Task & Finish Group

Review of models of residential care for children and young people

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1 Introduction

1.1 Objective

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 (such as the Early Intervention Foundation, Research in Practice and the California Evidence-Based Clearing House for Child Welfare) as well as Google searches. It also drew on suggestions from 4Cs and the Centre of expertise on child sexual abuse. 39 models were identified[1].

This long-list was considered by the Task and Finish Group for Residential Care[2] and a total of 17 were identified for more in-depth research. Of these, 11 were reviewed more fully via a desktop review, four received site visits, one model was in the early stages of development so was not progressed, and one model wasn't able to participate within the timescales available.

Profiles were produced for each model. 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, based on our assessment of the evidence base.

1.3 Overview of models & key findings

The grid below provides an overview of each model included in the review. This report also draws together the profiles to identify key findings and commonalities. This is explored in more detail in Section 2.

[1] The full list is available as a separate document.

[2] Under the Ministerial Advisory Group for Improving Outcomes for Looked After Children.

Figure 1: Summary characteristics of included models

Name	Brief description	New/embedding or established?	Focus on transition?	Any specialist needs catered for?
Child Protective Services Reintegration Project (CRP) (U.S., Texas)	Care co-ordinator supports young person in residential care to transition back to community through six stage wraparound planning process.	New/embedding	✓	• 5 to 17 year olds • Mental, behavioural, or substance use disorders
Children and Residential Experiences (CARE) (U.S. and N. Ireland)	Principle-based programme designed to enhance relationships in residential care settings through staff training.	Established	×	• None identified
Core and Cluster (Worldwide)	Network of homes located close to each other that often share resources.	Established	×	• Varies across models
Dyadic Developmental Psychotherapy (DDP) (Worldwide)	Residential programme that aims to facilitate attachment and improve relationships.	Established	×	• Trauma and attachment disorders
Model of Attachment Practice (MAP) (Northern Ireland)	An attachment and trauma-led way of working with children. Originally established for children's residential care it is expanding to other settings and services, e.g. children with disabilities and foster care.	New/embedding	×	• All groups of children in care
Neurological Reparative Therapy (NRT) (U.S., Oregon)	Intensive residential programme involving therapeutic interventions. Wraparound work and step-down foster placements provided prior to or following NRT.	Established	✓	• 4 to 13 year olds • Experience of trauma and abuse • Multiple placements

Name	Brief description	New/embedding or established?	Focus on transition?	Any specialist needs catered for?
No Wrong Door (England)	A range of residential placements are provided from a "hub" and each young person is supported by a key worker.	New/embedding	✓	• 12 to 25 year olds
Positive Peer Culture (Worldwide)	Peer-helping model involving 90-minute group sessions 5 days a week designed to improve young people's social competence and cultivate strengths.	Established	✗	• 11 to 22 year olds • Offending behaviour • Experience of neglect or abuse (emotional, physical or sexual)
Priority Childcare (Wales)	Residential children's home provider with skills programme and on-site flats to support transitions to independence.	New/embedding	✓	• 8 to 18 year olds • Experience of CSE • Challenging/ difficult behaviour (e.g. self-harm)
Restorative Justice (Worldwide)	Approach to dealing with incidents that occur between young people and/ or staff which involves resolving them collectively.	New/embedding	✗	• None identified
Safe Steps (London)	Two high supervision children's homes with staff trained in social pedagogy and relational security.	New/embedding		• Young women at risk of CSE
Social Pedagogy (Worldwide)	Holistic and relationship-centred approach based on informal learning.	Established	✗	• None identified

Name	Brief description	New/embedding or established?	Focus on transition?	Any specialist needs catered for?
Step Down (Scotland)	Provider of residential care and support including children's homes, self-contained flats, foster care and support for care leavers.	New/embedding	✓	• 11 to 25 year olds • High support needs • Pregnant young women or with babies
Stop-Gap (U.S.)	Model of residential care involving a schedule of specialised, environment-based and discharge-related interventions.	Established	✓	• 6 to 17 year olds • Disruptive behaviour disorders
Treatment Foster Care Oregon (Adolescents) (TFCO-A) (Worldwide)	Young people live with a trained foster carer (rather than a residential care placement) who receives support from a team of professionals.	Established	✓	• 12 to 18 year olds • Offending behaviour • Emotional and behavioural disorders

2 Key findings

This section highlights key findings and commonalities in relation to:

- Outcomes that models are trying to achieve.
- Measuring impact.
- Strength of evidence base.
- Costs and return on investment.
- Commonalities in practice.
- Lessons learned.

2.1 Outcomes that models are trying to achieve

There are a wide range of outcomes that models are trying to achieve. The degree of specificity and the extent to which these are clearly articulated varies between models. We identified five domains that many of these models share:

- **Health and wellbeing.** Improving mental health and emotional wellbeing is an explicit aim for many models. The language used varies. Models aim to affect positive changes to young people's: "emotional functioning" (CARE); "emotional wellbeing" (Safe Steps); "wellbeing" (No Wrong Door); "social functioning" (Social Pedagogy). Other models, which do not refer to improving wellbeing as an aim, provide therapy to meet residents' emotional and mental health needs (Priority Childcare; CRP).

- **Educational achievement and developing skills**. Most models also seek to help young people develop skills and competencies whilst in residential care. For many of the specialist models of residential care (such as Stop-Gap and NRT), developing young people's skills and competencies is a primary aim. Skills referred to in model aims differ slightly, for example: "social competence", self-management, and more effective or socially acceptable ways to express their needs. Developing young people's skills is synonymous in some of these models with improving behaviours; such models take a skills-deficiency approach to understanding young people's disruptive behaviour.

- **Improving relationships.** Several models have a focus on improving relationships including those within the residential care setting and with follow-on carers. In some cases, models seek to achieve this by improving young people's "relational skills".

- **Reducing "high-risk" behaviours.** This tends to be related to the model's specific target group. Where referral criteria include disruptive or high-risk behaviour, models generally seek to reduce these behaviours. For example: Safe Steps, for young women at risk of CSE, aims to reduce risk of CSE; and

Stop-Gap, for young people with disruptive behaviour disorders, aims to reduce these behaviours.

- **Transitions from residential care.** Facilitating young people's transition from residential care or improving outcomes for young people in their post-discharge environment is another shared aim (e.g. No Wrong Door, Child Protective Services Reintegration Project, Stop-Gap, Priority Childcare, and Treatment Foster Care Oregon – Adolescents, Step Down).

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. 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. Examples of standardised tools for young people used in these evaluations include:

- **Strengths and Difficulties Questionnaire** (SDQ). This is a brief behavioural screening questionnaire about 3-16 year olds. It covers the following domains emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and prosocial behaviour. It is used by No Wrong Door, Safe Steps, TFCO-A, and Social Pedagogy.

- **Vulnerable Attachment Style Questionnaire** (VASQ). This questionnaire measures insecure or mistrustful and anxious elements of attachment style. It is used by Safe Steps.

- **Teenage Attitudes to Sex and Relationships Scale** (TASAR). This indicates the young person's attitudes to sex, pressure to have sex, gender roles and equality in relationships. This is used by Safe Steps.

- **Trauma Symptom Checklist for Children** (TSCC). This measures post-traumatic distress and related psychological symptoms (reported by the child themselves) including anger, anxiety, and depression. This is used by Safe Steps.

- **Children's Global Assessment Scale; Health of the Nation Outcome Scales for Children and Adolescents** (CGAS/ HoNOSCA). These are

summary measures of general adaptive functioning, and mental health symptoms, social and physical functioning. These are used by TFCO-A[3].

Ideally, these outcome measurements are taken at "baseline" (prior to the young person's enrolment in the programme) and at later time points to indicate change in attitudes, behaviours, and wellbeing. Some evaluations struggled to achieve this level of robustness: for instance, Stop-Gap highlighted that follow-up data was collected for less than half of their baseline sample.

Administrative data

Some evaluations use administrative data, which is collected routinely often by residential care staff or other services. For instance:

- Placement moves. The average number of placement moves or rate has been used to indicate accommodation stability.
- Recorded behavioural incidents. Frequency of disruptive behaviour incidents within a setting has been used to indicate changes in confrontational or aggressive behaviour for young people, or nature of relationships in the residential care setting.
- Police call-out data. This has also been used as an indicator of young people's aggressive or disruptive behaviour.
- 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. In addition, 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 (CARE), and their experience of placement stability (No Wrong Door).

[3] Alongside CGAS/ HoNOSCA outcome measurements, Biehal et al's evaluation of TFCO-A uses standardised measures of emotional and behavioural difficulties (SDQ, and Child Behaviour Checklist (CBCL) and attachment (Development and Well-being Assessment – Attachment Disorder (DAWBA-AD)) to examine their association with the primary outcome measure.

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.

Longer-term outcome measurements (over 12 months) are available for No Wrong Door, Positive Peer Culture, CARE, CRP, Social Pedagogy, DDP, and Restorative Justice. However for all these models, what the type of measure chosen can tell us about outcomes for young people is limited. In some cases (No Wrong Door, Social Pedagogy), 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 5 years but is not independent (NRT). 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 (Safe Steps and TFCO-A). In practice, evaluations do not achieve the intended length-of follow up and sample size. Although evaluation designs are robust, the data collected makes it difficult to draw conclusions about the model's long-term sustainability. Factors including young women leaving the home or refusing to take part in the evaluation or delays in homes returning questionnaires, impede follow-up data collection.

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. Models that fall into this category are:

- Positive Peer Culture
- TFCO-A

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. Models that fall into this category are:

- CARE
- Child Protective Services Reintegration Project
- Dyadic Developmental Psychotherapy
- No Wrong Door
- Neurological Reparative Therapy

- Restorative Justice
- Safe Steps
- Social Pedagogy
- Stop-Gap

A considerable number of these models, already in operation, are supported by relatively limited evidence of impact. These models are:

- Core and Cluster
- Model of Attachment Practice
- Priority Childcare
- Stepdown

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. Information that is available is summarised in Figure 2. Please note, however, these are not directly comparable, ranging from individual costs to whole treatment centre costs, to pilot implementation grants.

Figure 2: Range of set-up or running costs

Model	Indication of set-up or running costs
CRP	CRP costs $382,312 based on enrolment of 32 young people over 30 months.
CARE	Set-up costs of £45,000 and annual running costs estimated to be £60,000 in a Northern Irish Health and Social Care Trust. No cost-effectiveness analysis.
Dyadic Developmental Psychotherapy	Costs per case for young person's therapy (not total care costs) range from £6,700 to £14,500.
MAP	Estimated annual cost of sustaining the integration of MAP was £60,000.

Model	Indication of set-up or running costs
NRT	Total annual running costs for entire residential treatment site almost $6 million. No link to outcomes provided.
No Wrong Door	Total annual costs in one county of £2.25 million (service's second year. A short-term package (up to 28 days) estimated to cost £5,000/ week per young person.
Priority Childcare	Core Placement costs per week are: 1st phase £2,900, 2nd phase £1,450 and 3rd phase £225.
Restorative Justice	Training costs from UK residential care implementation range from £150,000 (county-wide training) to £180,000 (for 8 homes over 3 years). No analysis of any savings associated with training.
Safe Steps	Pilot implementation received £1.19 million investment but no cost-effectiveness analysis provided in evaluation. Placement cost for one young person is £4,200 per week.
Social Pedagogy	Training costs total £22,500 for 6-8 days' training in 4 residential children's homes. No cost-effectiveness analysis.
TFCO-A	Local Authorities received grants of between £280,000 and £400,000 to cover set-up costs. Average annual cost of maintaining one TFCO-A placement estimated as £68,544.

Source: Costs are taken from model profiles. References are provided in profiles.

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.

Return on investment calculations are available for two[4] models included in this review.

For implementation of **Treatment Foster Care Oregon – Adolescents** in England, Holmes, Westlake and Ward 2008 compares costs incurred by young people (n=24) who spent at least six months in a TFCO-A programme with those incurred by similar young people in alternative placements. It found:

[4] The CRP model also claims a positive return on investment but their estimates do not include young people who drop out of the model into account. Given that around half of young people who are enrolled in the model drop-out, these estimates are questionable.

- TFCO-A was less expensive compared to in-house and out-of-authority residential care, but similar to independent foster agency placements;
- Social care costs decreased by around 15% in the first six months of a TFCO-A placement compared to the six months prior to entry.

There is also evidence of costs savings associated with the **No Wrong Door** implementation in North Yorkshire. Although a cost-benefit analysis is forthcoming, initial evidence suggested savings across services were as much as £1,280,000 (Lushey et al 2017). This included:

- Reduced use of other residential children's home placements, saving approximately £600,000.
- Reductions in arrests and missing incidents saving £200,000 annually through costs avoided to the police.
- The assessment of cases within NWD rather than being directly referred to CAMHS is estimated to have saved £160,000 annually.
- Annual cost savings associated with the work of the communication support workers are estimated at £300,000.
- Placement changes are estimated to cost from £250 to £1,500 per change. The costs incurred by placement changes for the NWD cohort fell by £20,000 from the year prior to NWD to the first year of NWD due to improved placement stability.

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. For example, CARE, Priority Childcare, DDP, MAP and NRT all draw on developmental trauma and attachment theories. Other models are based on theories of competence. For instance, the literature on TFCO-A directly refers to social learning theory. While models such as Stop-Gap, Safe Steps and NRT do not reference these theories, they use points or rewards systems informed by the theory, and provide training for staff.

Some theories, such as ecological theories and Social Pedagogy, emphasise reflective practice, encouraging staff to critically evaluate their own work and understand the impact of their own behaviour in the residential care setting. Social Pedagogy features as a model in its own right; is described as an

orientation (Haus Conradshöhe, Core and Cluster); and training is offered to staff in its key concepts (Safe Steps).

Unlike other models, No Wrong Door does not give prominence to a theoretical orientation. However, the model draws on theories of restorative practice through its training programme for staff. Like other models, this gives staff a common language and framework to talk about the young people they are working with and understand their work.

As SCIE 2012 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 included in this review. 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 (DDP, CARE), and core training must be delivered to staff by a certified provider. Other training often relies on established external providers such as Thempra's social pedagogy training; or is delivered by in-house teams (e.g. MAP). Not all training is standardised; for example, the training package for NRT is not specified, and training in Restorative Justice varies considerably.

Some models emphasize a "whole team" approach to training. For example, training in the CARE model focusses on team-building and supporting staff as a team. No Wrong Door also takes a whole staff training approach providing universal training in restorative practice, therapeutic crisis intervention and Signs of Safety. MAP takes 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. TFCO-A provides training in core principles to professionals already in post who come into contact with the model; for example training for social workers.

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. Examples of ways in which these opportunities were scheduled into staff timetables include:

- Regular team meetings, development days, and culture and practice days for all staff to resolve any issues, highlight best practice and implement training plans (No Wrong Door, MAP).

- A daily telephone call and weekly group meetings with foster carers working with young people with similar issues (TFCO-A).

- Group consultation (fortnightly and external for Safe Steps; monthly and internal for MAP).

- Training manuals and opportunity to follow up in group meetings (Social Pedagogy, MAP)

Ongoing supervision for staff was a feature of some models. Safe Steps, CARE, No Wrong Door and MAP, all emphasise scheduled and ongoing supervision. 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 people as individuals, but also the social and material aspects of the environment. Some models describe this as taking a "total therapeutic milieu" approach (PPC), 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 (for example CARE and NRT). 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 (Safe Steps).

Environment-specific interventions are a key component of Stop-Gap and NRT, 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. Two exceptions are Positive Peer Culture which focusses on a group of young people rather than young people as individuals with different needs, and Restorative Justice, which offers a process for resolving disputes within the setting.

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 such as No Wrong Door, CRP, and Stop-Gap 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. For example, TFCO-A establishes a programme of therapy, skills training, and education tailored to each young person. The type of treatment and interventions offered to each child in NRT varies according to their level of need.

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:

- enabling residents to participate in virtual learning or support from tutor, facilitating referral to schools (Safe Steps);
- hiring an Education Support Worker whose job was to help young people obtain education placements (TFCO-A);
- including improving young people's educational outcomes in the remit of Portfolio Leads (No Wrong Door).

Two models have on-site schools for residents unable to access mainstream education (Priority Childcare, NRT). 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.[5] Several models involve the young person's family or follow-on carer.

For example, involvement of a young person's family in their care, planning and treatment is a core principle of the CARE model. Safe Steps also involves

[5] 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.

families in care planning, and shares any strategies with them. For CRP families and young people are encouraged to take the lead in setting goals.

The extent to which families or follow-on carers are involved varies. It may involve encouraging contact between young people and their families (Stepdown). Some are designed to be conducted in the family home (CRP) or may provide support families as "early intervention" to prevent use of residential care (Stepdown).

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. Examples are Stop-Gap, Stepdown, and TFCO-A. Although there is no focus on family support in DDP, the model is designed for transition to a family home.

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 CRP, evaluators note the worrying and probable implications of financial insecurity of families on long-term outcomes (Madden et al 2012).

Other 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 of No Wrong Door, particularly 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 the Safe Steps model), had difficulty recruiting and retaining staff in stressful and low paid roles and staff turnover problems were a main reason for closure of a pilot home. Local changes in funding priorities and sustainability problems once grant funds were spent affected TFCO-A model implementation in England, leading to staff and carer turnover and recruitment difficulties.

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 (Restorative Justice, Safe Steps, Social Pedagogy, MAP). Particularly for models which required a shift in culture, such as 'managing risk differently' (Safe Steps), 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 (Social Pedagogy). External social workers without knowledge of the models could thwart the model's intended potential, and be a possible point of conflict. In CARE implementation in Northern Ireland, evaluators noted external partners (including social workers) had not received CARE training and often did not see its relevance, impeding successful model implementation. (SCIE 2012)

Strict referral criteria

The importance of targeted and thorough referral processes emerges across evaluations, especially for pilot implementations.

Whereas pressure to accept inappropriate placements affected CARE implementation, evaluators of the No Wrong Door model cite its strict referral and acceptance criteria as key to the model's success.

In some instance such as with Safe Steps, the approach to referral was changed to incorporate clearer guidelines about who could benefit from a placement, any effects on existing residents. This was considered necessary, even if it made it harder for homes to reach capacity.

Context-specific translation

Evaluations identified changes that are needed to implement a model in a different context. Concern is identified about some models' universal applicability for different age groups and needs (Social Pedagogy, CARE, Restorative Justice).

When implementing models from outside the UK into UK settings, changes to language and concepts were sometimes made. For example, changes were made to some language for the CARE model developed in the US. These were considered necessary for staff to implement the model. Other changes needed to implement US models include accommodating children in their own rooms rather than shared dormitories to comply with UK care standards (Johnson 2016).

Similarly, evaluations of UK implementation of established continental European models often noted the "risk-averse" culture of residential care in the UK, which made it difficult to implement some elements of a Social Pedagogy model or Safe Steps for example. Evaluations also describe differences in the cohort of young people in residential care, with the assumption that this should be considered when implementing an established model from a different social care context.

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).

4 Child Protective Services Reintegration Project

4.1 What is it?

4.1.1 Introduction

The Child Protective Services Reintegration Project (CRP) supports children and young people in residential care with a diagnosed disorder (mental, behavioural or substance misuse) to transition back to their communities. An assigned Care Co-ordinator works with the young person and their caregiver in the community to identify their strengths, access training and community resources. CRP uses a wraparound planning process, where young people and their families are encouraged to take a lead both in setting goals and deciding how they will meet them. There are six stages from referral to case closure.

4.1.2 Model aims

Overall, the CRP aims to reduce the number of children and young people in the child welfare system due to their mental health needs.

To do this it supports these children and young people to leave residential care settings and re-integrate with their caregivers.

4.1.3 Origin and implementation

CRP originated in 2007 in the USA. It has been implemented in Texas.

The CRP model is implemented in six phases by CRP Care Co-ordination staff:

- **Referral.** This takes place 3 to 6 months before the young person's planned re-integration in the community.
- **Screening period** (lasting 30 to 45 days). This comprises three face-to-face visits with the parent/caregiver and one or two face to face visits with the child/adolescent. During these visits, which last between 1 and 3 hours, staff and the young person's family agree CRP enrolment details.
- **Pre-integration planning** (lasting 3 months). This phase comprises two Child and Family Team Meetings; one contact with the child; and numerous telephone calls and e-mails to collaborate with team members.

  CRP Care Co-ordination staff help young people and caregivers articulate their family's strengths and needs, and form an individualised Wraparound plan of care and Crisis/Safety plan.

  Plans are made in partnership with young people and their caregivers and establish a timeline for the young person's participation in CPS, and identify

services that will be used in the community.[6] Bespoke support services are provided where needed, and may include: coaching, individual or family therapy, as well as financial contributions to rent or utilities.

Caregivers are supported to plan for challenges they may experience when the youth comes home after residential treatment and connected with other caregivers in the community. If needed, they are provided with training to increase their knowledge of and improve interactions with mental health, educational, health, child welfare, and other systems.[7]

- **Re-integration period at home** (lasting 6 months).There is ongoing CPS involvement once the young person has returned home. At first, CPS contact takes place weekly, and is scaled down to fortnightly contact. There is also weekly contact with school staff (telephone, email, and meetings) in this phase.

- **Ongoing period**. The young person and their family can continue to receive support for 6 months or more, if needed, post-CPS involvement.[8] During this phase, frequency of contact with CPS varies depending on the family's needs (usually fortnightly or monthly).

- **Case closure.** This takes place following successful completion of all stages, once the family is fully transitioned to support in the community.

According to the model website, on average the process from referral to a case being closed lasts 16 months.

4.2 Target groups

Children and young people (5 to 17 years old) with a diagnosed clinical disorder (mental, behavioural, or substance use) that required placement in a specialised setting such as a residential treatment centre.

4.3 Inputs and resources

4.3.1 Staff, expertise and resources required

According to the CEBC profile, CRP tends to be conducted in family homes and requires the following resources:

[6] 10 Principles of the Wraparound process: family voice and choice; team based; natural supports; collaboration; community-based; culturally competent; individualised; strengths-based; persistence; and outcome-based.

[7] Parent Engagement and Self-Advocacy course (PESA) for parents and caregivers to learn about the child welfare system over 5 sessions covering: child/adolescent development and mental health; the child welfare system; the school system; communication and organisational skills; and advocacy.

[8] No information is available on whether there is a maximum duration.

- Two Care Co-ordination Staff.
- One Clinical Supervisor.
- Location to store confidential files.
- Software program to maintain case notes, demographics, diagnostic information (Clinical Manager (TCM) Integrated software system)
- Laptop computers and mobile phones.
- Flexible funding to meet individual needs of families, e.g. crisis respite, mentoring, parent coaching, behavioural aides, non-traditional therapies (music and art). Where needed, CRP has also used these funds to cover families' basic costs (rent, utility bills, clothes, and furniture).

No information is provided on how many children and young people this level of resources can cover.

Training and qualifications

The three-day training course takes place in Austin, Texas; content is guided by the CRP Brochure, Caregiver Guide, Youth Guide, Policy and Procedure Manual, Referral Form, and Enrolment Form. Training and manuals are available in English and Spanish.

Staff implementing the model are required to have the following minimum training and qualifications:

- System of Care Values and Wraparound Process training.
- Social Work, Psychology or related undergraduate degree field (with over 5 years' experience or Master degree with 2 years' experience).
- Experience with child/young person mental health.
- Experience with child welfare system.

In addition, supervisors should have a Master's Degree in behavioural sciences.

4.3.2 Set-up and running costs

Casey Family Programs 2011 summarises CRP costs over 30 months based on enrolment of 32 young people (Figure 3).

Figure 3: Cost of the Reintegration Project

Total cost (over 30 months, for 32 enrolled young people with 52 young people screened)	
Re-integration staff	$258,401
Flexible services component	$125,692
Total	**$382,312**

Source: Casey Family Programs 2011 based on data provided by CRP project staff

4.4 Effectiveness and impact

4.4.1 Overall evidence base

The CEBC reviewed available evidence for the CRP but did not find any published, peer-reviewed research on the model. As such, even though CRP is already in use across Texas, the model has not been given a scientific rating.

Two qualitative evaluation reports are available; however due to the study design and lack of rigour, limited conclusions can be made about CRP's effectiveness and impact.

4.4.2 Evaluation findings

One evaluation report (Madden et al 2012) examines the barriers to successful reunification, through in-depth case reviews and interviews with youth (n=6) and caregivers (n=6) who were reunified during the first 10 months of the pilot. Another (Casey Family Programs 2011) reviews case files and interviews CRP participants from Travis County Texas CRP's inception in December 2007 to August 2010. Participants included children and young people, their caregivers, CPS caseworkers and CRP staff.

Between December 2007 and August 2010 there were 32 enrolments, 18 of which had were eventually closed (Casey Family Programs 2011). Half of these were in a stable placement (n=9); however, the other half had not experienced successful reunification but had had their case closed either during the re-integration preparation phase or after reunification (n=9).

Reasons for discharge pre-unification included (Casey Family Program 2011):

- CPS did not approve the caregiver as appropriate or ready for reunification
- CPS determined that the youth was not ready for reunification
- The proposed caregiver declined participation
- The youth declined reunification

Madden et al 2012 identified numerous barriers that delayed reunification. At a **system-level** these included:

- Problems working with RTCs to plan young person's discharge from residential care: reluctance to consider less conventional alternatives
- Finding well-qualified service providers: lack of providers or providers who accepted Medicaid limited ability to individualise approach

At a **programme-level, barriers** noted included:

- Ineffective communication and collaboration between CRP and CPS staff
- More cultural competency needed: in particular staff tended to be White whereas young people and caregivers were almost all African American or Latino

4.4.3 Potential cost savings

Casey Family Program 2011 estimates cost savings using administrative records and staff interviews. Averaged across all youth with an average enrolment of 180 days, they estimate a cost of $17,242 per young person for specialised group or therapeutic foster care and $24,885 for residential facilities at a specialised level.

From these estimates, they argue cost savings from CRP start to accrue after 87 days of sustained placement in the home for children who would otherwise be in residential treatment centres, and after 125 days for children who would otherwise be in group or therapeutic care. They reason as the number of days in the community increases, the cost savings will also increase but provide limited additional detail (Casey Family Program 2011).

