Task & Finish Group

Executive summary: Review of models of residential care for children and young people

May 2018

1 Introduction

1.1 Remit

This review is designed to understand the range of models of children's residential care that exists across Wales, the rest of the UK and internationally. The purpose is to identify what works well and what doesn't in terms of improving outcomes for children and young people: both in relation to individual models and in terms of common themes.

1.2 Methodology

A long-list of models of children's residential care was developed via a search of key databases and Google as well as suggestions from 4Cs and the Centre of expertise on child sexual abuse. 39 models were identified.

Detailed profiles on 15[1] of these models were developed following consultation with the Task and Finish Group for Residential Care. Each profile lays out the model's aims, origin and implementation, target group, resources required and set-up and running costs, where available. We also summarise the available evidence base for each model in terms of impact, effectiveness and cost-benefit, indicating any major limitations or lessons learned from the model's roll-out. Finally, we provide suggestions for future research on each model. The detailed profiles for each model are included in the main report. This executive summary focuses on key/common findings in relation to: (1) outcomes that models are trying to achieve; (2) measuring impact; (3) strength of evidence base; (4) costs and return on investment; (5) commonalities in practice; and (6) lessons learned.

2 Key findings

2.1 Outcomes that models are trying to achieve

There are a wide range of outcomes that models are trying to achieve. We identified five domains that many of these models share: (1) health and wellbeing; (2) educational achievement and developing skills; (3) improving relationships; (4) reducing 'high-risk'

[1] These were: Child Protective Services Reintegration Project (CRP); Children and Residential Experiences (CARE); Core and Cluster (Worldwide); Dyadic Developmental Psychotherapy (DDP); Model of Attachment Practice (MAP); Neurological Reparative Therapy (NRT); No Wrong Door; Positive Peer Culture; Priority Childcare; Restorative Justice; Safe Steps; Social Pedagogy; Step Down; Stop-Gap; Treatment Foster Care Oregon (Adolescents) (TFCO-A).

behaviours; and (5) facilitating transition from residential care. The degree of specificity and the extent to which these are clearly articulated varies between models.

2.2 Measuring impact

A range of outcome measures are used to measure impact. The validity, reliability and robustness of these outcome measurements, and what they can tell us about outcomes for young people, varies.

Standardised outcome measurements

Some evaluations use standardised outcome measurements[2]. This means the measurement tool has been tested and validated and is a reliable indicator of whatever it is designed to measure. A key advantage of using these tools is that outcome measurements may be more easily compared over time and across studies. Ideally, these outcome measurements are taken at "baseline" (prior to the young person's enrolment in the programme) and at later time points to assess changes over time. Some evaluations struggled to achieve this level of robustness: for instance, one model highlighted that follow-up data was collected for less than half of their baseline sample affecting the conclusions that could be drawn.

Administrative data

Some evaluations use administrative data, which is collected routinely often by residential care staff or other services. For instance: placement moves; recorded behavioural incidents; police call-out data; and records of substance use, criminal activity, missing episodes. Where evaluations only use administrative data, it is difficult to compare outcomes for young people across different models. This is because the procedure for recording incidents across homes (as well as the definition of an 'incident') may differ.

Consultations with staff and young people

Evaluations draw on interviews with staff to give an indication of, for instance, how well staff adopt and implement model principles, as well as their experiences of implementing the model. Staff are also sometimes asked to articulate (either as part of the model or as part of an evaluation) their perspective on improvements achieved by children and young people. Some evaluations interviewed young people to understand, for example, their perspective of model implementation, and their experience of placement stability.

Outcome measurement timing

Allowing for longer-term outcome measurement (after one year) helps to understand whether changes are sustained in the long term, and give an idea of model sustainability. Few studies identified by this review included robust outcome measurement beyond 12 months, which makes comparing long-term effectiveness of models difficult.

[2] Standardised tools used in these evaluations include: Strengths and Difficulties Questionnaire; Vulnerable Attachment Style Questionnaire; Teenage Attitudes to Sex and Relationships Scale; Trauma Symptom Checklist for Children; Children's Global Assessment Scale; and Health of the Nation Outcome Scales for Children and Adolescents.

Longer-term outcome measurements (over 12 months) are available for seven models. However for these, what the type of measure chosen can tell us about outcomes for young people is limited. In some cases, outcomes are proxy measures such as placement stability, or young people's "missing-ness". In other cases, follow-up data is available over more than five years but is not independent. Outcomes tend not to be standardised, sample sizes are small and not randomised. For other models, evaluation designs incorporate collection of robust long-term follow-up data. In practice, evaluations do not achieve the intended length-of follow-up and sample size (e.g. due to attrition from the service or from the evaluation) which makes it difficult to draw conclusions about the model's long-term sustainability.

