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# Implementing therapeutic approaches to residential child care in Northern Ireland: report of interviews with trust staff

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# Implementing therapeutic approaches to residential child care in Northern Ireland

## Report of interviews with trust staff

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# 1 Introduction

Residential child care is an important component of the looked-after children system in Northern Ireland. The 2007 Regional Review of Residential Child Care (RRRCC) proposed a number of options for improving the skill mix of staff within the residential care sector.

One of the proposals was the adoption and promotion of 'therapeutic approaches' to residential child care. The term 'therapeutic' is interpreted differently within different disciplines, and is sometimes interpreted as referring to approaches practised by staff with specific therapeutic qualifications. However, the way in which this term is used in the Northern Ireland context is in relation to training generic residential care staff in particular models of care that, broadly:

- recognise that children in residential care have suffered trauma and disadvantage
- encourage staff to understand and address the needs and emotions underlying challenging behaviour, rather than simply responding to the behaviour
- provide staff and/or children with techniques for being aware of, and regulating, their responses to stressful situations.

This report presents early findings from an evaluation of therapeutic approaches to residential child care in Northern Ireland.

## 1.1 The development of therapeutic approaches

At the time of the RRRCC, health and social care trusts had, in fact, already started working with a particular therapeutic model; some had made significant progress on this, and others were embarking on the first steps.

Perhaps because these were 'ground up' developments, each trust opted for a different model or approach. While recognising the difficulties that might arise as a result of this, the Department of Health, Social Services and Public Safety (DHSSPS) did not wish to impose a model, because (a) this might risk backtracking on what was recognised as good work and (b) there was an opportunity to learn from the experiences across the trusts. The models being implemented in each trust are as follows:

- South Eastern Health and Social Care Trust – Sanctuary model
- Northern Health and Social Care Trust – Children and Residential Experiences (CARE) model
- Belfast Health and Social Care Trust – social pedagogy
- Southern Health and Social Care Trust – Attachment, Self-Regulation and Competency (ARC) model
- Western Health and Social Care Trust – Model of Attachment Practice (MAP).

A brief description of each of these therapeutic approaches is given in Appendix A1.

## 1.2 Evaluation of therapeutic approaches

In April 2010, the Social Care Institute for Excellence (SCIE) commissioned the Institute of Child Care Research to undertake an evaluation of the impact of each of these models. The evaluation was designed to provide information and evidence to inform the regional training and development strategy for residential child care workers in Northern Ireland, focusing on training in therapeutic approaches, with the aim of improving quality of care and outcomes for looked-after children and young people.

When the research was commissioned, the indications were that the Department thought it would be possible to maintain a plurality of local approaches, provided that the approaches showed evidence of being effective. However, it also anticipated that there might be key commonalities between the approaches, which could form the basis of a 'core' regional training programme.

The evaluation therefore aimed to provide:

- descriptive information regarding each of the approaches and the rationale for selecting these
- detailed information regarding how the approaches have been implemented and the resources involved in doing so
- views of various stakeholders (including managers, practitioners and children and young people) on the process, and impact, of implementing each approach
- early indications of whether the approaches are effective, and why
- early indications of whether any approaches are likely to be ineffective, and why
- evidence regarding what organisational/contextual factors facilitate or hinder the successful implementation of the models
- evidence regarding what would be needed to sustain implementation.

In particular, the research sought to explore the following questions.

1 What is the logic model underpinning each approach and what evidence base exists for each?

2 What factors led each trust to choose its particular therapeutic approach?

3 How closely does the implementation of each approach follow the hallmarks of the approach as identified by relevant programme developers or theorists, and what is the rationale for any departures from, or tailoring of, the approach?

4 What is the experience of key stakeholders regarding the acceptability and contribution of each approach, both to changes in practice and perceived impact on children and staff?

5 What organisational/contextual factors facilitate or hinder the successful implementation of each approach?

6 What is needed to sustain and/or improve implementation?

We aimed for the evaluation to be formative as well as summative. The research was conducted with the guidance of the regional Therapeutic Approaches Steering Group, comprising Heads of Service and training leads from each of the trusts. This group shaped the research and questions, and the research team fed back findings as they emerged.

A scoping literature review addressed research question 1. It concluded that, with the exception of CARE, no model provided an explicit 'logic model', although a sympathetic reading of the programme literature indicates an implicit theory of change within each.[1] It also concluded that many of the 'principles' and 'building blocks' of each approach enjoy a coherent rationale and often an established evidence base, albeit not necessarily emerging from, or including, work with children in residential care. There was little evidence available of the effectiveness of any model (see Section 3.1).

The remaining questions were addressed by means of semi-structured interviews with key stakeholders, including policy makers within the DHSSPS and a representative sample of home managers and residential child care staff within each trust.

[1] Macdonald, G. and Millen, S. (2011) *Therapeutic approaches to residential childcare in Northern Ireland: scoping review*, London: Social Care Institute for Excellence.

## 1.3 Respondents

Eighteen home managers and 38 residential child care workers from 18 homes were interviewed. We selected homes that represented a span of training and implementation, including homes where staff had received training and had implemented the model for some time, and homes that had been more recently trained, that is, had not had extensive experience of implementation. The purpose of this was to enable us to capture 'live' issues in implementation, and to map the lessons that had already been learned about the general aim of improving services in residential care by adopting a specific therapeutic approach, as well as those particular to each model.

In each case we interviewed the home manager and two or three residential child care staff. We sought to ensure that the latter were representative in respect of variation in professional/career bands, gender and length of experience. The homes selected included a Secure Unit.

