – all staff from both homes • Staff training split into 2 sessions	• Team meetings • ThemPra manual
ARC (S)	• Conference (2 days) aimed at staff from the Intensive Support Unit (ISU), and attended by other residential care staff • Meetings with trust Lead (TL) and Principal Practitioner (PP) for ARC Champions • In-house training by TL	• Conference – 2 • Meetings with TL+PP • In-house training – 5 sessions over a number of weeks	• ISU staff and some others • Meetings with TL – each home nominated 2 members of staff • In-house training – few staff yet fully trained	• Originally aimed at ISU staff • No clear pattern	• ARC manual/books • More recently, a concise guide developed by trust lead
MAP (W)	• In-house training from a senior practitioner and clinical psychologist • Training by specialist in trauma and attachment problems	• In-house – 5 • Specialist – 1	• All staff in the one home received in-house training • Some staff attended the specialist training	• Staff teams	• File containing relevant literature • Monthly visits by specialist clinical psychologist to talk about strategies relating to MAP

4.4 Challenges and support in implementation

We asked interviewees what factors had helped or got in the way of putting the model used in their home into practice. Table 4 gives a summary of the issues raised at the time of interview, and these are discussed in more detail in the following sections. Some of these were common to all trusts and models and others were specific to individual trusts and models. In some cases, steps were taken to look at gaps or weakness – for example, more concise manuals have now been produced for ARC and a manual is currently being developed for MAP. Others are ongoing.

Table 4: Factors for successful implementation of therapeutic approaches

Issues of significance	**Sanctuary**	**CARE**	**Social Pedagogy**	**ARC**	**MAP**
	South Eastern	Northern	Belfast	Southern	Western
Comprehensive training delivered to all staff with supporting materials	✓	✓	✓	×	×
Other systems work in a supportive manner, e.g. placement panels, planned admissions, small units	✓	✓	✓	✓	✓
Opportunity for reflective practice and provision of emotional support for staff	✓	✓	✓	×	✓
Good fit of the model with existing culture or language	×	×	✓	×	✓
Buy-in from fieldwork staff (social workers working outside the residential child care environment)	×	×	×	×	✓
Risk-accepting work environment (encourages enabling young people to take 'safe' risks)	✓	✓	×	✓	✓

NOTE: 'x' indicates that a problem was identified by respondents and a '✓' indicates experience of good practice.

4.4.1 Effectiveness of training

Unsurprisingly, staff saw training as vital for putting models into practice effectively. Things usually went wrong when all staff in a home were not trained – either because of

trained staff leaving and untrained staff replacing them, or because staff had not been released for training with their colleagues. In the Southern Trust (ARC) the 'roll out' of the training has been slower than anticipated, with most staff having limited or no experience of the model. Something as complex as a change in professional and organisational practice is not likely to succeed if teams and individuals are not supported properly – through both training and more routine support mechanisms, such as supervision and team consultations.

Programme developers delivered the initial training in CARE and Sanctuary, and some of those taking part became 'Champions' and rolled this training out to the rest of the trust (see Table 5 below). Survey respondents (including the internal trainers or 'Champions') generally felt that internal trainers were not as effective as the 'outside experts' who had extensive experience of putting the models into practice as well as often having specific clinical expertise.

Staff turnover is a significant threat to putting the models into practice. As with any form of good practice, if a home does not consistently practice a model, it is not likely to see the benefits, and this can cause problems for both staff and young people. Managers need to ensure that all staff are trained in the therapeutic model they use. Survey respondents with experience of 'whole team' training (this included managers and staff in support roles) saw this as particularly helpful to improvements in practice because of the extra benefit it had of helping with team building. This 'whole team' approach can only be used effectively at the start, although a combination of introductory training for new staff and 'whole team' refresher training would give some of the advantages of whole team training.

Training should not be thought of as a 'one-off immunising dose'. Staff consistently argued the importance of ongoing training and supervision, to help them to stay up-to-date, to add to their learning and to discuss issues in relation to practice examples.

4.4.2 Systemic support

A number of survey respondents highlighted that the support of other organisational systems and decisions was important to the successful practice of a therapeutic approach. They observed that it was more difficult to work therapeutically in homes where admissions were regularly unplanned – with large numbers of children (more than 3 or 4) – and where children are inappropriately placed. Limiting the numbers of young people to 3 or 4 was thought to help the practice of a therapeutic approach as it allowed residential child care staff to build more effective relationships with each young person.

CARE training is designed to target the organisational system, and this seemed to be an extra benefit for some staff:

> *'I'm very enthusiastic ... you know it's a very clear model with very clear principles and... it's also coming right across the whole of the trust, it's not just about me as a social worker working with young people, it's my manager working with me and right up the managerial ladder.' RCCW-26 (CARE)*

The Northern Trust – which uses CARE – set up a placement panel to avoid unplanned admissions and the problems these caused to an otherwise stable environment. Senior

managers were also aware of and concerned that cutbacks were now threatening their ability to manage placements in all trusts. Since the interviews were conducted, some homes have closed. This has further limited choice and increased the pressure on the remaining homes to admit children in a placement that is not appropriate (perhaps because it is a short-term placement that depends on other arrangements, which can be disruptive for other residents).

4.4.3 Reflective practice

There appears to be a relationship between the models and reflective practice. To some extent, the models encouraged staff to be more reflective in their practice. However, it is also necessary to include opportunities for reflection in individual and team supervision for models to be put into practice effectively. These opportunities for reflection gave staff time to 'digest' the new ways of working and incorporate them in practice, share and support new ways of working with other team members, and helped to monitor strengths and weaknesses in the practice and adjust accordingly.

Some staff also commented that effective practice of the models depended on staff having greater emotional support available. Staff need high levels of emotional awareness to practice these models – including reflecting on their own lives and experiences, which can lead to staff feeling exposed and vulnerable. One of the areas that some staff struggled with was that most models placed less importance on the use of punishments to deal with poor behaviour. This left some staff feeling that they were surrendering their authority, and feeling more vulnerable given the very challenging behaviour of some young people in residential care. However, as the model was put into practice and their confidence grew, many staff reported that they saw advantages in using alternative approaches. The following quote from a staff member using the MAP model, gives one example:

> *'I think people are definitely coming round to it. I still see ... people struggling with their own value base and about being a bit more open-minded about stuff of what we can restrict here and what we can't … But I do feel that ... we have come to a really good place, definitely do ... RCCW-23 (MAP)*

4.4.4 Buy-in from key stakeholders

Most of the focus of putting the models into practice was on engaging all those directly involved in residential care, from senior managers through to social work unqualified staff. However, the issue for survey respondents across all trusts was the lack of engagement with field social workers, and the division of responsibility between field and residential staff.

Responsibilities for young people in residential care are shared between parents, field social workers and residential care staff, particularly the key worker and home manager. Staff felt that this division of responsibility limited the potential benefits of some models because residential care staff did not have the decision-making power that the models assumed they had. This was particularly the case for Social Pedagogy. More significant was the fact that field social workers did not have the knowledge of the models that residential care staff had, and this was seen as both a limit to the model's potential, and possible point of conflict. Many staff thought field social workers should be trained in the

model used in the trust to address these problems. Arguably the most effective way of work with social work colleagues outside the home would be for residential care staff to clearly state their assessment of a young person's behaviour, their progress and the goals that have been agreed. This would also allow theories to be tested in relation to individual young children – i.e. are interventions having the desired effect, in line with the analysis or assessments being made? The models give workers a theoretical framework that allows them to do this more easily. The fieldworkers interviewed certainly felt that it would be useful for them to know about the model, but not appropriate to be trained in it.

4.4.5 Institutional opposition to risk

Modern day institutions are largely opposed to risk, and social care organisations are no exception. There was a tension between the fact that some models encourage the young people to have greater independence and ability to take risks, and the perceived 'risk averse' culture that exists in the homes. This can make the introduction of new ways of working particularly difficult, as appears to be the case with Social Pedagogy. This approach supports young people to take considered risks as 'part and parcel' of the model, to encourage resilience and coping. Although staff specifically working with this model highlighted the opposition to risk, similar concerns were evident in other trusts. As all the models emphasise attachment, resilience and competence, this will continue to be a challenge for management if they want to see the full potential of therapeutic approaches. Allowing children to 'learn by doing' is also 'part and parcel' of human development. It is, after all, what parents – including corporate parents – do, or should do. An environment that is opposed to risk and that does not do this, results in young people leaving care without a range of essential life skills.

There was also a tension between the fact that some models encourage the young people to have greater independence and ability to take risks and the perceived 'risk averse' culture that exists in the homes.

4.5 Model integrity, reasons and effect of change

We were interested to know if staff were able to put the models – particularly those that were 'franchised' such as CARE and Sanctuary – into practice 'to the letter'. We were also interested in the changes, if any, that were necessary, and the impact that this may have had on the how effective the model was. In general home managers had a reasonable understanding of the theoretical framework of the model they used. However, residential care staff generally struggled to describe the model in any detail. Interviews showed that all staff were taking on board a different way of thinking about the children they cared for. They also began to understand how the histories of the young people had shaped them and how they should use this information to understand their behaviour, assess their needs and respond to them. This perhaps explains the fact that, even though the trusts practiced different models, the effect on staff seemed to have more similarities than differences. The shared emphasis across the models on key concepts like trauma, attachment and competence, also added to this.

Two of the models – MAP and ARC – were in development at the time of the study. Both were based on work done elsewhere, but were being developed specifically for a Northern Ireland context. MAP drew on work in foster care settings and a Canadian

project for 'conduct-disordered' youth and their families. ARC drew on the work of Blaustein and Kinniburgh (2007) and was specifically developed for the Southern Trust by its clinical psychologist, who also provides clinical supervision to the residential child care staff who are putting the model into practice. For these two models, the issue of integrity will emerge when the models are finalised and rolled out to all residential child care settings. Neither trust was at this stage.

Social Pedagogy refers to the broad based training given to residential care staff in other European countries, where they are known as social pedagogues. The Belfast Trust was trying to introduce key aspects of this general approach into residential child care, so it was not appropriate to look at the model's practice in terms of 'programme effectiveness'. However, as stated earlier, some staff did think that the division of responsibilities and 'risk averse' nature of social care in the UK was a barrier to putting into practice key aspects of the relational work that is seen as fundamental to social pedagogy. This finding is similar to that of a study in England (Cameron 2010) where a number of social pedagogy pilot programmes were set up based on practice in Europe. These programmes recruited social pedagogues who had been trained in Europe to work in residential child care settings in England with staff, managers and young people. As in the Belfast Trust, Cameron and colleagues showed that staff had a positive response to the social pedagogic approach. The social pedagogues built on the importance of building relationships with young people to help make an assessment of their needs, and the unique view of the shared everyday life of a residential setting that a pedagogical approach brings. In the UK context however, Cameron (2010) reports that social pedagogues faced difficulty in merging this 'relational' role with their role as a key worker.

Sanctuary and CARE were both developed in America and are used in Northern Ireland through a franchise. The expectation is that the model will be used as it has been designed, that staff will be appropriately trained and supervised, and the license to practice as a recognised programme deliverer will be regularly renewed. Unsurprisingly, some of the terminology and practice components do not translate easily from a North American to a Northern Irish context. Staff using Sanctuary felt that some of the language did not feel comfortable for their staff and residents, so it was changed to make it more 'user-friendly'. Culturally, we are less willing than our American peers to be open about thoughts and feelings, and so what was expected of people taking part in community meetings was more than most young people or staff felt comfortable with. Also, some aspects of the language on the 'psycho-educational programme[5]' were adapted in a few of the homes to better suit a Northern Irish context.

[5] Psycho-education is a group taught curriculum that focuses on the S.E.L.F. framework, which addresses the problems of exposure to violence without the need to focus on specific individual events.

This was also the case with CARE (and ARC), but to a lesser extent. The challenges were: to what extent can changes be made without threatening the integrity of a model or breaching a franchise, and does it matter? Without a controlled study, these questions are difficult to answer. The general view was that the changes were relatively small, and had not significantly altered the models. The programme developers of CARE were satisfied that the model was being delivered with sufficient integrity to be presented as an example of the model in practice in the UK. The South Eastern Trust has continued contact with the programme developers in America, in the hope that their use of the model will be accredited.

5. Impact on staff

This chapter focuses on the effect on staff knowledge and practice of the introduction of the therapeutic models. It looks at data from interviews with a representative sample of 18 home managers and 38 residential child care staff from homes that had already begun training. It also looks at evidence from a survey of a larger group of 116 residential care staff from across the region.

5.1 Impact of training on model-related knowledge and skills

Both the interview and survey data suggested that, on the whole, the training had equipped staff with the knowledge and skills needed to put the models into practice. The exception was in the Southern Trust, where some staff felt that they had not received enough training to allow them to successfully put into practice the ARC model. A shortage of manuals was reported in some homes in the Southern Trust, which also made it more difficult for staff to learn about the model.

Interviews

During the interviews with staff, a number of themes were identified on the training process that were common to all trusts:

- In general, staff were satisfied with the training. They felt it gave them enough knowledge to begin to put the various models into practice.
- Overall, the initial training from programme developers was engaging and interesting. Staff thought the practical activities were of particular benefit.
- Band 5 (unqualified) workers thought the training was particularly beneficial as they felt more equipped to carry out their role and did not feel as inferior to qualified workers as they had previously felt.
- As a whole, staff felt that there was too much information during the training sessions. They agreed that further reading was essential to successfully putting the models into practice.
- Staff did not think that 'cascading training' from external trainers (often the programme developer) to 'in house' champions or trainers within residential social work, was an effective method for training new staff, or for giving further training or staff development.

Respondents from the Northern Trust (CARE) were most forceful in making the last point, but respondents from other trusts also expressed similar views. The main issue seems to be that you cannot substitute a trainer with extensive practice experience in a particular model, with someone who themselves has only had limited training – even if this training was from the model developer – and limited experience of the model in practice.