2.3 Strength of evidence base

In general, the evidence base for models of children's residential care lacks robustness:

- Few studies employ random methods that would enable evaluators to attribute with certainty any observed outcomes to the residential care model under study. Those that do, tend to show relatively limited improvements typically in very specific domains. Two models fall into this category.

- A larger proportion of the evidence base employs less rigorous methods but, perhaps because of this, often makes claims to larger or more comprehensive impact. Nine models fall into this category.

- Four models, already in operation, are supported by relatively limited evidence of impact.

This presents commissioners with a difficult choice. For instance, whether to choose a model that has a very robust evidence base but knowing that improvements achieved may be limited or very specific; or choose a model which may – on the surface – have more comprehensive or wide-ranging impact but where the strength of the evidence base is relatively weak.

2.4 Costs and return on investment

In many cases, information is not available on set-up or running costs. Where information on costs is available, it tends not to be of a detailed nature to enable calculation of the scale of return on investment. We lack information on what the money was spent on, how many young people received treatment, or what the outcomes were. Without this information, it is difficult to determine any return on investment. That said, return on investment calculations are available for two models. One highlighted cost savings to social care of 15%. An evaluation of another model found that costs (£1.99m per year) exceeded savings achieved (£1.3m) but concluded, nevertheless, that it offered value for money.

2.5 Commonalities in practice

The models share many features. This review identifies six main commonalities, i.e. use of theory; training and supervision of staff; environment; individualised approaches; education and developing competences; and involving families and follow-on carers.

Theory-informed

Many models draw closely on theories of attachment and trauma, focussing on how these concepts affect the behaviour and needs of children in residential care. Other models are based on theories of competence. Some theories emphasise reflective practice, encouraging staff to critically evaluate their own work and understand the impact of their own behaviour in the residential care setting.

A small number of models do not give prominence to a theoretical orientation, but do draw on frameworks, e.g. as part of training.

As SCIE[3] notes, having a framework or theory to understand one's work is likely to be helpful for staff not least because

> *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.*

Training and supervision for staff

Requirements for staff training is a common feature of most models. What training involves, who receives it, and how it is delivered differs across models. For example, the length, location, and resources involved in training vary, and may be: on-site, off-site or on-line; one-to-one or in groups; over a day or over two weeks; by a colleague or by an external provider.

Some models are franchised and core training must be delivered to staff by a certified provider. Other training often relies on established external providers or is delivered by in-house teams. Not all training is standardised.

Some models emphasize a "whole team" approach to training, ensuring that all team members undergo similar training and share a common framework. One model placed a particular emphasis on a systemic approach, i.e. it aims not only to train those directly associated with children's residential care but to expand to other stakeholders (e.g. social workers, foster carers) so that there is common approaches and understanding across those working with children and young people.

Few models view training as a one-off event. Most incorporate opportunities for staff to "top-up" on training, encourage "reflective practice" or involve supervision. Ongoing supervision for staff was a particular feature of some models. Interviews with staff from available evaluations suggest this is valued by staff.

The residential care environment

Several models emphasise the importance of the residential care setting environment as therapeutically beneficial. This means that their focus is not only on working with young

[3] SCIE (2012) *Therapeutic approaches to social work in residential child care settings: Literature review*

people as individuals, but also the social and material aspects of the environment. Some models describe this as taking a "total therapeutic milieu" approach, whereas others refer to the importance of the "environment" more generally.

Enriching the physical environment and furnishings of homes is often considered an important aspect of model effectiveness. This is also noticeable in evaluations of emerging residential care models in the UK, which emphasize details designed to create a more "homely and attractive" environment, such as using more discreet security measures.

Environment-specific interventions are a key component of two of the models and range from controlling diet and access to films to providing young people with anger management training and establishing a rewards system. These recognise that environments are social, and can promote and impede behaviours. For example, one person's disruptive behaviour or interaction can influence the behaviour of their peers.

Individualised approach to each child/ young person

Most models recognise children and young people have different backgrounds and needs. To address this, many describe taking an individualised approach to care for each child or young person, rather than using a "one size fits all" model. Some models describe taking an "individualised approach" or "tailoring" the service to meet individual young people's needs. In practice this might mean formulating a care plan for each young person upon referral comprising therapy, skills and education support, or assigning them a key worker or care co-ordinator who supports them individually.

For models where intensive case management, co-ordination or individualised support is provided, this individualised approach is at the heart of the model. That said, most models in this review tailored services in some way.

Education and developing competencies

Children in residential care often have lower levels of competencies due to the high levels of trauma they have experienced (SCIE, 2012). The importance of helping children develop a range of skills is recognised (in more or less explicit terms) in each of the models.