Table 1 provides an overview of the staff members interviewed in each trust. We also interviewed three policy makers within the DHSSPS. Interviews took on average 40 minutes and, when permission was given by respondents (all bar two), were audio-recorded, transcribed and analysed using the QSR NVivo data management programme. Thematic analysis was used to analyse the qualitative data, and interesting features of the data were coded across the existing dataset in a systematic way.

Interviews were carried out between the end of January and the end of June 2011. The research team also had regular meetings with the relevant leads within each trust, at which progress on the study and emerging issues were discussed. This report draws on those discussions in the final chapter.

**Table 1: Distribution of interviews with residential care staff in Northern Ireland**

| Trust | Home managers | Residential care staff | Male | Female |
|---|---|---|---|---|
| South Eastern | 4 | 6 | 4 | 6 |
| Northern | 3 | 7 | 5 | 5 |
| Belfast | 4 | 9 | 2 | 11 |
| Southern | 4 | 8 | 7 | 5 |
| Western | 3 | 8 | 4 | 7 |
| Totals | 18 | 38 | 22 | 34 |

## 1.4 Interview content

The interviews were designed to answer research questions 2 to 6. Home managers and residential care staff were each asked about their understanding of the rationale for the choice of therapeutic approach made within their trust, how it had come about, what alternatives were considered (if any) and what their view was of the model chosen.

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

## 1.5 Structure of the report

The report begins with a summary of key findings from respondents across all five trusts (the Appendices A2 to A6 report in more detail the experiences of staff within each trust). It then considers the experiences of respondents in the light of the scoping review and concludes with a summary of key issues for the future.

# 2 Summary of key findings

In this chapter we provide an overview of the respondents' views, starting with their understanding of the models used in their trust. We then look at their experiences of implementation and the training they received; their perceptions of what helped and hindered implementation; and the impact that the introduction of the models had on their job satisfaction, and their practice. Appendices A2 to A6 provide trust-specific overviews, arranged under similar headings.

## 2.1 Understanding of how the models were selected

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

In all trusts, information days were held during which alternatives were considered. A decision about which model to adopt was subsequently taken by senior management.

In a significant number of cases, models were thought to be chosen because of already existing knowledge and enthusiasm for the approach within a trust.

## 2.2 The process of implementing a therapeutic approach

The initial reaction reported by most staff was one of scepticism and concern about the prospect of yet more change. Initial responses fell into one or more of the following categories:

- apprehension from the majority of residential child care workers about the prospect of unnecessary change to practice and increased workloads
- concerns that the training was going to be similar to other recent training
- a general feeling that the models/approaches basically represented no more than good social work practice and skills that have been conveniently packaged into a single model
- resistance towards a change in practice from longer-serving members.

However, respondents also reported that overall enthusiasm increased as staff learned more about the models and began to see the value in what they had to offer residential child care. In particular it was generally felt that the models provided:

- additional tools to enhance practice
- consistency and congruency within and across homes.

## 2.3 Experience of the training process

Trusts have taken different approaches to training staff in the model. Three of the trusts (South Eastern, Northern and Belfast Health and Social Care Trusts) have made more use of formal training sessions, with at least some sessions delivered by the programme developers. Two trusts (Western and Southern Health and Social Care Trusts) have used a 'consultancy' model, working mainly with clinical psychology staff within the trust

who provide ongoing advice and support, although with some dedicated training sessions as well. The training provided in each trust is summarised in Table 2.

Common themes identified throughout all the trusts regarding the training process were as follows:

- Overall, the initial training received from the programme developers was engaging and interesting and the practical activities were found to be particularly beneficial.
- In general, staff were satisfied with the training, which they felt provided them with sufficient knowledge to begin to implement the various models.
- Band 5 workers found the training particularly beneficial as they felt more equipped to carry out their role and did not feel as inferior to qualified workers as had previously been the case.
- As a whole, staff felt that there was too much information to retain during the training sessions, and were in agreement that further reading was essential in order to successfully implement the models.
- The strategy of cascading training, from external trainers (often the model developer) to 'in-house' champions or trainers, was not regarded as an effective method for training new staff, or providing further training/staff development.

The last point was most forcefully put by respondents from the Northern Health and Social Care Trust (see Appendix A3), but similar views were expressed by respondents in other trusts. The central issue appears to be that it is not easy (some would argue not viable) to substitute a trainer with extensive practice experience in a particular model, with someone who themselves has only had limited training (albeit from the model developer) and experience in implementation.

**Table 2: Overview of training experiences of residential care staff**

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

Other key points highlighted by interviewees about the training process for each of the models included:

**Sanctuary (South Eastern Health and Social Care Trust)**

- The initial training for the Sanctuary model involved everyone who worked within residential child care, from cleaners to senior management. This was considered a significant factor in the successful implementation of the model as everyone was now talking the same language.
- Overall within the South Eastern Health and Social Care Trust the training was said to be well organised, and the home managers appreciated senior management supporting them in freeing up staff to attend training.
- Various components of the model were introduced in stages and so implementation did not feel rushed, which home managers particularly found helpful.

**CARE (Northern Health and Social Care Trust)**

- Initial training for the CARE model was a five-day course, taught by the programme developers. This was mainly attended by senior management, senior practitioners and home managers.
- As with the Sanctuary model, the attendance of senior management at the training gave a clear message to staff about the importance of the model.
- Two staff members from each home within the Northern Health and Social Care Trust were trained as ‘CARE champions’, whose role involved training other staff members.
- All other residential child care workers then attended a five-day training course to learn about the model.