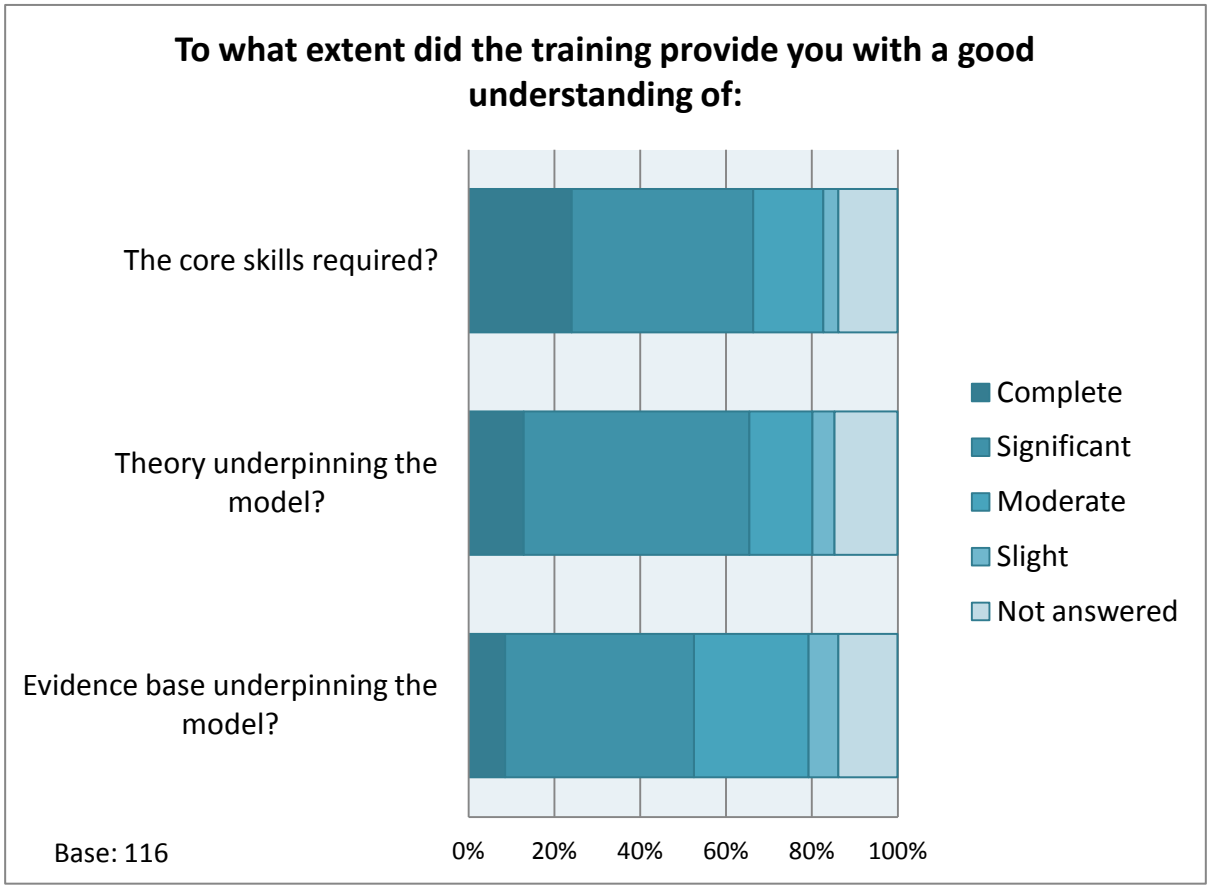
Survey responses

Only 12 per cent of staff completing the survey said they were familiar with all aspects of their trust's model before the training. After training, 51 per cent said they were

familiar with all aspects of the model, and a further 30 per cent said they were familiar with some aspects of the model.

Figure 1 summarises the effect that training had on survey respondents in relation to their understanding of the theory behind the model, its evidence and the core skills needed by those using it. Across the trusts, just under 69 per cent of those who had received training said they were 'very confident' or 'completely confident' that the training had given them an understanding of *how* to implement the model, and the necessary skills to do so.

Figure 1: Understanding key aspects of models as a result of training



5.2 Concepts seen as most important

The concepts identified as most important to staff in the interviews and survey largely matched those outlined in the literature review. There was an overlap between the key concepts of the models. However, social pedagogy was something of an 'outlier'. Resilience and the development of self were in the 'top three' for this model, but not in any of the others.

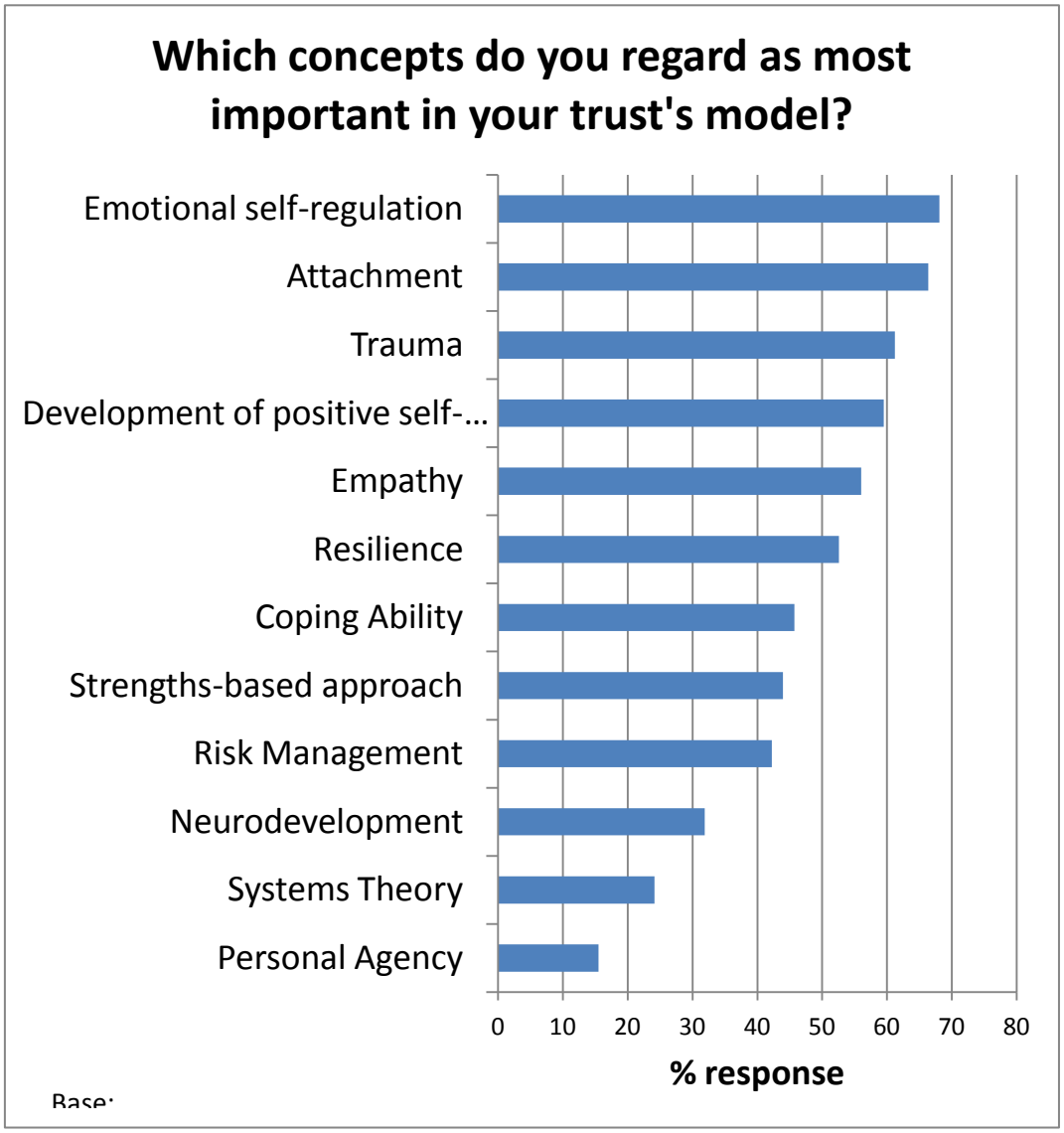
Survey responses

Survey respondents identified emotional self-regulation, attachment, trauma and the development of positive self-concept and relationships, as the most common and

important features across all models. However, there were differences, and these mainly reflect the core components that describe each model, outlined in chapter 3.

The core concepts of the Sanctuary model were empathy, emotional self-regulation and trauma. For the ARC model, they were attachment, emotional self-regulation and trauma. Survey respondents working with MAP identified attachment, emotional self-regulation and empathy as key core concepts, and those working with CARE identified trauma, emotional self-regulation and development of self-concepts and relationships. Those most frequently identified concepts for Social Pedagogy included resilience, attachment and development of self-concepts and relationships. Figure 2 gives information on the complete set of responses from survey respondents.

Figure 2: Concepts regarded as important features by survey respondents



Interviews

Survey findings reflect the views of staff interviewed as part of the study. Interviewees talked about developing a different mindset about the behaviour and needs of young people, particularly those with challenging behaviour. Staff consistently said they felt better equipped to understand the behaviour of a young person and reasons behind it, instead of interpreting the behaviour as a personal attack directed at them. Staff also reported that they had found it helpful to understand children's developmental levels – which were sometimes significantly behind their actual age – and to tailor their expectations and activities accordingly.

5.3 Techniques considered most important

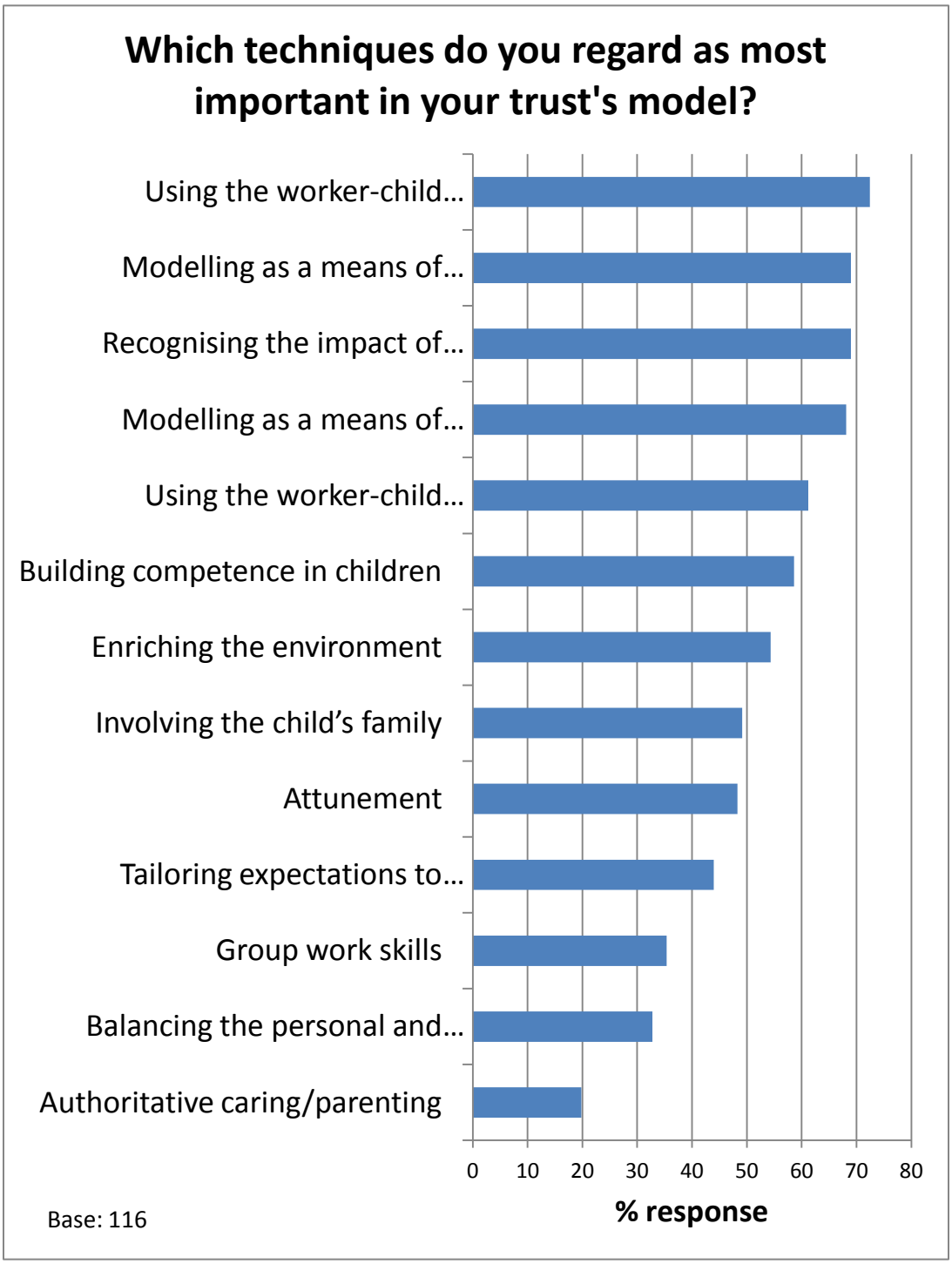
Interviews

Interviewees commented that the introduction of the models had improved consistency in the practice for both individuals and teams. They felt that staff were better equipped to deal with stressful situations, and that they now placed less emphasis on punishing challenging behaviour and more on negotiating with the young person, with positive overall effects. Staff said they better understood the importance – and consequences – of good social conduct as a way of helping young people change their behaviour and relationships. They also felt that integrating the language of the models into written reports and logs added to the consistency of practice in teams. Survey respondents observed that the putting the models into practice had resulted in a number of improvements.

Survey responses

Staff completing the survey were asked which technique associated with 'their' model was most important to them. Survey respondents across all models most often highlighted the worker-child relationship to provide opportunities for 'relearning' about relationships. Recognising the impact of trauma, and tailoring responses accordingly, was commonly reported as an important technique of ARC, CARE and Sanctuary. Modelling as a means of teaching children new skills was considered one of the more important techniques of MAP, Sanctuary and Social Pedagogy. Again, this is in line with the core components emphasised in each of the models. Figure 3 gives the response profile of those completing the survey.

Figure 3: Techniques considered important features of a model by respondents



5.4 Impact on practice

Interviews

Overall, the evidence from interviewees was that all of the models had improved practice in some significant way. This included changes in the way that staff view and respond to the children in their care, and in particular to challenging behaviour.

Interviewees also reported a positive culture change in homes, improved staff morale and confidence and increased job satisfaction (see the next section). Interviewees talked about a shift in perspective from managing – which often meant containing – behaviour, to a focus on trying to understand what children had been through and why they might be behaving in a particular way at a certain point in time. They also felt that the models better equipped them to deal with stressful situations, and that they now placed less emphasis on punishing challenging behaviour and more on negotiating with the young person, with positive overall effects.

This shift in thinking went hand in hand with a significant shift away from the use of punishment as a way to manage difficult behaviour. Respondents in all trusts commented on this issue. They attributed this change to the therapeutic approach they were using. The said the knowledge and skills they gained through training in the model they were using gave them alternative strategies to use. Respondents also commented on the fact that using the models had improved consistency in the practice of individuals and teams.