Models signal a commitment to education by supporting mainstream education placements. Where this is difficult or not possible, strategies were in place to support young people. These included virtual learning, deploying education support workers, and allocating education 'champions' within teams. Two models have on-site schools for residents unable to access mainstream education. Other models describe helping young people to build their competencies in self-management or social skills.

Involving families or follow-on carers

Evidence suggests contact with family is an important driver to securing positive outcomes for children in residential care.[4] Several models involve the young person's family or

[4] Kilpatrick, R., Berridge, D., Sinclair, R., Larkin, E., Lucas, P., Kelly, B., & Geraghty, T. (2010). Working with challenging and disruptive situations in residential child care: Sharing effective practice.

follow-on carer. The extent to which families or follow-on carers are involved varies. It may involve encouraging contact between young people and their families. Some are designed to be conducted in the family home or may provide support families as "early intervention" to prevent use of residential care. Another group of models, alongside providing support for young people, provides training for parents or follow-on carers to help them develop effective parenting skills.

2.6 Common lessons learned

This section describes four key factors that affect successful model implementation. These factors are cited in the available process evaluations or studies considering implementation: type and nature of funding; multi-level and multi-agency support; strict referral criteria; and context-specific modifications.

Type and nature of funding

The type and nature of funding for models affected implementation, perceived effectiveness, and ultimately model impact. For instance, evaluations note well-trained and motivated staff are a key component to model implementation, and some funding models had an adverse effect. For example, fixed-term funding and, in turn, the use of temporary and fixed term contracts, had a negative impact on staff members and led to uncertainty in the team. Pilot implementation of models had difficulty recruiting and retaining staff in stressful and low paid roles affecting service viability and sustainability.

Overall, securing longer term funding commitments is likely to be important for staff morale, effective leadership and team stability as it enables longer term fixed or permanent contracts, which will support model impact.

Multi-level and multi-agency support

Support from other organisational systems was often cited as important to the successful practice of therapeutic approaches. Many evaluations noted responsibilities for young people in residential care are shared between parents, social workers, in addition to residential care staff.

Having professionals outside the setting who understood the approach was important. Particularly for models which required a shift in culture, such as 'managing risk differently', shared understanding of what this involves and commitment by commissioners, providers, children's social workers, police and other stakeholders is important.

Conversely, other evaluations recognised model impact was limited because residential care staff did not have the decision-making power models assumed they had. External social workers without knowledge of the models could thwart the model's intended potential, and be a possible point of conflict. In one evaluation it was noted that external partners (including social workers) had not received training in the model and often did not see its relevance, impeding successful model implementation.

Strict referral criteria

Evaluations highlight the importance of having in place targeted and thorough referral processes, especially for pilot implementations. This helps to ensure that the needs of the

children and young people who are supported are closely aligned with the aims and purpose of the model.

Context-specific translation

A number of evaluations highlight the importance of ensuring that models are aligned with the local context. This is particular the case for models that were originally developed outside of the UK. A number of changes were implemented to some models. This included changes to the language and concepts used, age groups targeted, and changes to the format of delivery (e.g. moving from shared dormitories to individual rooms). Evaluations of continental European models that were applied to the UK often noted the 'risk-averse' culture of residential care in the UK, which made it difficult to implement some elements of these models.

3 Conclusions

The conclusions that we draw from this review are:

1. There is no single model of children's residential care with sufficient evidence to support a wholesale move across.

2. That said, the review has identified some of the key/common threads that should feature in any model:

    a. Theory-informed.
    b. Extensive training and supervision of staff.
    c. Ensuring an appropriate environment.
    d. Taking an individualised approach.
    e. Ensuring strong links with educational and developing competencies.
    f. Involving families and/or follow-on carers.

3. There is a need to ensure that all models are robustly measuring impact. This involves:

    a. A clear idea of the outcomes to be achieved and the scale of change that is expected, especially for the level of resources invested.
    b. Use of a validated tool.
    c. Measuring distance travelled over time.
    d. Ensuring that outcomes are measured over the long-term to ensure that any change/improvements are sustained.

4. There are some advantages in having a model of practice that is mainstreamed across different types of support, e.g. young people receive a consistent approach to support across the setting in which they are cared for(family, foster care, residential).

5. There is a trade-off between choosing an off-the-shelf model and developing something locally. The former is likely to have a more robust and longstanding evidence-base. The latter may be better suited to local circumstances and have greater buy-in from staff.

6. There is an increasing focus on promoting transition out of residential care and/or using it sooner in a child's life. To date, evidence of impact is limited but there is emerging evidence to suggest that this is worth pursuing (subject to ensuring effective practice as detailed above).