**Social pedagogy (Belfast Health and Social Care Trust)**

- Staff in the Belfast Health and Social Care Trust attended two-day training exercises for four consecutive months, resulting in a total of eight days’ training.
- The vast majority enjoyed the training and favoured this format. It was felt to provide people with the opportunity to digest, discuss and reflect on the information learned with other staff members, and to implement the approach gradually between sessions.
- Staff teams from two homes in particular valued being trained alongside staff from other residential child care homes from within the trust. They said that it allowed individuals to bond with one another and to share common issues and concerns with staff from another home. This was regarded as one of the most positive aspects of the training.

**ARC (Southern Health and Social Care Trust)**

- Training in the Southern Health and Social Care Trust was rather different. A two-day training event was provided by the programme developers, but this was initially aimed at the Intensive Support Unit within the trust. Only three workers from the other homes were able to attend. Attendees thought that the training was informative and interesting.
- This was followed by fortnightly in-house training by the trust's consultant clinical psychologist for looked-after children. This continues to take place.
- As in the Northern Health and Social Care Trust, each home then nominated two members of staff to attend meetings with the consultant clinical psychologist, and with a principal practitioner to receive training to become 'ARC champions', with the aim of training other workers.

**MAP (Western Health and Social Care Trust)**

- Within the Western Health and Social Care Trust, all staff received introductory in-house training on the MAP model from a senior practitioner and a clinical psychologist.
- A training event was also held by an external trainer, with a video of the training available to those unable to attend.
- The clinical psychologist then visited the homes within the trust on a monthly basis to provide further guidance on the model.

## 2.4 Factors that help or hinder implementation of the model

Interviewees were asked about what factors had helped or hindered the implementation of the model. Some issues were common to all trusts and models; others were model/trust specific. These are summarised in Table 3, where '✗' indicates that a problem was identified by respondents and '✓' indicates experience of good practice.

The table summarises the status quo at the time the fieldwork was conducted. In some cases, steps have been taken to address gaps or weakness, for example more concise manuals have now been produced for ARC while a manual is currently being developed for MAP. Others are ongoing.

**Table 3: Challenges in successful implementation of therapeutic approaches**

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

### 2.4.1 Comprehensive training

Unsurprisingly, the extent to which training had been delivered was a key factor in determining implementation. Clearly, where training has not yet been fully rolled out, staff are unable to implement approaches to the same degree. As highlighted in the previous section, progress in delivering training is variable, although all trusts are continuing to make progress with this.

### 2.4.2 Other systems supportive of the therapeutic approach

A number of respondents highlighted the role of other organisational systems and decisions in supporting a therapeutic approach.

As indicated earlier, a placement panel in the Northern Health and Social Care Trust had helped to avoid unplanned admissions and the inevitable problems these caused to an otherwise stable environment. Senior managers were aware that cutbacks were now threatening their ability to manage placements in all trusts, and this was an issue of

considerable concern. At the time of writing, homes are closing, so choices will be fewer, and the pressure on homes to admit children for whom the placement is not appropriate (perhaps because it is a short-term placement pending other arrangements, which can be very disruptive for other residents) will be greater.

Staff also commented that having fewer young people in each home helped/would help implementation of a therapeutic approach, as it allowed residential childcare staff to build relationships more effectively with each young person.

### 2.4.3 Opportunities for reflective practice

There appeared to be a reciprocal relationship between the models and reflective practice. To some extent, the models had encouraged and enabled staff to be more reflective in their practice. However, effective implementation of the model also required opportunities for reflection to be built into individual and team supervision. These opportunities for reflection played a number of roles, including time to 'digest' the new ways of working and incorporate them into practice, and to monitor strengths and weaknesses in implementation and adjust accordingly.

Some staff also commented that effective implementation depended on having greater emotional support available to staff. The models demand high levels of emotional awareness from staff, and require them to reflect on their own lives and experiences, which can lead to staff feeling exposed and vulnerable.

### 2.4.4 Fit with existing culture, language or practice

Those models developed in America, and which are used via a process of franchise, come with a range of practices conceptualised and described in a particular language, which was not felt always to sit comfortably within the Northern Ireland context. In particular, the language of the Sanctuary model sometimes sat uncomfortably with the staff and residents, with the result that it was changed to make it more 'user friendly'. Culturally, we are generally less inclined to be open about thoughts and feelings, and so the expectation of participants in community meetings was more than most young people or staff felt comfortable with. To a somewhat lesser extent, this was also the case with CARE and ARC. The challenges (or the questions) that staff are engaging with are: to what extent can changes be made without threatening the integrity of a model or breaching a franchise, and does it matter?

### 2.4.5 Securing buy-in from key stakeholders

Most of the focus during implementation was on engagement with all those directly involved in residential care, from senior managers through to social work unqualified staff, but the lack of engagement with field workers, and the division of responsibility between field and residential staff, was seen as an issue by respondents across all trusts.

Responsibilities for young people in residential care are shared between parents, field social workers and residential care staff, particularly the key worker and home manager. There was a feeling that this division of responsibility limited the potential of some models because residential care staff were not in a position to make some of the decisions that the models assume lie within their gift. More significantly, perhaps, the

lack of knowledge about the models on the part of fieldwork staff was seen not only to act as a limit to a model's potential, but also potentially as a point of conflict.

