SCIE Knowledge review 22: Working with challenging and disruptive situations in residential childcare: Sharing effective practice

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Appendix 1: Technical appendix

Search strategy

The search strategy was developed by the two researchers in consultation with the trial search coordinator (J. Abbott) from the Cochrane Developmental, Psychosocial, Developmental and Learning Problems Group. Due to the breadth of the literature that we wished to locate and the lack of uniformity in study descriptions and cataloguing, the search terms used were necessarily broad. Terms were combined for children and childhood and residential settings. Exact search strategies were tailored to each database according to their characteristics but an example strategy (PsycINFO) is reproduced as Appendix 2 and all search strategies are available from the authors on request.

Searching

Extensive searching of bibliographic databases, websites and libraries was undertaken to identify studies of relevance to the review. In addition, experts in the field were contacted to identify additional studies that may be of relevance. Table A1 shows the sources searched and the number of 'hits' produced from each (including duplicates). In addition to these bibliographic and internet sources, experts were contacted, and certain key UK child welfare journals were hand searched (*British Journal of Social Work*, *Children & Society*, *Child & Family Social Work* and *Research Matters*). Searches were conducted during August and September 2006 using free text searches (see Appendix 2, for example). In addition, references of included studies were screened for additional studies. The large number of research overviews and reviews were not screened because of the large number of studies already screened.

Table A1: Databases searched

Database name	Number of hits (including duplicates)
Applied Social Science Index and Abstracts (ASSIA)	1,720
ARK database (Northern Ireland)	0
British Education Index	180
British Library Catalogue	4
Childdata (National Children's Bureau)	36
CINAHL	797
Dissertation Abstracts	19
Educational Resources Information Centre (ERIC)	1,546
ESRC Society Today	0
International Bibliography of the Social Sciences (IBISS)	317
MedLine	1,851
PsycINFO	6,749
SIGLE	549
Social Care Online	718
Social Science Information Gateway (SOSIG) (INTUTE)	14
Social Services Abstracts	3,549
Sociological Abstracts	838
ZETOC	21
References from field experts and first authors	40
Total number of hits	18,948

Screening procedure

The title and abstract of the first 1,000 studies were read by both authors of the research review to judge broad relevance, using double screening to ensure that they were applying the same criteria for inclusion and exclusion. Inter-rater agreement ('I') was 85%. Reviewers met and reviewed how they were approaching the tasks to ensure a closer fit in future and to review disagreements, all of which were resolved. After this point 25 per cent of papers were double-screened and the remainder screened by individual reviewers. Reviewers discussed studies where inclusions were unclear. All studies meeting original inclusion criteria as judged by either reviewer were marked and a list of

potentially relevant studies obtained. A second stage of screening was then applied (see inclusion criteria below).

Inclusion criteria

We took an iterative approach to inclusion. Since we did not know prior to the review beginning the likely size of the literature that it would be possible to locate, we set inclusion criteria that would capture a large proportion of potentially relevant studies. The original inclusion criteria were:

- published in English language
- published after 1975 (inclusive); no upper date limit was set
- studies of children aged 5-17 years (inclusive)
- studies of children living in group residential settings; mental health and psychiatric settings were excluded (including specialist drug/alcohol treatment centres), juvenile prison settings/young offender institutions (YOIs) were excluded, foster family care was excluded (caution needed to be taken with the US literature, which uses the generic term 'foster care' to refer to both foster family care *and* residential group care)
- a range of anti-social and disturbing behaviours (general non-compliance and defiance; theft and damage to property in the home; school refusal; violence to residents and staff, including physical, intimidation, sexual and verbal; problems in the residential home linked to religion, culture, sectarianism and gangs; 'runaways/absconding'; regular alcohol or drug misuse; risky sexualised behaviour including promiscuity, unprotected sex and prostitution; self-harm, including self-cutting and suicide attempts; depressive or eating disorders; extreme uncommunicative or withdrawn behaviour). Studies relating to behaviour *outside* the residential setting were excluded
- public, voluntary and private sectors were included
- study set in the UK, Ireland, the US, Canada, Australia, New Zealand, Denmark, Norway and Sweden

- any research studies were included, including qualitative and quantitative approaches. Individual practitioner case studies, programme descriptions, theoretical propositions, research overviews/reviews and other non-research reports were excluded, such as inspection reports and professional social work literature.

Once screening had taken place, we proposed to consider the following categories of studies for exclusion, in order of priority (categories in bold were included in final review). The order of priority was arrived at in consultation with the advisory group of the knowledge review and with partners at SCIE to ensure that the most important categories of studies were those most likely to remain in the review. This approach was taken to maximise transparency in decision making, while allowing for flexibility in the conduct of the review to allow for the unknown nature of reviewing in this field.

(1) Intervention trials
(2) Studies of incidence of behaviour (how often behaviour occurs)
(3) Young people's perspectives
(4) Antecedents/immediate causes
(5) Service evaluations
(6) Staff views
(7) Effects of challenging behaviour
(8) Facilities for disabled children
(9) Boarding schools (including residential special schools)
(10) Papers that will only contribute 'risk factors' for challenging behaviour (that is, long-term risk factors, not immediate causes or antecedents)
(11) Residential treatment facilities
(12) 'Short breaks' or respite services
(13) Focus on young offenders/delinquents

(14) Studies of prevalence of behaviour (how many young people exhibit general behaviour).

Inclusion decisions post-screening

Although all the topics identified above were potentially relevant, priorities were set as to which were most likely to be useful if all papers could not be included. For example, 'prevalence' was seen to be a low priority since we knew that general prevalence of challenging behaviour would be high in this population, but research data on the actual number or frequency of challenging incidents was seen as of more importance. Topics 1-8 were included in the final review. In addition, the team had originally planned to review all studies published since 1975. This resulted in a field of literature that was too large to review within the scope of this knowledge review. Therefore, the cut-off date was later revised to 1985 (inclusive). Since this decision was made after screening of studies, but before full data extraction, we do not consider that this decision is likely to have biased the studies included in the review. Our general approach was time-consuming but thorough. Therefore the final inclusion criteria were:

- published in English language
- published after 1985 (inclusive); no upper date limit was set
- studies of children aged 5-17 years (inclusive)
- studies of children living in group residential settings including facilities for disabled children; mental health and psychiatric settings were excluded (including specialist drug/alcohol treatment centres), juvenile prison settings/YOIs excluded, foster family care were excluded
- a range of anti-social and disturbing behaviours within the residential home; studies relating to behaviour *outside* the residential setting excluded
- public, voluntary and private sectors were included
- study set in the UK, Ireland, the US, Canada, Australia, New Zealand, Denmark, Norway and Sweden

- studies included were intervention trials, studies of incidence of behaviour (how often behaviour occurs), studies of young people's perspectives, studies examining the antecedents or immediate causes of challenging behaviour, service evaluations, views of staff towards challenging behaviour, and studies of the effects of challenging behaviour on staff or children.

A flow chart of included and excluded studies is provided in Appendix 3, and numbers of studies excluded because of revision of inclusion criteria are shown there.