> *'I think it's had a positive effect. It's meant that everyone is singing from the same hymn sheet it has provided us with a more formal framework ... It can also create good structures in terms of supervisory processes ... I feel that it has created a more measured, more balanced way of working with your colleagues ...' (RCCW, CARE)*

Incidents became less 'personal' for staff. After training in a therapeutic approach, they were more likely to see difficult or self-defeating behaviour by the young person as an opportunity to work with them towards better self-awareness and self-management.

> *'It allows you to look behind the behaviour to see what's causing the problem with the young people, [I] feel Sanctuary enables you to do this no matter how short a time you have to work with the child.' RCCW-8 (Sanctuary)*

> *'If you are getting baffled or confused about where a kid is at or whatever to refer back to the framework helps you put it into perspective, so it gives you a good tool to work from as well and I think that has been helpful... it helps us to formulate better when young people are going through difficult times and understand it in a therapeutic context.' Home manager-12 (ARC)*

Interviewees said they better understood the importance – and consequences – of modelling good social conduct as a way of helping young people change their behaviour

and relationships. More subtly, many respondents commented on the ways the use of language had changed in the homes. Staff now talked about the home as a 'home' rather than – as previously – a 'unit'. As a result, some young people have also started to use these new terms.

> *'I would say there are big changes already as in people are more relaxed and less rigid and there is less anxiety about we have to control everything, I definitely feel that. We are noticing wee things, wee small changes for them are big changes for us like they are no longer frightened to ask for a piece of toast at 11.30pm at night. Even them having the freedom to go into the kitchen to get a snack or a drink without them having to ask one of us to unlock the kitchen is a big change for the better. Although I can understand the health and safety issues behind why the doors have always been locked but I think that it denies opportunities then to grow and develop.' RCCW-4 (Social Pedagogy)*

Table 6 gives a summary of how responses were patterned across particular models.

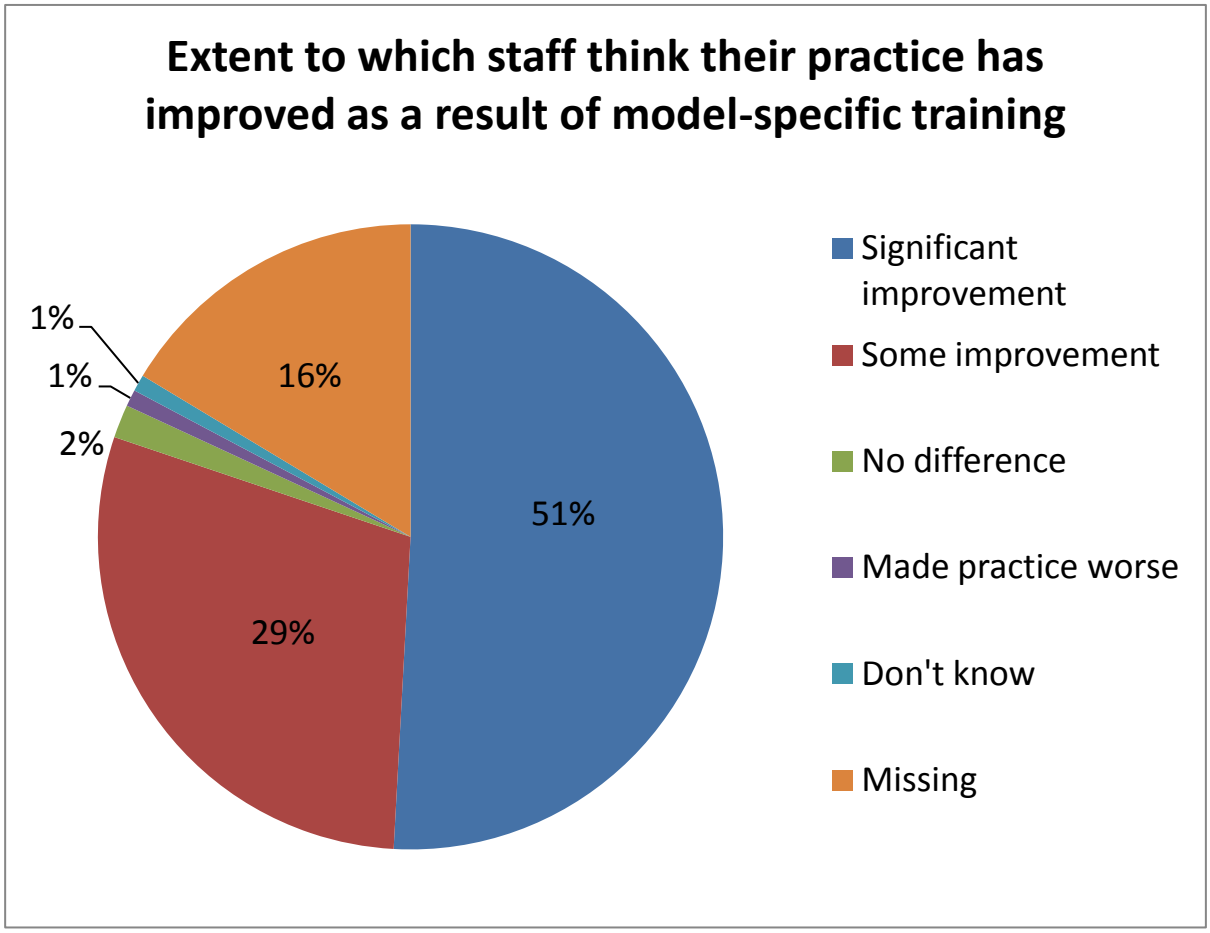
Table 6: Perceived changes to practice emphasised by those *interviewed*

Changes in practice	Sanctuary (SE)	CARE (N)	Social Pedagogy (B)	ARC (S)	MAP (W)
Ability to reflect and 'step back' from challenging situations	✓	✓	✓	✓	✓
Ability to understand a young person's behaviour and interpret 'pain-based' behaviour	✓	✓		✓	✓
Ability to tailor responses to young person's stage of development	✓			✓	
A reduction in aggressive incidents	✓	✓	✓	✓	✓
More relaxed/calm/more informal relationships with young people	✓	✓	✓	✓	✓
Better use of supervision	✓	✓		✓	
Increased contact with families		✓			✓

Survey responses

This picture of the impact on practice was reflected in the staff survey. Eight out of ten (80 per cent) of those who answered a question about the difference that training was making to their practice, said their practice had either shown some improvement or had improved significantly as a result of the model-specific training they had received. Only two respondents felt that the training had made no difference to their practice. And just one person reported that the training had a negative impact on their practice.

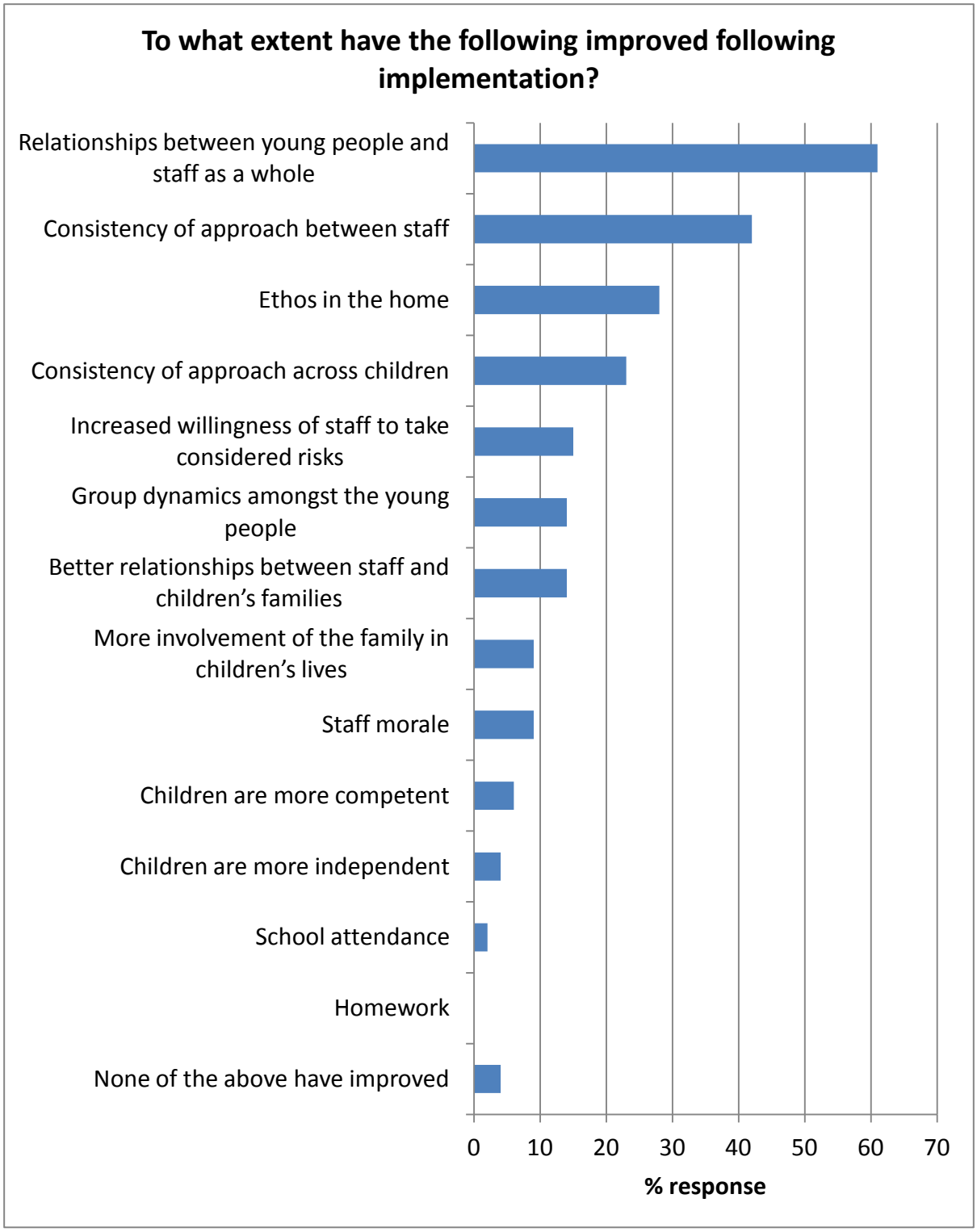
Figure 4 Improvements in practice following training



Base: 116

Survey respondents were asked what they thought had improved following the introduction of a therapeutic approach. Survey respondents reported that the greatest improvement has been in relationships between staff and young people, followed by consistency of approach taken by staff. Only two respondents thought that the implementation of a therapeutic model had resulted in improvements in school attendance, and none noticed an improvement in homework completion. Figure 5 summarises responses from the survey.

Figure 5 Perceptions of improvements following the implementation of a therapeutic model



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5.5 Impact on organisational culture within the home

Interviews

Most interviewees believed that introducing a therapeutic model had changed the culture in the home for the better. We have already discussed particular practice changes that contributed to this, or possibly followed from it (see previous section). However, interviewees highlighted a number of other aspects of organisational culture.

These included improved morale, a sense of being valued and a renewed sense of purpose and professionalism. Unqualified staff (Band 5) felt the model had given them a clearer sense of purpose, so that they now considered themselves more as equals to qualified social workers.

Staff understood that the models both required and enabled them to be more reflective in their practice. Achieving this was challenging, but it was accepted as important, and was taken seriously by most of the home managers interviewed.

> *'You can look at people's practice and feel that you're being fair if you're saying that someone perhaps is being too authoritarian with the child. You should be concentrating on more therapeutic approaches … it can create a more balanced way of working with your colleagues.' RCCW-11 (CARE)*

The shared understanding of the professional task seemed to give staff a common language, which itself facilitated reflection and shared learning. These opportunities for reflection served a number of purposes, including time to 'digest' the new ways of working and incorporate them in practice, and to monitor strengths and weaknesses in the practical application of the model and adjust accordingly.

A number of respondents also said that the models seemed to have shifted their perceptions of families, to focus on increased contact between young people and their families. This is an explicit aim of the CARE model.

> *'I like it because you sort of have to know the children better; you have to get to know them on a different level... it's totally different, our relationships with our young people's families are totally different. And I attribute that to MAP.' RCCW-30 (MAP)*

Survey responses

Survey respondents were asked to show the extent of any improvements in a number of areas relevant to organisational culture. Table 7 summarises the responses. The areas thought to have shown the highest improvement included reflective practice, tolerance levels of staff and confidence in roles, with more than two thirds of staff in each case reporting that these had improved a lot or slightly.

Table 7: Key areas of improvement (percentages in brackets – based on those who answered question only)

	Improved a lot	Improved slightly	Stayed the same	Got worse	Don't know	MISSING
Your reflective practice	39 (40)	39 (40)	19 (20)	0	0	19
Tolerance levels of staff	32 (34)	36 (38)	22 (23)	3 (3)	2 (2)	21
Your confidence in your role	31 (33)	39 (41)	22 (23)	3 (3)	0	21
Consistency in your practice	29 (30)	44 (46)	22 (23)	1 (1)	0	20
Your ability to avoid conflict	24 (25)	53 (55)	17 (18)	1 (1)	1 (1)	20
Staff communication	26 (27)	43 (44)	24 (29)	3 (3)	1 (1)	19
Staff morale	24 (26)	38 (40)	25 (27)	5 (5)	2 (2)	22
Feeling of being in control	18 (19)	33 (35)	31 (33)	9 (10)	4 (4)	21
Staff safety at work	16 (18)	24 (26)	44 (48)	6 (7)	1 (1)	25
Young people's willingness to form relationships	19 (20)	51 (53)	24 (25)	3 (3)	0	19
Young people's confidence	17 (18)	52 (54)	23 (24)	2 (2)	2 (2)	20
Feeling of being valued	16 (17)	43 (45)	28 (29)	7 (7)	2 (2)	20
Behaviour of young people in general	15 (16)	47 (50)	26 (28)	5 (5)	2 (2)	21

5.6 Perceived limitations of the models

During interviews, staff in all of the trusts pointed to some limitations of the model they had been trained to use.

Despite considerable enthusiasm for the models, staff thought that no single model covered the entire range of behaviours or situations that they faced in their day-to-day practice. Some felt that particular models were not suited to some groups of young people with particular difficulties. For example, staff often said that their model – whatever it was – did not give them the tools to deal with physically aggressive behaviour. They also said that the models were more difficult to put into practice in the short-term, as staff did not have enough time to work with the young people.