Many respondents voiced the view that fieldworkers should be trained in the model used within the trust, as a means of addressing these problems. It is not clear whether this is appropriate. It is possible that this issue could be better addressed by improving communication between residential care staff and fieldworkers. All practice is theoretically driven. The models provide workers with a theory that they can make explicit use of in their work, and arguably the most effective way of working collaboratively with fieldwork colleagues would be for residential care staff to make explicit their assessment of a young person's behaviour, their progress and the goals that have been agreed. Such explicitness also enables theories to be tested in relation to individual young children, that is, are interventions having the desired effect, in line with the analysis or assessments being made? Certainly, the fieldworkers we talked to felt that it would be useful for them to know about the model, but not appropriate to be trained in it.

### 2.4.6 Institutional aversiveness to risk

Modern-day institutions are predominantly risk averse, and social care organisations are no exception. This can make the introduction of new ways of working particularly difficult, as appears to be the case with Social Pedagogy, with its emphasis on encouraging young people to take considered risks as part and parcel of the model, which emphasises resilience and coping.

While most explicitly mentioned by those working with this model (Belfast Health and Social Care Trust), similar concerns were evident among those working with other models. In so far as therapeutic approaches emphasise attachment, resilience and competence, this will remain an important challenge for management, if the potential of therapeutic approaches is to be realised. Allowing children to learn by doing is part and parcel of human development and is, after all, what parents, including corporate parents, do – or should do. Risk-averse environments that do not do this, result in young people leaving care without a range of essential life skills.

## 2.5 Benefits for professional practice

On the whole, it was evident that the implementation of the various models had had a positive influence on practice. A number of common themes were identified across trusts (see Table 4).

### 2.5.1 Improvements in practice culture

Staff generally believed that the introduction of a therapeutic model had improved the overall practice culture within the home. Respondents talked about a shift in perspective from managing behaviour (which often meant containing behaviour) to a focus on trying to understand children in terms of both what they had been through and why they might be behaving in a particular way at a certain point in time. Incidents became less 'personal' for staff who, after training in a therapeutic approach, were more likely to see difficult or self-defeating behaviour as an opportunity to work with the child towards better self-awareness and self-management.

This shift in thinking went hand in hand with what staff saw as a very significant shift away from the use of sanctions as a means of managing difficult behaviour. This was commented on by respondents in all trusts, who attributed this change directly to the ethos of using a therapeutic approach, and the knowledge and skills gained through training in the particular model they were using, which provided them with alternative strategies.

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

The introduction of the models had also had a levelling effect (or a confidence-boosting effect): Band 5 staff felt the model had provided them with a clearer sense of purpose, such that they now considered themselves more as equals to qualified social workers.

Finally, the models appear to have shifted perceptions of families, and there was felt to be a greater emphasis on increased contact between young people and their families.

**Table 4: Changes to practice emphasised by staff using different therapeutic models**

| Changes in practice | Sanctuary (South Eastern) | CARE (Northern) | Social pedagogy (Belfast) | ARC (Southern) | MAP (Western) |
|---|---|---|---|---|---|
| Ability to reflect on and 'step back' from challenging situations | ✓ | ✓ | ✓ | ✓ | ✓ |
| Ability to understand a young person's behaviour and interpret 'pain-based' behaviour | ✓ | ✓ | | ✓ | ✓ |
| Ability to tailor responses to a young person's stage of development | ✓ | | | ✓ | |
| A reduction in aggressive incidents | ✓ | ✓ | ✓ | ✓ | ✓ |
| More relaxed/calm/informal relationships with young people | ✓ | ✓ | ✓ | ✓ | ✓ |
| Better use of supervision | ✓ | ✓ | | ✓ | |
| Increased contact with families | | ✓ | | | ✓ |

### 2.5.2 A better understanding of young people

Staff talked about developing a different mindset about the behaviour and needs of young people, particularly challenging behaviour. In particular, staff consistently said that they felt better equipped to understand the behaviour of a young person and reasons behind it, instead of interpreting the behaviour as a personal attack specifically directed at them.

The staff within the Western Health and Social Care Trust found it extremely useful to apply their knowledge of attachment to build up an understanding of what stage of their life a young person is at. The purpose of this was to try to explain a young person's behaviour. Elsewhere, staff reported that they had found it helpful to understand children's developmental levels (which were sometimes significantly behind their chronological age) and to tailor expectations and activities accordingly.

### 2.5.3 Improvements in managing challenging situations

Respondents commented on the fact that the introduction of the models had improved consistency in the practice of both individuals and staff teams. They felt the models resulted in staff feeling better equipped to deal with stressful situations; they said there was now less emphasis on handing out sanctions and more emphasis on negotiating with the young person, with very positive effects overall. Staff said they better understood the importance (and consequences) of modelling good social conduct as a means of effective change in young people's behaviour and relationships.

The integration of the language of the models into written reports and logs further enhanced the consistency of practice within teams. The respondents observed that the implementation of the models had resulted in a number of improvements in practice.

### 2.5.4 Reflective practice

To varying extents, each of the models emphasises the importance of staff understanding how their work impacts on them, and vice versa. Staff recognised the contribution this made to improvements in their practice. They particularly talked about becoming more able to reflect on their own emotions and their views of others, and how these impacted on their practice. They felt that this helped them to make more considered, constructive and consistent responses.

### 2.5.5 Challenges to staff

As well as the benefits to practice, the models resulted in some challenges. A number of respondents commented that the change from sanctions to natural consequences resulted in some workers feeling disempowered, as they had to surrender some of their authority. This reinforces the importance of leadership and effecting culture change within homes.