Data extraction

Data extraction and study quality appraisal on the 62 studies that met the inclusion criteria were conducted by individual reviewers using a standard data extraction form (see Appendix 4). Where multiple publications were produced from the same study, data extraction was pooled into a single data extraction form. Conversely, in some studies it was possible to report on 'sub-studies' within a larger study where only part of a publication was relevant. For example, where incidence of a behaviour was compared between foster homes and children's homes, only the data from children's homes were extracted. In other cases where sub-studies were of varying quality, only those elements rated 'A' or 'B' were extracted and reported.

Twenty-five per cent of studies where full data extraction took place were extracted by two reviewers and their findings compared. Any disagreements were discussed and resolved by consensus, and in two cases involving unusual studies, by referring to a third reviewer (I. Sinclair), external to the team.

Quality appraisal

Quality of research within data extraction was judged against the following criteria:

- clarity of research question
- appropriateness of design
- sampling
- data collection
- data analysis
- propriety.

These categories are described in the study appraisal section of Appendix 4. Overall judgements were made by reviewers on the basis of these categories as shown in Table A2.

Table A2: Coding of quality status

Category A	Studies that meet the quality appraisal criteria with no, or very few, flaws	Included in final review
Category B	Studies that meet all or most of the appraisal criteria well, with some flaws	Included in final review, with study concerns noted
Category C	Studies that include many and/or serious flaws that have the potential to affect the findings	Excluded from final review
Category D	Studies that include insufficient data on methodology to allow an appraisal of quality	Excluded from final review

Data synthesis

A narrative approach was taken to data synthesis, in which the characteristics and results of studies were brought together and similarities and differences compared. [1] The general theoretical and methodological influences on our approach are discussed further in the introduction to the research review chapter (Chapter 2).

Appendix 2: Example search strategy (PsycINFO)

#1 child* or boy* or girl* or young person* or young people* or adolescent* or teen* or schoolchild*

#2 group care* or therapeutic care* or treatment care* or boarding school* or children* home*

#3 institutional care or institutional child* or group home*

#4 (therapeutic placement* or therapeutic unit*) or (treatment placement* or treatment unit*) or (secure placement* or secure unit*)

#5 homes for children or care home* or orphanage*

#6 residential care or residential unit* or residential home* or residential treat* or residential therapy*

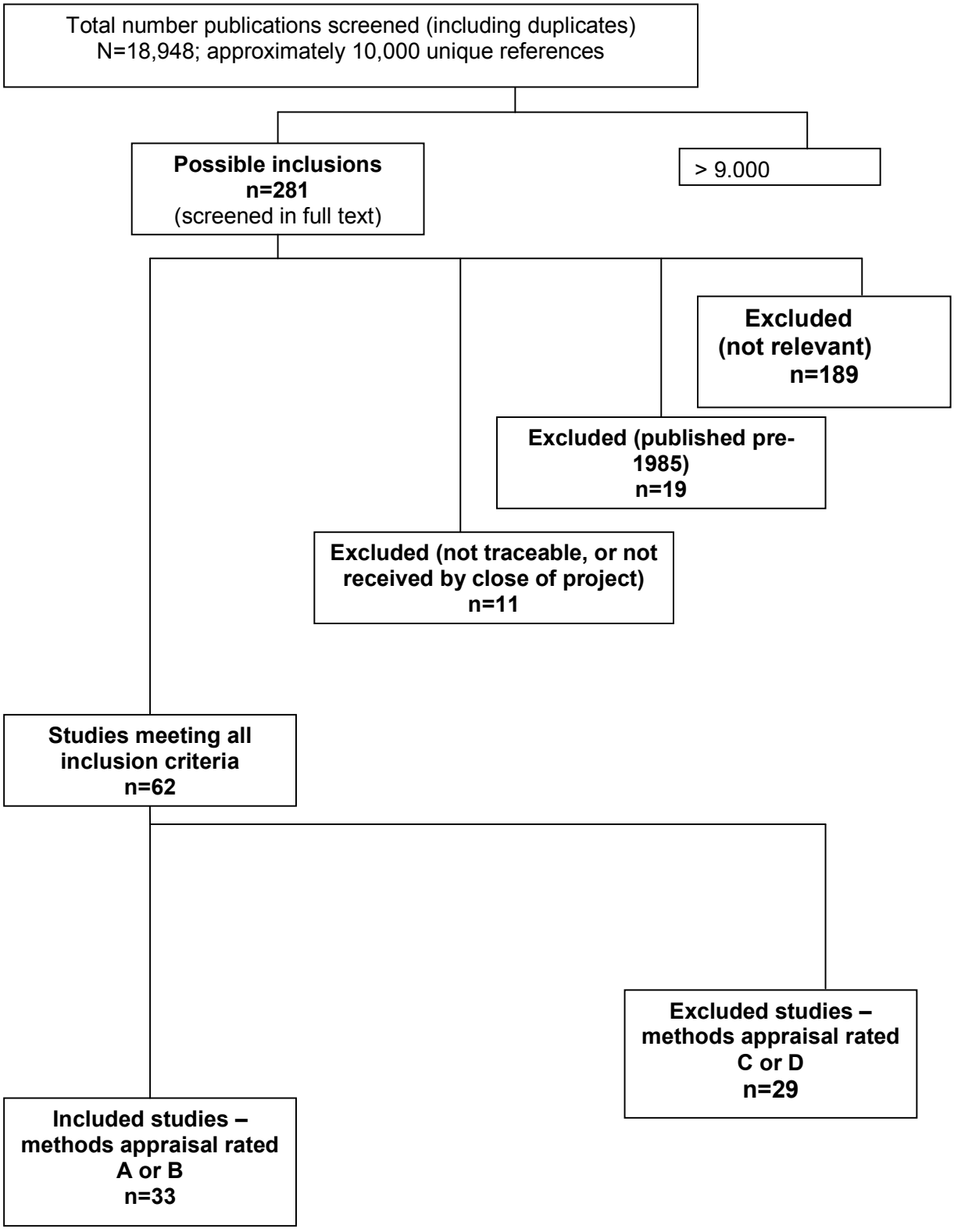
#7 residential child* or residential girl* or residential boy* or residential young person* or residential young people* or residential adolescent* or residential teen* or residential schoolchild*

#8 #7 or #6 or #5 or #4 or #3 or #2

#9 (#1) and (#8)

#10 (#9) and (PY:PSYI = 1975-2006)

Appendix 3: Inclusion flow chart



Appendix 4: Data extraction form

Reviewer Name: **Date extracted:**

Study ID (First author date and ID number)	
Shortened title	Please provide abbreviated title (eg first few words or key phrase)
Relevance of study (tick all that apply)	
Publication year (after 1975 include)	
Population location Please delete all categories that don't apply	UK Ireland US New Zealand Australia Canada Denmark Norway Sweden Other (exclude)
Participant characteristics Please delete all categories that don't apply	Age 5-17 Specific focus on juvenile offenders
Characteristics of residential facility Please delete all categories that don't apply	Not residential (exclude) Residential with family (exclude) Drug & alcohol treatment centres (exclude) Mental health facilities (exclude) Foster family (exclude) Boarding school (exclude) Planned short-term or respite care Specialist facilities for disabled children 'Residential treatment' facility (exclude) All other residential childcare (eg children's home, secure units, orphanages, group homes)
Study type Please delete all categories that don't apply	Evaluation of service (eg entry and later assessments) Intervention study Study of risk factors (which young people and staff are associated or involved in the behaviour) Study of predictive factors (personal, social and institutional antecedents, context and causes of the behaviour) Study of incidence Effects of behaviour on staff Effects of behaviour on children