All of the homes in this study were also practicing either Restorative Practice or Therapeutic Crisis Intervention, or both, alongside their chosen models. Respondents felt that using the best aspects of each practice equipped them with the best tools to deal with any given situation. Almost all respondents felt that these approaches

complemented their chosen models to some degree. Some staff said the models had similar aims, such as attempting to reduce the instances of potential outbursts, learning constructive ways to handle situations, and encouraging the young person to become more involved with decision-making and resolving their own situations.

Respondents expressed concerned about applying any of the models to all children. Almost all those interviewed in the Northern Trust said that the CARE model was not suitable for use with young people suffering from behavioural or learning difficulties such as Autistic Spectrum Disorders (ASD) or Attention Deficit Hyperactivity Disorder (ADHD). Some staff members thought these young people would benefit more from a behavioural intervention. Choosing the best approach for children at different ages was a recurring concern. For example, a significant number of respondents using CARE thought that it was most suitable for a younger age group, as they thought they were more open to forming relationships with staff. A small number of people from the Belfast Trust said they had to identify age-appropriate techniques to successfully implement social pedagogy.

Incorporating other interventions as part of an overall model – for example, to help staff manage very challenging behaviour – is probably uncontroversial. We should however carefully consider staff concerns about the relevance of these models to certain children, such as those with intellectual impairment or ADHD.

5.7 Summary

The results of the survey were consistent with the findings from interviews with home managers and residential care staff. Despite some specific reservations, the evidence from those taking part was generally that all of the models had improved practice in some significant way. These improvements included bringing about positive culture change in homes, improving staff morale and confidence, and bringing about changes in the way that staff view and respond to the children in their care, and in particular to challenging behaviour. Staff also reported increases in job satisfaction.

By refocusing their work onto the emotional wellbeing of children and young people, all five models reminded staff of their original reasons for working in residential care – often in challenging organisational contexts – namely, to help young people who have had troubled lives and experienced considerable trauma. The theories supporting the approaches used gave staff a better understanding of how those earlier experiences negatively affected young people in the ‘here and now’ – emotionally, psychologically and behaviourally. The theories that helped them better understand this also allowed them to respond more constructively, to avoid conflict whenever possible, and to ‘depersonalise’ challenging behaviour.

Most interviewees said these benefits came from a mixture of the model itself and the training they had received, which had resulted in a shared approach in homes and, in some cases, across the trust. They thought the models complemented other approaches used across the trust, including Therapeutic Crisis Intervention and Restorative Practice.

6. Impact on young people

This chapter looks at the evidence of the effect on young people. It draws on interviews conducted with 29 young people in homes where a therapeutic approach had been implemented. At the start of the study we had hoped to interview young people who had lived through the introduction of a therapeutic approach, and to look at the differences they had seen, for example in the way the home was run, how staff behaved, and so on. However, by the time the interviews took place in the first half of 2011, most young people would only have known the home under its new regime, so there were few opportunities to compare young people's experiences before and after the introduction of a therapeutic model.

6.1 Young people's awareness of the approaches being used

Only respondents from the Belfast Trust (Social Pedagogy) and the South Eastern Trust (Sanctuary) knew that a named therapeutic approach was being used in their home. This is not necessarily a bad thing. The Therapeutic Approaches Steering Group was clear that it is not usual to let young people know of any changes to staff training or approaches used. They did not think this was necessary for the models to be effective. However, the limited awareness of the young people does affect their ability to comment on the models specifically.

In the South Eastern Trust, a few of the young people interviewed were living in one of Northern Ireland's regional secure units. Others were living in residential care homes throughout the trust. Most had heard the term 'Sanctuary' but knew little or nothing about it. One young person was, however, able to give a brief description.

> *'Yeah, like about the SELF model – and safety, emotions, loss or future and how like, it's like to help young people with things that have happened to talk and how you have got like a safety plan to keep you safe whenever you're angry or whatever and psycho ed and that.' YP-19 Sanctuary*

Psycho-education is the term used in the Sanctuary model to describe a group-based curriculum designed to familiarise young people – and staff – with the psychobiological effects of serious, recurrent and chronic stress. The rationale is that by understanding these processes, you can become more aware of how events effect behaviour – including your own – and can therefore better understand and deal with it. It was the most commonly identified component of the Sanctuary model. However one young person's response shows that we need to be careful with the 'jargon' used in such settings:

> *'Psycho-education is a stupid word for it because we aren't "psycho" if you know what I mean.' YP-17 Sanctuary*

For this young person, the term 'psycho' had a rather different meaning than the one intended, and one that was highly stigmatised.

None of the young people interviewed in residential settings in the remaining trusts had heard of the therapeutic models used in their home apart from a few respondents in the Belfast Trust who also had only heard of the term but did not know what it meant.

6.2 Perceived changes in the home

Around half the young people interviewed had noticed no changes in the running of their home but, as stated above, this was mainly because most had been in their current residential setting for less than a year. Most of those who had been in the same home for more than a year said they felt that staff were more relaxed and that they had noticed a general improvement in the atmosphere.

> *'Staff members seem more friendly or something now, they can have a bit of craic with us now which improves the mood of the house in general ...' YP-7 Social Pedagogy*

A small number also said that planned admissions were another change for the better as residents were able to get to know the new person and vice versa before they moved in. One young person said that the length of time someone was removed from the group because of bad behaviour had reduced.

> *'You don't get kept out of the groups as long for doing something wrong. We only get kept out of the group for, like, an hour – just to calm us down – then back in again.' YP-13 Sanctuary*

Another young person from a secure unit that used Sanctuary explained that the existence and frequency of community meetings was a big change, as these can be held up to three times a day.

> *'Sometimes it's really boring like ... We do it three times a day... We do it like in the morning, and like afternoon like after lunch and then do it again just before night. Sometimes... if nobody wants to do it then they can go and talk to the staff after.' YP-21 Sanctuary*

This same young person also explained that there was now a points system in place. Staff mark young people around the clock and award points according to behaviour and achievements. The goals are linked to the Sanctuary commitments and positively reinforce the use of the model in the unit. These are awarded on a weekly basis and determine, amongst other things, what time a young person goes to bed.

A large number of respondents across the trusts said that there was less emphasis on punishing challenging behaviour. The majority agreed that the new approach was more effective. This was a strong point of agreement between staff and young people, with the exception of young people in the secure unit (who still received punishments such as early bedtime).

When asked, almost all young people said that they did not think punishments stopped them from repeating the same behaviour again. A small number of young people also reported some undesirable changes. For example, one young person in the Northern Trust (CARE) felt that, as a whole, residents were unfairly treated in the home.

> *'Most of them don't go to school, but if they go to school they'll get top ups, they'll get this, they'll get that, but yet the ones that go to school don't get anything for it. Like <YP> goes to school every day and doesn't get anything. She couldn't even get a £10 top up for her dongle to do her course work, but yet there's people getting phone top ups, like going out for meals and getting their nails done and that, just for going to school because they refuse to go ... like in my other care home people aren't allowed electric appliances in their room unless they go to school ... So basically the people that are lying in to whatever time they want, getting up, getting ready, blasting their music until whatever time they want and going out and then maybe they'll come back like late on at night or not come back at all but then they don't get punished. Like there was girls in here that ran away for four days and came back and went out the next night ... With staff like as a treat, it was like well maybe I'll run away for four days and see what I get ... But we wouldn't get anything so.' YP-5 CARE*

It is a good principle to reinforce (rewarded) appropriate behaviour rather than punish inappropriate behaviour, and there is sound evidence to support this. However, for any system to succeed it needs to be fair and to be seen to be fair. It is possible to have systems in place that reward individual children for different things as long as you explain the reasons behind it, and involve them in agreeing rewards. In the above case, the problem might have been a lack of understanding by this particular young person. However, it might reveal a more fundamental issue about the organisation – of using reinforcement (rewards) as a motivational technique.

6.3 Experiences of living in residential care

There was a mix of young people's initial impressions of residential care, but these were not vary significantly according to gender or age. Around half said that their first impressions of their current residential care home had been positive. Factors that made a positive experience included having day visits to the home before moving in and, for some, having lived in another residential unit before.

Around half the young people interviewed said they felt frightened at first and worried about living in residential care. They said this was mainly because they did not know any of the other residents in the home and had not been in a residential setting before. On average respondents said it took approximately one month for them to settle into their new surroundings, and around two-thirds were now satisfied with where they were living.

All those interviewed from the two secure units remembered feeling scared when arriving at secure accommodation for the first time. However, for the majority interviewed, this was not their first time, and most described feeling more at ease and satisfied with their experience this time round. In fact, a significant number wanted to stay instead of moving back to their previous residential setting. A common explanation for this was that they felt safe there.

> *'No one likes being locked up ... like them windows only open a certain amount, do you know what I mean. Them doors are mahogany, you can't kick them through. There is nothing to throw apart from a china cup. And everywhere is locked. 10 o'clock is lockdown ... it's not good like but ... I love it, I don't want to leave ... I like having boundaries, like stuff you can do and stuff you can't do. I'm going to come back. I'm going to get out soon, come back in January, get out in June, come back in January, get out in June ... I love it here ... I suppose yeah it's because I feel safe here.' YP-20 Sanctuary*

Almost all young people said that they would recommend their current residential home to someone who could not live with their parents for a particular reason. Indeed, young people often commented on the value of residential care, and the difference it had made to them. This may be because of the therapeutic approaches now in use, but it is not possible to say from this study.

6.4 Perceptions of care staff

All of the young people in the five trusts said that, in general, they got on well with staff and found them helpful when discussing issues:

> *'They helped me with my past and they help me with all my plans for the future.' YP-10 ARC*

In particular, young people enjoyed spending time with staff. A small number specifically described how they found the staff approachable and easy to talk to:

> *'They are friendly and they just come in and they don't have that, I don't know the way to put it, stuck up social workers if you know what I mean ... You know, they are human beings – they are civil like, that way, and I wouldn't like someone coming in and being like a robot, do you know that sort of way.' YP-11 MAP*

> *'See in secure – they aren't those kind of social workers that read things off a book – most of them has had experiences. You can tell like if someone's had experience or not just by the way they get on with you – they have open thoughts.' YP-16 Sanctuary*

Most felt that they got on better with some members of staff more than others. A small number had issues with particular members of staff and felt that they could be more helpful. A few described how they sometimes felt that staff continued to have a conversation with them when they would rather have some time alone, and another young person described feeling frustrated when staff ignored him when he was angry.

In general, young people felt that the best way to build and maintain a relationship with staff was to spend one-to one time with workers – particularly after first moving in – to build trust and get to know one another better. Most felt that one-to-one interaction with staff was much more productive than socialising as a group, as a significant number did not feel comfortable in groups:

> *'I'm not really good in a group. I would be the paranoid one in the group. I would be, we are all paranoid but I'm more paranoid. It's good one-to-one though.' YP-21 Sanctuary*

Although only one young person said they disliked groups, this respondent highlighted an important issue. Homes where group meetings are part of the therapeutic process might need to look at how they present this to potential residents, so that young people can decide whether or not it is 'for them'. This is also an issue for placement panels and other decision makers. It raises the more general point of how open staff should be about the approach taken to care for young people, and how much say should young people have in decisions about placement.

6.5 Positive and negative aspects of residential living

Young people thought the nicest thing about their care home experience was the staff, who they described as approachable and easy to talk to. Almost all said that their stay in their current residential setting had helped them to deal with their emotions and past issues. Around half of the young people living in homes other than the secure unit, thought that having freedom and independence was a positive aspect of where they lived. They particularly liked being allowed to go most places whenever they wanted and staying overnight with family members. Other aspects that were particularly valued by individual young people included having your privacy respected, feeling like you belonged in the home, and feeling that the home was '*like living with my family*'. Most felt that their stay in the home had helped them to become more settled and sort out their problems.

Life in residential care was not without its problems, though. One young person did not like LAC reviews being held in the unit, as they did not feel that this helped to create a homely environment. A large number of respondents across all five trusts described incidents of intimidation and bullying by other young people in their living environment.

> *'You want to put up a big front to protect yourself and I understand all that, because you're in a new environment with rockets during the night. You have people in here who are absolute rockets and you need to find some kind of protection, so walking with your fists clenched and walking pure stiff, that's for protection.' YP-20 Sanctuary*

6.6 Young people's suggestions for improvement

When asked what changes they would like to see, respondents had a number of suggestions for improvements. Not surprisingly, the young person who had commented on what they saw as inconsistent treatment of young people by staff, said that all young people should be treated equally. A small number highlighted how frustrating it was for them to always have to ask to get a door unlocked. They suggested that as many doors

were left unlocked as possible to make their environment feel more homely. This was not only the case for those living in secure units, but was a common complaint from the majority of young people throughout all of the trusts.

> *'The doors would be allowed to be open ... See all them locked doors, I can't ... It's just having to wait until the staff open us all the doors and you're like, oh Jesus Christ … Really bores you like. Be better if staff like treated everybody the same because they do sometimes treat everybody really differently.' YP-21 Sanctuary*

One older resident felt that there should be more emphasis on preparing young people for moving out.

In the secure unit, the majority of young people said that they should get rid of all punishments. One young person suggested that if they misbehave they should have a Life Space interview[6] with a member of staff. In addition, more than half of those interviewed in the secure units felt that a more gradual reintegration back into society would be more beneficial to them.

> *'It's better them ones gradually letting me out rather than when I do get out I'm going to be in the deep end do you know what I mean ... because when you get out you just start drinking again.' YP-20 Sanctuary*

6.7 Summary

All in all, young people were positive about their experiences in care, and those who had been in other care homes felt that their present setting was better. Relationships with staff were clearly highly valued. It is not possible to say whether this was a result of maturity, or a consequence (direct or indirect) of the therapeutic approaches now in use. However, many of their views were reflected by staff, for example in relation to the use of punishments and the general atmosphere in the home. There was little evidence in the interviews to suggest that the models were having a negative impact, with the exception of a sense of unfairness by one young person about the use of rewards in a home.

[6] The Life Space Interview was originally designed as a technique for educational settings, and is now included in the Therapeutic Crisis Intervention system developed by Cornell University, who also franchise CARE. It has been described as 'emotional first aid on the spot' and is designed to help calm a young person and resolve a problem quickly.

7. Indications of effectiveness

The original proposal had been to compare the experiences of staff and young people in homes that had been trained – using a prospective comparative design – with those who had not. It took almost a year to get approval from the five trusts to take part. This meant that by the time we were in a position to gather data from participants, we had effectively lost the comparison homes, as training had been rolled out to staff during this period. Together with the nature of the data (essentially based on self-report), this seriously weakened our ability to confidently report changes on the introduction of the training. This left us with only one source of 'longitudinal' evidence: administrative data gathered from monthly monitoring reports that the trusts have to provide to the HSCB.