4.4.4 Limitations to the evidence

All available evidence is from the pilot phase of the model in one location, in the U.S.A. Understanding CRP's **transferability** outside the U.S. health context is difficult.

Study design. Both evaluation reports use a qualitative interview and case study design. Without an experimental research design and with small numbers of young people involved, it is not possible to attribute reunification outcomes to the CRP. Both reports mention patterns in the data but neither performs any statistical analysis; the findings may be attributable to chance. Neither evaluation report provides data excerpts from the interviews to back up its conclusions, which threatens credibility of the authors' "comprehensive understanding" of young people's experience (Madden et al 2012).

We have a very **little indication of how CRP works and for whom**. Multiple factors are likely to affect model effectiveness including: the young person's placement history (which ranged from 9 months to 6 years in Madden et al 2012), placement location (residential treatment centre, therapeutic foster care, or emergency shelter); caregiver involved (e.g. biological or adoptive parents,

grandparents or aunts/uncles); young person's clinical diagnoses, which were often multiple and changing diagnoses. With such a small sample size, it is not possible to draw any conclusions about factors that may modify the effect of the model or run any sub-analyses.

Furthermore, all the young people whose placement was disrupted post-reunification were African American, yet an understanding of **the role of race and other factors** in reunification is lacking (Casey Family Program 2011).

Without a longer time-frame, we have **no indication of young people's long-term outcomes** after their cases are closed. In addition, given nearly 30% of young people in the Casey Family Program 2011 report had their case closed without successful reunification and no follow-up data is provided, it is important to know if there are any adverse outcomes or negative consequences for their enrolment in the CRP. Madden et al 2012 only interview young people who were reunified with their caregivers in the first 10 months of participation; they may be more likely to have a positive experience of the CRP model compared to those for whom reunification is not achieved.

Cost savings estimates are based on questionable assumptions and costs of young people who are not successfully re-integrated are not accounted for.

4.4.5 Lessons learned

Casey Family Program 2011 notes the following "practice improvements" to the model needed for more successful CRP implementation:

- Strengthening young people's engagement during the re-unification preparation stage.
- Considering short-term (90 days) "step-down" placements in the community where the change to the living situation is more incremental so the youth can adapt (Travis County is redesigning one contract with a local shelter to include a 90-day transitional program to ensure young people attend local schools once in the community.)
- Increasing the caregiver's tolerance of perceived "misbehaviour" and lowering general expectations of young people's ability to act independently and self-regulate.

Importantly, Madden et al 2012 note case-level barriers to model implementation and issue of financial insecurity. All but one family needed and received financial assistance (such as utility payments, rent, buying beds or groceries). Once discharged from the programme, it is not clear how these families will manage and the implications for long-term reunification outcomes.

4.5 Recommendations for further research

There is an urgent need for more robust research into the CRP model. In particular, attention should be paid to more robust study design (e.g. control

group, some measure of changes attributable to the intervention) and a larger sample size which would enable us to determine any effectiveness and impact, and the effect of any modifying factors such as race or ethnicity.

Despite the poor quality of evidence available, significant barriers and challenges are identified (Madden et al 2012). These should be enough to deter any implementation of the model in its current form unless evidence for its effectiveness materialises or substantial changes in policy, practice and training are made.

4.6 More reading

- CEBC profile http://www.cebc4cw.org/program/child-protective-services-reintegration-project-crp/detailed
- Intervention website: https://www.traviscountytx.gov/health-human-services/children-and-youth/welfare/crp
- Principles of the wraparound process: https://www.traviscountytx.gov/images/health_human_services/Docs/Wraparound_Process.pdf
- Casey Family Programs (2011) *Travis County Reintegration Project:* Permanency outcomes for youth with complex mental health needs served by the Child Protective Services Reintegration Project in Travis County, Texas. Phase II eval report https://caseyfamilypro-wpengine.netdna-ssl.com/media/TravisCounty_PhaseII_FR.pdf
- Madden, E. E., Maher, E. J., McRoy, R. G., Ward, K. J., Peveto, L., & Stanley, A. (2012). Family reunification of youth in foster care with complex mental health needs: Barriers and recommendations. *Child and Adolescent Social Work Journal.* Advance online publication. doi:10.1007/s10560-012-0257-1

5 Children and Residential Experiences (CARE)

5.1 What is it?

5.1.1 Introduction

Children and Residential Experiences (CARE) is a principle-based programme designed to establish care practices that improve outcomes for children in residential care and enhance relationships in residential care settings. Drawing on attachment, trauma recovery and ecological theories, the model focusses on improving two competencies across the care setting: (i) leadership and organisational support for change, and (ii) consistency in how all staff think about, and respond to, the needs of the children in their care.

The model is orientated around six research-informed principles designed to guide staff's care practice and interactions with children that are:

- relationship-based,
- trauma-informed,
- developmentally focussed,
- competence-centred,
- family-involved, and
- ecologically oriented.

5.1.2 Model aims

According to its CEBC profile, the Children and Residential Experiences (CARE) model aims to:

- Improve relationship quality between staff and children/adolescents
- Increase the use of trauma-informed practices by staff
- Improve social and emotional functioning among the children and adolescents
- Reduce the number of high-risk behavioural incidents such as aggression, property destruction, and running away
- Reduce the use of physical restraints and other restrictive practices
- Improve academic achievement and overall functioning in school or vocational settings among children and adolescents

- Increase contacts between children and their families while in care
- Increase agency's capacity to collect, analyse, and use data in decision-making
- Reduce staff turnover

5.1.3 Origin and implementation

The CARE model originated in 2005 in the USA as a collaboration between Cornell University and statutory services. The model was first introduced in residential care organisations in South Carolina in 2006 and 2007.

To implement the model, CARE consultants[9] deliver 5 days of on-site training to staff across all levels at the setting (including administration, supervision, clinical care, education, and direct care). Consultants follow standardised steps and training begins with instruction on the six CARE principles (Figure 4).

Figure 4: Six Guiding CARE Principles for Childcare Practices

CARE Principles	
Relationship-based	Form healthy models of adult-child relationships and build capacity for future relationships
Trauma-informed	Use professional practice that is sensitive to young person's trauma history
Developmentally focused	Provide normative developmental experiences and adapt expectations to meet individual needs
Competence-centred	Foster self-efficacy and competence for dealing with life circumstances
Family-involved	Understand and adapt to families' cultural norms and promote active family involvement
Ecologically oriented	Enrich the physical and social environment (such as improving building furnishings and social interactions)

Staff are then encouraged to apply these principles to actual or simulated situations. Along with practical tools provided in the training sessions, these principles give carers objectives for daily routines, leisure activities, and establish a framework for all staff in their interactions with residents, colleagues, and external organisations.

[9] CARE trainers must undergo a 5-day manualised program and be recertified regularly

Implementation of the model typically lasts 3 years and involves quarterly on-site training visits from CARE consultants.[10] In addition, a local Implementation Team is set up. Crucially, it must be representative of staff from all levels and functions of the organisation. Along with the existing Leadership Team, the Implementation Team develops a setting-specific plan for implementation following a 4-day manualised programme. Staff receive support, modelling and mentoring from the Implementation Team, but are encouraged to use their own creativity and professional judgment when integrating the principles in their work.

5.2 Target groups

Child care staff, clinical staff, and agency administrators working with 6- to 20-year-old children and youth living in residential care settings.

5.3 Inputs and resources

5.3.1 Staff, expertise and resources required

The typical resources for implementing the program are:

- Commitment of agency leadership to at least a 3-year implementation process
- Funding for 3 years of implementation assistance through training and technical assistance
- Time and resources to provide 5-day CARE training for all staff
- Time and resources for regular implementation meetings for key staff
- Staff available to commit the time and effort to lead local implementation and serve as trainers for agency personnel
- No specific concrete resources are viewed as essential, as the program is adaptable to the real-world setting in which it is implemented.

This program may be conducted in foster and family care settings and schools, as well as residential care facilities.

5.3.2 Set-up and running costs

Set-up and running costs are expected to vary depending on the size of the organisation.

[10] Quality assurance activities based on continues self-assessment; participation-centred management strategies; education, training and technical assistance; data informed decision-making; practical tools and principles to guide work.

The Cornell CARE Information Bulletin estimates a three-year partnership to cost USD $99,000.[11] Costs for implementation outside the U.S.A are expected to vary though Cornell does not provide any cost estimate (Cornell 2016).

The Northern Trust implementation of CARE in Northern Ireland was approximately £45,000.[12] The Trust estimated continual annual costs of CARE implementation to total £60,000, including employment of a Band 7 Co-ordinator, funds for further training and training venues (SCIE 2016). No information is provided on the size or capacity of the homes.

5.4 Effectiveness and impact

5.4.1 Overall evidence base

While evaluation data gathered on implementation of the CARE model since 2006 is generally positive, evidence for change mechanisms, effectiveness and impact is still limited. Research evidence on the model is described as "promising" (CEBC profile).

5.4.2 Evaluation findings

Most evidence is on CARE implementation in North America and study authors tend to be associated with the model (Holden et al 2010, Anglin 2016, Izzo et al 2016, Nunno et al 2017).

In addition, this review identified one evaluation of CARE implementation (prospective comparative design) in a Northern Irish setting as part of a regional review of five residential child care models (SCIE 2012).

Outcomes for residential care staff

U.S. evidence suggests participants achieve knowledge gain and are satisfied with the CARE curriculum, and, following training, are using self and organisational reflection (Holden et al 2010).

Staff at the Northern Ireland site, when surveyed about their working practices before and after CARE implementation, perceived the following positive changes

- Increased ability to reflect and 'step back' from challenging situations;
- Increased ability to understand a young person's behaviour;
- Reduction in aggressive incidents;

[11] If implementation includes Therapeutic Crisis Intervention the estimate increases to USD $132,000 over 4 years.

[12] Of this, £15,000 was invested by the trust itself (in addition to DHSSPS funding) to train all the homes.

- More relaxed/ calm/ more informal relationships with young people;
- Better use of supervision;
- Increased contact with families.

However, the model made no perceptible difference to staff's ability to tailor responses to young person's stage of development (SCIE 2012).

Outcomes for young people

Several studies attempted to measure changes in behavioural incident rates before and after CARE implementation to examine the impact of CARE on staff and young people's interactions.

Two studies (Izzo et al 2016, Nunno et al 2017) use staff logs of behavioural incidents and perform an interrupted time series analysis. Izzo et al 2016 found significant decreases in all types of incident rates measured of 4% to 8% per month at the first time-point. However, the findings were less consistent after 3 years with significant declines for just three types of incident measured: aggression toward staff, property destruction, and running-away. Nunno et al 2017 show that a reduction in behavioural incidents is sustained at 6-year follow-up.

Although SCIE (2012) envisaged calculating the odds of behavioural incidents before and after CARE training using monthly monitoring reports, it did not have a big enough sample size to carry out the statistical analyses. While staff were confident in interviews that training had brought about improvements in young people's behaviour, explanation backed by quantitative evidence is absent.

Across the studies few negative changes for young people are mentioned that are not a result of residential care itself. However, one young person felt that the model resulted in some children being treated unfairly (SCIE 2012).

5.4.3 Potential cost savings

This review did not identify any cost saving estimates for the CARE model.

5.4.4 Limitations to the evidence

There are several limitations to the CARE evidence base, which include:

- **Attribution.** It is difficult to attribute outcomes to the CARE model with the available evidence. No study used a randomised comparison group or control and the study designs lack robustness. For example, the SCIE evaluation was unable to use its intended "before and after" evaluation design, which makes it even harder to sketch any conclusions on changes that may be attributed to the model. No study considers the effect of additional models and therapies that were being practiced alongside CARE, which may affect outcomes in the setting (e.g. Restorative Practice, and Therapeutic Crisis Intervention in use SCIE 2012).

- **Young people's experiences of CARE.** While a key overall goal is improving outcomes for young people, evidence on their experiences of CARE is very scarce. Use of behavioural incidents reported by care staff sheds little light on how young people experience CARE. SCIE 2012 is the only evaluation that interviews young people, but does not indicate how many (n=29 divided among five models). Due to the small number of young people interviewed it is not possible to know whether the negative experience the study reports concerns one individual or reveals fundamental issues about the model.

- **Sustainability of CARE.** Most studies measure outcomes at 3 years (though Nunno et al 2017 measure at 6 years) which does not give a real indication of how settings adapt once they are no longer receiving regular visits and support from CARE trainers. Understanding sustainability is further compromised by a lack of long-term outcomes, and no evidence around care transitions or educational achievement, to name two.

- **Non-standardised incident reporting and reliance on self-reported outcome measures**. Staff reports of behavioural interaction present a potential for under- or overestimation due to observer bias. Staff may feel invested in the programme and so under-report behavioural incidents or overestimate change they perceive as attributable to CARE.

- **Generalisability.** Implementation relies on substantial organisational buy-in and resources. It is unclear how well 3-year implementation would work in resource-stretched settings, where Leadership have not chosen to implement CARE. For example, the thirteen agencies in Izzo et al 2016 received CARE services free of charge.

- **Regression to the mean.** Agencies in some studies may have been particularly well-placed to show an effect for CARE that would not be applicable elsewhere. For example, Izzo et al 2016 used thirteen agencies that had previously relied on "homegrown" rules, had no coherent model guiding management, and had never received any similar intervention. In this case, any intervention would have probably shown some effect.

- **Lack of methodological rigour.** For example, Anglin 2016 claims to use a grounded theory approach to understand staff experiences of CARE implementation but does not provide any data extracts from interviews.

5.4.5 Lessons learned

The CARE model recognises that the implementation support given to residential care settings is "as important as the efficacy of the model" (Cornell information sheet). Key success factors and challenges identified from the literature include:

Key success factors

- Emphasizing **co-creation** between facilitators and staff in training (i.e. joint production rather than instruction) is crucial for model implementation. (Anglin 2016)

- Putting processes in place to support **ongoing reflective practice**[13] for all staff (for example scheduling time for discussion and reflection about work). (Anglin 2016)

- Staff, and particularly supervisors, are **comfortable with abstract concepts**, able to adapt to new and complex situations, self-aware and self-critical, and able to question authority. (SCIE 2012)

- A consistent **"whole team" approach** to training**,** focussing on team-building and supporting staff as a team. Where staff turnover issues impede this, new staff complete introductory training followed by refresher training for the whole team. (SCIE 2012)

Key challenges

- **Sustained momentum** (at least two years of concerted effort) are needed to implement the CARE model. (Anglin 2016)

- **Translation of CARE terminology** and model components may be needed for different cultural contexts; staff implementing the model in Northern Ireland were uncomfortable being open about thoughts and feelings. (SCIE 2012)

- **Receiving training from peers perceived as ineffective by staff.** as they had limited experience of the model in practice. (SCIE 2012)

- **External factors** such as service cutbacks or, pressure to accept inappropriate placements affect CARE implementation. External partnerships (e.g. with social workers) were also sometimes challenging for CARE implementation as partners had not received training and did not see the relevance of CARE. (SCIE 2012)

- **Not suitable for all children.** Almost all staff interviewed at the Northern Ireland CARE site thought the model was suitable for younger children (who were more open to forming relationships with staff) but unsuitable for young people with behavioural or learning difficulties such as Autistic Spectrum Disorders (ASD) or Attention Deficit Hyperactivity Disorder (ADHD) for whom behavioural intervention were considered more appropriate. (SCIE 2012)

5.5 Recommendations for further research

- To what extent can changes be made to the CARE model (for example implementation outside North America) without threatening its integrity or breaching a franchise, and does it matter?

[13] Reflective practice i.e. learning through focused attention and ongoing reflection to one's own work.

- Understanding of the elements and dynamics of change at play in implementing the model.
- Contribution of the model depending on the extent of other therapeutic support available.
- Young people's experiences of the model.
- Outcomes for children and young people associated with the model.
- Whether CARE is universally effective or whether it really is less appropriate for some children and young people or in specific circumstances (as perceived by staff at the Northern Trust).

5.6 More reading

Anglin, James (2016) Translating the Cornell CARE Program Model into Practice: Lessons from the Pioneer Agencies on Changing Agency Cultures and Care Practice. In CARE Information Bulletin (6): 11-16. Available at: http://rccp.cornell.edu/_assets/CARE_INFO_BULLETIN_2016.pdf [Accessed 07/02/2017]

CARE Information Bulletin. (2016) Children And Residential Experiences: Creating Conditions for Change. Edition 6. Available at: http://rccp.cornell.edu/_assets/CARE_INFO_BULLETIN_2016.pdf [Accessed 07/02/2017]

CARE webpage: http://rccp.cornell.edu/care/care_main.html

CEBC CARE profile webpage. Available at: http://www.cebc4cw.org/program/children-and-residential-experiences-care/detailed [Accessed 07/02/2017]

Holden, M. J., Izzo, C., Nunno, M. Smith, E. G., Endres, T., Holden, J. C., & Kuhn, F. (2010). Children and Residential Experiences: A comprehensive strategy for implementing a research-informed program model for residential care. *Child Welfare, 89*(2), 131-149.

Izzo, C., E. Smith, M. Holden, C. Norton, M. Nunno, and D. Sellers (2016) Intervening at the Setting Level to Prevent Behavioral Incidents in Residential Child Care: Efficacy of the CARE Program Model. *Prevention Science. 17(5):* 554–564 Available at: https://link.springer.com/article/10.1007/s11121-016-0649-0 [Accessed 07/02/2017]

Nunno, M. A., Smith, E. G., Martin, W. R., & Butcher, S. (2017). Benefits of embedding research into practice: An agency-university collaboration. *Child Welfare, 94*(3), 112-132.

Social Care Institute for Excellence. (2012) Report 58: Therapeutic approaches to social work in residential child care settings. Published: May 2012. Available at: https://www.scie.org.uk/publications/reports/report58/ [Accessed 07/02/2017]

6 Core and Cluster

6.1 What is it?

6.1.1 Introduction

A "Core and Cluster" or "Hub and Spoke" model of children's residential care typically describes networks of children's homes that share common resources (facilities, staff). In this case, we have focussed on those that are located close to each other and/or co-located (e.g. in a campus). Core and Cluster models draw on diverse psychological theories, and vary considerably in size, approach and scope.

Although in operation worldwide, in the UK Core and Cluster homes have generally been phased-out and replaced by smaller-scale models which are perceived to be less institutional and have less potential for abuse (Ellis 2012; Narey 2016).

This section details two larger-scale Core and Cluster models of the sort not currently implemented in the UK: Haus Conradshöhe in Germany and SOS Children's Village Bergen in Norway. With key differences in approach, we summarise each model and its potential relevance in the UK[14].

6.1.2 Model aims

Haus Conradshöhe offers a Christian environment for children and young people and aims to do "whatever it can" to help their development (Haus Conradshöhe 2018).

SOS Bergen aims to provide long-term foster homes to children who need them and enable siblings to live together where possible.

6.1.3 Origin and Implementation

This section provides background on children's residential care provision and home size in the UK. It then introduces the German and Norwegian models (Haus Conradshöhe and SOS Bergen).

The UK context

Historically, residential care settings for large numbers of children and young people have been considered a concern in the UK. A 1946 report found larger institutions were "unstimulating and austere", and recommended no more than twelve children should be accommodated in any single home (Care of Children Committee 1946). Since then the size of children's homes in the UK has continued to decrease. The average children's home currently provides around

[14] Unless otherwise specified information is taken from organisation websites or Ellis 2012.

four places though newly registered homes tend to be even smaller (Narey 2016).[15] An independent review of UK children's residential care in 2016 noted smaller homes "are not likely to be any more effective than slightly larger units" and are more expensive (2016: 33). Research has suggested attitudes held by residential care staff, home décor and culture are more important than size in creating a stimulating and non-institutional environment (Berridge et al 2011). Despite this, the view is still widespread in the UK that homes with four places or less are likely to be more effective than larger homes (Narey 2016).

Germany: Haus Conradshöhe, Berlin

Haus Conradshöhe accommodates over 100 children and young people (from babies up to 20 years old). Individual homes on-site house 6 to 10 young people, generally of mixed genders and ages.[16] Individual homes have discrete staff teams. Approaches to care within the homes are based on Social Pedagogy theory (Ellis 2012).

According to Haus Conradshöhe's website, there are about 110 employees across the site, two thirds of which have education or therapeutic background. Staff within homes hold professional qualifications as Social Pedagogues, Social Workers or ErzieherInnen ("Educators"[17]).

Haus Conradshöhe Core and Cluster features include:

- **Shared therapeutic provision**. Haus Conradshöhe employs 5 psychologists who work with children, their families, and staff across the homes.
- **Accommodates different needs on-site.** Several types of care provision are available on the same site: children's homes; short-term crisis and assessment provision for teenagers; and shared and individual flats to help prepare older teenagers for transitions from residential care.
- **Other shared facilities.** As well as therapy (see above), administrative, leisure and other facilities are also shared across the site (23,000 m²).

Norway: SOS Children's Village (SOS Bergen)

SOS Bergen opened in 2009 and comprises eight family foster houses on one site. In total, the site "village" has capacity for up to 32 children. This review did not identify any specific information about the target group for the Norwegian

[15] Of all children's homes registered between 2012-2016 in the UK, more than three quarters were for five children or fewer, and a quarter for two or fewer children (Narey 2016).

[16] Although Haus Conradshöhe accommodates a range of ages (from babies up to the age of 20), most residents are teenagers. Age-specific and gender-specific homes are also available.

[17] State-recognised youth or child-care workers in Germany, who have completed broad training for work in a variety of sociopedagogical settings. Training includes: pedagogy, psychology, sociology, juvenile and family law, basic medical and health training and interviewing skills.

implementation of the model. That said, the model is designed for siblings to be placed in the same house, where appropriate.

Foster carers recruited by SOS rent an on-site family foster house. Each foster carer is provided with regular relief and practical support by one or two dedicated assistants, allowing carers to spend one-on-one time with children; attend professional meetings; and have time-off or take annual leave. Children and young people attend local schools. SOS Bergen Core and Cluster features include:

- **Shared therapeutic provision**. Specialist support is provided by professional on-site staff (for example a psychologist) across the eight houses.
- **Shared facilities.** Facilities are shared across the eight houses (and available to the local community) consist of: a multi-purpose hall; a guest house; administration offices; a sports room; a music room; a woodworking workshop; and a cafeteria. There is also a house for the SOS Bergen Director.

6.2 Target groups

Haus Conradshöhe caters for a very wide age range (from babies up to 20 year olds) and has a range of services on-site to meet diverse needs (for example young people in need of intensive or therapeutic support, or with learning disabilities).

Few specifics are available about SOS Bergen's target group of "Norwegian foster children". Children and young people attend existing, local schools, which suggests they must be able to attend mainstream education.

6.3 Inputs and resources

6.3.1 Staff, expertise and resources required

Detailed information available in English on each model is limited. Figure 5 provides an indication of the staff and facilities involved in implementing each model.

Figure 5: Example resources for Core and Cluster model implementation

	Haus Conradshöhe	SOS Bergen
Staff, qualifications **Staff shared across homes**	110 employees including: • 65 with an education or therapeutic background; (Social Pedagogues, Social Workers or Educators) • **5 on-site psychologists**	• Director • 8 Foster carers • 8-16 Foster assistants • **Psychologist and other on-site professionals**

	Haus Conradshöhe	SOS Bergen
Facilities shared across homes	• Therapy rooms and services • Administration offices • Leisure facilities (for example swimming pool)	• Multi-purpose hall • Guest house • Administration offices • Sports, music, woodwork facilities • Cafeteria

Source: All information is taken from homes websites and Ellis 2012.

6.3.2 Set-up and running costs

No information regarding the costs of any of these models was identified.

6.4 Effectiveness and impact

6.4.1 Overall evidence base

This review identified no evaluations of these models in English. One report (Ellis 2012) reflects on the models' relevance for UK children's residential care based on the author's professional experience and site visits.

Available information on model effectiveness and impact is observational and anecdotal, and therefore prone to considerable bias. Due to the lack of robust evidence, we cannot confidently make any inferences about the effectiveness or impact of these models.

6.4.2 Evaluation findings

We include key observations made in Ellis 2012. These may be of interest to commissioners and providers of residential care in the UK but, as noted above, must be interpreted very cautiously.

Distinctive Core and Cluster features considering the residential care context in the UK include (Ellis 2012):

- **Larger size and age range.** Compared to the UK, Ellis observes these continental European Core and Cluster models accommodate higher numbers of young people (both in the individual clusters, and in total).[18] At Haus Conradshöhe, the individual homes do not feel institutional, more "like family homes, with ornaments, wine glasses in the living room (which would be very unusual in English children's homes) and a lack of education/health posters"

[18] Ellis 2012 calculates the UK average is less than six children per home based on information in the Ofsted Children's Social Care Annual Report 2010/11.

(Ellis 2012: 8). One advantage to larger sized homes and age ranges, Ellis observes, is enabling sibling groups to remain together.

- **Benefits of community.** In informal conversations and interviews at Haus Conradshöhe and SOS Bergen, staff highlighted benefits to the community setting in terms of professional expertise, additional facilities and peer support (Ellis 2012).

- **Staffing levels and qualifications.** Ellis 2012 observes that staffing levels in these homes tend to be lower but that staff are more qualified, compared to UK settings: "it seems likely that this contributes to staff's confidence in their ability to work with larger numbers of children" (Ellis 2012: 10)

- **Child-centred practice**. Ellis observes two distinct features of child-centred practice at SOS Bergen (i) children remain in their homes during Foster carers' respite breaks and (ii) where placements break down, children remain in their home and a new SOS foster carer is provided.

Ellis 2012 does not make any observations about the effectiveness or impact of components to the models such as a Social Pedagogy approach to care in operation at Haus Conradshöhe. Data on model implementation or outcomes for young people at each site are not provided.

6.4.3 Potential cost savings

In general, Core and Cluster models are assumed to reduce service costs. This is because they operate on a larger scale which enables them to benefit from cost advantages (economies of scale). For example, sharing a swimming pool across ten homes rather than building one on ten different sites, or sharing a psychologist, rather than hiring one for each home, is likely to reduce the overall costs of treating a child.

That said, no detailed information is available on cost savings.

6.4.4 Limitations to the evidence

Lack of evidence. As discussed, information in English is very limited, and tends to be observational and anecdotal, rather than rigorous studies involving a comparison group and randomisation. It is not possible to attribute any impact to these models or draw conclusions about their effectiveness or impact.