	Research review or overview Staff perspectives Young people's perspectives Prevalence (for studies that only fit this criteria please complete additional prevalence studies list) Other (please state)
Has study met inclusion criteria?	1=yes, 2=no, 3=uncertain

Study aim (verbatim where possible)	This section does not need to be completed for studies with a 2 or 3 above (ie those that may not be included in review)

Prevalence studies only – mark all of following that are assessed or described	
General non-compliance and defiance	
Theft and damage to property in the home	
school refusal	
Violence to residents and staff, including physical, intimidation, sexual and verbal with particular reference to Northern Ireland, problems in the residential home linked to religion, culture and sectarianism regular	
'Runaways/absconding'	
Alcohol or drug misuse	
Risky sexualised behaviour including promiscuity, unprotected sex and prostitution	
Self-harm, including self-cutting and suicide attempts	
Depressive or eating disorders	
Extreme uncommunicative or withdrawn behaviour	
Psychometric assessment (eg CBC, MMPI, please name)	
Application of one or more standardised scales/checklists/psychometric assessments	
Other (please describe)	

Details of young people, staff and residential intervention	
Location of setting	Country, region, urban or rural etc
Number of settings included	(Give details below on each where they vary)
Age of residents (average, range)	
Gender, ethnicity of residents, disability, other characteristics	
Type of residential facility/ies	Type of unit such as children's home/group care home/secure unit/approved school,/community home with education (CHE)/mental health facility etc
Management	Public/voluntary/private
Purpose of home/s	Short- long-term/treatment/rehabilitation etc
Admission criteria	
Planned length of stay	
Therapeutic/treatment/theoretical approach	Psychodynamic/behavioural etc, and which practitioner groups deliver any intervention
Size of facility/ies	Number of residents in total and/or per unit
Characteristics of staffing	Including number, seniority, gender, experience, training/qualifications
Other key features of residents, staff and facility/ies	
Details of research sample	
Residents, staff or mixed	
Sample size (total and per group)	
Proportion of residents/staff in sample	
Age, gender, ethnicity, disability, other characteristics of sample	
Characteristics of staff (if research sample)	Including number, seniority, gender, experience, training/qualifications
Other key features of sample	

Study methods	
Study design	eg Intervention studies (RCT, comparison study, un-controlled trial) Qualitative study (focus group, interview study, ethnographic study) Quantitative attitudinal (standardised assessments, rating scales, closed

	questionnaires) Mixed methods
What methods were used to identify and recruit participants for study?	
Sampling method eg cross-section purposive sample convenience sample (any restrictions) random sample (any restrictions)	
What was the non-participation and/or drop-out rate from study?	
How were non-participants and/or drop-outs dealt with in the analysis? Please record any details given	
Comparison data – use of comparison groups, comparison settings or triangulation	
Ethical procedures	
Where and how did data collection take place?	
Are examples of data collection tools given? (eg discussion guide)	
How was data recorded?	
Is validity of data discussed?	
What was response rate for findings?	
Is a theoretical basis for analysis given?	
Were different views of data/findings compared?	
How are findings presented?	
Any other relevant information given	

Study appraisal	Quantitative research	Qualitative research
Essential criteria		
Clarity of research question	Are the research aims/objectives clear?	
Appropriateness of design	Are study design, methodology and data collection methods transparent and appropriate to address the research aims/objectives?	
Sampling	Is the sample appropriate and its size adequate for the analysis used? Where there is a comparison group, is this adequate in terms of size,	Is the sample adequate to explore the range of young people, residential staff or residential settings?

	selection method and characteristics?	
Data collection	For quantitative studies, are the indicators and data collection instruments adequate (eg reliability and validity)? Is the response rate sufficient and has non-response been analysed? Is any response bias reported?	Were the methods of data collection explicit and in-depth?
Data analysis	Were the analysis techniques clear and appropriate?	Was the data analysis explicit and replicable?
	Is attrition adequately dealt with? Are the findings substantiated by the data?	
Propriety	Are there legal or ethical concerns about the study? Were there any conflicts of interest for researchers carrying out the study?	
Desirable criteria		
Reflexivity	Is there consideration of alternative explanations of the results?	
Generalisability	If claims to generalisability are made, do these follow logically, theoretically or statistically from the results?	
Evaluative summary	Summary of strengths and weaknesses of the study	
Quality overview	A=meets appraisal criteria well with no or very few limitations B=meets all or most of the appraisal criteria well with some limitations C=has many flaws that have potential to affect the findings D=insufficient information on methodology to allow appraisal of quality of the work	

Evaluations of services or interventions only	
Details of intervention therapeutic approach	
Detail of intervention or approach to changing behaviour (eg theoretical/therapeutic approach, regime or management style, staff approaches, specialist support, CBT)	
Detail of co-interventions or approaches in comparison groups	
Number of staff or young people in each group	
What were the target outcomes and	

how were they measured?	
Findings for evaluations of services or interventions	
Reported impact on target children	
Reported impact on other children	
Impact and effectiveness of approach(es) and strategies on residents' behaviour	
Reported impact on staff	
Reviewer's comments	

Findings – all studies	
Nature of anti-social and disturbing behaviour/s and prevalence or incidence of them	eg general non-compliance; property theft/damage; school refusal; violence (physical, intimidation, sexual and verbal); religion/culture/sectarianism/ethnicity/race; runaways; alcohol/drugs; sexualised behaviour; self-harm; mental health eg depression and eating disorders; uncommunicative/withdrawn
Risk factors for behaviours – which young people or are staff involved?	
Context of behaviours	Timing, location etc
Antecedents and causes of behaviour – young people	Personal
	Group/social
	Institutional
	Community
Antecedents and causes of behaviour – staff	Personal
	Group/social
	Institutional
	Community
Involvement	Which young people are involved in and/or affected by behaviour?
	Which staff are involved in and/or affected by behaviour?
Effects of behaviour on young people	
Effects of behaviour on staff/reaction	
Young people's views	
Staff views	
Implications for national/local policy	
Other important findings from study	
Author's conclusion (where relevant	

to this review)	
Are author conclusions consistent with results presented?	
Reviewer's comments	

Appendix 5: Details of studies included in, and excluded from, the research review