These reports give data across a range of aspects of life in a residential care setting, from numbers of staff, to numbers of serious incidents and how these were handled. We might reasonably consider the changes over time of some aspects to show the effect of introducing a therapeutic approach on the practice of staff, changes in young people's behaviour and staff-resident relationships. Qualitative data from interviews shows that staff believe introducing a therapeutic approach has a positive effect on the amount and serious nature of incidents in homes. Data on the number of Untoward Events and Notifications – per schedule 5 – was therefore gathered from the monthly monitoring reports. This data has its own problems (see below), but it less subjective than the views of staff who have invested their time and energy in a particular approach. This chapter gives an account of this aspect of the study, and its findings. For a full list of selected indicators see Appendix 1.

7.1 Sampling

Of the 33 residential children's homes across the region, administrative data were collected from a sample of 18 homes (55 per cent). A sample was selected because the data in the monthly monitoring reports was not created electronically, and the research team had to source the reports from each trust and manually extract the data.

Data were collected at both a trust and 'study home' level. A stratified random sampling strategy was used to select homes to ensure equal representation from each Trust. Trained homes were randomly sampled from each trust, along with untrained homes, where these were available. We compared the performance of trained versus untrained homes in those trusts where it was possible to get data from untrained homes for some of the 18 month period September 2009–March 2011 (Belfast, Western and Southern). For trusts where there were no untrained homes (South Eastern and Northern) we compared performance before and after training over a longer period (24 months, March 2009–March 2011). Appendix 2 provides detailed information on the sampling frame.

All comparisons in this study are referred to as 'before' and 'after' training, even though there was no training in some homes during the study period. Table 8 shows the total observation time before and after (or with and without) training. For trusts without control homes, the 'post training' period is much greater than the 'before-training' period. For others the balance was more even, and in some cases there were more 'before training' observation points before than after. Factors that are beyond the control

of this study – relating to observation time – may influence the results. For example, there are likely to be fewer new entrants to a home during a nine-month period than during a 57-month period. A new entrant (which we cannot control for in this study) may greatly increase the rate of certain incidents in a home. Our analysis models the risk of incidents independently of the length of follow up time. However, it cannot account for changes occurring over time such as new entrants.

Table 8: Number of months that homes were observed pre- and post- training by trust

Trust	Observation in months					
	Before training			After training		
	Never trained[1]	Pre-training	Total	Always trained[2]	Post-training	Total
South Eastern	~	9	9	~	57	57
Southern	38	5	43	~	33	33
Western	19	~	19	~	57	57
Northern	~	25	25	50	~	50
Belfast	19	14	33	38	5	43
Total	76	53	120	88	152	183

[1] Not trained during the data collection period

[2] Received training prior to the data collection period

7.2 Limitations

There are several limitations to these analyses. The low number of events in any given month (e.g. challenging behaviour), the low number of homes in each trust, the limited time frame of data collection, and differences in the way that data is collected makes it very difficult to detect genuine changes that are an effect of the training. From the reports, it is not always possible to identify which individuals were responsible for which incidents. Some records did note that one or two individuals were repeatedly responsible for taking part in – and recording – particular incidents. However, without having this information for all individuals in all homes, we cannot assess the effect of staff training on reducing the unruly behaviour of these individuals. Similarly, there was no way to assess the movement of children between homes and across homes serving different purposes (e.g. assessment, medium- to long-term and secure units). Therefore it is not possible to see the difference between reduced incident rates due to the training of staff, and reduced incident rates due to a young person leaving a home. Other variables include, but are not limited to: the experience, qualifications, post-qualification training of staff, stability of the staff group, the quality of leadership, culture in the home, and the home's track record with challenging children.

In particular, the analysis of how incidents were dealt with differently before and after training was based on very few incidents. Because of the low numbers, it was also not possible to look at changes in the trusts.

7.3 Handling of incidents

Serious or untoward incidents are important. Not only do they cause distress to young people and staff, but they can result in a series of events that make problems worse for young people. This includes further trauma and potential criminalisation. For example, if staff are unable to manage an incident in the home, they may involve the police – who may bring charges or remove a young person into custody – or seek a move to secure accommodation. While incident occurrence is an appropriate way to measure how young people have responded to the therapeutic approach used in a home, the *way* that incidents are dealt with is also important.

Arguably staff response, as a measure, is less sensitive to the 'incomplete' before-after design of the present study. Analysing staff responses allows us to compare current management styles across homes where (or when) staff have not been trained to the management styles of homes where (when) staff have received training, even when we are not directly seeing the *effect* of that training.

The monthly reports show how incidents were dealt with – these were grouped in the following way: those dealt with by staff alone, and those where staff involved external services. All criminal incidents involved the police, so are not reported. Because of low numbers, one incident – where the police had been involved with a young person abusing prescription drugs – was included as an incident where the health services were contacted. This occurred in a home before training.

Table 9 shows how each incident was handled, comparing before and after staff received training. Statistical tests gave no clue that – for most types of incident – the method of management differed before and after homes received training. The two exceptions were incidents of substance abuse by a young person (significant at better than the standard 5 per cent cut point) and suicide attempts (significant at a more tentative 6 per cent level). For substance abuse, the health service was contacted for 57 per cent of incidents before training, compared to 25 per cent of incidents after training. Police were contacted for substance abuse roughly equally before (24) and after (21) training; however, staff handled incidents in the home only 19 per cent of the time before training, compared to 54 per cent of the time after training. The response to suicide attempts follows a similar pattern: staff-managed strategies increased from 15 per cent before training to 55 per cent after training.

The general conclusion from the data seems to be that – for both substance abuse and suicide attempts – homes with trained staff were more inclined to use staff-managed strategies than homes where the staff had not received training in a therapeutic model. However, across other incidents recorded, and at the level of detail recorded, there were no noticeable differences in response (see Appendix 4).

Table 9: Methods for handling incidents before and after training; (percentages in paretheses)

Incidents			
	Before training	**After training**	**p value Chi^2 test$^+$**
Physical aggression			0.47 (exact)
Staff-managed	9 (75)	12 (60)	
Police involved	3 (25)	8 (40)	
Damage to home			0.53
Staff-managed	9 (35)	19 (42)	
Police involved	17 (65)	26 (58)	
Assault on staff			0.91
Staff-managed	13 (59)	17 (61)	
Police involved	9 (41)	11 (39)	
Self harm			0.81
Staff-managed	4 (29)	6 (25)	
Health service involved	10 (71)	18 (75)	
Suicide attempt			0.06 (exact)
Staff-managed	2 (15)	17 (55)	
Health service involved	11 (85)	14 (45)	
Missing less than 24 hours			0.81
Staff-managed	9 (26)	19 (28)	
Police involved	26 (74)	49 (72)	
Abusing prescription drugs			~
Staff-managed	4 (80)	5(100)	
Police/Health service involved	1 (20)	0 (0)	
Threatened staff			1.00 (exact)
Staff-managed	1 (25)	1 (20)	
Police involved	3 (75)	4 (80)	
Threatened young person			1.00 (exact)
Staff-managed	2 (50)	3 (33)	
Police involved	2 (50)	6 (67)	
Assault on young person			1.00 (exact)
Staff-managed	8 (62)	13 (59)	

Police involved	5 (38)	9 (41)	
Substance abuse			**0.03 (exact)**
Police involved	5 (24)	6 (21)	
Health service involved	12 (57)	7 (25)	
Staff-managed	4 (19)	15 (54)	
Absconding			0.34
Staff-managed	13 (29)	12 (21)	
Police involved	32 (71)	46 (79)	

[+] Fisher's exact test rather than Chi^2 where noted

6.4 Further analyses

The above analysis comparing months 'before' and 'after' training yielded some useful insights. However, it remains important to attempt a more formal evaluation controlling for the common characteristics shared by any month from a given home, and for the variations in the residents of each home across months. We therefore modelled the data using multilevel logistic regression to further investigate the impact of the approaches.

7.4.1 Statistical approach

Several alternative statistical approaches were applied to the data before deciding on a final method. Since the number of incidents – or more strictly speaking, the number of incidents controlling for size of home – could claim to be an intensity-sensitive measure of outcome, Poisson regression, and zero inflated Poisson regression models were fitted to assess how training affected the number of incidents occurring per month. Though these models gave results broadly similar to the method finally chosen, it was decided that they were poorly specified, as the number of times that incidents happened more often than once per month was low. There was also no indication of which resident was responsible for an incident; one resident could have been behind several incidents in one month.

In contrast, fitting models that look at 'any' versus 'no' incidents occurring each month allows for robust modelling of variance in occurrence of incidents, without the drawback of only having a few incidents to assess variation in the frequency of events. Modelling binary data also reduces any misspecification due to a single individual contributing to many of the incidents in a home.

Accordingly, the data on incidents per month was collapsed into binary (no incident vs. any incident) variables. Multilevel logistic regression models, clustering by residential home, were used to assess if the occurrence of incidents differed between homes before and after training was received, after accounting for variation in rates of incidents between trusts. The first set of models assessed if there was any difference across all homes combined. The second set of models looked at each trust individually (Appendix 5). All of the regressions controlled for *size* of home in addition to the reported variables, so the results can be read as effects net of size.

Table 10: Odds ratios showing the shift in the odds of incidents occurring in homes after training compared to before training

Reported behaviour	Odds Ratio (95% CI)	Variation between homes
Physical aggression	0.67 (0.23,2.02)	0.19**
Damage to home	0.82 (0.37, 1.81)	0.25***
Assault on staff	0.49 (0.20, 0.91)*	0.00
Self harm	0.51 (0.18, 1.46)	0.29***
Suicide attempt	1.37 (0.59, 3.19)	0.07
Missing less than 24 hours	1.77 (0.76, 4.16)	0.45***
Abusing prescription drugs	0.48 (0.12, 1.93)	0.00
Threats to staff	0.75 (0.21, 2.71)	0.00
Threatened young person	0.89 (0.25, 3.14)	0.00
Assault on young person	0.58 (0.19, 1.73)	0.49***
Drug use	0.75 (0.29, 1.94)	0.33***
Criminal activity	0.44 (0.16, 1.23)	0.07
Absconding	0.55 (0.30, 1.02)+	0.07*
Complaints	1.18 (0.54, 2.62)	0.01

+ p <0.1; * p<0.05; ** p<0.01; *** P<0.001

7.4.2 Odds of incidents before and after training in all trusts

Table 10 shows the shift in the odds of incidents occurring before and after training, by reporting the odds-ratio – namely the after/before ratio between the two odds of a particular incident. An odds-ratio of unity would show no difference, an odds-ratio of 2 would say that the odds of a particular incident had doubled, and an odds-ratio of 0.5 would say that the odds of that incident had halved. The table also records the amount of variation between homes in terms of likelihood of incidents.

Looking at all homes combined, it seems that after training, the odds of staff being assaulted was 51 per cent lower than odds of assault before training took place (OR 0.49, 95 per cent CI 0.20, 0.91). There was also some evidence, at a 10 per cent significance level, suggesting the odds of absconding were 45 per cent lower than those before training (OR 0.55). For the remaining events (assaults on staff, attempted suicide, prescription drug abuse, threatening staff or young people, criminal activity or

complaints against the home) this analysis saw no significant difference between 'trained' and 'untrained' homes in the odds of their occurrence. This type of analyses should be read as having no evidence for an effect, *not* as evidence for there not being an effect. Notice that for several characteristics, there were large variations between homes, ranging from 7 per cent of the variation in absconding rates being between homes, up to 49 per cent of the variation in assaults on other young people due to variation between homes.

7.4.3 Odds of incidents before and after training in individual trusts

Since there is reason to see different trusts as having different management and implementation structures, the analysis reported in Table 10 was replicated for each trust separately (see Appendix 4). However, there were striking variations even within each trust (see Appendix 5) in incidents between homes, and we are not able to investigate whether these were driven by differences in staff teams or the characteristics of the young people living in the homes.

South Eastern Trust

In the South Eastern Trust, data was collected from March 2009, and all homes were trained from September 2009 (so the study period 'before training' is shorter than the 'after training' period). As with the overall model, there seemed to be a reduction in assaults on staff after training. There was a somewhat puzzling, tenfold increase in the odds of 'short term missingness' after training. This may reflect the fact that the South Eastern Trust manages two Intensive Support Units for young people with particularly complex needs and/or challenging behaviours. These units take referrals from both the South Eastern and Belfast Trusts., and the young people are referred due to particularly complex needs and/or challenging behaviours.

Southern Trust

In the Southern Trust there were fewer incidents reported, and in some homes there were no incidents of a particular category in the 'before' or 'after' group, making it impossible to fit a meaningful regression model for these incidents. For the models that were run, there were no signs of significant variation in the odds of incidents.

Western Trust

In the Western Trust, odds of assaults on staff showed some reduction for the 'after training' homes, with a 92 per cent reduction in odds, though with only a 10 per cent significance level. Again, at this relaxed significance level, there were hints of a 71 per cent reduction in the odds of absconding.

Northern Trust

For the Northern Trust the low numbers made it difficult to fit some models. Where models were fitted, there was no evidence of change before and after training.

Belfast Trust

In the Belfast Trust, the models showed clear evidence for reduced odds of 'missingness', with an estimated 92 per cent reduction in the odds. If again we consider the more relaxed 10 per cent significance level, to locate indicative findings, we have some additional evidence for a reduction in the odds of drug use (by 76 per cent), of absconding (by 82 per cent) and complaints (by 93 per cent).

7.5 Summary

Given the pattern of training across homes in and across trusts, the research team was faced with a very limited – and rather complex – set of data from the monthly monitoring reports. We have therefore been cautious in our approach, both in analysis and interpretation. Little can be said with any degree of certainty. However, there is evidence to support the views of staff that training in a therapeutic approach had brought about some changes in the numbers of incidents within homes and in how staff approached these, and that incidents resulting in assaults on staff also diminished. That said, there is a huge variation across homes and the available data cannot sustain a rigorous explanation of these. The analysis of practice in residential children's homes – and outcomes for the young people in those homes – would be greatly strengthened with the standardisation of incident reporting across trusts and homes. It would also help to link information on incidents within the home to individuals e.g. via SOSCARE[7] records or Health and Care Number.

[7] Social Services Client Administration and Retrieval Environment data

8. A therapeutic approach to social work in residential child care – does it make a difference?

8.1 Building the evidence base

This study was commissioned by SCIE in May 2010. SCIE had discussed the then new initiative to improve practice in residential care by introducing a therapeutic approach to children's residential care with the Department of Health, Social Services and Public Safety (DHSSPS). The DHSSPS was interested in any differences these approaches might make, and the implications for a future training strategy for residential social work for looked-after children.