Model coherence. Given the diversity of Core and Cluster models in operation, this review considers model features such as shared facilities and shared staff. The extent to which these constitute a model of residential care is questionable. Across the models in this review, additional models of treatment are in operation for example Social Pedagogy at Haus Conradshöhe. These aspects may be more crucial than the model's Core and Cluster features in achieving positive outcomes. Without robust evaluation addressing model coherence, it is not possible to determine critical success factors for Core and Cluster models.

Transferability. Care is influenced by legislation, ideology, staff competence, other community resources, residential home setting, and the characteristics of the cohort of young people. For example, there is some indication that residential care in Germany caters for a fundamentally different cohort of young people. Children in UK residential care tend to be older and a larger proportion are looked after by court order, compared to Germany (Ellis 2012). Consequently features such as wider target group age ranges and considerable involvement from parents in their children's care may not be transferable to UK settings.

6.4.5 Lessons learned

This review did not identify any information on the roll-out of these models.

6.5 Recommendations for further research

As this review of established Core and Cluster models shows, the term encompasses a range of features, psychological orientations and is implemented in diverse contexts for different target groups.

Considering this, further research could:

- Examine the effectiveness and impact of key components to the overall Core and Cluster model such as sharing resources, services or professional staff.
- Consider the effectiveness and viability of model features such as renting homes to foster parents (SOS Bergen) and providing shared support resources.
- Explore to what extent economies of scale may be implemented effectively in other existing UK models of residential care.

6.6 More reading

Berridge et al (2011) Living in Children's Residential homes: David Berridge, Nina Biehal, and Lorna Henry. Department for Education

Care of Children Committee (1946) Report of the Care of Children Committee (Chairman: Myra Curtis) Cmd. 6922 London: His Majesty's Stationery Office.

Narey, M. (2016). Residential care in England: report of Sir Martin Narey's independent review of children's residential care: July 2016.

Ellis, Geneva (2012) "International children's home models; what is transferable to the UK?" Winston Churchill Memorial Trust Fellowship Report: December 2012. Available at: https://www.wcmt.org.uk/sites/default/files/migrated-reports/1025_1.pdf [Accessed 26/02/2018]

Haus Conradshöhe (2018) [online resource] Available at: https://www.haus-conradshoehe.de/ [Accessed 26/02/2018]

SOS Children's Village Bergen, Norway (2018) [online resource] Available at: https://www.soschildrensvillages.ca/norway/sos-childrens-village-bergen [Accessed 26/02/2018]

SOS Children's Village Bergen, Norway (2018) [online resource, in Norwegian] Available at: https://www.sos-barnebyer.no/ [Accessed 26/02/2018]

7 Dyadic Developmental Psychotherapy

7.1 What is it?

7.1.1 Introduction

Dyadic Developmental Psychotherapy (DDP) is an attachment-focussed therapy for complex trauma and attachment disorders that aims to facilitate attachment security between children and parents. In residential care, it can be used by practitioners as part of a strategy to improve attachment or can be used where the practitioner takes the role of parent in a therapeutic intervention.

DDP aims to support children to form functional relationships through supporting them to: develop attunement[19], primary and secondary intersubjectivity[20]; and "integrated autobiographical narratives"[21].

Although DDP models of residential care are currently in use worldwide, evidence for DDP both as a therapy and as a residential care model lacks robustness. Unless otherwise stated, information on principles, and stages of DDP applied in a residential care context is taken from Clarke 2011.

7.1.2 Model aims

The central treatment goal is to "facilitate attachment security". Attachment security refers to a child's readiness and ability to establish attachment or relationships with their caregivers[22]. However, definitions in the DDP literature lack precision.

7.1.3 Origin and implementation

DDP was originally developed in the 1980s by an American clinical psychologist, Dr Daniel Hughes, as an intervention for children with emotional distress resultant from traumatic experiences. The approach to treatment is based on attachment theory as well as Hughes' clinical experience working with children and families.

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[19] Attunement is understood as a process for developing parent–child attachment: when matched positive affective states occur within the parent-child relationship (i.e., feelings of joy, excitement and fun) the relationship becomes contented and satisfying.

[20] Primary intersubjectivity is the 'interactional process in which children's view of self emerges from their experience of what their parents are recognising and responding to'. Secondary intersubjectivity is the process where a child or young person can share attention, feelings and intentions regarding an object, event or action with another person.

[21] There is no clear definition of the "integrated autobiographical narrative" concept in the DDP literature. It appears to refer to individuals' development of a personal life story that helps to understand and make sense of past and present life events.

[22] DDP is based on attachment theory. This theory considers a child's ability to develop a relationship with at least one primary caregiver crucial to their social and emotional development.

The therapeutic treatment is based on the principle that developing **attunement** (sharing feelings of joy, excitement and fun), **primary and secondary intersubjectivity** (view of self and ability to share feelings and attentions) and an **integrated autobiographical narrative** (ability to make sense of past and present events in one's life) will support children and young people to develop functional relationships.

Originally developed to improve outcomes within a family, more recently DDP has been adapted as a model for children's residential care.

Three developmental stages

Clarke 2011 describes **three developmental stages** to DDP in residential care settings. The first stage (**Trust of Care**) emphasises dependency on staff by keeping doors locked, and supervision overt. Staff provide young people with nurturance unsolicited (emotional and physical nourishment and care given to someone no matter what behaviour they are exhibiting).

The second stage (**Trust of Control**) involves staff demonstrating discipline and control by setting limits for young people. This aims to help young people to meet adult expectations and regulate their behaviours and emotions

In the third stage (**Trust of Self**) the child or young person takes more responsibility for themselves and is encouraged to regulate their own behaviour. Transition from the residential setting to home occurs at the end of this stage (Blackwell & McGuill, 2008).

Staff behaviour, skills and strategies

In residential care settings, the entire staff group's relationship with the child or young person is understood as the primary agent of change. The success of the model depends on the behaviour and skills of staff who must:

- **Adopt a PACE attitude** (an attitude of Playfulness, Acceptance, Curiousity, and Empathy'). According to the DDP literature, applying this attitude to the care of children and young people with attachment difficulties, results in the formation of attachment. However, detail on how PACE is implemented or more in-depth description is lacking.

- Complete **training** in the stages of healing, attachment and trauma theories

- **Support themselves and their colleagues through** self-care and identifying and addressing any personal issues.

- Provide **unconditional nurturance**[23] to children and young people by maintaining close relationships that show children and young people caregivers are dependable.

- Focus on "the **here and now**" with children and young people (in contrast to any DDP therapy sessions which address past events). This review did not identify any requirements for use of one-to-one DDP therapy sessions (for example format, duration) in residential care settings following a DDP model.

Rules

The residential care facility is guided by the following concepts (Blackwell & McGuill, 2008, p. 149):

- Children get what they need, not what they earn.

- Nurturance is a right of the child.

- Fairness is getting what you need (not getting the same thing as getting what other people get).

- Change is driven by intense interpersonal relationships rather than by techniques.

- Everyone has permission to feel.

- All interactions with children are therapeutic opportunities.

- Care prioritises alliances rather than compliance.

Information on how to incorporate these concepts in residential care settings is lacking in the DDP literature. However, Clarke 2011 outlines three rules for residential care settings designed to support effective relationships between staff and young people (Figure 6).

[23] Emotional and physical nourishment and care given to someone no matter what behaviour they are exhibiting.

Figure 6: Three rules for children and young people in residential care settings

Rules	Rationale
Rule 1: The child needs to ask for everything they need and want.	Promotes the concept that staff meet children's needs and promotes dependency interactions between staff and children.
Rule 2: Staff must know where the child is at all times.	Helps children understand staff cannot care about them and keep them safe if they do not know where they are.
Rule 3. No hands on without permission.	Allows children to understand they will not be hurt and teaches them meaningful relationships should not hurt.

Source: Blackwell & McGuill, 2008.

The DDP model (integrative attachment therapy residential program) used in the U.S. (Chaddock's) suggests ideal treatment or residential periods last between 9 and 18 months, with children and young people between 8 and 16 years living in cottage-style residential care facilities (Clarke 2011).

However, intensity of model implementation varies. We provide details of two approaches in the UK below (Figure 7).

Figure 7: Examples DDP model implementation in the UK

	Clover Childcare Services[24]	Crossreach (operated by Church of Scotland)
Description	Clover Lodge residential care home in Norfolk, England.	House of Newburn (HN), and Millmuir Farm (MF) part of a network of six homes in Scotland, which includes education services.
Capacity and target group	Five children and young people aged between 7 and 17 years old on admission.	Three short to medium placements for 8 to 18-year olds (HN) and two long-term placements (MF).
DDP theory and practice	Practice "informed by DDP principles" and "follows the model of therapist led care found in DDP". Staff practice communication style and	PACE model of care based on attachment parenting and creating a supportive environment. Inspection report describes 'very good' care and

[24] All information is taken from the home's statement of purpose

	Clover Childcare Services[24]	Crossreach (operated by Church of Scotland)
	PACE attitude in group meetings.	relationships although DDP is not referred to.
Additional specialist DDP support	Clinical Psychologist delivers individual DDP sessions if needed.	Psychologist may advise staff (specific training not mentioned).
Staff	4 managers and 9 care staff. All trained in basic DDP.	1:1 staffing ratio. All staff trained in dyadic theory, PACE, therapeutic crisis intervention.

Source: Clover Lodge 2017; Care Service Inspection Report 2014; Cross Reach Residential Accommodation 2018

7.2 Target groups

Children and young people in residential care, particularly those with "relational" issues or experiences of trauma.

7.3 Inputs and resources

7.3.1 Staff, expertise and resources required

Residential care staff are all required to undergo comprehensive education and training. No details on staff to child ratios are available.

According to the DDP website, core training must be delivered to staff face-to-face by a certified provider[25]. Two courses are available, basic (level one) and advanced (level two), both of which last 28-hours, delivered over 4 days.

Certification at an organisation-level is also available. According to the DDP website, meeting the certification requirements is "an active process of staff training, program/service evaluation and development, and organisational change".

Alongside the approach taken by residential staff, trained clinical psychologists may also deliver therapy sessions where needed. Resources needed to implement therapeutic treatment will vary depending on intensity and whether:

- Transport is needed (e.g. therapy is delivered at clinical settings not on-site)
- Recording equipment to record therapy sessions

[25] To become a certified trainer, trainers must undergo a 56-hour course at a minimum.

- Extra sofas and toys are provided to make the setting comfortable

Provision of other therapies (e.g. mental health services) or input from a psychiatrist may be required depending on children and young people's needs.

7.3.2 Set-up and running costs

Set-up and running costs are likely to vary according to model intensity, training and setting size. No detailed information regarding the costs of the DDP residential care model was identified nor its associated training costs for staff.

In a review of DDP therapy (i.e. one-to-one sessions with a trained psychologist), Boyer et al 2014 estimate costs per case may range from £6,700 to £14,500[26] depending on length, number of sessions, duration of sessions, location and number of psychotherapists present.

7.4 Effectiveness and impact

7.4.1 Overall evidence base

The quality of evidence for the DDP treatment approach is very low. The National Institute for Health and Care Excellence (NICE) in the UK notes the need to evaluate DDP using a robust study design (NG26).

Evidence on the DDP model in residential settings is also very limited and hampered by lack of robustness. Clarke 2011 mentions three pieces of research undertaken on the DDP approach to residential care but these appear to be by people associated with the model and are not publicly available.

According to Clarke, one study describes demographic and clinical characteristics of children in a DDP model of care over 2 years. The others examine outcomes for the children in the first study and find:

- "Statistically significant positive changes in externalising problems, conduct problems and depression".

- "Statistically significant changes were found in reality testing, healthier perceptions of human interactions, more mature conflict resolution skills, improved self-reliance, less cognitive confusion under stress, less distorted reasoning and decreased feelings of rejection and depression" (Clarke 2011).

7.4.2 Potential cost savings

No cost-benefit or cost-effectiveness analysis has been undertaken.

[26] Costs for a clinical NHS psychologist in the UK (NHS staff salary Band 8) range from £60 to £135 per hour depending on whether treatment is provided on-site or in primary care.

7.4.3 Limitations to the evidence

The studies referred to by Clarke claim to show the positive impact of the DDP model in residential settings. However, it is **impossible** to use this information to draw any conclusions about the model as **no information on study design or methodology** is provided.

The DDP model has yet to be evaluated against a comparison group. It is therefore **not possible to attribute any outcomes** to the model.

The evidence base is further limited given that study authors tend to be associated with the model. This suggests existing evidence may be biased and more likely to show improvements unlikely to be observed in a real-world setting.

Descriptions of the model in residential settings **lack precision**. Without a detailed description of the model, **implementation fidelity is impossible** and we cannot judge whether a setting is using the model as it should. For example, it would be helpful to know how many therapeutic sessions are provided to each child. Similarly, the model's three phases and the strategies employed by staff are not referred to.

Likewise, **we cannot compare the model** across different settings. We know DDP is being implemented in the UK. The amount of one-to-one therapeutic treatment provided and how principles guide interaction with children, young people, and colleagues is unclear. It is difficult to compare evidence when similarity of models (in terms of service delivery and conceptual thinking) is variable.

Research into how the model's multiple components interact and contribute to positive outcomes for children and young people is very limited. Without a more detailed **understanding of the model's 'active ingredients'**, understanding how it should be replicated in different settings is impossible. For example, how settings achieve and measure PACE.

7.4.4 Lessons learned

This review did not identify any information on DDP implementation and so no associated key success factors or challenges to rolling the model out.

Inspection reports for some homes associated with the DDP model (for example Crossreach) are favourable. However, due to the limitations already discussed, we cannot assume the standard of care in the homes is a result of its association with DDP.

7.5 Recommendations for further research

An evaluation of DDP in residential care settings is needed urgently given that the model is already in use with no robust evaluation available.

A randomised controlled trial (RCT) should be carried out to compare DDP with an evidence-based treatment for attachment difficulties. Turner-Halliday et al 2014 has assessed the feasibility of doing this and conclude an RCT of DDP is both feasible and timely.[27] Primary outcome measures could include: attachment; parental sensitivity; placement disruption; educational performance; and behavioural problems.

Understanding model efficacy, effectiveness, impact and process is crucial. For any impact evaluation, outcome measures should be recorded at 6 or 12 months post-intervention as a minimum. Potential harms associated with DDP also need to be accounted for.

Staff, parents' and children's' experience of the intervention should also be explored, for example in a qualitative study or process evaluation using in-depth or semi-structured interviews.

Alongside a trial examining DDP effectiveness, cost-effectiveness or cost-utility analysis should be performed. See Boyer et al 2014 for further details.

7.6 More reading

Blackwell, S., & McGuill, J. (2008). Dyadic developmental psychotherapy in a residential treatment. In A. Becker-Weidman & D. Shell (Eds.), *Creating capacity for attachment: Dyadic developmental psychotherapy in the treatment of trauma-attachment disorders* (pp. 143–163). New York: Wood 'N' Barnes.

Boyer, N. R., Boyd, K. A., Turner-Halliday, F., Watson, N., & Minnis, H. (2014). Examining the feasibility of an economic analysis of dyadic developmental psychotherapy for children with maltreatment associated psychiatric problems in the United Kingdom. *BMC Psychiatry*, *14*, 346. http://doi.org/10.1186/s12888-014-0346-0

Casswell, G., Golding, K. S., Grant, E., Hudson, J., & Tower, P. (2014). Dyadic Developmental Practice (DDP): a framework for therapeutic intervention and parenting. *The Child and Family Clinical Psychology Review*, *2*, 19-27.

Clarke, A. (2011). Three therapeutic residential care models, the sanctuary model, positive peer culture and dyadic developmental psychotherapy and their application to the theory of congruence. Children Australia , 36 , 2 , 81–87. DOI 10.1375/jcas.36.2.81

Clover Lodge (2017) Statement of purpose [online] Available at: http://www.cloverchildcareservices.co.uk/SP_CloverLodge.pdf

[27] See Turner-Halliday et al 2014 for RCT design recommendations including randomisation, potential control interventions within sites, measurement of change and how sites define their eligible population for DDP.

Care Service Inspection Report (2014) Crossreach Children's Residential Support Services Care Home Service Children and Young People

Cross Reach Residential Accommodation (2018) [online resources] Available at: http://www.crossreach.org.uk/residential-accommodation and http://www.crossreach.org.uk/sites/default/files/intensive_support_through_care_service.pdf

Dyadic Developmental Psychotherapy website (not specific to residential care settings): https://ddpnetwork.org/about-ddp/research-evidence-base-outcomes/

NICE (2015) Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care NG26 https://www.nice.org.uk/guidance/ng26/resources/childrens-attachment-attachment-in-children-and-young-people-who-are-adopted-from-care-in-care-or-at-high-risk-of-going-into-care-pdf-1837335256261

Turner-Halliday, F., Watson, N., Boyer, N. R., Boyd, K. A., & Minnis, H. (2014). The feasibility of a randomised controlled trial of Dyadic Developmental Psychotherapy. *BMC psychiatry*, *14*(1), 347.

8 Model of Attachment Practice

8.1 What is it?

8.1.1 Introduction

Developed by the Western Health and Social Care Trust (WHSCT) in Northern Ireland, the purpose of the Model of Attachment Practice (MAP) is to help staff to understand the meaning and causes of children and young people's behaviour and to respond accordingly (WHSCT, n.d.). Though originally developed for children's residential care, interviews with stakeholders highlighted that there is an aspiration for it be systemic practice. In light of this, MAP is being rolled-out to other types of support for children and young people (e.g. foster care, children with disabilities service, social worker teams).

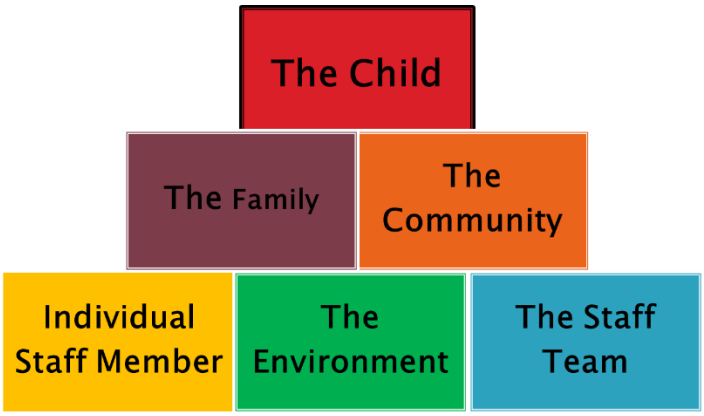
MAP draws on a number of different theories and models. Theories of attachment and of neurodevelopment are at its core, though the grid below highlights the full range of ideas, models and theories that are incorporated into MAP (WHSCT, 2014). It encourages staff to be 'actors' and not 'observers' and equips them with an understanding of children and young people's behaviour. It helps them form better relationships, and, in turn, equips children and young people with more adaptive and prosocial ways of relating and behaving (WHSCT, n.d.).

Figure 8: Theories and models drawn on by MAP

Attachment Theory Understanding Development and Styles	Developmental Trauma/ Impact on Brain Development	Systemic Thinking in Practice	Attachment Practice within Supervision
Neurodevelopment Brain Development	Trauma Informed Practice	Emotional Intelligence Competence in Practice/ Containment	Building Blocks of MAP Practical Application in Attachment Focussed Practice
Attachment Principles in Practice	Intersubjectivity in Practice	Brain Based Parenting	Attachment Profiles/Life Story Work
Attachment Focussed Behaviour Management	PACE in Practice	Resilience Building in Practice	MAP Intervention Plans

The MAP model uses the following 'building blocks' to help consider the main relationships experienced by the child and the principal levers and type of support/action available. Within this, MAP resources help the worker identify ways of working that can help to address the child's needs. These building blocks were developed by various workstreams involving social workers, managers and psychologists.

Figure 9: MAP building blocks



Three other key components of the MAP model are: (1) training; (2) supervision; and (3) support (see below for further information).

8.1.2 Origin and implementation

MAP was initially influenced by a Canadian project for conduct-disordered youth and their families at the Maples Adolescent Treatment Centre, in British Columbia (Munroe, 2007), and the 'dyadic developmental' approach which helps professionals and parents to support children to recover from trauma and disrupted attachments (DDP Network, n.d). Combining the influence of these projects, with principles of attachment theory, and research on neurodevelopment (and other models, see above), MAP was developed in-house and implemented by the Western Health and Social Care Trust from 2011.

This model of practice helps workers understand children's behaviour in an attachment and trauma focused way. It also helps workers to understand family relationships and how behaviours are attachment based and formed, to acknowledge their own histories and how that influences their engagement with others. It acknowledges the importance and influence of positive working relationships in order to support and empower families with their respective challenges. At the core of this relational model is empathy and connection. In strengthening the capacity of workers to be the therapeutic resource in working with children and families; it aims to positively enhance the empathic experience of service users and the quality and safety of the service provided to them. The primary purpose of MAP is to deliver qualitative outcomes for children and in particular their right to have their emotional needs met (UNESCO, 2017).

8.2 Target groups

MAP was originally designed for children and young people living in residential care homes but is being extended to include other teams, e.g. children and young people in foster care (reported in 2015/2016 accounts).

8.3 Inputs and resources

8.3.1 Staff, expertise and resources

MAP is designed to be used and applied by existing staff working with children and young people. It has been developed – and continues to be coordinated – by a core team of four, consisting of MAP Project Lead (Social Worker), Senior Practitioner for LAC Therapeutic Needs (Social Worker) and two Consultant Clinical Psychologists. The focus is on ensuring that MAP is part of everyday mainstream practice. It does this via training, supervision and support.

Training

There are a number of different training programmes within MAP (WHSCT, n.d.):

- MAP Foundation Level (2 days). This is focused on understanding attachment and brain development and the principles needed to apply in practice.
- MAP Building Blocks (1 day). This examines the application of MAP to practice.
- Intermediate Level (2 days). This includes trauma, attunement and PACE (see DDP profile).
- MAP Reflective Supervision for Managers (2 days). This is designed to ensure managers have a comprehensive understanding of how reflective supervision should be used within MAP.
- Advanced Level (2 days). This introduces more detail about systemic thinking, emotional intelligence, building resilience and brain-based parenting.
- Refresher training. This is undertaken on an annual basis.

WHSCT has also developed 'train the trainer' training, enabling staff outside of the core team to lead the above training courses for other staff. This has, in turn, created space/time for the core team to work on applying MAP to foster care.

A potentially unique aspect of MAP is that all staff working with or supporting children and young people are trained in MAP. As well as residential care staff, this includes social workers, cleaning and cooking staff and managers.

Supervision

A core element of MAP is ensuring that staff have access to high quality reflective supervision. A training module (see above), manual and MAP Reflective Supervision Tool have been introduced to help ensure this (WHSCT, 2014). Reflective supervision "…is a process that allows the worker time and space to reflect upon the work that they do; to consider the relationships and interactions they have with service users in the context of their own values, emotions and experiences" (WHSCT, 2014: 3). Within MAP, this supervision encourages the lens of attachment theory to be applied to reflection. The MAP Reflective

Supervision Tool ensures that all of the building blocks of MAP (see diagram above) are considered.

Support

A number of mechanisms have been put in place to support practitioners and managers to effectively implement MAP (WHSCT, n.d.). Principally, these are forums that work alongside reflective supervision and help ensure practitioners and managers have opportunities to explore MAP in peer-led, psychology-led or group settings. For instance:

- Psychologist led reflective practice group meeting twice per month in each home with staff team.
- Social Work led peer supervision with managers (held monthly).
- Meetings between Head of Service, Service Managers and Core Project Team (held quarterly).
- MAP practice group meeting with home's Managers Social Work Led (held quarterly).
- Psychologist led reflective practice group meeting monthly for managers and assistant managers of all homes.

8.3.2 Running costs

Based on reports from 2012 (MacDonald et al., 2012), the estimated annual cost of sustaining the integration of MAP was £60,000[28].

8.4 Effectiveness and impact

8.4.1 Monitoring outcomes

MAP uses a number of tools to understand the needs of the child. These are regularly updated in order to reflect changes in the child's life and are used to measure progress. These include (WHSCT, n.d.):

- Attachment Profile. This is similar to a chronology or roadmap of a child's life to date and highlights key events and experiences that may help to understand their circumstances and behaviour.
- Care Plan.
- Risk Assessment.

[28] During interviews, stakeholders reported that the figure is likely to be higher as some costs are absorbed as part of existing roles.

- MAP Progress Report (monthly).
- Reviews (six monthly).

In addition, questionnaires (with ratings scales) are used to monitor the extent to which (a) children are satisfied with the support that they receive; and (b) staff feel that MAP is being embedded in practice and is helping to make a difference. Data is also collected about staff attendance at supervision and MAP-related forums. This includes monitoring of attendance by senior members on MAP governance meetings.

8.4.2 Evaluation findings

MAP was included as part of an evaluation by MacDonald et al. (2012) considering five therapeutic approaches to social work in residential child care settings. Key findings were:

- Staff reported that they were able to: (a) step back from challenging situations; (b) understand a young person's behaviour and interpret 'pain based' behaviour; (c) see a reduction in aggressive incidents; (d) have increased contact with families.
- Staff believed that the use of a therapeutic model had improved the culture of the residential home.
- Young people were generally unaware that models had been introduced, but a large number said that there had become less emphasis on punishing behaviours.

The WHSCT have completed an audit profiling the challenges young people in residential care in the Trust are experiencing using the Assessment Checklist for Adolescents (Tarren-Sweeney). This has been adopted by the MAP Project Board as one of the measures in an approach to outcome measurement. There are plans to develop a longitudinal approach using this measure to obtain an assessment of each young person as they journey through residential care and to assess the impact of MAP. That said, stakeholders reported during interviews that on the strength of reported experiences locally, the Health Trust plans to extend the MAP way of working and MAP training to foster carers.

8.4.3 Limitations to the evidence

To date, data collected on impact is a mixture of anecdotal evidence, individual case studies and self-reported (mainly staff) views on their experiences of MAP. As highlighted above, during interviews stakeholders highlighted plans to use the Assessment Checklist for Adolescents in order to introduce a quantitative approach to measuring outcomes that could be aggregated across cohorts of children. That said, interviews emphasised that the children and young people that MAP supports arrive with complex and entrenched needs and, as a result, improvements take time to materialise in observable behaviour and can, at least initially, be very small (though significant for the child).