Table A3: Studies included in the research review

Study	Country	Study focus	Sample (sample type, size, gender and age as available)	Quality status[1]
Barter C. et al (2004)	UK – England	Qualitative study exploring young people's and staff's understanding of the meaning and effects of violence in residential care.	74 young people (3 later excluded); 44 male/27 female, ¼ from minority ethnic groups. Living in 9 mixed units, 4 male-only unit and 1 female-only unit. Aged 6-17, but most 13+ years old. 71 staff interviewed; 39 female, 32 male.	A
Bell, L. and Stark, C. (1998)	UK – Scotland	Experts observed videotapes of residential childcare workers practising physical restraint techniques and rated their competence in order to design and test rating instrument.	13 trainers who taught on the TCI programme	A
Berridge, D. and Brodie, I. (1998)	UK – England	Multiple and mixed methods used to analyse changes in the structure and use of residential childcare services over the previous decade.	12 children's homes. Sample included 77 young people, of whom 21 resident in two short-breaks homes for children with physical and	A

			severe learning difficulties, 12 from minority ethnic groups. Also 101 staff, 3:2 ratio for females:males and 90% white.	
Nunno, M. et al (2003)	US	Pre-/post-design implementation study coupled with qualitative interviews to explore the process and impact of implementing a TCI methodology within 1 medium-sized facility.	Sample of staff only, with different samples for different stages of research. 104 pre- and 96 post- for knowledge levels. Confidence levels involved 44 childcare staff pre-implementation and 34 post-. Interviews conducted with 22 childcare supervisors and staff pre-implementation, 16 post-implementation.	A
Sinclair, I. and Gibbs, I. (1998)	UK – England	Postal questionnaires with some individual interviews. Purpose: to measure and explain the different outcomes achieved by residential homes.	Data provided for 48 local authority children's homes in England. Information from staff: 47 heads of homes; 304 other staff; 223 resident interviews; 99 parents; 176 social workers. Follow-up completed with 141 young people and 141 social workers.	A
Wade, J. et	UK –	Both qualitative and	272 young people	A

al (1998)	England	quantitative methods exploring why young people go missing from substitute care and what happens when they do.	from children's homes. 14 focus groups with young people, social workers, residential workers and foster carers. 36 qualitative interviews with young people, their social workers and carers. ⅔ of young people aged between 13 and 15. 58 per cent females (in line with per cent in residence overall); 25% black.	
Bell, L. (1997)	UK – Scotland	Qualitative study aiming to develop a picture of the current use of physical restraint.	16 staff members.	B
Berridge, D. (1985)	UK – England	Multiple mixed methods used to provide empirical information about children's homes: how many there are; who lives there and why; how they relate to the wider childcare system; and how participants perceive the residential experience.	Study of 20 children's homes. 14 located in 3 English local authorities. Sample included 234 young people, 59 per cent males, 41 per cent female; median age 14 years (range 2-16) and 136 staff in the 20 homes (20 heads of homes and 116 others, ⅔females ⅓ males).	B
Colton, M. (1988)	UK – England	Observations of care practice in children's homes. This is one part of a larger study.	Observations completed in 12 children's homes. Staff interviewed in only 4 of these and	B

			34 young people interviewed out of population of 145.	
Delfabbro, P.H. et al (2002)	Australia	Closed question interviews used to assess children's satisfaction with their current placement experiences in South Australian alternative care.	12 children in residential care.	B
Dura, J. et al (1988)	Assumed to be US	A problem behaviour checklist was constructed and used to assess the rate and extent of problem behaviours within a group of severely disabled children (physical and severe learning difficulties).	101 young people, average age 13.4 years. 51 male, 50 female all resident in a single institution (although divided into 5 units).	B
Epps, K. et al(1999)	UK – England	Mixed methods including questionnaires and interviews used to assess staff evaluation and perceptions of a training programme in the management of violence at a secure youth treatment centre.	77 staff completed questionnaire; 34 female, 43 male. 31 individually interviewed.	B
Farmer, E. and Pollock, S. (1998)	UK – England	Qualitative interviews and study of records used to describe the characteristics and experiences of a sample of sexually abused and abusing children in	21 young people, 11 girls, 10 boys. 15 interviews with keyworkers and 1 with head of children's home. 10 female, 7 male overall.	B

		substitute care.		
Fischer, R. and Attah, E. (2001)	US	Intervention study: pre-and post-programme and follow-up evaluation to examine the impact of a 7-day outward bound wilderness experience on a group of young people from residential care.	23 young people, average age 16 years, over quarter aged 13-14. Mostly African-American.	B
Gibbs, I. and Sinclair, I. (1998)	UK – England	Mix of interviews and questionnaires to consider whether there are differences between the public and private sector homes in planning and perceived quality of care, and to try to explain any differences seen.	Public sector – 223 residents (54 per cent male, average age 14½ years); 303 staff; 177 social workers. Private sector – 49 residents (80 per cent male, average age 14 years); 59 staff; 26 social workers.	B

Giles, G. (1994)	UK – England	Statistical analysis of behaviour and sanctions in a secure unit. Analysis of misbehaviour and staff sanctions from the unit punishment book.	32 young people, 16 female and 16 male.	B
Heron, G. and Chakrabarti, M. (2003)	UK	Interviews with residential care staff to examine perceptions of their tasks and the context of their work.	30 staff from 7 children's homes in 2 local authorities.	B
Hibbard, R. et al (1991)	US	A service evaluation undertaken to examine relationships between child abuse, depression and self-esteem in a residential facility.	82 young people aged 12-18 years (mean 14.5 years). 52% male, 82.9% white.	B
Kools, S. (1999)	US	Qualitative study exploring adolescents' perceptions of their care experiences.	17 young people aged 15-19. Older, predominantly African American adolescents, from low socioeconomic status backgrounds, who resided in a large urban area.	B
Kroll, L. et al (2002)	UK	Service evaluation of mental health, social and educational needs of young people at admission and during residence in a secure unit.	97 young people, all male, all new admissions. Age range 12-17 years, mean 14.9 years. 80 per cent white, 10 per cent dual heritage, 3 per cent African-Caribbean, 2% Asian.	B

			43 per cent were on remand. 43 per cent had sentence for serious offence.	

Lamanna, J. (1992)	US	Intervention studies (RCTs) to examine the effect of a skills training programme on perceived competence and job stress of youth care workers.	51 members of staff. Most aged 25 or older (42/51). Most had more than 1 year experience (44/51).	B
LeSure-Lester, G.E. (2002)	US	Intervention study, comparing a cognitive-behavioural-based treatment to a more traditional, active listening approach. Aimed at the reduction of aggression in African-American adolescents with a history of abuse living in a group home facility.	12 young people aged 12-16 years; mean 13 years. All African-American males, all from poor socioeconomic backgrounds.	B
Lochman, J. et al (1991)	US	Quantitative study of the level of agreement between residential staff and others completing behavioural checklists.	34 young people, 22 male, 12 female. 23 black, 10 white, 1 Hispanic. Mainly with conduct disorder problems.	B
Mainey, A. and Crimmens, A. (2006)	UK – all 4 countries	Semi-structured postal questionnaires with some qualitative interviews. Purpose: to examine morale and job satisfaction in residential childcare in the UK.	958 care staff and 239 managers completed questionnaires. 114 semi-structured telephone interviews. 61-71 per cent female per country.	B

Mann-Feder, V.R. (1996)	US	Evaluation of treatment in a therapeutic community for conduct-disordered adolescents.	Sample size not specified – 28 young people in total, but not clear how many in subsample of interest. Gender ratio not known but fewer female than male. Age range 14-18 years, mean 15.2 years.	B
Mills, M. (2000)	US	Pre–post evaluation of 'paradoxical interventions' with conduct-disordered youth to reduce acting-out behaviour.	3 young people aged 14, 15 and 17. All white with diagnosis of conduct disorders.	B
O'Neill, T. (2001)	UK – England	Largely qualitative study describing secure accommodation: the backgrounds of young people admitted; young people's experiences; care and therapeutic provision; staff views of young people's needs.	29 young people, 18 female and 11 male. 24 semi-structured telephone interviews with social workers. 65 managers/staff in focus groups.	B
Rawson, H. and Tabb, L. (1993)	US	Intervention study to test impact on depression of children experiencing short-term residential therapy. Quantitative – closed questionnaires completed by therapists at beginning and end of the treatment programme.	Intervention sample of 99 young people (90 male, 9 female). Age range 8-12 years. 4 were African-American. Plus 27 non-resident young people formed comparison group (18 male, 9 female), age range 8-12 years.	B