Not unusually, the proposed study found itself playing 'catch up' with the realities of practice. The trusts began to roll-out training in the new ways of working while the study design was being finalised and agreed, contracts issued, ethical approval obtained and trust governance arrangements put in place. By the time the study was 'ready to roll', the planned comparison group of homes had almost disappeared. This is a fact of applied research, but it has resulted in a less definitive study than it might otherwise have been. This is not only a disadvantage for researchers – but more importantly – for policy makers and practitioners.

If we know that the intervention we are making is effective and beneficial then we would not need research. But the history of social work research shows that the best trained, best supported and best-intentioned staff can sometimes make things worse for people using services. Building an evidence-base therefore requires us to understand that no matter how much we believe what we are doing is beneficial, we do not know that to be true without rigorous, independent evaluation. The scoping review showed that there is a sparse evidence-base for some of the models that have been introduced, and for others, none. There is evidence of enthusiasm, commitment and a sense of achievement in the literature, publicity materials, and in the responses of the staff in Northern Ireland who were using them. These qualities are probably essential to effective working in a challenging context, but the important question is whether they are enough? Unfortunately, this study is not able to answer this, and this is a lost opportunity for making a significant contribution to an important area of practice with a very vulnerable group of children and young people.

That said, this exploratory study does give evidence of the potential benefits of equipping staff with a systematic way of thinking about their work with children and young people who are looked-after. In this final chapter we summarise the most important issues that have emerged from the work.

8.2 Putting the 'therapeutic' back into residential social work

Children and young people in residential care have – almost without exception – had very troubled pasts. The majority of looked-after children are removed from the care of their birth parents because of physical abuse, neglect, emotional abuse and sexual abuse. Most have experienced more than one form of maltreatment, often over many years. Some young people find themselves in residential care after a series of

placements with foster carers – and sometimes other residential care homes – have broken down. Those working in residential care have to help minimise the damaging consequences of such traumatic pasts. Amongst other things, they need to help young people overcome their difficulties, regain or develop a sense of self-worth and self-efficacy, and help them to develop the skills and competence to negotiate and maintain interpersonal relationships and other adult roles. It is no easy task. Arguably, it is not something that can (or should) be done 'intuitively'. It is in this broader sense that residential care is inherently therapeutic – or should be.

Some – perhaps most – children who are in residential care will need specialist help from experts trained in therapeutic interventions such as trauma-focused cognitive-behavioural therapy, counselling and so on. One of the debates among senior managers in this study has been whether the term 'therapeutic approaches' is appropriate:

- Does it imply a level of skill that mainstream social workers do not have, unless they have undertaken additional training?
- Could it lead to a confusion of roles and loss of accountability?
- Does it downplay the expertise of those – like clinical psychologists – who have a set of clearly recognised and proven skills?

None of the participants in this study seemed to see themselves as 'therapists' in this sense. They were well aware of their connectedness with other services, such as CAMHS, and the need for specialist help for individual children. However, it was equally clear that their training in each of the five models allowed them to *think* more clearly and more strategically about their work, and respond more appropriately to the challenges they faced on a day-to-day basis.

Residential social work staff believed that the training they received better equipped them to 'make sense' of children's apparently self-destructive or self-defeating behaviour. For example:

- training about the impact of trauma – particularly maltreatment – on children's self-perception and their abilities to form and maintain relationships
- training on the importance of attachment, and the impact of disrupted or disordered attachment relationships.

This allowed them to be more analytic in their assessment of why children were behaving or reacting as they did, and to respond in ways that were more likely to help children develop self-regulation, problem-solving and adaptive life skills. Residential social workers said that training helped them to better understand how children's behaviour affected them. Some might call this counter-transference. They also thought that the organisational systems they worked in could easily become part of the problem rather than the solution. Taken as a whole, they believed that this allowed them to reduce conflict and confrontation.

It is in this broad sense that residential social work is – or should be – 'therapeutic'. Residential care staff are *carers*. Children look to their carers to nurture and support them. They look to them to help overcome odds that have often and increasingly

become stacked against them. One to one therapy is important, as are other services such as mentoring, personal advisors, and so on. Some children need – and want – protected space to reflect on issues in their lives and develop particular skills for dealing with – for example – trauma. But more generally, if children are to relearn the art of relationships; if they are to learn to trust adults and to believe in themselves; if they are to look to the future with a sense of aspiration and optimism, this can only come from a more thorough 'relearning' than can be offered in weekly sessions of any kind. Therapeutic services from skilled clinicians might be fundamental to change – though the evidence is out – but the more mundane therapeutic task lies in the daily grind. If we are to improve outcomes for children looked-after in residential care, the task has to be essentially therapeutic, and we have to make sure that staff can approach their work in this way.

8.3 Need for a shared approach?

We could argue that any qualified social worker should be equipped to do this work, and compared with the rest of the UK, Northern Ireland has an usually high percentage of qualified social workers in children's residential care.

However, residential care is a challenging environment and a particular approach needs to be put into practice at the whole team level to be effective. This is not something that is typically addressed at qualifying level, where the emphasis is very much on individual competence and individual intervention.

An initiative such as this puts the approach on a level that is beyond individual responsibility, and potentially gives a stronger basis for changing practice on a systemic level. Although the degree of achievement varied across trusts, the extent to which *everyone* was trained and expected to develop a particular approach to their work, was significant. This was part of the reason for the general concern about developing a future strategy to train new staff that also gave 'top-up' training to those already trained and ongoing opportunities to consolidate their learning.

8.4 Young people's views

This was, as far as we know, the first study to look at young people's views on their experiences of living in homes where one of these therapeutic approaches was being used. If we could have used the 'before and after' design originally planned, we might have been able to shed a stronger light on the changes young people experienced as a result of the introduction of each model/approach. Unfortunately this was not possible, and few respondents had lived in a home long enough to experience the change in approach. However, around half had noticed changes in the running of the home. The most frequently changes reported were:

i. that staff were more relaxed and there was a general improvement in the atmosphere
ii. there was less emphasis on the use of punishments.

These perceptions are significant. They are in tune with the changes one might predict from the introduction of any of these models, and they reflect the claims made by staff. Other issues mentioned by young people were:

- better approaches to admissions (which managers said had happened as a result of the introduction of the model)
- fewer removals of young people for 'bad behaviour' (MAP)
- the increase in community meetings and introduction of a points system (Sanctuary).

Few negative changes were mentioned that were not a result of residential care as such, but one young person felt that the model adopted in the Northern Trust (CARE) resulted in some children being treated unfairly.

Those young people who were most aware of an approach being used – not necessarily a good or a bad thing – were those living in homes that used Sanctuary. This was largely because the approach used a particular language and set of named procedures that young people were introduced to – e.g. psycho-education, community meetings, safety plans, etc. It is clear that staff need to be very careful that young people have a good and accurate understanding of terms like 'psycho-education'. Generally the evidence from the interviews with young people was that they valued the contribution made by staff they felt they could trust. According to staff, young people sometimes tried to take advantage of changes in practice in the early stages of implementation. But we were not able to confirm this – or get this view of young people – from talking to them ourselves.

8.5 The views of staff

The staff we interviewed were confident that training and implementation of each of the five models had significantly improved their practice. As discussed in 7.2, staff said that the focus on the emotional wellbeing of children and young people reminded them of their original reasons for working in residential care. The theories that support the approaches used gave staff a better understanding of the damaging effect of those earlier experiences on young people in the 'here and now' – emotionally, psychologically and behaviourally. The theories that helped them to better understand this also allowed them to respond more constructively, to avoid conflict whenever possible, and to 'depersonalise' challenging behaviour. They felt better able to deal with difficult situations without resorting to punishments, instead using these as an opportunity for learning and teaching. All respondents in all trusts commented on this. They felt this change was a direct result of using a therapeutic approach, and that the knowledge and skills learnt in the training of a particular model gave them alternative strategies to deal with these situations. They also recognised that a unified approach brought greater consistency and that this was beneficial for young people. Perhaps not surprisingly, this had changed the way they thought about their work, resulting in improved staff morale, increased confidence and greater job satisfaction.

Despite this enthusiasm among staff, they generally agreed that the approaches were not appropriate – or not adequate – to use with some children and young people, for example, those with intellectual impairment or ADHD. There was also general agreement that whatever 'model' or 'approach' was being used, it was important to incorporate techniques and interventions specifically designed for issues that a model

might not be sufficient to deal with, such as physically threatening behaviour or self-harm.

Staff in the trusts had particular recommendations for the future consolidation of each approach, and these are discussed in Macdonald and Millen (2011). As discussed earlier, the common concern was ongoing training and staff development, and wider organisational support.

8.6 Any model, no model?

One question we had hoped to shed light on was whether one model or approach was better suited than others. For reasons discussed above, the eventual study design was not able to address this. The scoping review highlighted a number of similarities across the models in terms of core concepts and essential skills. Apart from the differences in language, there were more similarities than differences when talking with staff, and this was reflected in the staff survey. Does this mean that 'which model' doesn't matter? Does it mean that any systemic initiative that brings staff together and affirms their professional worth is as good as one focused on training in a named therapeutic approach?

This study cannot answer these questions, but the evidence strongly supports the value of providing staff with the necessary tools to do their job and an organisational context that allows a positive approach to children and young people. In an environment like residential child care, both need to be continually sustained. The findings of the scoping review and the various sources of primary data in this report point to the importance of equipping staff with a detailed understanding of:

- maltreatment and its impacts on young people
- attachment and the impact of attachment disorders
- the importance of self-regulation and how it develops (and is often not developed)
- identity, self-esteem and competence.

These are the core components of all five models. In training terms, these building blocks are probably more important than the models themselves, although they probably gives a framework that is important to organisational change, leadership and implementation. These are equally important for success. One possible advantage of a structured approach is in quality assuring practice, but this is not the only route to achieving this.

8.7 Does a therapeutic approach to social work in residential child care settings make a difference?

Yes. Staff reported improvements in their knowledge, skills, competence and confidence. Those who were initially sceptical usually became converts after seeing the difference that training and implementation made. It made a difference to how staff felt, to their morale and their practice. Young people reported changes that reflected these claims by staff that life was less confrontational, children were better understood, relationships improved and fewer serious incidents were happening.

The one source of less biased evidence was data from the monthly monitoring reports from three homes in each trust. Our analyses showed that after training, staff were noticeably more willing to manage incidents of substance abuse and suicide attempts without contacting outside agencies, than those who had not received training, These were the only significant differences in staff response to incidents. The evidence also suggests that the likelihood of assaults on residential care staff was significantly lower after staff were trained in a model and that the chances of children absconding was also lower – although the evidence for the latter is weak. Again, no other differences emerged. But as stated in chapter 7, it is important to note that this type of analyses should be read as having no evidence for an effect, *not* as evidence for there not being an effect.

8.8 CODA: Sustainability

The sustainability of new initiatives depends – to some extent – on the availability of resources to give ongoing training, supervision and quality assurance. There was considerable variation in the costs of the models put into practice across the trusts.

8.8.1 Implementation costs

There was considerable variation across the trusts in the costs of implementing a therapeutic model. Perhaps unsurprisingly the two franchised models (CARE and Sanctuary) were the most expensive during the practice phase. Putting Sanctuary into practice cost approximately £84,000 in total, with a basic breakdown of costs being:

Breakdown of Sanctuary	**Cost**
Sanctuary facilitator	£40,000
Resources	£6,500
Initial training costs for all homes	£37,500
Total	**£84,000**

The implementation cost of CARE in the Northern Trust was approximately £45,000. Of this, £15,000 was invested by the trust itself (in addition to DHSSPS funding) to train all the homes. The approximate cost for the implementation of MAP was £40,000. The approximate cost for the implementation of MAP in the Western Trust was £40,000, and estimate for the implementation of Social Pedagogy in the Belfast Trust was approximately £22,500. In the Belfast Trust, most of the money was spent training staff teams from four homes. Putting ARC into practice cost approximately £22,000. Clearly there are other costs not represented here – e.g. rolling out the training for Social Pedagogy.

8.8.2 Sustainability costs

Trusts gave the following estimates of their annual cost (at present rates) of sustaining the integration of their chosen therapeutic approach:

Model (trust)	Estimated annual cost	Cost breakdown
Sanctuary (South Eastern)	£50,500	£40,000 Sanctuary facilitator
		£6,000 license
		£4,500 ongoing training
CARE (Northern)	£60,000	Includes cost of a Band 7 Co-ordinator, funds for further training and training venues
ARC (Southern)	£54,000	£34,000 Psychology Associate
		£10,000 Lead at principal practitioner level
		£10,000 Ongoing training
MAP (Western)	£60,000	
Social pedagogy (Belfast)	Estimated costs not available at the time of writing	

The cost of sustaining each approach – provided independently by each trust – is remarkably similar.

Is it justified? Unfortunately, the absence of independent data means that at present, it is not possible to judge the costs relative to evidenced impacts.

Staff who have already had training and professional development organised around these models will certainly support sustainability of these approaches. They believe it makes a noticeable difference to their practice and ultimately – one hopes – to outcomes for the children in residential child care settings.

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Appendix 1: Description of the models

1.1 Overview

The models being put into practice in each trust are:

- South Eastern Trust – Sanctuary model
- Northern Trust – Children and Residential Experiences (CARE) model
- Belfast Trust – Social pedagogy
- Southern Trust –Attachment, Regulation and Competency (ARC) model
- Western Trust – Model of attachment practice

1.2 Sanctuary

Origins

The Sanctuary model was developed in America. The principal architect describes it as a whole system approach to creating a system that can effectively meet the needs of traumatised children.

Core components

The Sanctuary model highlights the effect of trauma on children. It recognises that organisations and the staff within them can produce dysfunctional (defensive) ways of behaving. Change therefore has to be at a systems level. The model incorporates a trauma-informed, shared language – SELF – standing for Safety, Emotion management, Loss and Future. The language and philosophical foundations of the model are reinforced by a set of practical tools for staff and children to use.

Theory of change

The Sanctuary model is complex, with no explicit ‘theory of change’ or ‘logic model’. The implicit theory of change appears to be that: by bringing staff to a shared understanding of trauma and its effects, and giving them a language to communicate that understanding, staff can bring about the changes in organisational behaviours, structures and processes needed to address the damaging effects of trauma.

1.3 CARE (Children and Residential Experiences)

Origins

CARE originated in 2005 in America. It aimed to develop a competency-based curriculum to help residential care staff set up practices that would improve outcomes for children.