8.5 Lessons learned

Lessons learnt about the Model of Attachment Practice include:

- As part of a wider review of therapeutic models, staff reported that no single model covered the entire range of behaviours or situations that they faced in their day to day practice. MAP helps to address this by drawing on a range of different proven models and perspectives.

- Staff felt that further reading was important to successfully implement MAP. As a result, additional time might be needed for MAP outside of training, supervision and support structures.

- During interviews, a number of stakeholders highlighted the importance of MAP having been developed locally. In their view, this increased the amount of buy-in from staff as it was seen to reflect local need, they knew (or at least were aware of) the people who were important in developing it, it did not incur recurring membership or accreditation fees, and staff could have some influence over the future shape/content of the model.

- Interviewees also highlighted the power of a model - and especially the training - that could be applied and adapted across different agencies and forms of care. They reported that a key strength of MAP was not predominantly as a model of residential care, rather as a model for working with children and young people and families.

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9 Neurological Reparative Therapy

9.1 What is it?

9.1.1 Introduction

Neurological Reparative Therapy (NRT) is a model of trauma-informed care for young children who have experienced abuse or grown up in traumatic environments. Through a programme of intensive therapeutic interventions, it aims to produce lasting changes to the brain and return it to a state of "positive functioning" (Ziegler 2011).

The model draws on theories of attachment and resilience, trauma treatment, and brain development research conducted at the Jasper Mountain treatment centre in the U.S. (Ziegler 2011).

9.1.2 Model aims

Neurological Reparative Therapy (NRT) has five main goals for children (Ziegler 2011). It aims to:

1) Change the child's "internal working model" (perception of oneself in relation to others)
2) Enhance neuro-integration[29]
3) Alter the area of the child's brain used in processing sensations and feelings
4) Activate the areas of the brain involved in self-control and self-management
5) Develop new neuro-pathways[30] through practicing and repeating activities

To achieve these goals, the model uses several treatment styles and interventions.

9.1.3 Origin and implementation

NRT originated in 1982 at the Jasper Mountain Centre, an independent treatment centre for "traumatised children" on a large ranch in Eugene, Oregon (Ziegler 1994).

It is an intensive, individualised residential treatment programme for children that lasts, on average, for 14 months (Ziegler 2011). The type of treatment and interventions offered to each child varies according to their level of need.

[29] This improves collaboration between key regions of the brain

[30] Neural pathways connect relatively distant areas of the brain

Children live in dormitories at an on-site residence. Key also staff live at the residence, providing continuity of care and promoting attachment (Ziegler, 2015). Each child is part of a "treatment family" (professionals play a "parent" role and organise celebrations, family meals, and camping trips).

In addition, children attend one-to-one sessions with therapists and a psychiatrist to help them process any trauma (Ziegler 1994). A therapeutic school on-site supports children's educational development (Jasper Mountain, 2017) and participation in a programme of behaviour management-focussed and physical activities (Ziegler 2015).

Broadly, the model comprises four types of intervention (environmental, behavioural, psychotherapeutic, and self-esteem) (Ziegler, 1994). Further details are included in Figure 10.

Figure 10: Neurological Reparative Therapy interventions

Intervention type ***Aim***	**Example**
Behavioural *Managing and improving behaviours*	• Behaviour management systems such as a "levels" reward system in which children can earn or lose privileges
Environmental *creating a healthy and safe therapeutic atmosphere*	• careful control of all aspects of the model's environment (building design and construction, controlled diet, controlled access to non-violent films)
Psychotherapeutic *Promoting development of healthy relationships*	• Individual, group and family therapies • Art and play therapy • Medical intervention (e.g. medication) through sessions with the program's psychiatrist
Self-esteem *Building and promoting a child's self-worth*	• Concentration and meditation training • Therapeutic recreation (horse-riding program, hiking and rock climbing, gardening, visual and performing arts, computer skills)

Source: Ziegler 2015; Ziegler 1994

The model aims to instil five skill sets in children: making good decisions, self-love and self-care, spiritual health, co-operation, and empathy (Ziegler, 2015).

NRT staff are trained in Crisis Prevention Institute non-violent interventions. All rooms are monitored at night with cameras to ensure the safety of children (for

instance, against peer on peer violence). Seclusion or isolation strategies are not used with children (Ziegler 2015).

Other residential and community-based services provided by the Jasper Mountain Centre may be provided prior to or following NRT. These include:

- Treatment Foster Care program (Jasper Mountain 2017). Community-based programme, that acts a step-down, "practice placement" for children aged 4 to 13 years old who have completed NRT residential treatment. Treatment Foster Care allows children time to adjust to a family setting before moving to their long-term family placements (Jasper Mountain 2017). To provide this service, Jasper Mountain recruits and pays foster families, who are provided with home certification, training, regular therapeutic and coaching support.

- Wraparound work and outpatient therapy. Community-based services which provide additional step-down support for children transitioning out of the residential treatment model (Jasper Mountain 2017).

- Short-term residential assessment and treatment program (SAFE). Short-term (30–90 day) "crisis stay" residential placements for children (aged 3 to 13) with destructive behaviour and emotional difficulties.

9.2 Target groups

NRT is for children aged 4 to 13 years old with childhood experiences of trauma and abuse (Jasper Mountain 2017). The residential model caters for children who have had multiple residential placements and are "hard to place" (Jasper Mountain 2017).

The model is not designed for children with chronic psychosis or significant developmental disabilities (Jasper Mountain 2017).

9.3 Inputs and resources

9.3.1 Staff, expertise and resources required

Delivery of the model at Jasper Mountain takes place across several treatment resources including a residence centre and therapeutic school. These require different numbers of staff, types and levels of training, and material resources. This review did not identify detailed information on the resources required to implement NRT.

Available reports indicate high staff-to-children ratios are a requirement of NRT; with a ratio of one staff member to every three children needed at the residential centre and therapeutic school (Jasper Mountain 2017).

The child's legal guardian, families, and referral organisations are encouraged to play an active role in their treatment (Jasper Mountain 2017). Onsite accommodation is provided for parents and carers "at no cost to families" so they can visit and participate in the program (Jasper Mountain 2017).

Considerable resources are needed to train staff. One report suggests trainers observe staff during their shifts, providing them with coaching and mentoring to improve consistency and fidelity to NRT (Johnson 2016).

9.3.2 Set-up and running costs

Jasper Mountain's 2016-2017 total running costs were reported to be $5,947,421[31] (Jasper Mountain 2017). Over the same period, total revenue was $6,694,990 (Jasper Mountain 2017).

These costs cover several services on site. Details are provided in Figure 11.

This review could not find information on the average cost per child of NRT.

Figure 11: Service breakdown and costs 2016-17

	Cost	Revenue
Jasper Mountain Centre (Intensive Residential program)	$2,217,311	$2,713,441
Treatment Centre Administration	$818,130	$43,436
Therapeutic School	$977,318	$1,215,301
SAFE (Short term residential assessment/treatment)	$1,631,487	$2,241,703
Community Based Services	$303,175	$333,131
Other	-	$147,978

Source: Jasper Mountain 2017

9.4 Effectiveness and impact

9.4.1 Overall evidence base

The evidence base for NRT is limited and lacks robust, independent research on the effectiveness of the model.

The only available studies on NRT are associated with the model developers and all research has been conducted at the Jasper Mountain Centre. This review did not identify examples of model implementation elsewhere.

[31] This is equivalent to GBP £4,239,679 according to February 2018 exchange rates.

9.4.2 Evaluation findings

All information provided here should be interpreted very cautiously; all evidence is prone to bias given its association with the model developers, along with other important limitations.

- **Evidence suggestive of some improved outcomes for children.** Staff at Jasper Mountain Centre measured children's problem behaviours, attachment difficulties, and functioning, upon children's referral to the centre (Jasper Mountain 2015). The most recent results identified by this review suggest the cohort of children who completed the programme in 2015 (n=14), displayed 95% less serious behaviour; had improved by 65% in treatment objectives; severity of psychiatric problems had decreased by 27%; and improved in relationship skills, and "overall severity of problems" (Jasper Mountain 2015).

- **Some indication of long-term improvement.** Interviews with NRT participants and their parents up to five years after leaving collected data on the child's success in school, problem behaviours, and daily living, social, and communication skills (n=100+) (Jasper Mountain 2018). These indicate positive progress of residents (Jasper Mountain 2018). At six months: 91% were obtaining pass grades at school; 82% indicated no illegal behaviour; 73% were showing more independence; and 64% demonstrated no violent or sexual behaviour (Jasper Mountain 2018). After five years, roughly two thirds of respondents had developed personal support systems, were not involved with the police and did not display violent or sexual behaviour (Jasper Mountain 2018).

- **Model had little effect on children's ability to live independently.** In follow-up interviews with parents and carers five years after their child's treatment (n=100+), 71% did not consider the child ready to live independently (Jasper Mountain 2018).

- **Better outcomes for younger children.** Children under the age of eleven tender to have better outcomes at follow-up compared to children over the age of twelve (Jasper Mountain 2018).[32]

9.4.3 Potential cost savings

This review did not identify any information on potential cost savings of NRT.

9.4.4 Limitations to the evidence

Research on NRT has very significant limitations.

[32] Explanations for this are unclear. However researchers hypothesize that children who receive treatment at a younger age experience more positive effects due to the more pronounced brain transformations (e.g. neuro-plasticity) that takes place during these earlier years (Jasper Mountain 2018).

No independent research has been conducted on NRT. The involvement of Jasper Mountain staff in outcome measurement, suggests that these results are prone to bias. Staff may be invested in the model and so more likely to observe and record evidence of improvements in outcomes for children.

Results may be chance findings. Without randomisation and statistical analyses, we cannot be confident that the changes are attributable to the effect of NRT, rather than due to pure chance. Although outcome measurements include standardised and validated measures, the small number of children in the cohort (n=14) and lack of statistical analyses means that it is difficult to draw conclusions from any changes in outcome measurements.

Very limited understanding of the model's sustainability. All follow-up data relies on self-reported data from interviews, which is prone to bias and may overestimate the model's ability to improve outcomes for young people. Parents who are grateful to the centre, may be more likely to "witness" positive changes in their child following residential treatment. Furthermore, there is no information on children and parents who were lost to follow-up and are likely to have had less positive experiences of NRT.

The model's transferability is questionable. All research on the development and efficacy of NRT has taken place at Jasper Mountain, a large, rural environment involving outdoor activities such as horse riding, and hiking. We do not have any evidence to support effectiveness of NRT in an urban setting, or outside the U.S.

9.4.5 Lessons learned

Information on challenges or lessons learned from NRT implementation is scarce.

A review of trauma-informed care models describes Jasper Mountain as an effective and innovative treatment model, but highlights important resource challenges in implementing NRT in the UK; considering the costs of operating a similarly intensive model prohibitive due to operational differences between U.S. and UK health economies (Johnson 2016).

For example, accommodating children in shared dormitories, rather than their own rooms, would not comply with UK care standards, posing challenges to NRT replication given the financial implications and constraints (Johnson 2016).

9.5 Recommendations for further research

Given the intensive, holistic nature of this model, and the high costs of service provision, a detailed cost-benefit evaluation of this program would be beneficial.

Further research should also consider the transferability of the model, and whether it may be replicated effectively in other non-rural settings and health economies outside the U.S.

Ideally, research should be conducted by independent evaluators.

9.6 More reading

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10 No Wrong Door

10.1 What is it?

10.1.1 Introduction

No Wrong Door (NWD) is a service for young people aged 12 to 25 who are in care, on the edge of care, or on the 'cusp of edge of care'[33] and who have complex needs. A range of residential placements are provided from a "hub", these are: emergency, short-term, medium-term and supported living placements. Each young person has a key worker who supports them across foster, and residential placements or in their own flat or birth family home. The nature and intensity of support is tailored to the young person's needs. The model has been developed under the Department for Education's Social Care Innovation Programme in England[34].

10.1.2 Model aims

The NWD model aims to improve:

- Accommodation stability.
- Engagement and achievements in education, employment and training (EET).
- Relationships with others.
- Planning of transitions from care to independent living.
- Resilience, self-esteem and wellbeing.
- Access to support in a crisis.

NWD also aims to reduce high risk behaviours (including criminal activity, self-harm, Child Sexual Exploitation (CSE), missing from home incidents, drug and alcohol substance misuse) and reduce costs to society (such as to the NHS and the Police).

10.1.3 Origin and implementation

The NWD model was developed by North Yorkshire County Council. The service opened in April 2015 and runs from two hubs, one in the East of the county in

[33] The report refers to this group as 'edging to care', i.e. when, without an intervention package being put in place, there is a strong likelihood of the young person progressing to edge of care. 'Edge of care' is when the young person is at imminent risk of becoming looked after.

[34] Unless stated otherwise, all information in this section is taken from Loughborough University's evaluation of the service (Lushey et al. 2017)

Scarborough and one in its West in Harrogate. Both hubs were adapted from existing residential children's homes.

NWD supported 355 young people in its first 2 years. The average intervention time was 3 months, with widely varying intensity of support.

Each young person in the service is assigned a key worker and NWD aims to meet all their needs within a dedicated multi-disciplinary team, rather than passing the young person from service to service[35]. The length and intensity of support offered to young people is tailored and varies widely, from daily face-to-face contact to as little as three hours a month. Young people can be offered support from NWD workers for as long as required, up to the age of 25.

The service is based in a "hub" that offers a range of accommodation options for the young people:

- 4 x medium term (one to 12 months) residential beds for working towards rehabilitation with family, long-term foster placement or independent living
- 2 x emergency residential beds for young people in need of intensive support and a quick and safe return home
- 2 x short/medium term or respite hub community family placements with NWD foster carers outside of the hub
- 2 x supported accommodation placements (one unit).

Young people are supported by the NWD team either in residential placements, or through outreach while still in their foster care placement, living with their families or living independently. All staff are trained in Signs of Safety, restorative practice and solution-focused approaches.

10.2 Target groups

No Wrong Door is for young people aged 12 to 25 with complex needs and who are either in care, on the edge of care, or on the 'cusp of edge of care' or who have recently moved to supported or independent living whilst being supported under the NWD model.

[35] According to No Wrong Door documentation, the model has ten distinguishing components: always progressing to permanence within a family or community; high "stickability" of the key worker; fewer referrals, less stigma; robust training strategy same/or similar to restorative practice and therapeutic support; no heads on beds culture; no appointment assessments; a core offer to all young people; multi-agency, intelligence-led approach to reduce risk; close partnership working; young people's aspirations drive practice.

10.3 Inputs and resources

10.3.1 Staff, expertise and resources required

Each NWD hub team comprises:

- One Manager
- Two Deputy Managers (one responsible for the residential service, one for the outreach service)
- NWD Hub Workers (who work both in the hub and on outreach, and take on the key worker role)
- Portfolio Leads (who work in the hubs as shift leaders and have a focus on improving outcomes for NWD young people in their assigned portfolio: education, employment and training; risk management; activities; building relationships; transitions to independence/adulthood; and self-esteem, wellbeing and resilience)
- One Communications Support Worker (a speech and language therapist)
- One Life Coach (a clinical psychologist)
- One Police Liaison Officer
- Two NWD foster carers (for the hub family placements)

Assisting the operational hub teams is a central support team:

- NWD Project Manager
- Two Analysts (one from NYCC, one from North Yorkshire Police, both of whom focus on intelligence gathering and information sharing)

10.3.2 Set-up and running costs

An evaluation by Loughborough University (Lushey et al 2017) identifies total costs for the service's second financial year as £2.25 million. They project this will fall below £1.99 million over the subsequent 3 years as the service becomes embedded. These costs include staffing and non-staffing costs such as recruitment, training, and expenditure related to placements.

The type and intensity of support varies widely within the model, however the evaluation team estimate the cost of the most expensive package (a short-term 28-day bespoke package) to be £5,000 per week.

10.4 Effectiveness and impact

10.4.1 Overall evidence base

There has only been one evaluation of the North Yorkshire NWD service to date. This evaluation ran from April 2015 to March 2017, by a team from Loughborough University, used a mixed methods approach.

10.4.2 Evaluation findings

The evaluators conclude that the NWD project has made substantial progress toward meeting its intended outcomes. Preliminary evidence suggests:

- **NWD is helping young people to remain out of the care system**. In comparison to matched cohorts of young people, more NWD young people ceased to be looked after and more NWD young people continued to remain out of care over the evaluation period.
- **Placement stability improved.** There was a decrease in placement moves after NWD began. Changes in baseline and follow-up interviews with young people provided further evidence of success in this respect.
- **High risk behaviours fell** within the cohort. This includes reductions in criminal activity, substance use and missing episodes.
- **CSE safeguarding practice was improved**. NWD hub workers successfully identified 9 young people at risk of CSE.
- **Resilience, self-esteem and wellbeing outcomes improved**. SDQ scores for the NWD cohort (n=472) improved over time, while scores for a matched cohort not under NWD remained static. A strong correlation was also identified between interventions from the life coach and communication support worker and SDQ score improvements.
- **Relationships** between NWD hub workers and the young people are generally positive. Interviews suggest young people felt genuinely cared for and around half the young people said they would turn to staff if they were worried about something.

Evidence on the impact on transitioning from care to independent living is more mixed. Some young people reported being well supported through the transition, whereas others described abrupt moves.

10.4.3 Potential cost savings

The evaluators highlight that a full cost-benefit analysis is in the process of being undertaken. Nevertheless, they conclude from initial evidence that it is likely to provide positive value for money for North Yorkshire County Council and partner agencies. Cost savings identified in the evaluation include:

- Reduced use of other residential children's home placements, saving approximately £600,000.
- Reductions in arrests and missing incidents are estimated to have saved £200,000 annually through costs avoided to the police.
- The assessment of cases within NWD rather than being directly referred to CAMHS is estimated to have saved £160,000 annually.
- Annual cost savings associated with the work of the communication support workers are estimated at £300,000.
- Placement changes are estimated to cost from £250 to £1,500 per change. The costs incurred by placement changes for the cohort fell by £20,000 from the year prior to NWD to the first year of NWD. This is due to the improved placement stability.

10.4.4 Limitations to the evidence

Although the evaluation methods are robust and appropriate, no long-term outcome data is available. This means we are not able to draw conclusions about the sustainability of any identified impacts.

10.4.5 Lessons learned

The evaluation identifies conditions that were key to the programme's successful implementation:

- **Consistent leadership** and **workforce stability**.
- **A committed and dedicated team**, fostering dependable and consistent relationships between NWD hub workers and young people.
- **Clear criteria** for referral and acceptance.
- **A range of supported accommodation** options to ensure gradual pathways to independence.

The North Yorkshire NWD team experienced some difficulties in the implementation process:

- The **funding stream timescale** meant that the hubs were being refurbished during early stages of implementation. This was felt to be disruptive by both staff and young people.
- The multi-disciplinary nature of the service brought challenges, with team members coming from **different working cultures**. Strong leadership from management was required to bring about successful integration.

- The change from children's home to hubs required **shifts in thinking**, particularly because there were young people in placement there throughout the process.

- Securing longer term funding commitments is important for **staff morale and team stability** as it enables longer term fixed or permanent contracts. Although the use of temporary and fixed term contracts was to some degree inevitable during the pilot (funded through a fixed-term grant), this had a negative impact on some staff members and led to uncertainty in the team.

10.5 Recommendations for further research

Further research should consider the cost-effectiveness of the model. Research should also consider longer-term follow-up to gain an understanding of the model's sustainability.

10.6 More reading

Lushey, C., Hyde-Dryden, G., Holmes, L., and Blackmore, J. (2017) *Evaluation of the No Wrong Door Innovation Programme,* Children's Social Care Innovation Programme Evaluation Report 51 for the Department for Education.

11 Positive Peer Culture

11.1 What is it?

11.1.1 Introduction

Positive Peer Culture (PPC) is an intensive peer-helping group work model designed to improve young people's social competence and cultivate their strengths. PPC has been implemented in a range of settings including residential care, schools, and young offender institutions.

Intensive group sessions (45-90 minutes, 5 days a week, for 6-9 months) aim to develop pro-social behaviour including care and concern for others, social interest, and responsibility. These sessions aim to help group members learn to trust, respect, and take more responsibility and, in doing so, establish new norms that discourage antisocial or hurtful behaviours.

Although the PPC model has been given the second highest scientific rating by the California Evidence-Based Clearinghouse for Child Welfare (CEBC), most evidence is from foreign youth offending settings and, with important limitations, not easily generalisable to a UK setting

11.1.2 Model aims

As stated by the CEBC, the overall goals of Positive Peer Culture (PPC) are:

- Meet the universal growth needs of young people for affiliation, achievement, autonomy, and altruism
- Improve social competence
- Cultivate young people's strengths
- Convert negative peer influence into care and concern for others
- Develop social interest through leadership and guidance from trained adults

11.1.3 Origin and implementation

PPC originated in the late 1950s in the U.S. as a peer-oriented treatment model at a residential programme for "delinquent" young people. Developed on-site by Harry Vorrath and colleagues,[36] the first iteration of PPC comprised structured group counselling sessions five times a week. Since then the model has evolved, guided by experiences working in residential settings rather than a theoretical base (although it is linked to theories of learning and group processes) and

[36] Guided Group Interaction (GGI).

Vorrath's book *Positive Peer Culture* was first published in 1985 (Vorrath and Brendtro 2013).

PPC is designed to "turn around" a negative youth subculture and mobilise peer group strengths. The model's premise is that young people must develop "self worth, significance, dignity, and responsibility and become committed to positive values of caring and helping of others" to develop pro-social behaviours (Vorrath and Brendtro 2013: xi).

In PPC, young people work in groups to identify, take responsibility for and resolve problems. Ideally group sessions should last for 45-90 minutes, and take place 5 times a week over 6-9 months. Groups should comprise 8 to 12 young people.

Essential components of PPC include (according to CEBC and Vorrath and Brendtro 2013):

- Group sessions are facilitated by a trained, adult leader.
- Meeting young people's universal **growth needs**[37]**.**
- "Total **therapeutic milieu"** approach (the culture and atmosphere of the setting where PPC takes place are considered to have therapeutic potential. All social interactions in the setting contribute to the social environment or "milieu").
- **Building group responsibility**: Although an adult facilitator is in charge, young people have responsibility for helping each other. Group members learn to keep one another out of trouble.
- Group meetings are structured. **Problem-solving** strategies are used for young people to help their peers through: problem reporting, awarding the meeting, problem solving, summaries by group leaders.
- Trained staff use a **common language**. For example a "problem list" specific to PPC is used.
- As part of PPC, young people **participate in community projects** ("service learning") which reinforce the value of helping others. This is to encourage a lifestyle of community responsibility and action, rather than community service as a punishment for misbehaviour.

[37] PPC focusses on asking whether young people are willing to give help (rather than receive it). The literature As the person gives and becomes of value to others, he increases his own feelings of worthiness and builds a positive self-concept.

- An approach to program management where "**teamwork**" is the highest administrative priority. Staff teams are organized around the groups of young people.

Vorrath claims that PPC is a "total system" and not "something extra" that can be added to an existing program (Vorrath and Brendtro 2013: 10). However, in practice PPC has been implemented in various forms outside the U.S. For example, the well-evaluated EQUIP program in Dutch correctional facilities draws on PPC but includes additional features.[38]

11.2 Target groups

The model targets high-risk young people aged 11 to 22 years old in residential settings, including young offender institutions, or schools (public, private, or alternative).

Although PPC was originally developed for young people at risk of "criminal" behaviours, its target group is no longer offender-focussed and now includes young people exposed to emotional abuse, domestic violence, physical abuse, neglect and sexual abuse (Vorrath and Brendtro 2013).

11.3 Inputs and resources

11.3.1 Staff, expertise and resources required

PPC works with existing services and can take place in residential care settings, schools, young offender institutions and outpatient clinics.

Staff working under a PPC model include:

- Direct service workers with undergraduate degrees in the helping professions.
- At least one trained adult group leader per group of 8-12 young people. Group leaders are expected to have a Master's degree in social work or a related field.
- PPC supervisors with five or more years' experience in positive youth development and a working understanding of child development, trauma, group dynamics and development, and Situational Leadership.

The model may involve family or other support systems.

There is a PPC manual that describes how to implement the model and training material is available in English and German. Classroom-based and immersion

[38] "Equipping Youth to Help One Another" (EQUIP) is a multi-component group treatment program for young people with antisocial conduct disorders or juvenile delinquents. EQUIP assimilates social skills training, anger management, and moral education components of Aggression Replacement Training (ART) into a modified PPC group format.

training is available, including a two-day on-site introductory course (Cultures of Respect).[39] According to the CEBC profile, coaching and implementation support for PPC is provided through Egsmark Associates. However, this review was unable to find additional detail online for this support or any of the training courses.

11.3.2 Set-up and running costs

This review was not able to identify any information on the costs of setting up or running PPC in any of its implementation sites.

Details on training offered by identified providers are not available.

11.4 Effectiveness and impact

11.4.1 Overall evidence base

PPC has been given the second highest scientific rating by the CEBC, rated as "2 Supported by Research Evidence". This means a randomised controlled trial (RCT) has been conducted which measures outcomes associated with PPC at least six months after model implementation.

11.4.2 Evaluation findings

Studies have measured the effects of PPC for diverse young people and in a range of residential settings worldwide.

A randomised controlled trial of PPC-based EQUIP at a medium-security correctional facility in the U.S. (n=57 male young offenders between 15 and 18 years old) measured moral judgement and social skills before and after participation[40] **(Leeman et al 1993)**. It found:

- EQUIP had no effect on moral judgement but improved social skills of those who participated compared to those who didn't.
- EQUIP participants showed "significant" improvements[41] in institutional conduct during the intervention suggesting gained social skills
- Compared to young men who did not attend EQUIP, participants had significantly lower recidivism rates after 12 months

A non-randomised study compared pre-intervention and post-intervention survey responses between young men (n=56, 12-18 years old) who underwent PPC-

[39] This review did not identify any details on the course or its content.