## 2.6 Perceived impact on children and young people

In general it was felt that the models had not yet been implemented long enough to have had any significant impact on children and their outcomes. Nonetheless, in each trust, staff were able to think of individual young people for whom they believed the model had had a positive impact. Respondents also reported that, in their view, relationships between staff and young people were better (respondents often referred to

things being 'more relaxed') as a result of the new ways of practice. They felt that there was a significant reduction in the number of recorded incidents since the implementation of the models.

Within the South Eastern Health and Social Care Trust in particular it was felt that the psycho-education programme[2] was having a positive impact on young people, as it was enabling them to develop insight into the origins of their problems, as a result of which staff believed that they were taking much more responsibility for their own care.

## 2.7 Perceived limitations

Despite considerable enthusiasm for the models, staff were overall of the opinion that no one model could accommodate the entire range of behaviours or situations that they faced in their day-to-day practice. Some felt that particular models were not suited to some groups of young people with particular difficulties.

### 'Necessary but not sufficient'

Staff felt that their model (whatever it was) did not provide them with sufficient tools to deal with physically aggressive behaviour, and that the model was more difficult to implement in short-term units, as staff did not have sufficient time to work with the young people. All of the homes were still practising either restorative practice or therapeutic crisis intervention, or both, alongside their chosen models. Respondents felt that by using the best aspects of each in their practice, it equipped them with the best tools to deal with any given situation. Almost all respondents felt that these approaches complemented their chosen models to some degree. Some staff described the models as having similar aims, such as attempting to de-escalate potential outbursts and learning constructive ways to handle situations, while encouraging the young person to become more involved with decision making and attempts to resolve their own situations.

### Applicable for some, or all?

Almost all those interviewed within the Northern Health and Social Care Trust reported particular concerns that the CARE model was not suitable to implement with young people suffering from behavioural or learning difficulties such as autistic spectrum disorders or attention deficit hyperactivity disorder. Some staff members considered that these young people would benefit more from a behavioural intervention. A large number of workers thought that CARE was more suitable for a younger age group, as they are often more open in general to forming relationships with staff; however, one staff member from the Western Health and Social Care Trust found MAP to be more successful with young people aged 15 years or over than those of a younger age.

[2] Psycho-education is a group-taught curriculum, which focuses on the SELF framework (Safety, Emotions, Loss and Future), the purpose of which is to address the fundamental problems surrounding exposure to violence without needing to focus on specific individual events.

A small number of people from the Belfast Health and Social Care Trust reported having a similar issue in that they could not apply the same social pedagogic strategies to all age groups. They had to identify age-appropriate techniques in order for the implementation of the approach to be successful.

We now turn to a consideration of how the experience of staff in Northern Ireland compared to experience elsewhere, as reported in the literature.

# 3 Headline comparisons with the literature review

In this chapter we discuss the extent to which the experiences of staff in Northern Ireland mirror, or differ from, the experiences of staff in other settings where the implementation of each of the models has been studied.

## 3.1 Summary of the evidence from research

While all of the models are based on sound theoretical principles, there is little research investigating their effectiveness in Northern Ireland. There are, at present, no Northern Irish studies that provide sound evidence that any or all of the models (as opposed to, say, recognition, investment and training more generally) bring about substantive changes in staff knowledge or behaviour, or – more importantly – changes in outcomes for children and young people. The lack of an evidence base for the models does not mean that they are *in*effective, but does highlight the importance of adding to the evidence base for these approaches.

The evidence base from studies conducted elsewhere tends to be weak with regard to evidence on effectiveness. Rivard et al (2005) reported an evaluation of the implementation of the Sanctuary model, which included measures of behaviour change at three and six months, in both staff and young people. The study was small and used multiple measures of youth behaviour, reporting changes on just a few subscales of these.

Holden et al (2010) reported the results of a before-and-after survey of staff who had been trained in CARE, which demonstrated changes in staff knowledge, their reactions to the training and their stated intentions to use what had been learned.

A study of social pedagogy is under way in England, and there are some descriptive and comparative data from inter-country comparisons, covering issues such as education, training, job descriptions, recruitment and retention (see Cameron et al, 2010).

With the exception of CARE and the Sanctuary model, there are no opportunities for comparison between the experiences of those interviewed as part of this study and staff who participated in other studies. However, we are able to examine how the experience and perceptions of respondents in this study reflect the characteristics of the models as described in the literature, and the extent to which their experiences of implementation are similar to reports from other studies of the implementation of CARE and Sanctuary, as examples of therapeutic approaches to residential child care.

We begin with the extent to which respondents' views of the key concepts of the models reflected those evident in the wider literature.

## 3.2 Theoretical and philosophical 'fit'

Table 5 is taken from the literature review, and summarises the commonalities across the models in respect of four key concepts: 'attachment', 'trauma', 'competence' and 'development as a bio-psychosocial phenomenon'.

**Table 5: Underpinning concepts**

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

These key concepts were reflected in responses to the interviews. Throughout, it was evident that both attachment and trauma theories informed practice for all those implementing Sanctuary, ARC, CARE and MAP. However, a focus on trauma theory was particularly evident in the implementation of Sanctuary, ARC, CARE and MAP, as was the use of attachment theory.

Developing the competencies of young people was central to the social pedagogy approach, but was also evident in the other models, with staff talking about the importance of engaging in activities with young people, to identify skills and provide them with experiences that they could learn from. The focus on neurodevelopmental/bio-psychosocial factors was most prominent in Sanctuary, social pedagogy, CARE and MAP.