Core components

CARE focuses on two core areas of competence: improving leadership and organisational support for change, and improving consistency in and across team members in how they think about, and respond to, the needs of the children in their care.

Theory of change

The CARE model works on the idea that improving the understanding of trauma and its impact on development will allow staff to improve interactions with children by:

- focusing on strengthening attachments
- building competencies
- adjusting expectations depending on children's developmental stage and trauma history
- involving families in the child's care and treatment
- enriching dimensions of the environment to create more therapeutic media (Holden 2010: 135).

Improving interactions between staff and children is thought to help children develop more positive perceptions about themselves and their relationships and interactions with staff. This also contributes to improvements in children's social and emotional wellbeing.

1.4 Social pedagogy

Origins

Social pedagogy has a long history as a recognised discipline in Europe. It aims to promote children's social functioning, social identity and social competence, and their social inclusion. In June 2007 the DfES (England and Wales) proposed piloting Social Pedagogy to explore its effectiveness.

Core components

It is difficult to identify 'core components' as such, as the main features of social pedagogy are based more on values than observed evidence, and reflect different approaches to children and different cultural histories of social interventions. However, the relationship between child and pedagogue is important and good communication essential. This relationship is seen as more collaborative or democratic than the hierarchical approach usually found in children's homes. So-called 'ordinary tasks or events' offer opportunities to encourage development, and social pedagogy blurs the dividing line between the personal and the professional, whilst also recognising the private.

1.5 ARC (Attachment, Self-regulation and Competency)

Origins

The ARC framework was developed at the Trauma Centre at Justice Resource Institute in Brooklyn, MA. It was first used in one of the Intensive Support Units in Northern Ireland, and then rolled out to other homes.

Core components

ARC is described as a flexible framework that allows practitioners to choose from a 'menu' of sample activities and interventions. These are organised into three areas:

attachment, self-regulation and competency. Carers help traumatised children to (re)build healthy attachments by:

- tuning in to children to better understand their behaviour and emotional responses
- managing their own affect
- responding consistently to children's behaviour and establishing routines that promote a sense of safety.

Theory of change

There is no explicit theory of change for ARC. Implicitly, it assumes that outcomes can be improved by:

- giving staff a theoretical framework to think about child development and how things 'go wrong'
- targeting those factors thought to disrupt normal development
- working with children, their families and carers to help remedy deficits.

1.6 MAP (Model of Attachment Practice)

Origins

The Model of Attachment Practice was – at the time of research – under development in the Western Trust. It had advanced to the roll-out stage at the time of writing. The trust used a range of sources, including work in foster care and residential care. A Canadian project for conduct-disordered youth and their families at the Maples Adolescent Treatment Centre has been particularly influential, together with the' dyadic developmental' approach.

Core components

MAP uses attachment theory and research on neurodevelopment to help staff understand children's behaviour and what it means. Core components include: trauma, systematic practice, the building of emotional intelligence, competency and resilience in children and young people. It encourages staff to be 'actors' rather than 'observers' and to recognise the effects of the emotional demands placed on them in their work with children. Other core components are the importance of authoritative parenting and 'attunement'.

Theory of Change

The implicit theory of change in MAP is that by allowing staff to see children's behaviour through the conceptual lens of attachment theory they can better understand the meaning and causes of their behaviour. The resulting changes in their attitudes to children and young people will allow them to form better relationships. This in turn will allow staff to help children and young people learn more adaptive and 'prosocial' ways of relating and behaving.

Appendix 2: Summary of the design and methodology of the study

The evaluation aimed to address the following research questions:

1. Why did each trust choose its particular therapeutic approach?
2. What is the 'logic model' and evidence supporting each approach?
3. How closely does the practice of each approach follow the features of that approach as identified by relevant programme developers or theorists, and what reasons are there for any departures from, or tailoring of, the approach?
4. What do key stakeholders think about the acceptability and contribution of each approach, both to changes in practice and perceived impact on children and staff?
5. What organisational / contextual factors help or get in the way of the successful implementation of each approach?
6. What is needed to continue and/or improve implementation?

Evaluation design

The evaluation was completed in three phases:

i. A scoping review of the six[8] approaches deployed within the trusts (addresses RQs 2 & 3).

ii. Qualitative research to record lessons learnt to date about the challenges involved in adopting and implementing a therapeutic approach (addresses RQs 1, 3, 4, 5 & 6).

iii. The administration of a staff survey and collection of administrative data that looked at the likely impact of the approaches on residential child care (addresses RQ's 3,4,5 & 6).

Research ethics and governance

The study received ethical approval from the Office for Research Ethics Committees Northern Ireland (ORECNI) in July 2010. Research governance approval was also obtained from Queen's University Belfast and from each of the Health and Social Care trusts.

Phase One – Scoping literature review

A literature review was undertaken primarily to identify the logic models and evidence supporting each of the models chosen, and to explore similarities and differences between the models. The inclusion criteria for the review included papers – or other publications – describing any of the following:

i) the therapeutic models, their theoretical and/or empirical origins and their subsequent development

[8] Resilience model only used in one home in Southern Trust

ii) the logic model (or theory of change) supporting each model

iii) outcome studies providing evidence of the effect of each model, irrespective of study design (other than Single Case Designs).

It was agreed that judgements on effectiveness would be based on studies with comparison groups, where these existed. In the original literature review we considered all six models then in use. In conducting the scoping review, we searched a wide range of databases and looked through 25,000 records, before identifying 63 that related directly to the six models. For further detail, see Appendices 1 and 2 of the literature review.

Phase Two – Lessons learned so far

Semi-structured interviews were conducted with a representative sample of 18 home managers and 38 residential child care staff from the 18 homes that had already put into practice training at the time of interview. Staff selected for interview represented professional/career bands, gender and length of experiences. The homes selected included a Secure Unit.

Homes represented a range of training and implementation, and included homes where staff had received training and had implemented the model for some time, and homes that had been more recently trained *i.e.* had not had extensive experience of the models. The aim of using this sample was to allow us to capture 'live' issues in implementation, and to record the lessons that had already been learned about the general aim of improving services in residential care by adopting a specific therapeutic approach, as well as those particular to each model.

home managers and residential care staff were each asked about their understanding of the rationale for the choice of therapeutic approach made in their trust, how it had come about, what alternatives were considered (if any), and what their view was of the model chosen.

The interviewer then asked a series of questions about how the approach had been introduced, what training had been given and how staff, including the interviewee, had responded. This was followed by a series of questions on the challenges of implementation, the factors that helped and got in the way of implementation, including what was needed to continue the model in the future. Respondents were asked to describe the model in their own words, and to say what impact it had had on their practice and on the young people in their care, with examples.

In this phase 29 young people from residential settings across the region were also interviewed to get their views, perceptions of any differences the approach has made and any concerns they might have. Given the sensitive nature of the study, consent was first sought from the Home Manager followed by that of the child's social worker. Both the home managers and the social worker were asked to assess the child's capacity to provide informed consent and – where they judged it appropriate – to seek parental consent. Only then was consent directly sought from those young people who were resident in the participating homes, to invite them to take part.

The children and young people with consent were given an information sheet outlining the purpose and nature of the research, what it involved, and an assurance of issues such as confidentiality, consent and right to withdraw at any time, up to the time of any report being published. The information was given in age-appropriate language. Each young person received a £10 'Love2Shop' voucher for their contribution to the project. A researcher also met with a team of fieldworkers from each trust to discuss their views on the therapeutic model being used in their trust and how relevant they thought it would be to integrate it into their everyday practice.

Three policy makers/senior managers who work outside of the Residential Care sector were also interviewed (i.e. designated leads in DHSSPS). This was to explore their understanding of the impetus for the initiative; their views on the variety of choices made by trusts; their expectations in terms of the impact of these initiatives on improving outcomes for children, and what they wanted to learn from the research/evaluation.

Phase Three – Evidence of impact

This section of the research was designed to show what *impact to date* the implementation of the therapeutic approaches had on residential child care.

A staff survey was conducted as part of the evaluation to get a representative sample of views from residential child care workers throughout the region on issues relating to the five therapeutic models currently being evaluated. One of the objectives of this was to examine any variations in responses from staff using different therapeutic models. The survey covered areas of knowledge and practice that might reasonably improve following training in *any* of the therapeutic approaches as well as a number of other issues such as percieved factors that help or get in the way of implementation and future training needs.

Impact on outcomes for young people

Out of a total of 33 residential children's homes throughout the region, administrative data from Monthly Monitoring Reports was collected from a sample of 18 homes (55 per cent). The purpose of this was to provide data on the number of serious incidents in a residential care setting and how these were handled before and after training. This data was collected at both a trust and 'study home' level. One of the aims of this was to assess the effect of training on incident rates. Comparisons were made between trained and untrained homes, however, as homes in the South Eastern and Northern Trust received training at approximately the same time (and did not contain any untrained homes), trained and untrained comparison was made between the same homes before and after training.

Data analysis and interpretation

Qualitative data

With permission from respondents, semi structured interviews with staff and young people were recorded for later review and transcription. Responses from both staff and young people were thematically analysed and presented in relation to each therapeutic approach, organised around the following main key themes:

- Understanding how the model was selected
- Experience of implementing a therapeutic approach
- Experience of the training process for social pedagogy
- Factors that help or get in the way of implementation
- Job satisfaction and improved practice of individuals and teams
- Strategy for maintenance and development of the approach
- Desired long-term changes through implementation of the model

Impact data

Collecting administrative data was the only longitudinal source of data in the evaluation that could potentially record a before and after picture of the effect of introducing a therapeutic approach on staff practice, changes in young people's behaviour and staff-resident relationships over a limited time frame.

There were several limitations to these analyses. The low number of events in any given month, the low number of homes in each trust, the differences in the way data was collected, and the limited time frame of data collection makes it very difficult to detect genuine changes due to the training. Regression models were used to model the risk of incidents from the length of follow-up time, however they could not account for changes occurring over time such as new entrants. All regressions controlled for size of homes in addition to the reported variables, so the results in chapter 7 can be read as effects net of size. Odds-ratio showing the shift in the odds of incidents occurring in homes after training compared to before training was reported, as was the amount of variation between homes in terms of likelihood of incidents.

Appendix 3: Training dates

Training has been provided at different times in different trusts. The table below summarises how many homes had received training at the time of writing the report, and when they had received training.

As this table shows, a number of homes received training during the evaluation period. The 18 homes included in the qualitative fieldwork therefore no longer represent the total number of trained homes.

Health and Social Care Trust	Number of homes not received training in therapeutic approach	Number of homes received training	Training dates – first home(s) to be trained	Training dates – subsequent homes trained
Belfast	2	4	June 2009	November 2010
Northern		6	September 2009	April 2010
South Eastern		8	September 2009	
Southern	1	5	August 2009 (resilience) June 2010 (ARC)	February 2010 April 2011
Western	4	3	February 2008	

Appendix 4: Data collected from Monthly Monitoring Reports

	Indicator of impact	Rationale for selection of indicator of impact
Number of	Residents in home	
	Places available	
	Admissions (secure only)	Qualitative data indicated that the introduction of a therapeutic approach had resulted in fewer admissions.
	Discharges	
	Requests for places	
	Young person (YP) in education/training	
Number of staff trained and days per person:	Model-specific training	
	Model-related training	
	TCI	
	Restorative Practice	
Frequency of team meetings		Qualitative data indicated that team meetings provide an opportunity for reflective practice for staff
Events and Notifications Number of incidents (per month) of:		Qualitative data highlighted the positive impact of introducing a therapeutic approach on the frequency and severity of incidents within the home.
	Physical aggression	
	Damage to trust property	
	YP physical assault on staff	
	YP self harm	
	YP threat of suicide	
	YP consumed unprescribed drug	
	YP threatening staff	
	YP threatening another YP	
	YP substance abuse	
	YP crime in the community	
	YP absconding	
	No of complaints	
	Nature of complaints	

Appendix 5: Overall change in rates of incidents before and after training

The first column records months, across all homes, when the incident was absent or present. So, for example, Physical Aggression was seen in 12 of the 133 months before training (nine per cent of these months); and in 20 of the 230 months after training (also nine per cent of these months). The second ('between homes') column tells us about the incidence across homes. So all 12 of the homes for which we have 'before training' information had at least one month during this period where there were no incidents of Physical Aggression; five of these 12 homes (so 43 per cent of the homes) had at a month with at least one incident. The final column gives the proportion of months during which these homes, on average, experienced aggression or its absence. So, considering those homes for which we have 'before training' information, they experienced no aggression, on average, for 87 per cent of these (pre-training) months, and they experienced aggression, on average, for 30 per cent of these months. These percentages do not sum to 100 per cent, as these numbers reflect the average of the 'within home' of time reporting aggression.