Rowe, J. et al (1989)	UK – England	Quantitative study using postal questionnaires investigating links between placement outcomes and organisation of services.	Study of all placements made by 6 local authorities. Number of placements: 591 to children's homes; 486 O&A; 359 CHE Records for 56 per cent male, 44 per cent female, 75 per cent 11 years plus, 16 per cent under-11s, 6 per cent pre-schoolers. How many children included not clear (as some may have experienced multiple placements).	B
Smith, M. (2002)	UK – England	Qualitative interview study 'asking the young women to explain as much as they could about the nature and process of their self-harming behaviours'.	3 young women aged 15, 15 and 16.	B
Swaffer, T. and Hollin, C.R. (1997)	UK	Qualitative interviews with young people, giving their accounts of 'anger-provoking incidents'.	18 young people; 15 males (mean 16.4 years), 3 females (mean 17.5 years). 13 white UK, 2 black Caribbean, 2 black UK, 1 Pakistani. All young people had at least one criminal conviction, 6 had a conviction for sexual offence, 9 had a conviction for a non-sexual violent offence, 3	B

			for fire setting.	
Triseliotis, J. and Borland, M. (1995)	UK – England and Scotland	Mixed methods study (using semi-structured interviews and standardised tests) examining social work interventions with teenagers.	116 young people: stage 1 – interviews with 105 young people, social workers, parents and keyworkers. At follow-up 1 year later – 97 young people interviewed, 73 parents, 109 social workers	B
Whitaker, D.L. et al (1998)	UK – England	Qualitative research with unit managers and staff to describe their experience of working in children's homes.	37 unit managers overall. Interviewed 22 males, 12 females (mean 42 years). 31/34 white. 6 units.	B

Note: Please see Table A2 in Appendix 1 for coding of quality status.

Table A4: Studies excluded from the research review

Study	Quality Status[1]
Altrows, I., and Alberts, G. (1990) 'Reducing confinements for disruptive behaviour in a residential centre: monitoring can help', *Journal of Child and Youth Care*, vol 4, no 5, pp 15–22.	C
Baez, A. (2003) 'A group approach to fostering self-cohesion and developmental progression in female adolescent group home residents', *Child and Adolescent Social Work Journal*, pp 351–73.	C
Baker, A.J., Schneiderman, M.**]** *et al.* (2001) 'A survey of problematic sexualized behaviors of children in the New York City child welfare system: estimates of problem, impact on services, and need for training', *Journal of Child Sexual Abuse*, vol 10, no 4, pp 67–80.	C
Barker, A. (1995) *Success of emotionally disturbed adolescents in a therapeutic wilderness program*, Texas, TX: Sam Houston State University.	C
Browne, K. and Falshaw, L. (1996) 'Factors	C

related to bullying in secure accommodation', Paper presented at the National Conference on Child Maltreatment, 1995, Seville, Spain.	
Emerson, E., Robertson, J., Fowler, S., Letchford, S. and Jones, M. (1996) 'The long-term effects of behavioural residential special education on children with severely challenging behaviours: changes in behaviour and skills', *Journal of Applied Research in Intellectual Disabilities*, vol 9, pp 240–55.	C
Fletcher, B. (1993) *Not just a name: The views of young people in foster and residential care*, London: National Consumer Council.	C
Friman, P.C., Jones, M., Smith, G., Daly, D.L. and Larzelere, R. (1997) 'Decreasing disruptive behavior by adolescent boys in residential care by increasing their positive to negative interactional ratios', *Behavior Modification*, vol 21, no 4, pp 470–86.	C
Gallagher, B., Brannan, C., Jones, R. and Westwood, S. (2004) 'Good practice in the education of children in residential care', *British Journal of Social Work*, vol 34, no 8, pp 1133–60.	C
Howard, R. and Hegarty, J.R. (2003) 'Violent incidents and staff stress', *British Journal of Developmental Disabilities*, vol 49, pp 3–21.	C
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Note: Please see Table A2 in Appendix 1 for coding of quality status. We reiterate that we are not implying that these excluded studies are not valuable but that they are not suitable **for our particular purpose**.

Appendix 6: Children's residential care in England

Introduction

Within the knowledge review on working with challenging and disruptive situations in children's residential care, funded by the Social Care Institute for Excellence (SCIE), it was agreed that most of the fieldwork for the practice review should be conducted in Northern Ireland. However, SCIE was keen to place these findings within the context of experience in England. To this end, some data were collected that related to England. This was not an attempt to ascertain data that could be used for comparative purposes, but rather to provide some further context for the Northern Ireland part of the study.
Information from England was provided from three sources:

- an analysis of the views of children on relevant topics from the Commission for Social Care Inspection (CSCI) reports (prior to the transfer of its responsibilities for children's social care services to the Office for Standards in Education, Children's Services and Skills (Ofsted) in 2007)
- two focus groups with managers and staff from a wide range of residential units
- a summary of the latest data from Inspections of Children's Homes, related to National Minimum Standards.

First, some descriptive information about children's residential care in England.

Children's residential sector in England

In England there are over 2,000 registered children's homes (2,025 in 2006) of which 61 per cent are in the independent sector, 32 per cent are run by local authorities and 6 per cent are operated by voluntary organisations. [64] However, the proportion of places within the independent sector is lower, at around 50 per cent. This is because homes in this sector tend to have fewer places (average of five places) than those run by local authorities (average of 6.5 places).

In addition, there are 227 registered residential special schools, half of which are run by local authorities, although the local authority homes provide only 30 per cent of the places as the number of independent and voluntary sector places are generally higher than those of the local authorities.

Just over half (53 per cent) of all homes are registered to cater specifically for children with emotional and behavioural difficulties, a sector that is increasing year on year. Only a small proportion of homes offer more than 10 places – with most (62%) offering fewer than six places.

Children's views

It had been hoped to replicate, in England, the focus groups that were to take place with young residents in Northern Ireland. Unfortunately, the plans to do this did not work out in practice. However, the CSCI has conducted several consultations to gather the views of young people living in residential care in England. We include a summary of some of the relevant information that has been gathered by CSCI in its focus groups with looked-after children and young people.

In 2007, summarising its work over the previous four years, CSCI identified the most important things that children and young people had told them during that time – some of these are general points; some are very relevant to addressing challenging situations in residential care. [65] This is what children say:

- **about how they want to be treated:** 'Treat us individually, not as children as a whole; treat our private worries confidentially – they're not for chatting and joking'
- **about the choices they want to make:** 'Children have a right to privacy; check for risks – but balance fun (and other things) and risks; if you are placing us somewhere, give us a real choice of placement'
- **about personal safety:** 'We have a right not to be bullied – and when dealing with bullying, please ask the bullied child and get it right so you don't make things worse; understand where to draw the line; beware untrained staff using

restraint; get police checks done properly to protect us after what happened at Soham' (the murder of two young girls by their school caretaker)

- **about consultation:** 'Listen to quiet children; even troublemakers have a point to make and need to be protected'.