[40] Using standardised measures (Sociomoral Reflection Measure—Short Form; Inventory of Adolescent Problems—Short Form)

[41] Unable to access this article, so further detail on improvements lacking

based EQUIP at a Dutch high-security young offender setting with young people from two other settings without the model **(Nas et al 2005).** It found:

- EQUIP participants improved on some attitudinal measures such as self-centeredness, blaming others, and lying, and had more negative attitudes toward delinquent behaviour.
- No differences in moral judgment, social skills, or social information processing scores between groups who participated and those who didn't.

Another non-randomised study examined recidivism over 9 years using State Police arrest data of young people (n=286) of unspecified genders who took part in PPC and were released from a residential programme in the U.S. **(Ryan 2006).** It found:

- Of the 286 young people released from the residential program, 67% were American American, 28% White and 5% Hispanic.
- The study found young people with a history of physical abuse and neglect were more likely to be arrested following release.

A non-randomised study assessed PPC at a residential treatment setting for teenage young men with behavioural problems and delinquency in Germany. Outcome measurements were taken from the young men (n=163) six times, every six months over three years. (Steinebach and Steinebach 2009).

- Results indicated reductions in violence and increases in pro-social behaviour and self-esteem.

11.4.3 Potential cost savings

This review did not identify any information on potential cost savings associated with PPC.

11.4.4 Limitations to the evidence

There is some evidence that PPC may have some effect in improving outcomes for young people. However almost all existing research has been conducted in foreign youth offending settings and there is no research from a UK setting. It is **difficult to generalise** these evaluation findings to UK residential care.

Although the model is rated relatively highly by the CEBC, there has only been one RCT with important limitations. Leeman et al 1993 had a small sample size n=57, and the study was an efficacy trial (i.e. under ideal circumstances). This gives **little idea of PPC effectiveness** (the degree of beneficial effect we would observe in a "real world" setting).

In addition the lack of randomisation in other studies means we cannot attribute any of the effects observed to the PPC model. There may have been other important differences between the intervention and control settings, that led to the difference in outcomes observed.

All the studies excluded young women (except for Ryan 2006 which does not specify participants' gender). We have **no idea about young women's experiences** of the model and we cannot say with any confidence whether PPC is likely to be effective for young women.

Vorrath and Brendtro claim PPC cannot be added to other models. However, the most robust evidence available is from studies examining the EQUIP model. This raises important questions about whether the findings are applicable to PPC. Similarly, there are no fidelity measures associated with PPC so it is **difficult to compare evidence from different studies**.

Publicly available information on what PPC training consists of, or *how* group sessions are implemented is very limited. This may be to protect intellectual property associated with the model e.g. training materials can only be obtained on completion of training, but we cannot assess implementation fidelity and compare results across studies with confidence.

Very **little evidence on long-term outcomes** for young people is available across the studies. Although Ryan 2006 examines recidivism data over 9 years, the data is from one U.S. state, suggesting a possible underestimation of the findings. The study observes recidivism outcomes are worse for African Americans and claims PPC may be less effective for some young people. However, due to the lack of randomisation or control group, our understanding is necessarily limited.

11.4.5 Lessons learned

No research has been conducted on how to implement PPC.

11.5 Recommendations for further research

Research into PPC implemented for more diverse groups of young people and how participants characteristics (such as gender, race, specific relationship issues) might affect outcomes is urgently needed.

Robust research outside young offender institution settings (for example in a residential care setting) and with longer and more detailed follow-up measures.

Research is needed on PPC implementation. Ryan 2006 observed young people in groups which experienced turnover of at least two staff were more likely to reoffend. Research into the effects of staff turnover and other factors affecting implementation would be helpful.

11.6 More reading

Brendtro, L, & Mitchell, M. (2015). *Deep brain learning: Evidence-based essentials in education, treatment, and youth development.* Albion, MI: Starr Commonwealth; Distributed in Collaboration with Research Press, Champaign, IL.

CEBC webpage: http://www.cebc4cw.org/program/positive-peer-culture/detailed

Leeman, L. W., Gibbs, J. C., & Fuller, D. (1993). Evaluation of a multi-component group treatment program for juvenile delinquents. *Aggressive Behavior, 19*, 281-292.

Nas, C. N., Brugman, D., & Koops, W. (2005). Effects of the EQUIP programme on the moral judgement, cognitive distortions, and social skills of juvenile delinquents. *Psychology, Crime, & Law, 11*(4), 421-434.

Osgood, D. & Bridell, L. (2006). Peer effects in juvenile justice. In K. Dodge, T. Dishion, & J. Lansford (Eds.). *Deviant peer influence in programs for youth: Problems and solutions* (pp. 141-161).

Ryan, J. P. (2006). Dependent youth in juvenile justice: Do Positive Peer Culture programs work for victims of child maltreatment?. *Research on Social Work Practice, 16*(5), 511-519.

Steinebach, C., & Steinebach, U. (2009). Positive Peer Culture with German youth. *Reclaiming Children and Youth, 18*(2), 27-33.

Vorrath, H. & Brendtro, L. (2013). *Positive Peer Culture* (2nd ed.). New York: Aldine.

12 Priority Childcare

12.1 What is it?

12.1.1 Introduction

Priority Childcare is a residential children's home provider with a network of six homes in Wales.[42] The homes provide children and young people with medium to long-term stays and are set-up to aid transition to or from family placements (family or foster care) or to independence. For the latter, Priority Childcare offers a vocational independent skills qualification and gives young people the opportunity to transfer to a semi-independent on-site flat.

The model is based on a 'therapeutic parenting' approach and draws on: (i) Attachment Theory and Developmental Trauma including Trauma Recovery Model (ii) Behaviour Change and Positive Behavioural Approaches, and (iii) Complex Systems.[43]

No evaluations of the model exist. We describe it using information from the company website, available statement of purpose documents, and a site visit. Following the site visit Cordis Bright obtained further documentation on the working arrangements between Priority Childcare and Tact Cymru (fostering and adoption) and Priority Childcare's goal review system for young people.

12.1.2 Model aims

The model aims to meet the individual needs of children and young people, by:

- **Proactive management of placements** providing time-sensitive residential care in order that informed decisions can be made by all interested parties as to the best course of action to meets the needs of the individual child/young person.
- Providing **good quality safe care** for young people with concerning behaviour who may have experienced abuse, exploitation or complex family issues, and require immediate support and stability for their needs to be assessed.
- Providing residential care, which **takes account of and is sensitive to age, gender, ethnicity and sexual orientation** of the young person concerned.

[42] (Figure 10 on page 79)

[43] As described on the company website and in statement of purpose documents. Complex Systems recognises children exist within complex systems both in terms of family of origin and their experience of professional services.

- Providing **purposeful care**, in collaboration with responsible Social Workers, to address identified needs and prepare young people for family reunification or appropriate residential resources.

12.1.3 Origin and implementation

Overview

Priority Childcare was established in March 2010. The company currently has six homes across South Wales, all of which have four beds and are located rurally (Figure 13 on page 87). Two of these homes (Rhos Cottage, Beach Tree Farm) have two semi-independence flats on each site. Forestry House has one flat on site.

Children and young people have a nominated key worker and social, emotional and behavioural guidance is provided by care home staff. If the young person's needs have been assessed prior to the placement, this assessment is used. If not, an assessment is made by a local institute, which also provides additional therapy services where needed.[44] Therapy packages are designed according to each child or young person's needs (determined during the initial assessment). For young people who have experienced CSE or displayed sexually harmful behaviour, specialist support is provided in partnership with Barnardo's Seraf and Taith therapeutic services respectively.

Transition to independence

For young people over 15 years of age whose care plan is to move to independence, the company has its own programme to help young people prepare for independent life. They can work towards Priority Childcare's 'Moving Forward' qualification in independent living which covers cooking, health and safety, social skills, financial skills, first aid and employment skills. Before transitioning to independence, young people can reinforce these skills living semi-independently at one of the network's on-site flats.

Transitions to family placement (home or foster care)

Two of the homes are set up to support transition, both to and from family and foster placements. To assist young people's transition to appropriate foster placements, the company has service level agreements with foster care agencies. Transitions are planned following a four-stage model:

- A period of stability for the young person.
- Delivery of an agreed programme of therapy (this is done using Local Authority professionals or Priority Childcare consultants at cost).

[44] Therapies contracted from the Hiraeth institute include CBT, play therapy, psychotherapy and life-story work.

- Identification of appropriate move-on hosts (including training).
- Support in the transition process (including agreed period of key worker contact and support for hosts) - transitions to foster care placements are supported by a therapeutic transition model ('Focussed Futures'). Further detail is provided in Figure 12.

Focussed Futures – model for transitions to foster care

This review obtained information from Priority Childcare on the model the service uses to support transitions from Priority Childcare's residential placements to foster care, 'Focussed Futures' (Figure 12). The model is implemented jointly by Priority Childcare and fostering providers Tact Cymru, and comprises four phases. According to this internal documentation, the model aims to support transitions by (i) taking a therapeutic approach alongside review and planning, (ii) and joint-working approach of both the residential and fostering provider.

Figure 12: Focussed Futures Therapeutic Transition Model (Residential to Foster Care Placements)

Phase	Description
Preparation phase	The matching process (between young people and future foster care placements) starts upon referral to Priority Childcare. Foster carers may participate in relevant trainings alongside residential care workers.
Phase 1	During the young person's placement at Priority Childcare (commonly lasting 6-9 months), a full assessment and therapeutic work is undertaken. If a suitable match with foster carers can be made, informal meetings and formal introductions take place "at the pace of the young person over an appropriate period of time".
Phase 2	The young person has six overnight stays at the potential foster care placement. A formal review meeting takes place to evaluate progress and determine the duration of phase two and any move on to phase 3.
Phase 3	The young person's residential key worker maintains involvement on an Outreach basis, working alongside foster carers "for a period that is deemed necessary and appropriate" (around 15 hours per month).

Source: Documentation provided to Cordis Bright by Priority Childcare. Note that each phase is subject to a formal review and duration of each phase is flexible.

Educational opportunities

Educational opportunities are provided as part of both transition programmes. Staff collaborate with statutory services and support residents to attend school. An independent on-site school was established in 2015 for residents unable to access mainstream education. The school is based at four of the Priority

Childcare sites and is served by a school team based at Trafle Lodge. As of May 2017, the school had five pupils and was ESTYN registered but did not meet the Independent School Standards (Wales) Regulations. The on-site school is working towards meeting the Independence School Standards.

12.2 Target groups

The target-group is relatively non-specific although specialist care is offered for:

- young people who have experienced child sexual exploitation,
- young people who have engaged in sexually harmful behaviour,
- young people with challenging behaviours such as self-harm,
- a younger 8 to 14-year-old age group,
- young people who require care from staff able to manage difficult behaviour.

The home does not accept emergency placements or anyone with moderate to severe mobility difficulties.

12.3 Inputs and resources

12.3.1 Staff, expertise and resources required

According to its website, the company employs over 100 people, both qualified and experienced staff (QCF 3 Health and Social Care, Children and Young People, specialist experience in CSE), and people looking to gain experience and qualifications. Staff undergo continuous and regular training. They also receive therapeutic supervision.

The on-site school employs one teacher; three teaching assistants, and a Head of Education who oversees education across the network. (Estyn May 2017).

12.3.2 Set-up and running costs

No information regarding the set up costs of this model or services associated with it was identified. However, placement costs per week are: Core Placement 1st phase £2,900, 2nd phase £1,450 and 3rd phase £225.

12.4 Effectiveness and impact

12.4.1 Overall evidence base and evaluation findings

To date, there has been no evaluation of the Priority Childcare model so it is not possible to determine any positive or negative outcomes attributable to it.

Pupils attending the on-site school undergo an assessment upon enrolment. Cordis Bright's site visit, obtained information about how young people's

educational progress is tracked by staff (LMF framework and WRAT4) and supports goal planning and review for each young person. Cordis Bright reviewed an example developmental profile (using Fagus developmental checklist), goal review sheet, and outcome measurement sheet.

12.4.2 Potential cost savings

Although the care model is described as "cost-effective" on the company website, no information is available on service costs, average length of stay, services accessed, or any social return on investment.

12.4.3 Limitations to the evidence

Evidence on the effectiveness of the Priority Childcare model and its two transitional programmes for children and young people is very limited. Information on home capacity, average length of stay, and outcomes for young people is not of a detailed and rigorous nature.

Educational opportunities

It is difficult to make judgements about pupil performance either against national standards or the school's aims. Evidence on educational outcomes and progress is not independently verified.

Transitions to foster placements (Focussed Futures)

Although internal documentation shows independent review and evaluation is conducted for each young person, this review did not obtain any such document. Although Priority Childcare records where young people go and how many transition to foster care or family placements, outcomes for young people are not recorded and no independent verification of the model's impact is available.

12.4.4 Lessons learned

No information was available on lessons learned from the roll-out of these services.

12.5 Recommendations for further research

An independent evaluation of the service would help to understand whether and how Priority Childcare is meeting its aims and objectives as described in its statement of purpose. Key gaps in understanding the model's effectiveness include:

- Whether and how the theoretical model the service draws upon contributes to its impact
- Service costs and cost-effectiveness
- Added value of on-site education

- Outcomes specific to children with specialist needs (for example experience of CSE)
- Effectiveness of the Priority Childcare independence programme, and four-stage family transition model
- Long-term outcomes for children and young people

12.6 More reading

Priority Childcare website: http://www.prioritychildcare.co.uk/

ESTYN. (2017) Annual monitoring inspection report on Priority Childcare. Cardiff, Wales – May: Estyn, Her Majesty's Inspectorate for Education and Training in Wales. Available at: https://www.estyn.gov.wales/sites/default/files/documents/Priority%20Childcare.pdf [Accessed 02/02/2018].

Trafle Lodge Inspection Report August 2017, Care and Social Services Inspectorate Wales: https://www.ccsr-wales.net/ccsr_documents/391/Trafle_Lodge_Inspection_Report_August_2017.pdf

Ty George Statement of Purpose: https://www.ccsr-wales.net/ccsr_documents/391/TyGeorgeSOP.pdf

Graig-Y-Bedw Statement of Purpose: https://www.ccsr-wales.net/ccsr_documents/391/Prioritychildcare_GraigYBedw_Statementofpurpose_042017.pdf

Barnardo's (2010) Taith Service: 10-year review. Barnardo's. Available: http://www.barnardos.org.uk/taith_10_year_report.pdf [Accessed 02/02/2018].

Barnardo's Seraf Service: http://www.barnardos.org.uk/serafservice.htm

Priority Childcare and Tact Cymru (undated) Innovative Working arrangements between Priority Childcare and Tact Cymru 'Focussed Futures' – A Therapeutic Transition Model (documentation provided to Cordis Bright)

Figure 13: Priority Childcare Network of Residential Homes

Home	Target	Transition to	Staff	Additional facilities
Trafle Lodge **Four bed house**, Gowerton	Aged 8 and 14	**Family placement**	1x Manager 1xDeputy Manager 2x Seniors 7x RCWs	On-site school

Home	Target	Transition to	Staff	Additional facilities
Rhos Cottage **Four bed house** near Swansea	Aged 13-18, Very vulnerable	**Transition to Independence**	1xManager 1x Deputy Manager 2 xSeniors 10x RCWs	2 transitional flats
Graig-Y-Bedw Very rural, near Swansea	Challenging behaviours (e.g. self-harm) or CSE	**Family placement or independence**	1x Manager 1x Deputy Manager 2x Senior RCWs 7 x RCWs	On-site school
Beech Tree Farm (Rhos Cottage sister service) Llangfellach	Aged 13-18	**Transition to independence***	1x Manager 1xDeputy Manager 2 xSeniors 10xRCW	2 transitional flats
Ty George **Four bed house** in rural location near Bridgend.	Aged 12 to 17, requiring care from staff able to manage difficult behaviour	**Transition to family placement or home**	1x Manager 2 x Senior RCWs 8 x RCWs	On-site school
Forestry House Four bed house Neath Valley	Aged 12 - 18 year olds	**Transition to independence***	1 x Manager 1 x Deputy 2 xSeniors 7 xRCWs	On-site school 1 transitional flat

*for young people over 15 years old whose care plan is to move to independence

13 Restorative Justice

13.1 What is it?

13.1.1 Introduction

Restorative justice is a way of responding to incidents and resolving conflict whereby "victims" and "wrongdoers" resolve how to deal with the offence collectively.

Restorative justice has been implemented in UK residential children's care settings as a way of managing anti-social or criminal behaviour, and dealing with incidents that occur between young people and/ or staff. Broadly it involves "victim", "wrongdoer" and "community" meeting to share perspectives and feelings in a "conference", which also addresses what can be done to put things right going forward.

In children's residential care settings, informal restorative justice approaches tend to be implemented alongside these formal processes.

13.1.2 Model aims

Restorative justice interventions in children's homes aim to respond effectively to incidents and resolve interpersonal conflicts that occur within the home, and manage any criminal or anti-social behaviour of residents (Littlechild and Sender 2010).

A secondary aim is to divert children in care away from the formal criminal justice system, by ensuring that incidents are dealt with by staff in a way that does not require police involvement (McCarney 2010). The rate of formal reporting of low-level criminal activity in care is high (RJC 2015); residential children's care staff are more likely to involve the police and rely on the formal criminal justice system when dealing with challenging behaviour than family members relatives in a family home would do (RJC 2015).

13.1.3 Origin and implementation

Broadly, restorative justice is "a process whereby parties with a stake in a specific offence collectively resolve how to deal with the aftermath of the offence and its implications for the future" (Marshall 1999).

There are four main principles to restorative justice processes (Littlechild and Sender 2010):

- To make space for those who have experienced crime (particularly the offender and victim)
- To view crime and anti-social behaviour within a social context
- To have a preventative and forward-looking problem-solving orientation

- To allow for flexibility of practice

These principles have been incorporated into various criminal justice settings, with a particular focus on youth offending settings (RJC 2015). A restorative justice model, "restorative conferencing", was introduced in some UK residential children's care sites in 2003 (McCarney 2010). This model involves a formal three-step process, whereby: (i) the "victim" and "wrongdoer" meet in the company of their immediate community (parents or carers) and others directly affected by the incident; (ii) everyone affected is given the opportunity to share their perspective and feelings relating to the incident/situation; and (iii) all parties discuss what needs to be done to move on and how things can be put right.

When "restorative conferencing" was introduced in some residential care settings, formal processes were recognised to not always be effective or practical, given the urgent nature of many of the incidents (McCarney 2010). Consequently, a range of less formal processes that can be implemented immediately are also in operation (McCarney 2010; Littlechild and Sender 2010; Wilmott 2007; Littlechild 2003). These include: "corridor conferences", "restorative chats" or "restorative discussions," and the literature also alludes to the importance of a "restorative ethos" throughout the setting (McCarney 2010; NCERCC 2007).

Restorative justice in children's residential care settings tends to be used in response to incidents between young people. The model can also be used for more serious incidents (for instance if a young person has been charged with a criminal offence) (Community Care 2011). In these cases, formal conferences can occur outside the home, with an independent chair (Community Care 2011).

According to McCarney's review of restorative justice in children's residential care, the model's suitability depends on the seriousness of incidents, victims' opinions, and perpetrators' willingness to engage in the process and acknowledge responsibility in wrongdoing.

13.2 Target groups

Suitability of restorative justice processes in managing and responding to incidents is determined by individual residential care settings (McCarney 2010).

The model addresses specific incidents within settings, where wrongdoer(s) is/are children and young people resident within the home, and the victim(s) are either fellow residents or staff (McCarney 2010).

13.3 Inputs and resources

13.3.1 Staff, expertise and resources required

This model relies heavily on the training of residential staff, who typically bear responsibility for implementing the model in residential care settings (Wilmott 2007). Staff input and resources required to implement restorative justice varies across settings, for example:

- One UK county, Leicestershire, recruited a "Restorative Worker" to develop a specialised, tailored restorative justice training package for staff working in eight children's homes across the area (Knight et al 2011).
- Elsewhere, restorative justice training for residential care staff has been provided through the police (Littlechild 2003; Community Care 2011).
- One pilot in an ISU developed a two-day training programme which it delivered to everyone who had regular contact with children, and included involvement of senior management in the training programme (McCarney 2010).

Additional follow-up meetings are often needed. These provide residential care staff with ongoing practical support and mentoring that encourages their use of the model (Knight et al 2011; McCarney 2010).

Implementation of a restorative justice in children's homes often also requires the involvement of partner agencies, particularly the police, YOT and Crown Prosecution Service (Wilmott et al 2007; Knight et al 2011; Community Care 2011).

13.3.2 Set-up and running costs

This review identified limited detailed information on the costs of implementing restorative justice in children's residential care.

That said the project to introduce restorative approaches to eight pilot homes across Leicestershire cost £180,000 for its three-year duration (Knight et al 2011).

The cost of developing restorative approaches across services for looked-after children in another county (Norfolk) was £150,000. This included training for 100 residential workers in the delivery of restorative approaches and took place between 2010 and 2015 (Community Care 2010).

13.4 Effectiveness and impact

13.4.1 Overall evidence base

This review identified relatively few robust evaluations of restorative approaches in children's homes. However, findings from the current evidence base indicate some preliminary support for the effectiveness of this model in promoting positive outcomes for looked after children.

13.4.2 Evaluation findings

There is some evidence that the **restorative justice model can reduce offending, antisocial behaviour, and criminalisation** of young people in care.

- In Norfolk, the number of young people in care who became involved in the criminal justice system dropped by 52% within two years of the county-wide implementation of restorative approaches within children's homes (RJC 2015).

- In Leicestershire, evaluators reported substantial reductions in total offences recorded for young people resident in the restorative justice homes (from 147 in Year 1 to 50 in Year 3). There were also reductions in the number of young people offending each year (80% of residents in Year 1, to 41% in Year 3) (Knight et al 2010).

Restorative justice approaches in children's homes have been linked to **decreases in police call-outs** to units (Littlechild 2003; Littlechild and Sender 2010; Wilmott 2007).

- Data from Norfolk County Council suggests the number of police call-outs to residential homes decreased by 19% following the introduction of restorative justice (Community Care 2010).

- In one report, review of offence-related police call-out data indicated a 23% reduction during the three years following RJ implementation, although this varied somewhat between the four units involved in the pilot (Littlechild and Sender 2010). Between November 1999-2002, 433 calls to police were made by the children's homes, compared to 340 in December 2002-2005; however, this finding must be interpreted cautiously given the challenges in attributing it entirely to the introduction of restorative approaches (Littlechild and Sender 2010).

Model is **valued by staff and young people** in residential settings

- One report suggests restorative approaches provide staff with a structure and confidence to deal with issues, and this may improve staff morale (Cooper 2005).

- Two evaluations of the model piloted in Hertfordshire suggest staff and young people had positive experiences of the model (Littlechild and Sender 2010; Littlechild 2003). Children and young people thought restorative justice had improved their ability to deal with conflicts and resolve problems, discuss feelings and learn about others' perspectives (Littlechild and Sender 2010). Managers and staff also associated the model with positive outcomes when interviewed. These included: improved anger management; improved sense of responsibility and guilt for antisocial behaviour; and more opportunities for residents to voice their concerns (Littlechild and Sender 2010).

- Some evidence suggests the model is effective in changing staff perceptions of their contribution to conflicts within homes, and increases their awareness of potentially confrontational or antagonistic behaviour or responses to young people (NCERCC 2007).

- One review of restorative justice in children's homes (Wilmott 2007) found improvements in staff confidence, empowerment, and ability to resolve and

manage difficulties within units were reported in several studies (Wilmott 2007).

13.4.3 Potential cost savings

This review did not identify any information on potential cost savings.

13.4.4 Limitations to the evidence

This review found relatively few robust evaluations of restorative justice in residential units for children and young people, suggesting this is a relatively new area of research (RJC 2015). Key limitations to the existing evidence base include:

- **Evaluation study designs are prone to bias.** Most evaluations identified by this review rely on interviews with staff or police call-out data as measures of outcomes, which may introduce bias. Using police call-out data to indicate the number of incidents requiring police intervention is problematic. Any observed reduction or increase in incidents must also address other factors that may explain any changes (for example, circumstances at the home or characteristics of the residents).

- **Generalisability of evidence is difficult as model interpretation differs.** Formal steps to implementing restorative justice exist (restorative conferencing). Most evaluations of the model highlight the utility of "informal processes" in lieu of formal conferencing, deemed unsuitable or impractical in residential children's care settings (Littlechild and Sender 2010; McCarney 2010). Informal approaches lack a structure which can be manualized, and will be operationalised differently by different staff involved. This makes it difficult to assess *what* is being implemented in each setting, compare evidence across settings, and replicate or roll-out the model.

- **Positive outcomes are highly dependent on context.** "Informal processes" involved in restorative justice implementation are contingent on context such as: staff expertise, training, or confidence; environmental factors such as the nature and make-up of the young people in the residential care setting; and relationships between staff and young people. In addition to the non-randomised study designs, these unmeasured contextual features make it difficult to attribute positive outcomes to the model.

13.4.5 Lessons learned

This review has identified key challenges and success factors from implementations of restorative justice.

Success factors

- **"Buy in" from senior management** and strategic partners is important for successful implementation of restorative justice in children's residential care settings (Knight et al 2011; McCarney 2010; NCERCC 2007).

- **Part of broader strategy or partnerships** that allow restorative justice principles to become embedded. Establishing a Restorative Approach Strategic Board responsible for running monthly evaluations to monitor utilisation of training by staff, and launching a joint initiative between children's services and Norfolk Constabulary was identified as central to one implementation (Community Care 2011). In another implementation of the model, a locality-wide restorative strategy across sectors was seen as fundamental to the model's success (NCERCC 2007). Likewise, the multi-agency steering group established in Leicestershire was considered critical to overcoming many potential barriers during the project set-up and implementation (Knight et al 2011).

- **Professionals outside the residential setting understand the approach.** Knight et al highlight this as particularly important when restorative approaches aim to reduce unnecessary criminalisation of young people in residential care settings (2011).

Key challenges

Some research has suggested that implementation of restorative justice approaches in residential settings is more challenging compared to criminal justice settings (e.g. court rooms, YOTs), as residential units often operate as a close community, where relationships can be more intimate (Littlechild and Sender 2010).

- **Informal restorative approaches may be needed.** Several evaluations note informal use of restorative justice principles and conflict resolution is important in residential care settings, and consider formal conferencing and mediation methods less useful (Littlechild and Sender 2010; McCarney 2010; Wilmott 2007).