Table A4.1 Incidents across home (see glossary above)

	Overall	**Between homes (percentage)**	**Within homes (percentage)**
Overall			
Physical Aggression			
Before training			
No	121 (91)	12 (100)	(87)
Yes	12 (9)	5 (42)	(30)
After training			
No	210 (91)	14 (100)	(92)
Yes	20 (9)	7 (50)	(15)
Damage			
Before Training			
None	107 (80)	12 (100)	(77)
One	13 (10)	7 (58)	(17)
Two or more	13 (10)	6 (50)	(26)
After Training			
None	185 (80)	14 (100)	(82)
One	29 (13)	9 (64)	(18)
Two or more	16(7)	8 (57)	(11)

Assault on staff			
Before Training			
None	111 (83)	12 (100)	(79)
One	13 (10)	6 (50)	(21)
Two or more	9 (7)	6 (50)	(22)
After Training			
None	202 (88)	14 (100)	(85)
One	21 (9)	7 (50)	(25)
Two or more	7 (3)	4 (29)	(10)
Self harm			
Before Training			
None	119 (89)	12 (100)	(85)
One	9 (7)	5 (42)	(21)
Two or more	5 (4)	3 (25)	(24)
After Training			
None	206 (90)	14 (100)	(90)
One	13 (6)	6 (43)	(12)
Two or more	11 (5)	3 (21)	(21)
Suicide			
Before Training			
None	120 (90)	12 (100)	(87)
One	11 (8)	7 (58)	(19)
Two or more	2 (2)	2 (17)	(13)
After Training			
None	199 (87)	14 (100)	(87)
One	21 (9)	8 (57)	(15)
Two or more	10 (4)	6 (43)	(10)
Missing <24 hrs			
Before Training			
None	98 (74)	12 (100)	(76)
One	13 (10)	6 (50)	(23)
Two or more	22 (17)	5 (42)	(31)
After Training			
None	162 (70)	14 (100)	(72)
One	28 (12)	10 (71)	(16)
Two or more	40 (17)	8 (57)	(28)

Misuse of prescription drugs			
Before Training			
No	128 (96)	12 (100)	(95)
Yes	5 (4)	4 (33)	(14)
After Training			
No	225 (98)	14 (100)	(98)
Yes	5 (2)	4 (29)	(7)
Threaten staff			
Before training			
No	128 (96)	12 (100)	(95)
Yes	5 (4)	4 (33)	(14)
After training			
No	223 (97)	14 (100)	(97)
Yes	7 (3)	4 (29)	(10)
Threatens young Person			
Before training			
No	129 (97)	12 (100)	(97)
Yes	4 (3)	3 (25)	(12)
After training			
No	221 (96)	14 (100)	(95)
Yes	9 (4)	6 (43)	(11)
Assault Young person			
Before training			
No	120 (90)	12 (100)	(88)
Yes	13 (10)	7 (58)	(20)
After training			
No	208 (90)	14 (100)	(91)
Yes	22 (10)	6 (43)	(20)
Drugs			
Before training			
No	112 (84)	12 (100)	(86)
Yes	21 (16)	7 (58)	(25)
After training			
No	201 (87)	14 (100)	(88)

Yes	29 (13)	7 (50)	(23)
Crime			
Before training			
None	115 (86)	12 (100)	(89)
One	10 (8)	5 (42)	(14)
Two or more	8 (6)	5 (42)	(12)
After training			
None	212 (92)	14 (100)	(93)
One	13 (6)	5 (36)	(14)
Two or more	5 (2)	3 (21)	(9)
Absconding			
Before training			
None	85 (64)	12 (100)	(64)
One	17 (13)	9 (75)	(18)
Two or more	31 (23)	10 (83)	(28)
After training			
None	172 (75)	14 (100)	(74)
One	26 (11)	13 (93)	(12)
Two or more	32 (14)	11 (79)	(18)
Complaints			
Before training			
None	119 (89)	12 (100)	(91)
One	12 (9)	6 (50)	(13)
Two or more	2 (2)	2 (17)	(14)
After training			
None	205 (89)	14 (100)	(88)
One	17 (7)	9 (64)	(13)
Two or more	8 (3)	5 (26)	(10)

The next table gives an overview of the rates of incidents, counting the actual number of incidents in each month. A version of this table adjusted by home size yields essentially the same picture.

Table A4.2 Summary average number of monthly incidents, without and with training, and the ratio of 'before' to 'after'

Incident:	without	with	ratio
Crime in the community	0.26	0.10	2.6
Consuming unprescribed prescription drugs	0.05	0.02	2.5
Absconding	0.97	0.49	2.0
YP threatening staff	0.05	0.03	1.7
Assault on staff	0.23	0.15	1.5
YP assaulting YP	0.15	0.11	1.4
Damage to trust property	0.29	0.27	1.1
Physical aggression	0.09	0.09	1.0
YP threatening YP	0.04	0.04	1.0
Self harm	0.14	0.15	0.9
Missing less than 24 hours	0.87	1.00	0.9
Substance abuse	0.26	0.30	0.9
Complaints	0.12	0.17	0.7
Suicide attempts	0.11	0.18	0.6

Appendix 6: Analysis of Monthly Monitoring Reports

Logistics, in military and statistical terms, derives its meaning from the process of transition between two states. Logistic regression models assess how a set of characteristics relates to something being in one of two states. In this study, we are looking at characteristics of residential homes – the number of residents in the homes, and (of primary interest) whether or not the home received training – and how these relate to two states; no incidents being reported, or incidents being reported.

While the monthly monitoring reports had greater than one incident per month, the incident data was re-coded into 'Any' versus 'None' for analysis. Preliminary analyses showed that there were too few incidents to make a meaningful differentiation between 2, 3 and 5 incidents; as they occurred very infrequently, and may have been caused by a single individual in the home. In the absence of data on individuals, the best way to account for the undue influence of single individuals is to look at only two incident states.

The results of the regression models show Odds ratios – namely the after/before ratio between the two odds of a particular incident – and intracluster correlation coefficients. An odds ratio (OR) of one suggests there is no difference between the homes before and after training; an OR of 0.5 suggests there is half the odds of incidents after training compared to before, and an OR of 2 suggests the odds of incidents is twice as high after compared to before training. Each OR is accompanied by a 95 per cent confidence interval, this can be thought of as the most conservative, and most optimistic estimate of the difference before and after training; hence we can interpret ('Incident A' OR 0.5 95 per cent CI 0.25, 0.75) as 'The odds of "Incident A" was 50 per cent lower after training compared to before', and we can be 95 per cent certain that the actual reduction was between 25 per cent and 75 per cent lower. The intracluster correlation coefficient ICC shows the proportion of variation occurring between homes, as opposed to variation across time. An ICC of zero suggests there is no difference between homes in the rates of incidents reported across time, while an ICC of one suggests each home has a different rate of incidents per month, which is constant across all time points of the study. A higher ICC thus indicates that some homes have higher incident rates than others, while a lower indicates there is little discernable difference. Given the small number of homes (particularly in the analysis for each trust), the ICC is prone to large variation; it should be interpreted with caution.

Table A5.1 shows the odds of incidents occurring before and after training, and the amount of variation between homes in terms of likelihood of incidents. Looking at all homes combined, it appears that after training, the odds of assaults on staff was 49 per cent of the odds before training took place (OR 0.49 95 per cent CI 0.20, 0.91). There was also some evidence suggesting odds of absconding were 45 per cent lower than those before training (OR 0.55 95 per cent CI 0.30, 1.02). For several incidents, there was no evidence that there were differences between homes in the rate at which they occurred, assaults on staff, attempted suicide, prescription drug abuse, threatening staff or young people, criminal activity or complaints against the home. For other characteristics, there were large variations between homes, ranging from 7 per cent of the variation in absconding rates being between homes, up to 49 per cent of the variation in assaults on other young people being due to variation between homes.

Table A5.1: Odds ratios showing the shift in the odds of incidents occurring in homes after training compared to before training

Incident	Odds Ratio (95% CI)	Variation between homes
Physical aggression	0.67 (0.23,2.02)	0.19**
Damage to home	0.82 (0.37, 1.81)	0.25***
Assault on staff	0.49 (0.20, 0.91)*	0.00
Self harm	0.51 (0.18, 1.46)	0.29***
Suicide attempt	1.37 (0.59, 3.19)	0.07
Missing less than 24 hours	1.77 (0.76, 4.16)	0.45***
Abusing prescription drugs	0.48 (0.12, 1.93)	0.00
Threats to staff	0.75 (0.21, 2.71)	0.00
Threatened young person	0.89 (0.25, 3.14)	0.00
Assault on young person	0.58 (0.19, 1.73)	0.49***
Drug use	0.75 (0.29, 1.94)	0.33***
Criminal activity	0.44 (0.16, 1.23)	0.07
Absconding	0.55 (0.30, 1.02)+	0.07*
Complaints	1.18 (0.54, 2.62)	0.01

+ p <0.1 ; * p<0.05 ; ** p<0.01 ; *** P<0.001

Table A5.2 shows the results for the South Eastern Trust. In this trust, data were collected from March 2009, and all homes were trained from September 2009. The study period 'before training' is shorter than the 'after training' period. As for the overall models, there appeared to be a reduction in assaults on staff after training. There was a tenfold increase in the odds of short-term missingness after training. There was evidence of variation between homes in terms of odds of physical aggression and assaults on young persons in the home, however as there were only three homes in the trust a value of 28 per cent or 90 per cent variation tells us little about relative magnitude of the variations.

Table A5.2: Relative odds of incidents in homes after training: South Eastern Trust

Incident	Odds Ratio (95% CI)	Variation between homes
Physical aggression	0.44 (0.09, 2.14)	0.28*
Damage to home	0.66 (0.21, 2.10)	0.00
Assault on staff	0.34 (0.11, 1.12)+	0.00
Self harm	0.44 (0.11, 1.69)	0.22
Suicide attempt	1.09 (0.28, 4.21)	0.00
Missing less than 24 hours	10.82 (2.03, 57.76)**	0.00
Abusing prescription drugs	0.59 (0.10, 3.64)	0.00
Threatened staff	2.37 (0.20, 28.35)	0.00
Threatened young person	1.59 (0.17, 14.90)	0.00
Assault on young person	0.80 (0.14, 4.66)	0.90***
Drug use	^^^	^^^
Criminal activity	^^^	^^^
Absconding	1.21 (0.37, 3.90)	0.04
Complaints	1.26 (0.22, 7.12)	0.00

+ p <0.1 ; * p<0.05 ; ** p<0.01 ; *** P<0.001 ~~~ Model did not converge

In the Southern Trust (Table 5.3) there were fewer incidents reported, and in some homes there were no incidents in the 'before' or 'after' group, making it impossible to fit a meaningful regression model. For the models that were run, there were no signs of significant variation in the rates of incidences.

Table A5.3: Relative odds of incidents in homes after training: Southern Trust

Incident	Odds Ratio (95% CI)	Variation between homes
Physical aggression	^^^	^^^
Damage to home	0.56 (0.01, 35.90)	0.46+
Assault on staff	^^^	^^^
Self harm	^^^	^^^
Suicide attempt	0.51 (0.05, 5.24)	0.21
Missing less than 24 hours	1.12 (0.12, 10.69)	0.14
Abusing prescription drugs	^^^	^^^
Threatened staff	^^^	^^^
Threatened young person	^^^	^^^
Assault on young person	^^^	^^^
Drug use	0.22 (0.01, 3.29)	0.15
Criminal activity	^^^	^^^
Absconding	0.69 (0.24, 2.02)	0.00
Complaints	1.27 (0.25, 6.34)	0.04

+ p <0.1 ; * p<0.05 ; ** p<0.01 ; *** P<0.001 ^^^ Too few incidents to fit model

Table A5.4 shows the change in the odds for the Western Trust. Odds of assaults on staff showed some signs of reduction for the 'after training' homes (OR 0.08 95 per cent CI 0.01, 1.08). Odds of absconding also appeared to reduce (OR 0.29 95 per cent 0.08, 1.01). There was some evidence of variation between homes in rates of short term missingness, assaults on young people and drug use.

Table A5.4: Relative odds of incidents in homes after training: Western Trust

Incident	Odds Ratio (95% CI)	Variation between homes
Physical aggression	^^^	^^^
Damage to home	0.70 (0.09, 5.51)	0.08
Assault on staff	0.08 (0.01, 1.08)+	0.00
Self harm	1.56 (0.09, 28.18)	0.12
Suicide attempt	^^^	^^^
Missing less than 24 hours	0.02 (<0.01, 7.33)	0.64***
Abusing prescription drugs	^^^	^^^
Threatened staff	^^^	^^^
Threatened young person	0.43 (0.05, 3.94)	0.00
Assault on young person	0.44 (<0.01, 93.55)	0.49*
Drug use	0.22 (<0.01, 45.93)	0.52**
Criminal activity	0.46 (0.05,4.06)	0.13
Absconding	0.29 (0.08, 1.01) +	0.00
Complaints	1.78 (0.17, 18.49)	0.00

+ p <0.1 ; * p<0.05 ; ** p<0.01 ; *** P<0.001 ^^^ Too few incidents to fit model

The results for the Northern Trust are shown in Table A5.5. The low numbers made it difficult to fit some models. Where models were fitted, there was no evidence of change before and after training. There was some between home variation in rates of damage to the home, missingness, assault on young people and drug use.

Table A5.5: Relative odds of incidents in homes after training: Northern Trust

Incident	Odds Ratio (95% CI)	Variation between homes
Physical Aggression	0.74 (0.05, 10.40)	0.00
Damage to home	1.04 (0.21, 5.26)	0.45***
Assault on staff	^^^	^^^
Self harm	^^^	^^^
Suicide attempt	^^^	^^^
Missing less than 24 hours	0.67 (0.14, 3.04)	0.70***
Abusing prescription drugs	^^^	^^^
Threatened staff	0.55 (0.02, 11.82)	0.00
Threatened young person	^^^	^^^
Assault on young person	0.24 (0.02, 2.68)	0.67*
Drug use	0.75 (0.14, 3.99)	0.42**
Criminal activity	0.35 (0.04, 3.21)	0.00
Absconding	0.61 (0.10, 3.74)	0.29
Complaints	^^^	^^^

+ p <0.1 ; * p<0.05 ; ** p<0.01 ; *** P<0.001 ^^^ Too few incidents to fit model

Table A5.6 shows the results for the Belfast Trust. The models here showed some evidence for reduced odds of missingness (OR 0.08 95 per cent CI 0.01, 0.92), drug use (OR 0.24 95 per cent CI 0.06, 1.04), Absconding (OR 0.18 95 per cent CI 0.03, 1.02) and complaints (OR 0.07 95 per cent CI <0.01, 1.05). There was some variation between homes in rates of damage to the home and absconding rates.

Table A5.6: Relative odds of incidents in homes after training: Belfast Trust

Incident	Odds Ratio (95% CI)	Variation between homes
Physical Aggression	0.48 (0.03, 8.99)	0.13
Damage to home	1.47 (0.10, 22.00)	0.27+
Assault on staff	6.65 (0.27, 166.67)	0.22
Self harm	^^^	^^^
Suicide attempt	1.31 (0.15, 11.47)	0.09
Missing less than 24 hours	0.08 (0.01, 0.92)*	0.00
Abusing prescription drugs	^^^	^^^
Threatened staff	^^^	^^^
Threatened young person	12.23 (0.12, >100)	0.00
Assault on young person	0.29 (0.03, 3.13)	0.00
Drug use	0.24 (0.06, 1.04)+	0.00
Criminal activity	0.95 (0.19, 4.63)	0.07
Absconding	0.18 (0.03, 1.02)+	0.21*
Complaints	0.07 (<0.01, 1.05)+	0.00

+ p <0.1 ; * p<0.05 ; ** p<0.01 ; *** P<0.001 ^^^ Too few incidents to fit model

MAY 2012

Therapeutic approaches to social work in residential child care settings

Children and young people in care are some of the most vulnerable in society. A small but significant proportion of looked-after children across the UK are cared for in residential settings such as children's homes.

Following a regional review of residential child care in 2007, the five health and social care (HSC) trusts in Northern Ireland introduced 'therapeutic approaches' in a number of children's homes and in the regional secure units. The aim was to improve staff skills and outcomes for young people.

This report gives the results of an evaluation of these approaches. The report also gives the results of an analysis of the patterns in reporting untoward incidents.

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