## 3.3 Significant dimensions of each model

Table 6 provides a summary of the most significant areas of common ground between the models in regard to providing a nurturing environment, building attachments (even if this is not a major conceptual feature) and helping young people to develop competence in a range of areas, including the practical, social and emotional.

**Table 6: Key model components**

| | Sanctuary | Social pedagogy | ARC | CARE | MAP |
|---|---|---|---|---|---|
| Creating a nurturing culture | ✓ | ✓ | ✓ | ✓ | ✓ |
| Building attachments | ✓ | ✓ | ✓ | ✓ | ✓ |
| Building competencies | ✓ | ✓ | ✓ | ✓ | ✓ |
| Building resilience | | ✓ | ✓ | ✓ | |

All models make reference to the notion of competency, a common problem area for children in care. Within the literature, the aim of building competency in *executive functions* and *social skills* is a key similarity between the ARC and CARE models, although more generally the importance of helping children to develop a range of competencies is recognised (more or less explicitly) in each of the models. Descriptions of all models include the importance of promoting resilience, although Sanctuary and

MAP talk primarily of the things that contribute towards resilience, such as 'self-efficacy' or coping skills.

Respondents talked about the role played by training in concepts and principles as a key factor in the implementation of all the models, alongside regular team meetings.

## 3.4 Changes in staff behaviour

Table 7 is taken from the literature review, and shows themes in the literature about the expected impact of the models on staff behaviour and practice.

**Table 7: Staff behavioural change**

| | Sanctuary | Social pedagogy | ARC | CARE | MAP |
|---|---|---|---|---|---|
| Staff training in concepts and principles | ✓ | ✓ | ✓ | ✓ | ✓ |
| Regular team meetings | ✓ | | ✓ | ✓ | ✓ |
| Non-confrontational approach | ✓ | ✓ | ✓ | ✓ | ✓ |
| Modelling of strategies and skills | ✓ | ✓ | ✓ | ✓ | ✓ |
| Family involvement | ✓ | | | ✓ | ✓ |

The reality of implementation did not exactly match the expectations set out in the literature: in some cases implementation exceeded the theoretical underpinnings, and elsewhere was somewhat behind.

***Training:*** Training was valued by all respondents, and appeared to be of a satisfactory standard for CARE, Sanctuary and social pedagogy. As MAP is still being developed, staff were finding it difficult to implement the model, particularly in the absence of a written manual. Some staff from the Southern Health and Social Care Trust felt that they had not yet received sufficient training to enable them to successfully implement the ARC model. A shortage of manuals was reported in some homes within the trust, making it more difficult for staff to learn about the model.

***Regular team meetings:*** Two models make explicit mention of the use of team meetings to support the approach. In contracts, staff throughout *all* trusts emphasised the importance of team meetings, for reasons such as discussing queries regarding the model, examining case scenarios using the model and developing a better understanding of the associated language of the model.

***Non-confrontational approach and family involvement:*** The need to develop non-confrontational approaches to challenging situations was emphasised by staff throughout all trusts, while an emphasis on family involvement was particularly evident in CARE and MAP.

***Modelling of strategies and skills:*** Modelling of strategies and skills was considered important in all of the models.

In interviews, respondents in all trusts identified the importance of creating a nurturing environment and culture within the home, and building strong attachments between staff and young people, as key aims of all the models. Resilience building was most evident in social pedagogy, as staff spoke of encouraging independence.

The literature review also identified a clear overlap between 'staff behaviours' and aspects of each model, for example family involvement. Implicitly, each model recognises the importance of non-confrontational approaches to problem resolution, and we know that all models provide training in concepts and principles, but not all models make explicit reference to these. For staff, the models made a major contribution to this area of practice.

From the findings it was evident that staff found the introduction of the Sanctuary model to be particularly well organised and this timetabled approach was described by home managers as facilitating the implementation of the model.

## 3.5 Experience of implementing the models

Holden et al (2010) suggest that the CARE model is a thoughtful and useful tool for use in children's residential care. The findings from interviews with respondents in this study echo this finding. Staff within the Northern Health and Social Care Trust frequently commented that CARE provided a good framework for practice and ways in which to achieve good therapeutic outcomes.

Holden et al highlight leadership and 'active work groups' as being particularly significant in securing 'buy-in' from staff throughout the agencies. Leadership support and engagement were identified as key facilitators in the integration of CARE principles into day-to-day work, to an extent that even in agencies whose staff had not yet received training, many of the principles were already successfully incorporated as a result of leaders modelling the required practices (Holden et al, 2010). Active work groups were groups of staff who were responsible for making decisions regarding staff training and organisational change, and were considered by the implementation team as playing an essential role in providing continuity throughout the implementation process.

## 3.6 Experience of the training process for the Sanctuary model

In her description of the implementation process of Sanctuary at the Community Residential Rehabilitation group in the United States (Bloom *et al.* 2003), Kelly Nice-Martini described the 'light bulb' moment of realising that perhaps children failed to comply with requests because they did not know how, rather than simply out of defiance. This realisation brought about changes in how staff spent their time (for example not fighting for 'control'), their attempts to understand, rather than control, children's behaviour, and how – as a team – to bring about changes. This realisation of a more effective approach to practice was evident throughout interviews with staff, and is captured particularly well by one home manager within the Northern Health and Social Care Trust (see Appendix A3, Section A3.6, Example 2).

Nice-Martini also described how the training for Sanctuary had a positive impact on staff, enabling them to demonstrate more patience and form stronger bonds with the young people.