Young people's views on restraint

The use of restraint can be an important part of managing challenging situations, so the views of young people in residential care on this issue are pertinent. The report by CSCI *Safe from harm* highlighted the concern of young people in residential care that not all staff knew how to use restraint properly – the young people recognised that restraint was necessary in some situations, but had to be done properly. [66] The CSCI held discussion groups with young people in residential care specifically on this topic. These discussions highlighted five key themes, which are detailed below: [67]

(1) Do not let things build up to danger level

- Staff need to handle the initial problem well and should use restraint only as a last resort.
- Something quite small – or something seen as unfair – can trigger a build-up that ends in restraint.
- It is vital to avoid problems building up to danger level and restraint wherever possible.
- Staff who try restraint when they do not know how to use restraint can make things even more dangerous for everyone.

(2) Know when to use restraint

- Restraint is sometimes necessary – but only when someone is likely to get hurt or property is likely to get seriously damaged.
- Restraint should not be used when people are 'just messing' or shouting and screaming.
- Restraint should not be used as a punishment.

- Calling the police is usually unnecessary.

(3) Know how being restrained makes young people feel

- Young people need to know that they can be restrained.
- Staff need to understand that some people do not like an adult touching or holding them because of past abuse.
- Restraint can make you want to get your own back – it is better to talk about what happened and why.
- Restraint also affects the people watching it happen.

(4) Know how to do restraint

- Restraint should never involve pain.
- Staff need to be trained in how to restrain without hurting and without making **you** get even more out of control.
- Restraint should calm you down – not make you more angry.

(5) Avoiding restraint

- It is important to try to calm someone down before restraint becomes necessary – and even when it does.
- Each individual's Placement Plan should describe how to deal with the person if they lose control.
- It is important to think of alternative ways to take the heat out of a situation.

Focus groups with managers and staff

Two groups were held with a total of 24 people in attendance. These 24 managers and staff were chosen to provide a spread of types of home and geographical regions. They were selected from the responses to an open invitation issued through the Newsletter of the Children's Residential Network. This Newsletter goes out monthly to several thousand members, through the National Centre for Excellence in Residential Child Care (NCERCC). The participants were asked to address the following questions:

- What sorts of challenging situations arise in residential childcare?
- What causes these to happen?
- How do staff respond to these?
- What affects how staff respond to these situations?
- What can be done to stop these situations happening or make them less serious?
- How should they be dealt with when they happen?

Very lively discussion took place, with staff sharing their thoughtful views. The themes that arose from these discussions were useful in structuring the analysis of the interviews and focus groups that took place in Northern Ireland. Most of the themes that arose from the discussion groups in England were repeated in one way or another in the practice survey in Northern Ireland and were noted in the research review. The discussions are summarised below under three headings:

- What are challenging/disruptive situations?
- What causes challenging/disruptive situations?
- What works?

What are challenging/disruptive situations?

The sort of situations that staff found challenging related to the impact of group living and the dynamics within the group, or to the behaviour of individuals. They also had some general points to make, which helped them distinguish the challenging behaviours or situations from the disruptive.

First, they noted that children's residential care is in its very nature challenging; bringing together a number of young people with difficulties will inevitably create challenging situations. However, often it is the persistent low level of disruption that is harder to deal with than the major one-off events. With respect to the behaviour of individuals this could often be very challenging to staff in terms of finding a solution that protected the young person, but it was not necessarily disruptive to the unit as a whole.

A major source of challenge was **group dynamics**: peer group issues, bullying and children and young people trying to establish the pecking order can all make other children's lives very unpleasant.

Even the **everyday management** of young people can be challenging: for example when you say *no* to an adolescent, and try to set boundaries, this can be challenged as many children and young people are used to different sets of rules and getting their own way.

With respect to **individual behaviours** that staff find challenging, several were mentioned: **sexualised behaviour**, for example by male residents to female staff; **damage to property**, for example fire setting, which some of the group said is not infrequent. **Self-harm**, for example cutting, is a major concern that staff can find more challenging than aggression. Similarly, **bizarre and unusual behaviour** in younger children, say 10-13 years, such as repetitive actions, disturbed and disturbing behaviour, where young people do not seem to be in control of their behaviour or to understand it, was found to be challenging. These children can deliberately and persistently harm themselves, their property or the property of others, and staff noted that they found it difficult to know how to respond to such situations.

Absconding was identified as another challenge. This is not made easier by the overlap between unauthorised absences and absconding and the statutory duty to report this. Sometimes it is necessary to distinguish between absconding and the children and young people who come home an hour or so late in the evening. The real worry is more around children and young people who go missing and staff have no idea where they are and they have no relatives to contact to find out.

What causes challenging/disruptive situations?

When considering what causes these situations the respondents again distinguished between triggers relating to **the group** and those focused on **the individual**. However, they also discussed triggers that were part of the **staff response** or related to the workings of the system.

Group dynamics is key, as mentioned earlier, but is easily disrupted when there is a change in residents that can lead to disruptive situations. This is often exasperated by the workings of the system with young people moving around between **placements**; senior managers are perceived to place children and young people 'willy nilly', without considering the dynamics of the existing group and this causes massive problems for staff.

The **environment**, both within and around a room, can also lead to disruption: for example, rooms that are too small, no outside space or outside facilities such as a garden, football pitch or local woods. Being located in the middle of an estate can be difficult because all the children and young people's troublesome friends come in.

Staff also mentioned that a **child's background** or their character can lead to disruptive situations. For example, children with attachment disorders may not know how to behave or be unable to control their anger; children with low self-esteem may victimise a weaker person; and a teenager's drug use can cause unusual and unpredictable behaviour. For some young people, experience of domestic violence becomes learnt violence, which, to them, is a form of survival behaviour.

Members of the group also recognised that the **staff** themselves and their responses can be triggers of disruptive situations. The impact of long hours and sleep-in rotas may mean that staff are overtired and therefore not sufficiently patient with the young people. Some staff are very young, they are inexperienced and still learning and they want to win (in conflict situations). Younger staff can play out the behaviour of the children and young people.

What works?

Responses to what works seem to fall into three groups:

- working with young people
- qualities of staff
- the management of the unit or system.

Working with young people

First and foremost, this means **building relationships** with the young people, sitting down and talking to them, getting to know them as individuals who all need different approaches; recognising that many young people need a flexible and caring response when they first go into care because of their backgrounds of emotional abuse and neglect; and being honest with the young people, setting and explaining boundaries.

It also means being respectful of the young person's personal space – just letting them be or to have time out. Managers recognised this is not always easy, as they can become worried about what the young person is doing. This raised the need to undertake **individual risk assessments** on every young person in order to develop individualised behaviour management plans. It was also noted that these plans need to be detailed, active documents and not just part of a procedure.

Any policy on sanctions needs to be offset with one on rewards that focuses on the positives. Therapeutic interventions were seen as important in working with the young people. Also, some units had started to work with young people on their diet, reducing junk food and fizzy drinks late at night, and which staff thought was having an impact on disruption.

Restraint may be necessary on occasion; some children and young people need restraint to feel safe. But restraint must be used only by trained staff; otherwise they are not doing young people justice. There are several good, gentle techniques around, such as **team-teach**. There is a need to consider physical de-escalating, and to communicate, listen and collect information. After a restraining incidient there is a need for a debriefingand an analysis of information to look for patterns, in order to provide an overview of the situation.