- **Changes within residential care settings may impede delivery.** The restorative justice model necessitates a "culture change" and takes time to fully incorporate. Factors including high staff turnover, new management, or other changes to initiatives within units, inhibit effective implementation (NCERCC 2007).

- **Incidents in residential settings are often complex and not one-off events.** Littlechild and Sender note staff in residential care settings may find it difficult to perform facilitator roles which demand objectivity (2010). Bullying amongst young people, especially, was considered very different to one-off events such as a theft and more challenging to address using the model (Littlechild and Sender 2010). In many cases abuse might be severe and/or continued, and perpetrators were not perceived by staff or young people to engage with the model's processes in a meaningful way (Littlechild and Sender 2010).

- **Model may not be universally appropriate.** Should young people or staff object to the model or not engage fully in the process, model implementation is difficult. Some studies have reported that restorative justice may not be

appropriate for children with complex needs who find it difficult to engage with processes; for example restorative justice interventions in groups with communication difficulties and/or difficulties with attention span were challenging for staff and considered to be less effective (Littlechild and Sender 2010).

- **Potential gaps in staff training.** Training should provide clarity around formal and informal restorative justice methods so that staff are empowered to use an effective combination of restorative justice, mediation, and relational conflict resolution strategies (Littlechild and Sender 2010; NCERCC 2007).

Considering unintended consequences to implementation

Following the implementation of restorative justice in residential care settings in Hertfordshire, the National Society for Prevention of Cruelty to Children (NSPCC) published recommendations addressing potential unintended consequences of restorative justice (such as ongoing bullying) (Littlechild and Sender 2010):

- Staff should ensure that all those involved in restorative justice meetings are participating voluntarily (Littlechild and Sender 2010).

- Staff should be involved in ongoing assessments regarding the extent to which young people participate fully and, if necessary, implement "alternative strategies" (Littlechild and Sender 2010).

13.5 Recommendations for further research

Research on the effectiveness of restorative justice when dealing with bullying and peer-on-peer or peer-on-staff conflict in residential units is needed.

Additional evaluations should work to clarify and measure the more informal restorative methods in use so that these can be operationalised effectively and consistently.

Finally, identifying some of the longer-term outcomes of restorative justice approaches for children would be valuable. These might use a longitudinal evaluation design with long-term outcome follow-up to ascertain whether the immediate benefits of this model (i.e. conflict resolution, reductions in unnecessary criminalisation) can be sustained over time.

13.6 More reading

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14 Safe Steps

14.1 What is it?

14.1.1 Introduction

Safe Steps is a specialist model of residential care for young women at high risk of child sexual exploitation (CSE) or other serious community threats. It was developed under the Department for Education's Social Care Innovation Programme in England[45]. Initially it comprised two specially adapted London children's homes, however one has since closed.[46] Staff are trained in a Social Pedagogy model and to work in ways that emphasise relational security and a personalised approach to risk assessment. The model operates within existing guidance on liberty restriction. Originally it aimed to enable young women to remain living in the area where they have been sexually exploited; however, this has changed and referrals are coming from other local authorities.

14.1.2 Model aims

The model's overall goal is "to improve the mental health and well-being of sexually exploited young women and enable them to build lives free of sexual exploitation" (Williams and Scott 2017: 45).

The intended outcomes for young women are: reduced risk of sexual exploitation, improved emotional wellbeing, stable living situations, supportive relationships – including rebuilding positive family relationships, awareness of rights and risks, and ability to make positive choices for themselves (Williams and Scott 2017).

Safe Steps aims to test whether providing intensive support and supervision, while working within existing regulations on restrictions to liberty, can keep young women safe outside a secure setting.

14.1.3 Origin and implementation

The St Christopher's Fellowship Safe Steps Innovation pilot was developed with local authorities as an alternative to placing young women being identified as sexually exploited, or at risk of sexual exploitation, in secure children's homes or homes far from their own area[47]. It was originally based in two specially-adapted

[45] Unless stated otherwise, all information in this section is taken from the University of Bedfordshire's evaluation of the service (Williams et al. 2017).

[46] This was due to the structure of Allen House making it difficult to manage risk and its location. The home has subsequently opened as a home for children with emotional and behavioural difficulties (EBD) with education provided on site.

[47] St Christopher's is a relatively small UK-based charity and provider of children's homes.

homes on suburban streets in London[48] as a response to growing concerns about the extent of CSE and exploitation, and especially for young women in London.

As with other St Christopher's children's homes, Safe Steps operates under a Social Pedagogy model,[49] combining evidence-based practice, understanding of emotions and practical skills. The model:

- authorises staff to give priority to creating positive relationships with the young women,
- supports staff to take a personalised approach to risk assessment, supervision and safety,
- empowers young women through trauma focussed therapy; opportunities for healthy personal development; and interventions that enabled them to make sense of the grooming and exploitation to which they had been subjected,
- supports young women to take a more responsible stance towards their own safety,
- engages local authorities and families from the outset of each placement to ensure well-planned and positive transitions from the home.

Places are commissioned by two consortia – the West London Alliance, comprising nine local authorities, and the North London Children's Efficiency Programme, comprising five local authorities.

Following a site visit, Cordis Bright obtained documentation covering Safe Steps programme of work. This provides additional detail on the service provided to young women:

> *All girls will have access to key work sessions and to the programme contents but the programme and timescales will vary depending on individual needs/ risks. A programme will be drafted as part of admission planning. This will be the responsibility of the allocated key workers in consultation with their supervisor / Manager.*
>
> *We use a lifespace approach, this means our staff make intentional use of everyday life and shared activities to build relationships and create learning opportunities for young people. Our young people's feedback has clearly told us that they do not like 'formal' professional interactions, what they value most in our staff is their ability to be flexible, to have professional boundaries while being relaxed, fun and doing activities together (SCF Children's Survey 2015). In practice, this means that while we have a structured programme underpinning*

[48] Allen House and Pelham House

[49] 'Head, Heart, Hands'

> *our work, it is woven into the fabric of daily life and the timescales and way in which we engage each young person or group is highly responsive to their individual circumstances, needs and views. Below are some of the core elements of how we work with each young person: Key work sessions; House meetings; Direct work- individual and in groups; Lottie programme[50]; Think U Know programme; ASI; Evaluation / Q Pack; CSE folder of resources; CSE Workshop; Women and Girls Network; Individual consultants/ specialists / therapists; Drug and alcohol workshop.*

Pelham House has a suggested programme of activities for young women. The following information is taken from the Programme of Direct Work documentation following an on-site visit.

Prior to admission: Young woman receives Young People's booklet and admission planning process which explains the work of the home and rules such as no electronic devices and supervised spend on admission, and supported travel arrangements. They are also provided with key contact numbers (CSE hotline, homes numbers and 0800 reverse for emergencies).

Month 1: Planned key work sessions take place twice a week. In addition, Think U know programme, baseline evaluation documents and ASI are completed by the end of the month.

Month 2: Planned key work sessions take place twice a week. CSE programme (Lottie, CSE, Workshop and individual and group CSE, Toolkit risk assessment review), drug and alcohol workshop, and use of other therapeutic or sexual health resources are also covered.

Month 3: Planned key work sessions take place twice a week. Three-month evaluation documents are completed. Additional CSE resources are drawn upon and Lottie and the CSE toolkit risk assessment undertaken again.

14.2 Target groups

Safe Steps is for young women identified as sexually exploited, or at risk of sexual exploitation, who would have been accommodated in secure children's homes or homes far from their own area.

14.3 Inputs and resources

14.3.1 Staff, expertise and resources required

Across the two sites, there were initially 35 operational staff. Each home was designed to accommodate up to four young women.

[50] Interactive simulation addressing the serious issues of online grooming and exploitation for professionals working with young people: https://www.kent.ac.uk/sspssr/ccp/game/Lottieindex.html

Staff at Pelham House comprise:

- One Manager.
- Two Deputy Managers.
- Nine Residential Support Workers (RSWs) (working from 8:00 to 19:00).
- Four night staff.

Following a review in April 2016, the structure of the team at Pelham House changed and duration of RSW shifts reduced to eight hours. Details are provided in section 0.

The current schedule of training (provided by Pelham House staff following an on-site visit) is provided in Figure 14.

Figure 14: Safe Steps staff training – additional details

Month	Training material covered
First month (three days of training)	**Day one:** Map/ overview of Safe Steps; journey of the child (past experience and now); the care experience; view of the child (rich and resourceful); staff (our journey, our diversity, motivation, what we bring, what we expect, values, learning and development); Social Pedagogy's Diamond model **Day two:** Working Together (care provider/SW case manager/child); L+S framework and processes of APR**;** accountability and (why services are regulated/inspected); the Social Pedagogy model in society and group contexts, and theory **Day three:** Safeguarding/child protection and CSE (basics, rights, and responsibilities)
Second month (three days of training)	**Day four:** Shared "life space"/ living experience in the home**;** care and support staff (values, the ideal, skills and qualities, professional working, team work, ethics and choices); lone working; relationships **Day five:** children's rights and participation; communication; strengths-based practice and recording **Day six:** Outputs-Outcomes; care and support; lifeskills; domestic and real-world learning; internal assessment and planning; Social Pedagogy Concepts

Month	Training material covered
Third month (three days of training)	**Day seven:** General risk assessment recap and relationship with risk in life; sexual exploitation, gangs, FGM, radicalisation, poverty; control (risk taking continuum and risk competence) **Day eight:** The health of the child/ young person; trauma; mental health quadrants; mental health first aid; impact of drugs and alcohol **Day nine:** Supporting and Developing behaviour; behaviour response approaches: sanctions and rewards; benefits and consequences (ST replacement behaviours); (keep safe) dealing with behaviour crises (crisis cycle); impact and empathy; development of the empowerment approach; communication; context of relationships
Fourth month (one day)	**Day ten:** Practitioners (supervision, reflective practice, learning from theory and key thinkers, ethics and choices); staff wellbeing and resilience; recap and overview (typical shift); induction and probation

Source: Training material provided by Pelham House, February 2018

Both homes were re-decorated to make them homely and attractive places for young women, with discreet security measures. For example, PC systems were installed to control access meaning staff did not carry bunches of keys.

14.3.2 Set-up and running costs

The project received £1.19 million from the Department for Education's Innovation Fund (Spring Consortium webpage). No further information is available about ongoing running costs. Placement cost is £4,200 per week.

14.4 Effectiveness and impact

14.4.1 Evaluation findings

To date, there has been one independent evaluation of Safe Steps. The authors use interview and survey data to assess whether outcomes were achieved for young women placed with Safe Steps at 12 months.

The study (Williams et al 2017) carried out 66 interviews with staff, stakeholders and residents four times, in three-monthly intervals. Standardised measures were used to assess outcomes for young women as well as the repeat risk assessments staff completed. In addition, 25 Safe Steps staff completed two surveys to assess knowledge, confidence and organisational support for working with CSE.

In the 12 month period under evaluation, a total of 12 young women aged between 14 to 17 years (mean age 15) were placed across the two homes. Eight

were transferred to other placements before the end of the 12 months due to anxieties about their safety. One young woman moved on in accordance with her care plan, and three were still making progress. The evaluation found:

- Some young women became **more secure and less confrontational** as relationships with staff developed (reflected in a decline in the frequency of 'incidents' involving actual or potential harm to self or others).
- Training and supervision increased staff competence, enabling **trusting and meaningful relationships** with the young women (young women began talking with staff about their past and current abuse and exploitation).
- **Variable engagement with education** (homes had some success getting young women to attend school or college or engage with in-house tutors).
- While Safe Steps staff and commissioners do not believe greater powers to restrict liberty of movement would be helpful, the practice of managing risk through relationship-building and empowering young women to make choices for themselves generated "**huge anxiety" amongst stakeholders.** (Williams et al 2017: 9). Young women are now not allowed access to a mobile phone and their access to a computer is restricted (on-site visit).
- Staff felt the model's CSE specialism facilitated opportunities for young women to talk and reflect, and mitigated risk for young women of being stigmatised by peers or staff (Interviews with staff).

14.4.2 Potential cost savings

The evaluation does not provide any information on potential cost savings associated with the model.

14.4.3 Limitations to the evidence

The evaluation does not include a comparator group, so the ability to attribute any impact to the service is limited.

Due to delayed Ofsted approval, the evaluation period lasted for 12 months. Only 12 young women accessed the service in this time, limiting generalisability of the evaluation findings. Moreover, most young women did not want to be interviewed for the evaluation so understanding their experience as well as key outcomes such as their active engagement are necessarily incomplete (2017:42).

It is not possible to draw conclusions about the long-term impact and sustainability of the model. No data was collected from girls who moved placement or after 12 months. The short time period many of the girls spent at the homes means there is no evidence of progression and development where they are making more decisions for themselves in the interest of their safety.

14.4.4 Lessons learned

The Safe Steps model initially comprised two homes, however one (Allen House) was closed because its structure and location made it difficult to manage risk.

One of the model's initial aims was to enable young women to remain living locally (in the area where they have been sexually exploited, often with ongoing risks posed by exploitative situations). However due to the level of risk, local authorities are choosing to place children out of their area and generally in more rural settings. Currently, Pelham House is receiving referrals from other local authorities.

Young women

- Both homes used external **therapists** to meet residents' trauma recovery and mental health needs. Most young women referred to Safe Steps had significant trauma recovery needs, and mental health difficulties. Referrals were not always acceptable to them and securing appointments with CAMHS did not prove easy.[51]

Staffing and management

- Following a staffing review in April 2016, the Pelham House **team was restructured** to include: one Manager, one Deputy, two Team Leaders, seven RSWs and 4 night staff. The duration of RSW shifts was also reduced to eight hours due to the intensity and complexity of managing the behaviours the young women demonstrated. Young women are always accompanied by staff when leaving the home.

- **Effective leadership** of homes, including line management support for operational staff, was needed. Difficulty securing an effective manager for Allen House impeded delivery.

- Difficulty **recruiting and retaining staff** also impeded delivery. Some staff did not fully understand the nature of CSE risk and impact on their behaviour. In addition, high stress and low pay work, as well as ineffective home management were perceived to contribute to high staff turnover.[52]

- Although there was some concern at the outset about there being male staff and no specific training was provided for them. However, having male staff did not cause problems.

[51] This information was obtained during an on-site visit to Pelham House.

[52] Twenty-3 out of 38 staff left between August 2015 and September 2016. Nineteen of these resigned and 4 were dismissed. One of the reasons for this high turnover is likely to be that the project initially attracted people who were idealistic but lacked residential experience.

Environment and the model itself

- **Multi-agency responses directed towards perpetrators** are also necessary to effectively safeguard exploited young women in their own communities. The evaluation observes instances where perpetrators used a young women resident at Safe Steps to entrap another (Williams and Scott 2017).

- 'Managing risk differently' can only work where there is a **shared understanding** of what this involves and a clear long-term commitment by commissioners, providers, children's social workers, police and other stakeholders. This is most likely where there are **mature, trusting multi-agency relationships** which can contain anxieties about risk.

- **Having social workers who share the programme's view** that a young woman going missing does not mean the placement has failed is crucial.

- **Targeted, thorough and cautious referral process is needed** although homes may struggle to reach full capacity**.** Safe Steps changed its approach to referral to (i) be clear about what can be provided and who can benefit from a placement (ii) gather evidence and information at assessment, especially about individual backgrounds, needs and risks from social workers (iii) carry out a thorough risk assessment regarding the effect of a new referral on the home and any timing implications, and (iv) recognise it does not have the resources to meet the needs of young women whose histories of complex trauma have profoundly affected their mental health and behaviour.

- **Commitment to education.** Many young women arrived at Allen House without education placements and risked being under-occupied. The Senior teacher worked with the Virtual Head to facilitate referral to Ealing's admission team and young women participated in virtual learning or worked with tutors in the meantime.

- **Family work.** Pelham House has shared strategies with families to ensure a consistent approach. One young person was returned home following family work (information from on-site visit).

- **Work with Police.** Police were wary about young people coming into the borough and increasing missing states. After sharing information with the police an officer was appointed as CSE link (information from on-site visit).

14.5 Recommendations for further research

- How the social pedagogy approach may affect outcomes (e.g. how is learning about CSE translated into outcomes).

- Any longer-term outcomes attributable to the model (such as impact on wellbeing, decision-making around personal safety, and educational achievement).

- Cost effectiveness.

- Understanding viable financial models for Safe Steps that are also acceptable to commissioners.

14.6 More reading

Safe Steps website: https://www.stchris.org.uk/services/safe-steps-home-cse/

Spring Consortium website: http://springconsortium.com/projects/safe-steps/

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15 Social Pedagogy

15.1 What is it?

15.1.1 Introduction

In its broadest sense, Social Pedagogy is a holistic and relationship-centred approach that links education, care, and support for families. It is a way of conceptualising informal learning which addresses the needs of the whole child in terms of their personal development.

The model varies across countries as does the specific role of being a Social Pedagogue. No single model is being implemented in children's residential care.

In the UK, there has been interest in applying Social Pedagogy to children's residential care and different models have been implemented in the past decade. This review focusses on two types of model which have been evaluated: training existing staff in Social Pedagogy (SCIE 2012; Milligan 2009) or employing professional European Social Pedagogues alongside existing teams (Department for Education 2011).

15.1.2 Model aims

Broadly, Social Pedagogy aims to promote children's social functioning, social identity and social competence, and their social inclusion.

15.1.3 Origin and implementation

Social Pedagogy has evolved in different ways in different countries but, overall, draws together theories from sociology, psychology, education, philosophy, medical sciences, and social work.

Depending on the country, training in Social Pedagogy is available at various levels, from short courses to university-level degrees. In some countries, such as Germany, Social Pedagogy is integrated into the welfare system and professionalised - Social Pedagogues (people with degrees in Social Pedagogy) work in diverse settings, alongside teachers, social workers and clinicians.

Based on fieldwork in Belgium, Denmark, France, Germany and the Netherlands, Petrie et al 2006 identify **key principles** common across Social Pedagogy models relevant for residential care settings. These are:

- A focus on the child as a **whole person** (this is often referred to in the literature as the "head, hands, and heart" principles, emphasizing that a child's cognitive, emotional and spiritual, practical and physical needs must all be met).
- Children's relationships with their peers are also important and group work is useful for supporting positive peer relationships.

- Social Pedagogy practitioners are encouraged to **use their individual attributes and skills in their work** with children.
- **Relationships between children and staff are seen as collaborative and democratic** rather hierarchical.
- Practitioners take a **reflective approach;** this requires continual reflection on their own practice and application of theoretical understandings and self-knowledge to their work.
- Importance of **practical skills**. Pedagogues are involved in children's daily lives and activities; so-called "ordinary tasks or events" such as preparing snacks offer opportunities to encourage development.
- Builds on an understanding of **children's rights** that is not limited to legal and procedural matters.
- Emphasis on **team work** and valuing the contributions of others (family members, other professionals and community members) in the task of 'bringing up' children.
- **Relationships are central**, together with the importance of listening and communicating (Petrie et al 2006: 22).

Irrespective of cultural context and setting, Social Pedagogy is characterised by *how* and *why* things are done: with shared underpinning principles, philosophy and *Haltung* (congruence between values and actions). The recently founded UK Social Pedagogy Development Network sets out standards for staff operating under Social Pedagogy models (see Figure 15).

Figure 15: Social Pedagogy Standards in the UK

Philosophy and Haltung **These standards address the philosophy and Haltung we expect Social Pedagogy Practitioners and Pedagogues to develop and maintain in their practice. These standards should be held in a person's heart and guide their way of living and working. *As a Social Pedagogy Practitioner / Social Pedagogue, I agree to:***	**Practice** **These standards represent level of practice for Social Pedagogy Practitioners and Pedagogues. We expect employing organisations to provide a working culture and support that enables Social Pedagogy Practitioners and Pedagogues to apply these standards within their practice.** ***As a Social Pedagogy Practitioner / Social Pedagogue, I agree to:***
• Develop and nurture an attitude of empathy and regard for people and cultures and the world of which we are a part • Foster relationships that respect human dignity and promote human rights, mutuality and well-being	• Engage with others in ways that respect their equal value and human dignity, understanding the part played by personal communication in supporting this • Make decisions with a high degree of situation awareness, recognising the complex factors involved in different circumstances

• Recognise the inherent resourcefulness and potential of human beings to bring about change • Appreciate that human relationships, in all their complexity, are intrinsically valuable and therefore central to Social Pedagogy • Enable people to use their voices and effect change within their own lives and wider society • Understand and work with the tensions inherent in valuing individual autonomy and social interdependence • Engage with social and political aspects of human development, childhood and community • Educate for community through community • Develop an attitude of professional curiosity and critical self-reflection • Be open to and informed of new theory, research and good practice relevant to social pedagogical practice • Use situated professional judgment and maintain appropriate confidentiality • Understand issues relating to the protection of vulnerable individuals, groups and communities and address social inequalities • Recognise the value of creativity, playfulness and adventure Be accountable for my practice, engage in meaning-making and know when to seek advice	• Recognise and respect that personal histories, characteristics and social and political contexts have brought each person and group to their current understanding of the world • Invite, consider and integrate multiple perspectives in decision making as a means of deepening social justice, community and well-being • Create opportunities and contexts for people to actively participate in society, express their own views and listen to those of others • Hold my relationship with the people I work with and support in the foreground in all my practice • Value the opportunities that everyday activities provide for developing relationships • Facilitate learning processes that enhance well-being and enable individuals to find meaning and purpose in their everyday lives • Work collaboratively and be willing to both support and challenge colleagues • Use theory and research in my everyday practice • Support the individuals, groups and communities I work with to realise their hopes and aspirations by identifying, with them, the steps required to meet their goals • Adapt my practice to take account of the physical, intellectual, emotional, spiritual, social and cultural needs and strengths of individuals, groups and communities, in keeping with the principles of Social Pedagogy • Practice safely and competently within the legal and ethical boundaries of my profession • Take into account relevant social policy and at the same time bring critical awareness to any tensions existing between our values and such policies.

	• Support community development by encouraging networking and connections through participatory processes that draw on the community's resourcefulness. • Promote inter-professional dialogue and co-operation across settings and agencies.

Source: http://www.socialpedagogyuk.com/images/pdf/2.social-pedagogy-standards-1.pdf

Two broad approaches to implementing Social Pedagogy in residential care have been piloted in the UK: (i) training existing care staff, and (ii) employing professional Social Pedagogues. Examples are provided below:

(i) Social Pedagogy training

- All staff in residential care homes attend training course delivered by ThemPra. Training lasted between 6-8 days, across two sessions. Staff given training manuals and opportunities to follow-up on training in team meetings. (Belfast Trust, Northern Ireland: SCIE 2012).

- Staff encouraged to attend 4 half-day sessions introducing the concept of Social Pedagogy delivered by ThemPra. Subsequently, core team of 16 (out of 90 staff) undergo 9-day training in three 3-day blocks. Core team also have one-day training six months later to review material. (Sycamore, Scotland: Milligan 2009)

(ii) Professional Social Pedagogues

- Social Pedagogues are employed full-time to work in a single home (England: Department for Education 2011).

- Social Pedagogues are employed part-time in a home and take on a wider consultancy role to raise awareness of Social Pedagogy among the local children's workforce (England: Department for Education 2011).

15.2 Target groups

There is no specific target group. Social Pedagogy is broadly seen as applicable to any child or young person.

15.3 Inputs and resources

15.3.1 Staff, expertise and resources required

Staff, expertise and resources required differ according to the intensity and type of Social Pedagogy model implemented.

Staff training comprises the majority of resources although some models require employment of professional Social Pedagogues.

All models require staff to allocate time for training, and the nature of Social Pedagogy also requires time and capacity for ongoing reflection.

15.3.2 Set-up and running costs

Set-up and running costs also vary according to the model implemented.

(i) Social Pedagogy training

One estimate of £22,500 is provided for the implementation cost of training all the staff in four residential homes over 6 to 8 days. This estimate does not include costs of rolling out the training or the model's estimated running costs going forward (SCIE 2012).

This review did not identify any other cost estimations.

(ii) Professional Social Pedagogues

Staff interviewed about implementation of the Social Pedagogues model thought implementation necessitated an increase in service costs[53] (Department of Education 2011).

However no detailed cost estimates were provided.

15.3.3 Overall evidence base

This review identified three independent evaluations associated with Social Pedagogy models. That said, Social Pedagogy models vary and there are limited outcome measurements associated with them. It is therefore not possible to determine model "effectiveness". Our understanding of Social Pedagogy's impact and potential contribution to improving outcomes for children in residential care is extremely limited.

15.3.4 Evaluation findings

(i) Social Pedagogy training

- Interviews with young people in homes that received Social Pedagogy training suggest that most were aware that a specific approach was being used with some indication of improved mood: for example "staff members seem more friendly now" (SCIE 2012: 38).

[53] During implementation, two homes had to hire extra staff to support Social Pedagogues who had difficulty performing their role in a new setting. Staff considered that the following factors would also necessitate increased service costs: higher salaries for more qualified staff, recruitment agency fees, training costs, and additional activities for young people (Department for Education 2011).

- Interviews with staff who underwent training found decreased perceptions of aggressive incidents following the training (SCIE 2012).

- SCIE 2012 compared administrative data from residential homes that underwent Social Pedagogy training with untrained homes in the same area over 18 months. Using regression analysis, they found significantly reduced odds of "missingness" though the effect of Social Pedagogy on drug use, absconding and complaints was less likely.

- Interviews with a core staff team who attended 9-days' Social Pedagogy training found they rated the training very highly and considered it useful and relevant (Milligan 2009).

(ii) Professional Social Pedagogues

- An 18-month evaluation of the introduction of Social Pedagogues in 30 residential children's homes across England found most homes and individuals who participated in the Pilot felt it was worthwhile and had some impact (Department for Education 2011).

- However, there was no evidence that employing Social Pedagogues had any impact on measurable outcomes (compared to homes that did not employ Social Pedagogues (Department for Education 2011). Homes which employed Social Pedagogues did not do any better with their residents across a range of outcomes than did comparison homes.

- During observation visits to pilot and comparative homes examples of insensitive practices were recorded (inconsistent with the Social Pedagogy approach) and it was not clear to evaluators how Social Pedagogue roles differed to other staff (Department for Education 2011).