Interviews with staff provide evidence that similar changes were being effected among residential care staff, as the vast majority of both home managers and residential workers found the Sanctuary training, and that of other models, interesting and beneficial for practice.

## 3.7 Winning 'hearts and minds'

In Bloom *et al.* (2003), Farragher described the lessons learned through the process of implementing Sanctuary at the Julia Dyckman Andrus Memorial Children's Centre in Yonkers, New York (known as 'Andrus'). As with the introduction of CARE, a core team was formed to facilitate the implementation of Sanctuary. The process evaluation confirmed the importance of modelling the type of behaviour that staff were required to demonstrate through their practice. Farragher reported this to be a struggle at times, and that patience was required:

> 'Early on I had to resist the impulse to throttle everyone for their passivity. Doing so would not have advanced the group process but would have only served to confirm their belief that as a leader, I was a scary guy.' (Farragher, cited in Bloom, 2003, p 179[3])

In order to comply with the expectations of Sanctuary, Farragher had to wait patiently for staff to 'buy in' to the model instead of trying to 'force' them to get involved. This account highlights the challenges of bringing about organisational change, particularly when culture is entrenched and staff have acquired an attitude of learned helplessness not dissimilar to the children within the residential settings.

Again, similar findings emerged from this study. Of particular relevance, the involvement of staff as much as possible in decision-making processes and in discussions regarding the models was found to promote understanding of the models, secure buy-in of workers and, as a result, improve consistency and congruency of practice within and across homes.

[3] Bloom, S.L. (2003) 'The Sanctuary model: a trauma-informed systems approach to the residential treatment of children', *Residential Group Care Quarterly*, vol 4, no 2, pp 3–5.

Similarly, when describing the introduction of the Sanctuary model, Nice-Martini noted that staff required self-discipline in order constantly to reflect on the behaviours and values they were modelling to young people. This was particularly problematic in the context of high staff turnover.

> 'It seems that just as we succeed in achieving a critical mass of experienced staff and things are going smoothly, a key staff member or several key staff—leave again. This is continually problematic, particularly since we now realize how vital it is for us all to be consistently on the same page.' (Nice-Martini, cited in Bloom, 2003, p 186)

The issue of staff turnover was also identified by staff in this study, particularly in relation to staff training and the need for formal induction days to train new staff on the therapeutic approaches.

## 3.8 Job satisfaction and improved practice of individuals and teams

McCorkle and Yanosy's (2007) account of the introduction of Sanctuary into Hawthorne-Cedar Knolls, which comprises three residential programmes for children and adolescents in Westchester County, New York, outlines how Sanctuary helped staff to refocus on their moral purpose through regular, open and honest group discussions about improving children's outcomes. They found these group discussions to be particularly beneficial for individuals and teams as well as practice. Again, the benefits of group discussion were commonly reported by staff in the present study. These group discussions were seen as serving several purposes: they provided staff with an opportunity to discuss issues relating to the therapeutic models, and to further their learning; and they also helped to maintain the approach by keeping it alive through group discussion.

# 4 Conclusions and next steps

There is a dearth of independent research that critically examines the impact of introducing a therapeutic model into a residential child care setting. Most of the literature on the topic has been written by programme developers and those who have sought to implement the model in close collaboration with them.

While the present study is making an important contribution to our understanding of the challenges of implementing therapeutic models in children's homes in Northern Ireland, there continues to be a need for robust research on the impacts of these changes on outcomes for children. In this concluding chapter we highlight some key messages for the future roll-out and sustainability of the models within the sector.

## 4.1 Impact on practice

Overall, the evidence from participants is that all of the models have enhanced practice in some significant ways, notably in terms of bringing about positive culture change within homes, improving staff morale and confidence, and effecting changes in the way that staff view and respond to the children in their care, and in particular to challenging behaviour. Staff reported increases in job satisfaction.

By refocusing their work onto the emotional wellbeing of children and young people, the models reminded staff of their original reasons for working in residential care, often in very challenging organisational contexts, namely to help young people who have had very troubled lives.

Most respondents attributed these benefits to a mixture of the model itself and the training they had received, which had resulted in a shared approach within homes and, in some cases, across the trust. Respondents also recognised that other approaches, including therapeutic crisis intervention and restorative practice, complemented the model as did procedures such as placement panels.

## 4.2 Training

Trusts were at different stages of the roll-out of their particular model at the time of the interviews, but even allowing for that, it was clear that providing adequate training to all staff was key to successful implementation. Things went wrong when not all staff were trained, either because of staff turnover or because they had not been released for training alongside their colleagues.

In some trusts (for example the Southern Health and Social Care Trust) the 'roll-out' of the training has been slower than anticipated, with most staff having had limited exposure to it, if any exposure at all. This has significant implications for any benefits arising from use of the model: it is unlikely that something as complex as a change in professional and organisational practice can succeed if not adequately supported in terms of training, as well as by more routine support mechanisms, such as supervision and team consultations.

All respondents emphasised the importance of ongoing training and support: training should not be thought of as a 'one-off immunising dose'. Periodic updates provide an opportunity for staff to stay up to date, to augment their learning and discuss it in

relation to contextualised practice examples – something that respondents thought was essential, alongside the use of practical exercises. Bringing together staff from different units was seen as helpful in providing an opportunity to share experiences and learn from one another.