Several participants noted, however, that they are not getting into confrontational situations as much as before. This was thought to be because better trained staff meant that fewer restraint situations are necessary, as staff look to alternatives to restraint.

Qualities of staff

It is important to recruit the right staff, those who see residential care as more than just a workplace, those who feel committed to the task and to the children. Some staff can be trained to the hilt but they are just not suitable for work with children and young people. Staff with weak self-esteem are not good at managing difficult situations, so building staff confidence is important. Involving young people in the recruitment of staff has been seen to have an impact on choosing the right people.

The management of the unit or system

Staff need to be properly trained and supervised so they that feel supported and able to discuss the emotional impact of their work. An effective team approach that allows for a debriefing after every incident, consistency in responses such as when to call in the police, and good communication.

Placements need to be managed so that inappropriate admissions are reduced and staffing needs to be managed such that consistency is promoted and that there are enough staff on duty at times when disruption may occur, such as at bedtime. Good record keeping of incidents and of complaints allows for reflection. A good manager will create a positive climate by listening to what has happened and not looking for somebody to blame; it is about seeking out a constructive, positive way to try and make sure that the situation does not happen again and communicating this to staff and residents.

National Minimum Standards

Children's Homes Regulations and National Minimum Standards (NMS) for Children's Homes in England were published in March 2002 as part of the implementation of the 2000 Care Standards Act. [68]

The NMS set out 36 separate standards against which performance in children's homes is inspected, previously by the National Care Standards Commission, then by CSCI and in the future by Ofsted. Of these 36 standards, those most relevant to 'challenging behaviour' come under the heading Care and Control:

Standard 21 on Relationships with Children; and most pertinent to this study Standard 22 on Behaviour Management.
Under Standard 22 the intended **Outcome** is**:-**
'Children assisted to develop socially accepted behaviour through encouragement of acceptable behaviour and constructive response to inappropriate behaviour.'

This standard is assessed through adherence to 16 substandards, but with a Key Standard that states:

'Staff respond positively to adaptable behaviour, and where the behaviour of children is regarded as unacceptable by staff, it is responded to by constructive, acceptable and known disciplinary measures approved by the registered person.'

The CSCI reports annually on the extent to which these standards are met, as well as highlighting issues of concern. These reports are a summary of the findings from the inspections of children's homes carried out by CSCI during the previous year. Over the past four years since the introduction of the NMS there has been an improvement in the extent to which all standards have been met. In 2006, CSCI could report that one in three homes meet more than 90% of the standards, compared to one in ten in 2003. While this may still fall well short, at least things are moving in the right direction. The standards met most often were those relating to contact, secure accommodation, privacy and confidentiality, consultation, absence of a child without authority and counter bullying. Those standards least likely to be met related to the adequacy of staff and to health, safety and security.
The level of achievement of Standard 22, relating to behaviour management, falls in the middle range in relation to the proportion of homes meeting particular standards – but there have been marked improvements in this standard in recent years, with the most recent report indicating that 70 % of homes inspected now meet this standard (see Table A5).

Table A5: Percentage of homes meeting Standard 22

2002–03	2003–04	2004–05	2005–06
46	57	62	70

In reporting this information, CSCI identified the following issues of concern: children placed out of area and with limited support from the local authority or contact with social workers, and limited follow-through on support to children or providers. Homes that failed on Standard 22 have fragmented records on restraint and sanctions and concerns over appropriateness of sanctions. Those doing well have clear policies and minimal use of restraint. The voluntary sector (which makes up just over 6 per cent of all homes) out-performs all other sectors on this and indeed every standard.

Appendix 7: Mapping of challenging situations

There is currently no central standardised system for collecting and summarising statistics on challenging situations (nature, type, who is involved and so on) in residential children's homes in Northern Ireland. The Regulation and Quality Improvement Authority (RQIA)* <footnote, see end of appendix> is currently working to develop a standard approach to recording and reporting information on critical incidents in residential children's homes. Prior to the Review of Public Administration (RPA) each of the 11 (Health and Social Services) HSS Trusts had a different system for processing and recording 'incidents' within residential care, and such information is not separated out from 'incidents' within other Board or Trust provision. It would have been too costly and time consuming to separate out and summarise information on incidents within residential care for each of the HSS Trusts for the purposes of this research.

However, the RQIA has provided RQIA Quarterly Reports for the period 1 July to 31 December 2006. These reports do not cover the full spectrum of challenging situations encountered in residential children's homes. However, they provide statistics on notification of events reported to the RQIA by children's homes, the nature of these events and the RQIA response to the events.

Events that are required to be reported to the RQIA under Regulation 29(1) Schedule 5, The Children's Homes Regulations (NI) 2005 include:

- death of child accommodated in the home
- staff misconduct under POCVA (protection of children and vulnerable adults): alleged abuse/other unprofessional conduct
- serious illness or serious accident sustained by child
- outbreak of infectious disease: serious in nature
- allegation of serious offence by child
- involvement/suspected involvement of child in sexual exploitation
- serious incident necessitating calling police to home
- absconding by child

- serious compliant about home/employees
- child protection enquiry involving child accommodated and
- child protection procedures followed.

July to September 2006

A total of 239 events were received by the RQIA from July to September 2006. There were 180 events reported to the RQIA that fully complied with the regulations as listed above. Absconding of children accounted for 75 per cent of the notifications received in accordance with the regulations. Twelve per cent of notifications received related to serious incidents that necessitating the police being called to the home. Four per cent of notifications reported related to serious illness/serious accidents sustained by a child and 4 per cent related to child protection enquiries.

There were 59 events reported to the RQIA that did not fully meet the definitions within the regulations. Events reported included incidents of fire, overdose, self-harm, serious assault by child on child, serious assault by child on staff, misadministration of medication, assault in the community, criminal damage and abuse of alcohol/drugs.

October to December 2006

A total of 247 events were reported to the RQIA from October to December 2006, which is comparable to the number of incidents reported in Quarter 2 (239). Absconding of children accounted for 48 per cent of the notifications received in accordance with the regulations. Fifteen per cent of notifications received related to allegation of serious offence by child. Fourteen per cent of notifications related to serious incidents that necessitating the police being called to the home. Six per cent of notifications reported related to involvement/suspected involvement of a child in sexual exploitation, serious illness/serious accidents sustained by a child and 6 per cent related to child protection enquiries.

In comparison to data collated in Quarter 2, the allegation of serious offences by a child increased and involvement/suspected involvement of a child in sexual exploitation increased. The numbers of notifications related to absconding decreased. There were 43 events reported to the RQIA that did not fully meet the definitions within the regulations. These events included fire, overdose, self-harm, serious assault by child on child and serious assault by child on staff.

Footnote

* The RQIA is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services.

Appendix 8: Children's residential child care in Northern Ireland

Policy and legislation

Introduction

The past 50 years have seen dramatic changes in residential childcare in Northern Ireland. The main developments have included:

- a shift in thinking so that residential care is increasingly seen as an integral part of the child welfare system and the placement of choice for some children
- a move from large institutions to smaller more homely settings
- greater emphasis on support, training and status of staff
- an increased awareness of the diversity of children's needs and consequently the need for a wider range of facilities
- an ever-increasing recognition of children's vulnerability in residential settings
- greater safeguards in terms of staff vetting, inspection and the establishment of complaints and representations procedures. [69]

Legislative and policy developments as well as a wealth of guidance, reports and reviews have attempted to address the needs of children and young people who are living in residential care. Most relevant to this report are the developments that have affected how residential childcare facilities are managed and, more specifically, how this guides the management of challenging and disruptive behaviour within these settings.