15.3.5 Potential cost savings

This review identified no information on potential cost savings.

15.3.6 Limitations to the evidence

It is hard to identify "core components" of Social Pedagogy models which tend to base themselves more on values than on implementable and observable steps. Evaluations **lack objective measures of changes in practice and outcomes**. This makes it difficult to determine the effectiveness of staff training, its ideal intensity, as well as the effectiveness or impact of introducing professional Social Pedagogues. The change in "missingness" observed in the Belfast implementation is not drawn from robust data: the sample size is small and incident reporting is not standardised.

Although two evaluations used some form of comparison across sites (Department for Education 2011; SCIE 2012), neither used random methods of allocation so we **cannot attribute any observed changes to Social Pedagogy** interventions with any certainty.

Introducing aspects of Social Pedagogy approaches through **staff training does not equate to model implementation.** In both cases, where Social Pedagogy training for staff was implemented, this was alongside other existing approaches such as the Sycamore Way (Milligan 2009) and the availability of therapeutic wraparound services (SCIE 2012). It is therefore not possible to examine or compare "model effectiveness".

Where Social Pedagogues were introduced, their ability to bring about change was likely to be affected by home quality, existing staff, agencies (some of which were more amenable to change than others). The evaluation also notes that Social Pedagogues are only one influence on young people's lives among many and its **findings are not easily transferable or generalisable**.

Pilot sites where the Social Pedagogy model was implemented are likely to have been more amenable to the approach, and the results **may not reflect implementation in a real-world setting**. Northern Ireland and Scotland site evaluations both note the approach fitted well into existing cultures, which may overestimate its acceptability.

Evidence on perspectives of and outcomes for young people in residential care is very limited. Only SCIE 2012 interviews young people but does not detail its methodology and sample size.

15.3.7 Lessons learned

(i) Social Pedagogy training

Characteristics of the UK social care context impede implementation. Fundamental aspects of the model such as supporting young people to take considered risks or using physical contact to reassure children were perceived as inappropriate for practitioners to implement in UK settings perceived as "risk-averse" (SCIE 2012).

There was concern about the **universal applicability** of Social Pedagogy. Some staff mentioned needing to identify age-appropriate techniques to successfully implement Social Pedagogy in their work (SCIE 2012).

Securing buy-in from other services and professionals, such as social workers, was a challenge (SCIE 2012).

(ii) Professional Social Pedagogues

Social Pedagogues introduced into existing teams generally struggled to effect changes in the practice of large, long-established staff groups, given their **lack of managerial status, authority, and often limited experience** (Department for Education 2011).

Introducing Social Pedagogy was perceived as a challenge within a **UK professional context**, where staff had limited background in Social Pedagogy or its underpinning disciplines (for example psychology, sociology and education) (Department for Education 2011).

Social Pedagogy translated less well to the UK context where homes tend to be **transitory, heterogenous and cater for a smaller more "problematic core"** of the population. These features made it harder to explore the benefits of 'the group', and impeded development of social education and personal relationships (Department for Education 2011).

15.4 Recommendations for further research

Although described as a model, the approach and content vary greatly across settings and countries. For UK residential children's care, a detailed model description is needed along with what is required to implement and embed the approach.

Currently there is no single way to implement Social Pedagogy, and its use in continental Europe is shaped by country context. UK evaluations note incongruencies between the wider UK system of children's services and Social Pedagogy models, which impede implementation (Department for Education 2011; Petrie et al 2009; McDermid et al 2016). That said, evidence for the impact of Social Pedagogy training on wider organisational context in the UK remains limited.

In addition, further research could:

- Measure objective outcomes for young people in addition to staff perceptions.
- Consider the contribution of Social Pedagogy training given other therapeutic support available or its addition to a model with a strong supporting evidence base.
- European Social Pedagogues have status, expertise and professional autonomy that most UK residential care staff lack (Department for Education 2011). Research might examine feasible ways to enhance the status, expertise and professional autonomy of English residential care staff and its effect on care standards, compared to employing European Social Pedagogues.

15.5 More reading

Department for Education (2011) Raising the bar? Evaluation of the Social Pedagogy Pilot Programme in residential children's homes. Research Report DFE-RR148. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181597/DFE-RR148.pdf

McDermid, S., Holmes, L., Ghate, D., Trivedi, H., Blackmore, J., & Baker, C. (2016). Evaluation of head, heart, hands: Introducing social pedagogy into UK foster care. Final report.

Milligan, Ian (2009) Introducing social pedagogy into Scottish residential child care: an evaluation of the Sycamore Services social pedagogy training

programme. [Report] Available at: https://pure.strath.ac.uk/portal/files/519335/strathprints026851.pdf

Petrie, P., Boddy, J., Cameron, C., Wigfall, V. and Simon, A. (2006) Working with Children in Care: European Perspectives, Maidenhead, Open University Press.

Petrie, P., Boddy, J., Cameron, C., Heptinstall, E., McQuail, S., Simon, A., & Wigfall, V. (2009). Pedagogy-a holistic, personal approach to work with children and young people, across services: European models for practice, training, education and qualification. Unpublished briefing paper. Available at: http://discovery.ucl.ac.uk/10000058/1/may_18_09_Ped_BRIEFING__PAPER_JB_PP_.pdf [Accessed on 21/02/18]

Social Care Institute for Excellence. (2012) Report 58: Therapeutic approaches to social work in residential child care settings. Published: May 2012. Available at: https://www.scie.org.uk/publications/reports/report58/ [Accessed 07/02/2017]

Social Pedagogy standards developed by SPPA, UCL, Thempra and others: http://www.socialpedagogyuk.com/images/pdf/2.social-pedagogy-standards-1.pdf

ThemPra Social Pedagogy website (Training provider): http://www.thempra.org.uk/

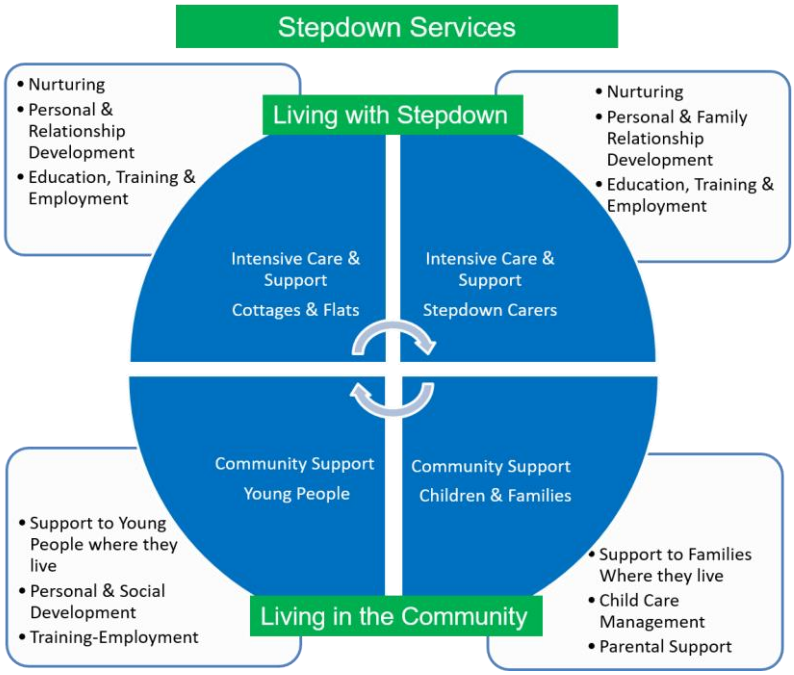
16 Stepdown

16.1 What is it?

16.1.1 Introduction

Stepdown is a charity that provides care and support services for young people and their families in Scotland. They have a range of services to meet different levels of support need: (i) intensive, full-time residential care; (ii) self-contained flats and bedsits where young people are supported to live independently; (iii) support for families in their homes; and (iv) foster, respite and supported care services. Young people may transition between the four services (Figure 16). This review focusses on (i) and (ii).

Figure 16: Stepdown's services



Source: Stepdown 2017

Stepdown has developed its own Referral Discussion System and Service Framework. These are designed to ensure detailed preparations are in place, from the point of a young person's referral to the service, for their eventual transition home or to the community. According to Stepdown's website, its services are based on continuity of care and tailored service provision principles.

Unless otherwise stated all information in this review is taken from Stepdown's website and a site visit.

16.1.2 Model aims[54]

Overall, "Stepdown aims to help young people and their families, where there are complex needs, to achieve stability and understanding" (Stepdown 2018).

To achieve this, Stepdown has the following aims for its services:

- Support young people with complex needs and their families/ carers to remain together at home.
- Support young people with complex needs and their families/ carers to remain at home through the provision of short periods of care away from home and programmed community support services.
- Support young people with complex needs in residential care/ secure care to return home to their family/ carer.
- Support young people with complex needs to move to alternative family care or to move on to independence.

On its website, Stepdown provides a set of statements which capture the charity's values, principles and way of working. Following a site visit, a document with additional detail was provided on these principles (Figure 17).

Figure 17: Stepdown Way of Work

Stepdown 'What We Do'

- The **young person is at the heart** of what we do, we aim to enable each young person to grow and develop in a positive environment.
- We will **tailor and build services around the needs** of each young person.
- We will work **collaboratively** with others to ensure that the young person receives the best support and care.
- We constantly seek to **innovate** in order to meet the needs of each young person and to improve.
- We acknowledge what we do carries risk, we take all reasonable steps to **minimise risk**, but we also acknowledge change only happens when new things are attempted.
- We will be **open and transparent** in what and why we do things, keeping in mind the confidentiality of the young person.
- We will only be effective where we have **trust**, we therefore will be honest and consistent, we will explain what we do and why, and we will always be there for the young person.
- We will have **high expectations** of each young person. Stepdown will expect to help young people to achieve their potential.

[54] All information on mission and aims is taken from a February 2018 "Mission Statement and Service Aims", internal document Stepdown provided to Cordis Bright following a site visit.

- We will listen carefully to young people, families, staff and stakeholders in order to be clear that we are making a positive difference. We will do this through the Stepdown evaluation system, 'How Are We Doing', and other quality measures.

Source: Stepdown website 'What We Do': http://www.stepdown.org.uk/what-we-do/ and Stepdown 2017 (internal document). Note that this list is not exhaustive.

16.1.3 Origin and implementation

Stepdown is a relatively young organisation incorporated in Scotland in 2002 (Registrar of Companies 2002), although it only became operational in 2008 (site visit). It has had a range of Directors with teaching, social work, primary care, social care and construction backgrounds. According to its website, it now operates as an independent charity.

The development of the model was informed by discussions with local authority colleagues and research into the needs of young people with complex needs making the transition from secure and residential care (Stepdown 2017). This recognised a need to orient services around:

- comprehensive assessment and planning;
- work with the family;
- quality of care;
- education and training for the growth of each young person; and
- the importance of detailed preparation for transition back home and to the community.

Based on these discussions and experience working in residential care, Stepdown developed its own Referral Discussion System and Service Framework. These support detailed planning throughout a young person's placement and are geared towards their eventual transition.

Stepdown Referral Discussion System

The process for referrals follows a Referral Discussion System. Initial contact by email or telephone is followed up within 48 hours. Stepdown can respond to some emergency referrals.

Referrers are invited for a **Referral Discussion** to discuss their case and receive feedback on support options available.

If Stepdown can provide a service, a **care support plan** is drafted on the basis of the needs discussed in the Referral Discussion. For residential placements, Stepdown will assess the impact of other young people at the same placement.

Stepdown Service Framework

The Stepdown **Service Framework** operates across all Stepdown Services and is based on 'What Works Scotland'.[55] The Framework focusses on **improving outcomes** for young people and their families, and recognises **three simultaneous stages** in the planning and delivery of services:

- Pre-placement referral report sharing, discussion and planning;
- Agreed Plan, based on GIRFEC/SHANARRI[56] principles, to include, care, training, education and family & community integration;
- Tailored planning and service delivery for successful aftercare.

All three stages are provided when a young person enters Stepdown. This means that when a young person enters a Stepdown Service, a plan is already in place for their eventual transition. The range of services and their intensity are tailored to the young person's needs. The Framework can adapt to focus on prevention if, at the pre-placement stage, it is appropriate to deliver services to the young person and family in the community.

Currently, Stepdown offers: full-time residential care for various support needs; foster, supported carer and respite care services; intensive community support for young people and their families in their homes. Full-time residential care is provided through two services, one of which offers self-contained flats and bedsits (Castlemilk and South) and the other 'cottages' for 2 to 3 young people (Bishopbriggs and Airdrie). Service details are provided in Figure 18.

Figure 18: Stepdown Services

Service ***Purpose***	**Who/ How**
Full-time residential care ('Cottages' and flats) *Support young people to return*	• **Stepdown Bishopbriggs and Airdrie**: Medium or long-term placements for up to 7 young people (12 to 21 year olds) who have been in secure accommodation and/or exhausted local authority provision (maximum of 3 young people per cottage)

[55] What Works Scotland was set up in 2014 to (i) improve the way local areas in Scotland use evidence to make decisions about public service development and reform and (ii) explore how public services could work towards the recommendations of the Christie Commission on the Future Delivery of Public Services and the Scottish Government's priorities for reform.

[56] GIRFEC (Getting It Right For Every Child) is a Scottish policy to improve outcomes and support wellbeing for children and young people nationally. It focusses on offering the right help at the right time from the right people, supporting young people and their parent(s) to work in partnership with services that can help them. SHANARRI refers to eight wellbeing indicators (Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible, Included) designed to help providers be consistent in how they consider the quality of a child or young person's life at a particular point in time.

Service ***Purpose***	**Who/ How**
home, move to another placement or achieve independence.	• **Stepdown Hurlford** provides an additional 3-bed cottage • **Stepdown Castlemilk and South**: 24-hour care for up to 7 young people (12 to 21 year olds) with high support needs or who may need less support ('singleton' placements in self-contained flats or bedsits) • **Stepdown North**: Registered for 3 young women, can be a mother and baby unit.
Intensive Community Support *assessment and early support to prevent breakdown.*	• High risk young people or with complex needs and their families • Family-home based support through planned programmes tailored to meet parent(s) and young people's needs.
Foster Care	• Placements in a supportive family setting with individual support packages tailored by the young person, their Social Worker, Carer and Stepdown. • For 11 to 21 year olds who require care in a family setting
Supported Carers	• For 16 to 25 year old care leavers, or young women who are pregnant or have a baby • Provides supportive family setting young people can live in on a full-time basis in preparation for transition to independence. • Young woman who are pregnant or have a baby are supported to develop their parenting skills in a family environment.
Respite Carers	• For 12 to 21 year olds who are in care or have been in care. • Short breaks in a Respite carer's home to support the young person and their family or present placement. Placements can be one-off or on a regular basis (e.g. one night a month). • Supports the young person in a range of recreational activities and social skills development and other agreed tasks.

Source: Stepdown website. Additional information on Stepdown Hurlford, Stepdown North was provided during a site visit. Note that the Supported Carers and Respite Carers services are assessed to foster care standards.

Key features of Stepdown

Each young person has a **care plan**. In line with these plans, Stepdown draws on specialist services and agencies where appropriate to gain education, social, training and employment opportunities. These include psychology and mental health services, education, training and employment services, leisure, housing and accommodation services.

The Stepdown website provides more detailed information on the **training and education opportunities** offering for each young person. For each young person, Stepdown will:

- Work with Employers and Training Agencies to support or mentor young people to achieve training standards, be work ready and gain employment.
- Develop links with employers to increase job opportunities for young people.
- Engage with external agencies and be actively involved in Local Employment Partnership strategies.
- Support the design, development and delivery of services which support young people into training opportunities and employment.

Stepdown supports the implementation of **Integrated Assessments and Pathway Plans** and undertakes work plans and outcome reports.

Stepdown **works in partnership** with local authorities, referring agencies, young people and their families, and has care partners.[57] Key features of this partnership work include: comprehensive preparation, assessment and planning, regular communication on progress using SHANARRI outcome indicators (see footnote 56), engagement in 'How Are We Doing' evaluations every two years and focus on after care and transition.

Monitoring and Quality Assurance. All services are monitored and this includes seeking perspectives of young people, families, referring agencies and other stakeholders on service quality and outcomes.

16.2 Target groups

Young people with complex needs and their families.

Young people in transition from Secure, Residential and other In Care settings.

[57] St Philip's Residential School and St Mary's Secure Care

16.3 Inputs and resources

16.3.1 Staff, expertise and resources required

The Stepdown website suggests ratios of staff to young people vary according to the young person's support needs. A breakdown of residential care services is provided in Figure 19.

Figure 19: Residential care services provided by Stepdown (staff

Residential Care Staff	Site details
Bishopbriggs and Airdrie. **Staff to young person ratios 1:1 or 1:2**	**Bishopbriggs** (3 cottages): 2 for up to 2 young people[58] and 1 for 3 young people **Airdrie** ('The Gatehouse'): 1 cottage for 2 young people
Castlemilk and South. **At least 2 staff at each site**	**Castlemilk**: two "bedsits"; and a ground floor flat for 1 young person (up to three young people in total) **South**: 2 self- contained flats and 2 "bed sits" (up to 4 young people in total)

All care staff are required to have or be undertaking a Higher National Certificate (HNC) in Health and Social Care.[59]

According to Stepdown's website, staff receive ongoing support and training however details on training providers, training duration and which staff receive training are limited. Training offered to staff includes:

- Trauma-informed approaches
- Therapeutic Crisis Intervention
- Child Sexual Exploitation

Other interventions and training drawn upon by Stepdown Community Services are listed below, although it is not clear whether these are offered to all residential staff and some may be offered to parents.[60]

[58] These cottages are often used for one young person with more complex needs as a 'singleton placement'

[59] This information was obtained during a site visit, and is equivalent to Scottish Vocational Qualifications Level 3.

[60] More information at: http://www.stepdown.org.uk/what-we-do/safe-programmes-psychology/

- Cognitive Behaviour Therapy (CBT)
- Eye Movement Desensitisation and Reprocessing (EMDR)
- Group Work Skills
- Motivational Interviewing
- Keep Your Cool (20 session programme by clinical psychologist, David Boag, aims to improve emotional management skills and coping strategies for anger expression)
- Offending Is Not The Only Choice/ Violence Is Not The Only Choice (for staff)
- Friends For Life (aimed at promoting resilience, emotional and social competencies in young people)
- Handling Teenage Behaviour (six week parenting programme for parents/ carers)

Inspection reports suggest practical and financial resources enable redecoration and refurbishment of the homes, and promote hobbies

> *Including powerlifting, attending the gym, cycling and football training would not have been possible without the support in both practical and financial terms from Stepdown […] Young people were given opportunities to try new activities, such as golf, fishing […] recent holidays had been successful ventures*
>
> *(Inspection report Castledown and South 2016: 3)*

A Psychologist offers support across services to children, young people and staff (site visit). Additional information on how existing services are integrated was not obtained.

16.3.2 Set-up and running costs

The weekly cost of a residential placement for one young person is £4,000 (site visit). If the young person's care package recognises the young person is unable to live with other young people (i.e. only one bed in the cottage can be filled), the placement cost will only exceed £4,000 if additional staff are required.

16.4 Effectiveness and impact

16.4.1 Overall evidence base

This review did not identify any evaluations of Stepdown's services.

Stepdown's residential care services (Bishopbriggs and Airdrie, and Castlemilk and South) have been inspected by the Care Inspectorate.

16.4.2 Evaluation findings

No evaluations of the service are available.

Although Stepdown sends an in-house questionnaire to carers every two years, this is not independently verified. Cordis Bright did not obtain a copy of the questionnaire and its validity cannot be determined.

Care home inspection reports to date (from 2010/2011) for four of the homes consistently rate the care provided, staff, environment and management favourably (good – very good – excellent). Based on site visits, inspectors are confident "Stepdown supports young people to make transitions to independent lifestyles".

16.4.3 Potential cost savings

No information is available.

16.4.4 Limitations to the evidence

Although the inspection reports are favourable, it is not possible to assess the effectiveness or impact of the service.

No information on outcomes for young people is available.

It is not possible to draw conclusions about the effectiveness or impact of Stepdown's Referral Discussion System or Service Framework or the added value of providing additional support services (for example early intervention family support) alongside residential care services.

16.4.5 Lessons learned

No information is available.

16.5 Recommendations for further research

An evaluation of Stepdown is needed to establish the model's effectiveness and impact, considering outcomes for staff, young people and their families.

It would be helpful to establish the impact of components such as Stepdown's Referral System and Service Framework, and whether these might be implemented outside a Scottish setting.

An analysis of the service's costs and its cost-effectiveness is needed.

16.6 More reading

Stepdown website: http://www.stepdown.org.uk

Stepdown (2018) Missions Statement and Service Aims (internal document dated February 2018, provided to Cordis Bright following a site visit)

Stepdown (2017) Management Team Presentation (internal document provided to Cordis Bright following a site visit)

Registrar of Companies (2002) Stepdown Certification. Edinburgh, Scotland 18th February 2002. Company 228195

Care Inspectorate Inspection Reports available at: http://www.careinspectorate.com/index.php/care-services

GIRFEC and SHANARRI further info: http://www.gov.scot/Topics/People/Young-People/gettingitright/wellbeing

What Works Scotland http://whatworksscotland.ac.uk/

17 Stop-Gap

17.1 What is it?

17.1.1 Introduction

Stop-Gap is aimed at children and young people in residential care with disruptive behaviour disorders. It intends to reduce "problem" behaviours that prevent the young person's re-integration in the community by providing a schedule of specialised interventions.

The model comprises three "tiers" of interventions for young people. All young people receive interventions from the first two tiers, which are environment-based and discharge-related. If the young person's disruptive behaviour does not improve, they receive more intensive "third tier" interventions.

17.1.2 Model aims

Overall, Stop-Gap aims to interrupt the "downward spiral" experienced by young people with disruptive behaviours (e.g. Conduct Disorder, Oppositional Defiant Disorder, and ADHD) and prepare them for re-integration in their community.

To achieve this, the model's primary goals are:

- Reduce length of stay in residential treatment
- Reduce disruptive and aggressive behaviours
- Improve outcomes in post-discharge environment

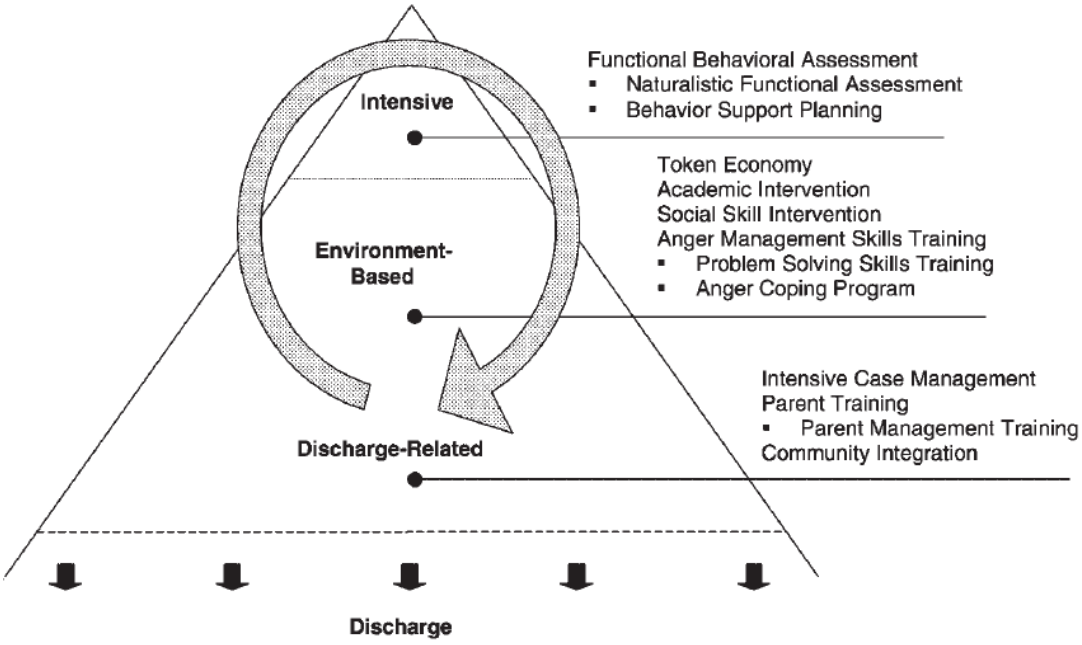
17.1.3 Origin and implementation

This model was developed by McCurdy and McIntyre at a U.S. non-profit behavioural health research institute (2004).[61] They observed that the numbers of young people with emotional and behavioural disorders (EBDs) in residential treatment centres (RTCs) had doubled in the previous 20 years. Stop-Gap was designed as a way for existing residential care services to incorporate and adopt evidence-based approaches for treating EBDs.

Stop-Gap comprises three tiers of interventions: (Tier One) environment-based, (Tier Two) discharge-related, and (Tier Three) intensive interventions (Figure 20).

[61] Devereux Institute of Clinical Training and Research

Figure 20: The stop-gap model of residential treatment: levels of service delivery and associated interventions.



Source: (**McCurdy and McIntyre 2004)**

Tier One. All children and young people arriving at a centre using the Stop-Gap model are provided with environment-based interventions. Examples of Tier One interventions are:

- **Token Economy.** A system for providing positive reinforcement of pro-social behaviours (e.g., following directions), which may use tokens as an alternative to monetary incentives/rewards.

- **Academic Interventions.** Uses direct instruction for reading and maths to incorporate key techniques students need for success at school. Direct instruction refers to the use of explicit, teacher-directed teaching methods, where young people are required to listen and respond to instructions.

- **Social Skills Training.** Children and young people are provided with direct training on social skills. This is accompanied by a system that monitors the child or young person's demonstration of these skills whilst in the centre.

- **Problem-Solving.** Problem-Solving Skills Training programme (PSST).

- **Anger Management Skills Training.** Anger Coping Program (ACP), a cognitive-behavioural intervention for children and young people with a history of aggressive behaviour.

Tier Two. Along with environment-based interventions, all residents receive discharge-related interventions. These are designed to prepare the young person

and their biological or prospective foster family for discharge to the home and community.

- **Intensive Case Management.** Provision of individualised case management services during the residential placement. A trained Case Manager (who is member of the RTC team) support the young person and their family to develop key skills, brokers services from other community agencies, monitors treatment plan effectiveness, and helps to adapt services to families' changing needs (McCurdy and McIntyre 2004: 148). This service may or may not continue after discharge.

- **Parent Management Training** (PMT)**.** Teaches caregivers procedures and skills to address child noncompliance, alleviate any violent or forceful interactions between caregivers and children, and improve the child's behaviour at home.

- **Community Integration Activities.** Accessing community-based services (for example school, part-time employment, or recreational activities).

Tier Three. Where "barrier" (disruptive) behaviours are not reduced via Tier One environment-based interventions, intensive Tier Three interventions that include **function-based behaviour support planning** are implemented. Examples include:

- **Function-Based Assessment.** Method whereby specialists observe the young person in their environment, noting what happens before and after occurrence of challenging behaviour, and develop a hypothesis about the behaviour's function. Functional Analysis may also be used; this involves practitioners changing what happens before or after the behaviour to test the hypothesis about its cause.

- **Function-Based Behaviour Support Planning**. Method whereby specialists develop de-escalation, distraction, and crisis management techniques for challenging behaviours, based on an understanding of the behaviour's function.

Stop-Gap is designed as a model that individual RTCs can adopt. The model is described as short-term and intended to produce short stays in RTC environments. Depending on individual needs, placements range from 90 days to one year.

17.2 Target groups

Children and young people (aged 6 to 17) with disruptive behaviour disorders living in residential treatment centres. Example disorders include: Conduct Disorder, Oppositional Defiant Disorder, and ADHD.

Additionally, the model provides services for parents and caregivers to develop effective parenting practices.

17.3 Inputs and resources

17.3.1 Staff, expertise and resources required

Stop-Gap may be conducted in hospitals or residential care facilities. Where implemented in a RTC, resources envisaged for implementation are:

- Direct care staff (ratio: 1 staff/ 8 young people)
- Direct care supervisor
- Clinical consultant

According to the CEBC Stop-Gap profile, direct care professionals are expected to have undergraduate degrees. In addition to a Master's degree, clinical consultants should be trained in Applied Behaviour Analysis.

*Training***.** A two-day training course is available which is conducted on-site. There is no manual that describes how to implement the model.

Existing services. The model makes use of a range of evidence-based and trademarked interventions. It appears to be up to individual RTCs how they implement these interventions and whether they employ external providers.

17.3.2 Set-up and running costs

No information regarding set-up or running costs of Stop-Gap were identified.

Although an array of interventions is involved in implementing the model, this review was not able to identify any cost estimations.

17.4 Effectiveness and impact

17.4.1 Overall evidence base

Evaluative work on the Stop-Gap model is still in its early stages although available research evidence is "promising" (CEBC profile).

To date, one study has drawn on process data (McCurdy and McIntyre 2004) but there is no research on outcomes, service costs or cost-effectiveness associated with Stop-Gap.

17.4.2 Evaluation findings

One study compared therapeutic hold rates[62] after twelve months at a RTC which had introduced environment-based interventions (n=25) with a traditional RTC

[62] This means immobilising the young person for example through use of limited force. Therapeutic holds may support child through an intervention when their behaviour poses a danger to themselves or others.

that had not introduced interventions (n=25) (McCurdy and McIntyre 2004). Environment-based interventions implemented were: incidental teaching of pro-social skills, PSST; and a token economy with a response cost feature. (Response cost features aim to decrease disruptive behaviour through punishment; for example, through removing access to a preferred object.)

At twelve months, the intervention residence showed a decline in therapeutic holds, while the comparison group showed an increase over the same period. Groups were matched on population number, gender and disability.

17.4.3 Potential cost savings

This review did not identify any cost-benefit analysis or social return on investment calculations for Stop-Gap.

Should Stop-Gap succeed in reducing the length of a young person's stay in a RTC, it may lower service costs. However, there is no evidence on outcomes and so it is not possible to comment on cost savings associated with Stop-Gap. Likewise cost estimates for each level of interventions are not provided.

17.4.4 Limitations to the evidence

McCurdy and McIntyre's study did not use random methods of assignment to intervention and comparison groups (2004). The authors did not perform any statistical analyses to determine any significant differences between groups. This makes it impossible to attribute any outcomes directly to the model (McCurdy and McIntyre 2004).

A small sample size (n=25) makes generalisability of these results difficult, further complicated by the fact the intervention group was 100% female, with no ethnicity specified. To date, there have not been any evaluations of the model outside the U.S.A. RTCs, and the health economy in the U.S. are likely to differ considerably from their international counterparts.

The current evaluation uses proxy measures and lacks long-term follow-up outcomes. This makes it hard to draw conclusions about the model's effectiveness and sustainability. It is worth noting that not only health economies differ across country contexts but also the post-discharge environment for children and young people.

Strong evidence may support individual interventions (for example functional behavioural assessment) however this may not be true of all Stop-Gap component interventions – importantly, the model is a complex intervention, more than the sum of its constituent parts.

17.4.5 Lessons learned

To date, no research has been conducted into implementation of Stop-Gap.

17.5 Recommendations for further research

Although the current evidence for the model is promising, research on outcomes is needed. This should consider community adjustment following the young person's discharge (for example, the amount and type of family contact, contact with police and juvenile justice, school attendance and academic achievement, and re-admission).

Overall costs of treatment and cost-effectiveness of the model.

Understanding for whom and in what circumstances the model is most effective, particularly regarding:

- **Participants**. For example understanding how background and differing emotional and behavioural needs may affect Stop-Gap effectiveness.
- **Setting**. Research into Stop-Gap implementation outside the U.S.A.
- **Implementation processes**. No fidelity measures, implementation guides or manuals exist for the programme and no research has been conducted on how to implement the model.

17.6 More reading

McCurdy, B. L., & McIntyre, E. K. (2004). "And what about residential...?" Re-conceptualizing residential treatment as a stop-gap service for youth with emotional and behavioral disorders. *Behavioral Interventions, 19*, 137-158.

California Evidence-Based Clearing House:
http://www.cebc4cw.org/program/stop-gap/detailed

Devereux website for Stop-Gap:
www.devereux.org/site/PageServer?pagename=ces_services2

18 Treatment Foster Care Oregon (Adolescents)

18.1 What is it?

18.1.1 Introduction

Treatment Foster Care Oregon-Adolescents (TFCO-A)[63] is a model of foster care treatment for young people (12 to 18 years old) with severe emotional and behavioural disorders or offending behaviour. It was developed at the Oregon Social Learning Centre, drawing on local research, social learning theory and systemic theory (Biehal et al. 2012:5).

In this model, young people live with trained TFCO-A foster parents for approximately 9 months. Foster parents receive ongoing and intensive support from a team of professionals. A structured and individualised programme of therapy, skills training, and education support is established for young people. The model supports transitions to longer-term care through coaching follow-on carers during the 9-month placement[64] and supporting them afterwards (usually for three months).

Although TFCO-A is considered "well-supported" by evidence (CEBC) and randomised trials indicate positive outcomes associated with the model, most studies took place in U.S.A young offender settings and were conducted by the model developers. Evidence directly relevant to UK social care settings is more limited. A national pilot of TFCO-A for young people at risk of secure care or in placements at risk of breakdown in England is suggestive of some positive outcomes but inconclusive.

18.1.2 Model aims

The TFCO model has two main aims: (i) to create opportunities for young people to live in family settings and (ii) to help parents (or other long-term family resource), at the same time, to provide effective parenting (TFCO 2018).

TFCO-A has age-specific goals for young people. According to the CEBC profile, these are to:

- Eliminate or reduce problem behaviours
- Increase developmentally appropriate and pro-social behaviour

[63] Treatment Foster Care Oregon was formally known as Multidimensional Treatment Foster Care (MTFC).

[64] The model was originally designed with a focus on the young person's return to their birth family, but in implementation elsewhere, this has included other long-term carers.

- Improve peer relationships
- Improve parent-child interaction and communication
- Improve coping and social skills
- Improve behaviour in school and provide academic support
- Transition to a birth family or lower level aftercare placement

18.1.3 Origin and implementation

TFCO was developed in 1983 at Oregon Social Learning Center (OSLC) in the U.S.A, and is grounded in social learning and systemic theory. Initially it was intended to be an alternative to institutional placement for boys with serious and chronic criminal behaviour, and was later extended to girls, and then to adolescents with mental health problems as an alternative to hospitalisation (Biehal et al. 2012: 5).

The OSLC team highlight five key areas to the model:

- a consistent, reinforcing and kind environment with mentoring and encouragement;
- daily structure, with clear expectations for behaviour and specific consequences;
- supervision of young people's activities and whereabouts at all times; and
- limited access to anti-social or problem peers along with support to develop social skills that will help form positive peer relationships (Chamberlain 2003).

There are three age-appropriate versions of the model for pre-schoolers (3 to 6 year olds), children (7 to 11 year olds) and adolescents (12 to 17 year olds). This review focusses on Treatment Foster Care Oregon-Adolescents (TFCO-A).

Support for TFCO-A Foster Parent and Clinical Teams

In TFCO-A, one young person is placed in a TFCO foster parent's home for approximately 9 months[65] (although siblings can be placed together in some circumstances). Foster parents undergo training in TFCO principles, theory and practice before the placement. Progress is tracked daily through a telephone call (Parent Daily Report) with TFCO staff which collects data on and monitors young people's behaviour. Should they need it, TFCO-A foster parents may contact their Programme Supervisor for immediate support at any time.

[65] The model is set up for treatment duration of between 6 and 9 months (TFCO 2018) although implementation in the UK had an increased treatment duration.

A clinical team (which includes the TFCO-A foster parents) meets weekly to address progress, direction and any problems for the young person. Teams are led by an experienced Programme Supervisor.

TFCO-A foster parents also meet weekly in groups of 7 to 10. Ideally, they are working with young people with similar problems. These meetings are also facilitated by the Programme Supervisor.

Support for young people and follow-on carers

Each young person has a **treatment plan** that is developed and reviewed regularly by the clinical team. Behavioural 'symptoms' are treated as **skills** deficits and young people receive therapy and support in line with their treatment plan (including problem-solving, coping and social skills training, educational support, individual and family therapy, behaviour management and managing relationships).

Young people's behaviour is monitored and **positive behaviour reinforced** using a points system based on social learning theory. Points are awarded for positive behaviours (for example getting up in time for school each day) and young people must accumulate points to move through the levels of the programme.[66] Negative behaviour leads to points deduction and young people may be demoted to the previous level.

The young person's **follow-on carer** (birth parent or other long-term care resource) is **involved** in their treatment throughout their placement, working with therapists to ensure consistency of care, support and authority in the long-term (Biehal et al 2012:6). During the young person's placement in a TFCO-A Foster home, the model provides follow-on carers with weekly activities and services to develop parenting techniques and confidence. Support is also available once the young person has transitioned to their follow-on placement.

Implementation

Since 2002 OSLC has provided guidance, training, and technical assistance to new and existing TFCO programmes (TFCO 2018). TFCO has been implemented in over 20 sites worldwide, including in the United States, Australia, Sweden, Norway, Denmark, The Netherlands, United Kingdom, and New Zealand (TFCO 2018).[67]

A TFCO programme has been introduced in Scotland ("Team Foster Care" in Glasgow) and TFCO-A was introduced as a pilot across 18 local authorities in England in 2002. The model does not appear to be in operation in Northern Ireland or Wales. Unlike most TFCO-A implementation in the U.S., the English

[66] Young people can only 'graduate' from TFCO once they have reached a specified level.

[67] TFCO-A training material is available in: English, Dutch, and Swedish.

pilot targeted looked after children and young people with emotional, behavioural and social difficulties and at risk of placement breakdown.[68]

OSLC supported a National Implementation Team (NIT) to develop local programmes, training and support for TFCO teams, and monitor model fidelity (Biehal et al. 2012:9)[69]. Differences between the model's implementation in the U.S. and U.K. are provided in Figure 21.

Figure 21: Key differences between TFCO-A U.S. model and UK implementation

	TFCO-A model	UK Implementation
Age criteria for young people	12 to 18 years old	11 to 16 years old
Pre-TFCO placement	Young person requires an out-of-home placement	Young person is **at risk of custody or secure care** or their current placement is unstable (at risk of breakdown or not meeting their needs)
Behaviour	Serious or chronic criminal behaviour focus	Showing complex or severe emotional difficulties and/or challenging behaviour
Intended follow-on carer	Birth parents/ families	Stable family-based placement (e.g. foster care)

18.2 Target groups

The U.S. model was originally developed for young people aged 12 to 18, with severe delinquency and/or severe emotional and behavioural disorders[70] who require an out-of-home placement and whose needs would not be met in lower levels of care.

TFCO-A's target group has since expanded. For example, a pilot implementation in England targeted young people in placements at risk of breakdown or who were at risk of custody or secure care.

[68] This was supported by pilot money from the former Department for Children, Schools and Families in response to the poor outcomes and placement instability often experienced by these children.

[69] The Youth Justice Board (YJB) in England has also introduced a TFCO programme called Intensive Fostering. This is for young people in the youth justice system rather than the care system (Biehal et al. 2012:3). TFCO has also been introduced in England as an early intervention for very young children at risk of long-term care (TFCO-P) (Luke et al. 2014: 187).

[70] Including hyperactivity, delinquency, school failure, history of abuse, depressive symptoms, aggression, anxiety, defiance, stealing, social aggression, and general anti-social behaviour.

18.3 Inputs and resources

18.3.1 Staff, expertise and resources required

Most of the TFCO-A work takes place in foster care settings; though community agencies; outpatient clinics; schools; and follow-on carer settings are also involved.

Clinical teams comprise diverse professionals along with the TFCO-A foster parents. Details on the role of each TFCO-A team member and required qualifications are provided in Figure 22.

Figure 22: Minimum Qualifications for TFCO-A Team Members

Team Member	Qualifications and/or attributes	Role
Programme Supervisor	• Master's degree in a clinical field • Experience in behaviour management approaches • Organisation, supervisory skills • thorough understanding of model	*Oversees therapeutic work of team with each young person*
Family Therapist	• Master's degree in a clinical field	*Works with follow-on carers*
Individual Therapist	• Master's degree in a clinical field	*Works with young person on one-to-one basis*
Skills Trainer(s)	• Bachelor's degree in a relevant field	*Works with young people on developing specific skills*
Foster Parent	• No formal education required • Basic understanding of child development and reasonable expectations for young people	*Provides home for one TFCO-A treatment young person*
Recruiter/ Trainer/ PDR Caller	• Thorough understanding of TFCO • Foster parenting experience • Education level is less important - position can be filled by an experienced (ex-) foster parent.	*Carries out recruitment, training or daily PDR calls with TFCO-A Foster parents*
Consulting psychiatrist	• Qualified psychiatrist	*One or two sessions a week to prescribe and*

Team Member	Qualifications and/or attributes	Role
		manage any medication if needed

Source: CEBC website. Note: Where there is no trained psychologist in the team (for example in the Individual Therapist role), weekly support from a clinical psychologist is recommended to assist with intake assessments

Implementation in the UK involved an additional two team members (Biehal et al. 2012). These were:

- A Programme Manager who managed the team, set up local systems and dealt with finance and sustainability
- Education Support Worker (often with a teaching background) to help with obtaining education placements; integration and support at school; and supporting school with reinforcement of positive behaviour

Additional resources required to implement TFCO-A include:

- Office space for a team of approximately 6-8 people: Programme Supervisor, Recruiter/Trainer/Parent Daily Report Caller, Family Therapist, Individual Therapist, and 2-3 Skills Trainers
- Conference room with video recording
- Internet access for Programme Supervisor

A manual that describes how to implement TFCO-A. According to the CEBC profile, 40-hour training is available on-site in Eugene, Oregon over 5 days.

18.3.2 Set-up and running costs

Set-up costs

Costs for setting up the TFCO-A model include:

- Recruitment and training of specialist TFCO Foster parents and the TFCO team (including specialists from a range of disciplines);
- Training for employees already in post such as social workers and family placement officers;
- Administrative activities such as contract negotiation, finding premises and the provision of support infrastructure (Holmes et al. 2008:29).

In their study of TFCO-A costs, Holmes et al. (2008) could not establish the detailed set-up costs incurred by local authorities piloting the scheme. That said, they note that out of the five local authorities included in their study, four received

a grant of £400,000 to cover set-up costs and one a grant of £280,000 (Holmes et al. 2008:29).

Running costs

In an analysis of TFCO-A costs in the England pilot, Holmes et al 2008 found negotiating and finding individual TFCO-A placements was, on average, £5,000 more expensive compared to the costs of arranging alternative placements (Holmes et al. 2008: 33).

However, the average annual cost of maintaining a TFCO-A placement was lower than the cost of a residential placement (which some of the young people in the TFCO-A pilot would have entered otherwise). Holmes et al. estimate annual costs[71] of maintaining placements for a looked after child with complex needs as follows:

- TFCO-UK (including reviewing and planning processes): £68,544[72]
- Agency foster care: £61,384
- Agency residential care: £118,960
- Local authority residential care: £161,548 (Holmes et al. 2008: 30).

Costs for different local authorities piloting the TFCO-A model varied greatly (Holmes et al. 2008). Running cost differences were attributed to: salary differences (regional differences and appointments at different pay grades); variations in fees paid to carers (perhaps due to differing levels of competition for carers); and accommodation costs (Holmes et al. 2008: 30). Costs overall also increased if TFCO-A placements were outside local authority boundaries (Holmes et al. 2008:55).

18.4 Effectiveness and impact

18.4.1 Overall evidence base

There is evidence from the USA and Europe on the benefits of TFCO for adolescents with challenging behaviour, Conduct Disorder and / or serious criminal behaviour.

[71] TFCO placements are typically 9 months long. Here TFCO costs are transformed to an annual approximation to enable comparison.

[72] In the English pilot programme, the TFCO-A teams were supported with training and advice from the National Implementation Service. The NIS was funded by central government and their costs are not included in these calculations (Holmes et al. 2008:18).

For young people in care, evidence on positive impacts associated with TFCO is inconclusive but suggests it may be particularly effective for young people in care with the most challenging behaviour.

18.4.2 Evaluation findings

TFCO-A is considered well-supported by research evidence (with the highest CEBC rating) and features in the U.S. National Registry of Evidence-based Programs and Practices.

For young offender settings

The OSLC team has conducted eight randomised controlled trials (RCTs) on the application of TFCO-A to young offenders in the U.S. These suggest that outcomes for older children and adolescents, compare favourably to residential alternatives.

Three independent RCTs have been conducted on the application of TFCO-A for young people with Conduct Disorders in Sweden. These identified a "trend towards positive" benefits: young people who had participated in TFCO were found to have spent less time in locked settings and committed fewer violent crimes at follow-up in comparison to the young people who had experienced Treatment As Usual (Bergstrom and Hojman 2015). However, the Swedish studies did not always find these benefits to be significant or persisting (Sinclair et al. 2016: 844).

It is only in England and Scotland that TFCO projects have been targeted specifically at children and young people in the care system (rather than defined by their offending history, Conduct Disorder diagnosis etc.) This review was not able to identify any evaluation of the Scottish implementation, and therefore focusses on the evaluation of TFCO programmes in England (Biehal et al. 2012).

TFCO-A for young people in care

The application of TFCO-A in the UK care system was evaluated using a combined RCT and observational case comparison study design (n=34; n=185) (Biehal et al. 2012). The evaluation compared outcomes for young people allocated to TFCO-A with a Treatment As Usual (TAU) comparison group comprising young people in residential care (61%) or foster care (31%) over one year.

Key findings were:

- **No improvement in overall outcomes for young people in the cohort**. TFCO-A had no significant effect on the combined social and mental health outcomes (CGAS/HoNOSCA)[73] of young people compared to those in the

[73] Children's Global Assessment Scale; Health of the Nation Outcome Scales for Children and Adolescents (standardised)

comparison group. There was no evidence that the TFCO-A model led to improvements at school, less delinquency, more placement stability once leaving the programme, or that young people's follow on placements were less costly compared to young people with similar needs in alternative placements such as residential care (Biehal et al. 2012:215).

- **Some improvement in outcomes for young people with the most challenging and complex behaviours.** Evidence suggested TFCO-A was beneficial for young people whose behaviours were the most challenging and complex.

- **Young people without anti-social behaviour problems tended to do better in alternative placements** such as residential or foster care. This is the case for all key outcomes including overall adjustment, education and offending, and supports previous study findings in the U.S. and Sweden. (Biehal et al. 2012:216).

Regarding follow-on placements for young people, Biehal et al 2012 found half of the total TFCO-A group were still in their TFCO-A placement after one year. Of those who had left, one-third were living in foster care or with relatives, 15% had moved to semi or independent living and almost half were in residential care. There was no difference in the type of placement young people transitioned to between TFCO-A young people and those in other placement.

Analysis suggested type of follow-on placement was associated with the amount of time a young person had spent in their TFCO-A placement. Those young people who moved to other foster placements had typically been in TFCO-A longer than those who moved to other placements. However, reasons for this are inconclusive: perhaps a result of having had more time to find and plan a follow-on placement; perhaps reflective of local authority placement availability; or that young people who cannot settle in foster care have their needs best met elsewhere (Biehal et al 2012).

18.4.3 Potential cost savings

TFCO-A's potential to save costs depends on the alternative the model is compared to.

One study compared the costs incurred by young people (n=24) who spent at least six months in the TFCO-A programme in England with costs incurred by young people with similar care histories and needs living in alternative placements. It found that social care costs were around 15 per cent lower in the first six months of a TFCO-A placement compared to costs incurred in the six months prior to entry (Holmes, Westlake and Ward, 2008).

The same study found TFCO-A costs were similar to independent foster agency costs, and less than in-house and out-of-authority residential care (Holmes, Westlake and Ward, 2008).

18.4.4 Limitations to the evidence

Generalisability of evidence

- Most research on TFCO-A (including eight RCTs) has taken place in the U.S.A, is associated with the model developers, and focusses on young offenders. It is questionable how robust, relevant or transferable these findings are to young people in the UK care system, with different cohorts, welfare systems, and wider policy and service contexts.

- The findings from Biehal et al's evaluation of TFCO-A pilot implementation in UK residential care suggests important differences between TFCO-A treatment young people and the wider in care cohort nationally (2012). Of all the young people in the pilot implementation evaluation at baseline (n=219), 53% were in residential care and 41% in foster care. This proportion is roughly five times higher than that for the English care population (DCSF 2009).

- It is also worth noting key differences in the function of TFCO-A placements in Biehal et al 2012 with comparison placements. TFCO-A aimed to change the young person in some way but, unlike most comparison placements, did not aim to provide a long-term home.

Fidelity issues

- As mentioned previously, the TFCO-A implementation in residential care in England differed from the U.S. model from the outset in terms of target group, staff, and transition focus. Support from OSLC and a National Implementation Team, was designed to achieve model fidelity. That said OSLC criteria stipulates models must achieve a graduation rate of 66% for young people to be certified TFCO-A providers. At one year follow-up less than half (45%) of the young people who had left their TFCO-A placement had "graduated" according the OSLC criteria (Biehal et al. 2012).

Study design issues

- The randomised study did not recruit enough participants to detect a plausible effect size (Biehal et al 2012). This was due to low acceptance of the random allocation method by participating local authorities and social workers who were relied on for recruitment. This small sample size reduces the evaluation's ability to identify impacts of treatment and could be responsible for the evaluation finding little evidence of TFCO-A's effectiveness (Biehal et al. 2012: 220).

- Introducing RCT methodology in a social care context was difficult. Evaluators in Biehal et al 2012 had to rely on co-operation from social workers for recruitment, and collection of baseline data on young people. Over one-third (191) of young people referred to the study did not take part due to difficulties in contacting them to request consent; in most of these cases this resulted from social workers' gatekeeping. Detailed data on emotional and behavioural difficulties were collected for just under half of the sample (Biehal et al. 2012: 21).

- Although the evaluation's observational component benefited from a larger sample, there were considerable differences between the TFCO-A and control group (the former were more likely to be in mainstream education and to be younger). It is hard to draw conclusions from this evidence as to whether differences between groups are attributable to the model or to comparison of fundamentally different cohort groups.

Lack of long-term follow-up

- Measuring outcomes for young people after one year was too soon to tell whether TFCO-A had had an impact on subsequent placement stability, particularly as half the TFCO-A group had not transitioned to another placement.

18.4.5 Lessons learned

Key successes

- When interviewed TFCO-A Foster Parents were particularly appreciative of the structured programme and intensive 24-hour support available from the clinical team (although some felt their own skills were not valued adequately). (Biehal et al. 2012)

- Incorporating the TFCO-A team within existing looked after children teams reduced model delivery costs; improved communications; reduced time social workers might have spent liaising; improved referral rates; and resulted in better placement finding and transition strategies (Biehal et al. 2012:59).

Key challenges

- Local **changes in funding** priorities and sustainability problems once grant funds were spent affected model implementation (Biehal et al. 2012:10).

- **Fidelity fluctuated and was difficult to achieve nationally.** It was affected by staff and carer turnover and recruitment difficulties. Some teams or local authorities introduced adaptations to the model, against the advice of the national team and ended up leaving the national programme because they wished to maintain local adaptations.

- The evaluators note that any potential long-term benefits from a TFCO-A placement are likely to be eroded if the young person's **subsequent placement** is not appropriate (Biehal et al. 2012:217).

18.5 Recommendations for further research

Further independent evaluation of the model in "real world" settings is needed.

Biehal et al 2012 shows TFCO-A offers benefit to at least some young people with complex behavioural disorders over alternatives.

Despite difficulties of conducting a robust and independent evaluation of a new model in a social care context, further research would be helpful, in particular to:

- determine whether any observed benefits last (for example with follow-up period of longer than one year)
- whether benefits can only be delivered by the full TFCO-A model or could also be delivered by models which keep some but not all features (for example adapting the model for placements where young people do not have to move, teaching TFCO-A techniques to existing foster carers experiencing difficulties dealing with behavioural problems.)
- test the generalisability of existing findings as applied to children's residential care in the UK (research should endeavour to include greater numbers of young people to determine whether outcomes are due to chance or whether there is a real difference)

Given evidence suggestive of worse outcomes linked to placing "social" young people in TFCO-A, further research is needed to consider the possible gains of placing this cohort elsewhere.

18.6 More reading

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