The *Children (NI) Order 1995*

The *Children (NI) Order 1995*, which commenced in November 1996, enacted much of the thinking found 16 years earlier in the Black Report. [70] The Order

replicates the 1989 Children Act and is the principal statute governing the care, upbringing and protection of children in Northern Ireland today.
Following the commencement of this Order the statutory bias in favour of fostering was removed and concepts of placements being selected according to their ability to meet the assessed needs of individual children was established as a way forward. Volume 4 of the guidance *Residential care* states that residential care is the best option for some children and underlines the importance of a system of inspection and quality assurance within children's homes. [54] Importantly, this Order also states that every children's home should have a Statement of Purpose and Function.
The 1998 Children (1995 Order) (Amendment) (Children's Services Planning) Order (NI) requires every Health and Social Services Board to prepare and publish a Children's Services Plan for its area.

Children matter

Further developments in Northern Ireland were prompted by a review of residential care, which gave rise to the *Children matter* report. [52] This identified the-then stock of children's homes as outdated and often institutionalised, recommended the development of small domestic homes located within the community and highlighted the need for more specialist facilities. The report stated that there was an insufficient supply of places to enable placement choice and that homes were generally 'general purpose' homes that dealt with a range of needs.
The *Children matter* review set out to change the perception of residential care as a last resort and adopted the view that:

- Residential care is a valuable service in its own right, and should be positively selected as a matter of choice.
- Residential care is an integral part of the range of services available for children.

- What happens in other parts of the child welfare system has a direct impact on the need for residential services.
- A level of residential care is needed that can support fostering, family support and diversion programmes as well as the social and emotional well-being of some children.
- Decisions to use residential care, or to admit to a specific home, should be based exclusively on an assessment of the individual needs of a child.
- The current supply of residential places is insufficient to support the sector's move to a more focused and specialist model of provision.
- Statements of Purpose and Function of homes provide a mechanism that enables them to operate to an explicit agenda, thereby improving the potential for children to experience positive outcomes from their time in residential care.
- Children in residential care today tend to have more complex needs than those placed during the 1960s and 1970s. Their needs have implications for the staffing, structure and management of children's homes.
- The respite and long-term needs of children with a disability are not well assessed.
- A needs-led approach is required to ensure that residential care is a dynamic and flexible service, responsive to changes within the wider welfare system. [52, p 19]

In 2000, the Children Matter Task Force was established. Its purpose was to secure the delivery of the Children Matter agenda and its main aims included an increase in the supply of places, the development of more specialist residential services and the replacement of residential units that are no longer functional. [53]

Implementing Children matter (EHSSB, 1999) was the four Health and Social Services Trusts' response to *Children matter*. [71]Some of the problems identified in the report included a lack of choice to meet children's needs, a rise in serious

untoward incidents in children's homes, an inability to adequately protect children who are absconding and an inability to control violent and aggressive children.

Managing challenging and disruptive situations

The *Children matter* report revealed that there were a total of 1,087 untoward incidents recorded between 31 March and 30 September 1997. [52] These incidents included physical violence, sexual abuse, self-harm, substance abuse, damage to property and absconding. It seems, then, that to ensure the safety and well-being of both staff and residents, guidance on dealing with challenging and disruptive situations is vital.

The *Children (NI) Order 1995* requires all children's homes to have written guidance on methods of care and control, disciplinary and grievance procedures, and methods for dealing with aggression and violence. [51]

Volume 4 of the guidance *Residential care* outlines acceptable intervention measures, such as the removal of privileges or extra chores and unacceptable interventions such as corporal punishment. [54]The guidance covers the principles governing holding, touching and physical restraint and encourages staff to involve children in discussing the implications of behaviour that would demand staff intervention. It clearly states that sanctions should be contemporaneous, relevant and just and a record of sanctions administered must be recorded in a logbook. Staff should be able to show that the method of intervention was in keeping with the incident that gave rise to it and the age and competence of the child should be taken into consideration in deciding what degree of intervention is necessary.

The guidance also points to the importance of vetting staff and providing them with support in meeting the particular demands of residential care through written guidance, supervision, staff meetings and external consultancy.

The Children's Homes Regulations (NI) 2005 offer guidance on behaviour management, discipline and restraint and require children's homes to keep a written record of any method of intervention used. The regulations state that the

following events must be reported to the Regulation and Quality Improvement Authority (RQIA):

- death of a child accommodated in the home
- staff misconduct under POCVA (protection of children and vulnerable adults): alleged abuse or other unprofessional conduct
- serious illness or serious accident sustained by child
- outbreak of infectious diseases: serious in nature
- allegation of serious offences by child
- involvement/suspected involvement of child in sexual exploitation
- serious incident necessitating calling police to home
- absconding by child
- serious complaint about home/employees
- child protection enquiry involving child accommodated
- child protection procedures followed.

Recent developments

On 22 March 2007, Health Minister Paul Goggins launched for consultation a strategy that looks at how young people can be supported to achieve their full potential. *Care matters in Northern Ireland: Building a bridge to a better future* proposes the integration of residential childcare within the wider childcare system and reasserts the need for placement choice within the residential sector to be assessed on the basis of need, rather than a placement of last resort. [56] The strategy also aims to reduce the number of children living in most residential children's homes to a maximum of four children per home and to plan future developments of new or replacement homes on this basis. If this strategy is successful it could be assumed that the reduction in the numbers of children living in residential care homes could be beneficial in terms of managing challenging and disruptive behaviour.

The report also states that the RQIA is to advise the Department of Health, Social Services and Personal Safety (DHSSPS) by March 2009 as to the quality of

residential care in Northern Ireland, adherence to Statements of Purpose, examples of good and innovative practice and areas where improvements need to be made. This combined with the current climate of political change in Northern Ireland will hopefully leave residential care in the advantageous position of being able to promote and implement positive change.

Homes and places: breakdown of children's residential care homes and places in Northern Ireland

Table A6: Number of residential childcare places available in each Board area

(i) Eastern Board area

Management type	Number of homes	Places available
Voluntary	8	65
Statutory	17	112
Total	25	177

Source: EHSSB Registration and Inspection Unit, January 2005

(ii)Western Board area

Management type	Number of homes	Places available
Statutory	12	73
Private	1[1]	7
Total	13	80

Note: [1] Since closed
Source: WHSSB Registration and Inspection Unit, January 2005

(iii) Southern Board area

Management type	Number of homes	Places available
Voluntary	3	11
Statutory	7	45
Total	10	56

Source: SHSSB Registration and Inspection Unit, January 2005

(iv) Northern Board area

Management type	Number of homes	Places available
Voluntary	3	17
Statutory	7	64
Total	10	81

Source: NHSSB Registration and Inspection Unit, January 2005

(v) Total across Northern Ireland

Management type	Number of homes	Places available
Voluntary	14	93
Statutory	43	294
Private	1	7
Total	58	394