Staff turnover is a threat to implementation. As with any form of good practice, a home in which practice is not consistent is unlikely to be one where the benefits of any model can be reaped, and may contribute to problems for both staff and young people. Managers therefore need to ensure that all staff are trained in the therapeutic model being used. Those respondents with experience of 'whole team' training (which included managers and staff in support roles) regarded this as particularly helpful in effecting improvements in practice, perhaps because of the dual role it played in helping with team building.

Staff emphasised the importance of having sufficient time for training, whether initial or ongoing. Provision for initial training and periodic refresher courses is a considerable long-term commitment, which requires ring-fenced budgeting at the appropriate level. Further, training by internal trainers was seen to be less effective than that provided by 'outside experts'. The latter were often responsible for the development of the models, or had particular clinical expertise.

Clearly, any approach that relies on the availability of such experts will, in the longer term, be more difficult to sustain. It is important that any individuals from within the trust taking on this responsibility are both knowledgeable and confident (and probably passionate) in what they are doing. Respondents felt that this was not always the case, and that the cascading of responsibility downwards through the organisation was possibly premature, and/or that these individuals did not themselves have the support they felt they needed.

## 4.3 Other factors that helped or hindered implementation

Getting sufficient training of sufficient quality for all staff was one of a number of issues that staff identified as helping or hindering the implementation of the therapeutic model used in their home. Other factors included:

- The extent to which other organisational factors supported a therapeutic way of working, including the way in which young people are admitted to homes, the numbers of young people in each home and staff turnover. There was a sense that it was more difficult to work therapeutically in homes that were chaotic in other ways, for example with high numbers of unplanned admissions.
- Whether staff were given opportunities and support to reflect on their practice.
- The fit of the model with existing culture, language and practice within the home. Some models had unfamiliar terminology or practices that sometimes made them more difficult to implement. There was also a tension between the fact that some models encourage young people to have greater independence and ability to take risks and the perceived 'risk-averse' culture that exists in the homes.

## 4.4 The wider organisational context

These therapeutic approaches were introduced alongside other organisational changes and initiatives. This is inevitably the case in complex organisations like Health and Social Care Trusts. These changes, and other features of the organisational structures in which staff operate, necessarily impact on the ways in which models are introduced and implemented. We have already referred to the impact of fiscal constraints on staffing, and the knock-on effect on staff training and support; and the adverse impact of risk-averse environments. Other issues include the nature of residential child care within Northern Ireland, the division of responsibilities across staff involved with looked-after young people and the characteristics of young people in residential care in Northern Ireland, compared with other settings in which the models have been rolled out.

Another suggestion under consideration is whether foster carers should be trained in these models. While this is understandable, it perhaps deserves some scrutiny. Foster carers do need support and training in order for them to care for some very troubled children and young people, who can present a range of challenges in many areas of their lives. Some of that training certainly needs to include an understanding of key concepts that contribute to many of these models, such as attachment, the impact of trauma and so on. However, whether they need to be trained in a 'model' *per se* is contestable. Residential care settings present particular challenges in providing caring and nurturing environments. Arguably, foster care should find this less challenging, in that the experience on offer there is one of substitute parenting, albeit of a professional nature. The costs of training residential care staff in these models is high, and it may well be that the 'active ingredients' needed for effective foster care are a subset of those needed within residential care settings.

## 4.5 Not for everyone?

While there is great enthusiasm among staff for a therapeutic approach to their work, there was general agreement that there are some children and young people for whom the approaches are either not appropriate or, where appropriate, not sufficient. Social pedagogy, because it is more accurately described as a discipline, rather than a model, easily accommodates within it a range of skills and other approaches. Models such as CARE and Sanctuary were originally thought to provide models that were sufficient to inform residential care practice, but staff now recognise the need to incorporate other practice approaches, such as therapeutic crisis intervention (rolled out across Northern Ireland) to manage particularly challenging situations. This is probably uncontroversial. What needs careful consideration is whether staff concerns about the relevance or applicability of these models to certain children, such as those with intellectual impairment or attention deficit hyperactivity disorder, are appropriate.

## 4.6 Next steps

The implementation and refinement of the models are ongoing tasks, and it is hoped that the information provided in this evaluation will help to continue to shape and improve the approaches.

### 4.6.1 Strategies for maintenance and development of the models

A number of strategies were suggested to help maintain and further develop the models. Those most commonly suggested were as follows:

- Refresher training days for the models were suggested in order to sustain implementation in the long term. There were various suggestions as to how regularly these should be held, ranging from once a month to twice a year.
- Induction courses for new members of staff in order to fully train them were deemed necessary.
- Time allocated on the rota to review the model's manual and read other literature relating to the model was considered to be crucial.
- It was suggested that funding for further training should be ring-fenced, as training was vitally important to keeping the models alive in everyday practice.
- The importance of maintaining interest and enthusiasm of all staff in practising the models was stressed throughout the trusts.
- The incorporation of the language of the models into written reports was deemed vitally important in maintaining the models.
- Ensuring that staff are supported in finding time to reflect on their practice was felt to be extremely important in maintaining their enthusiasm and in sustaining the implementation of the models.
- Strong relationships between with the young people and workers were thought to be essential in sustaining the models.
- It was felt that money should be made available for staff to take young people out on fun trips in order to facilitate the bonding process between the young people and their respective key workers.
- Small units were considered to be beneficial.

There was a strong desire for regular in-house training and guidance from outside the home regarding the models as this would greatly help staff to refocus and ask any questions they had relating to their practice. Other strategies to help maintain and develop specific models included the following:

- *Sanctuary:* It was suggested that it would be useful to devise a resource pack containing CDs and DVDs for the psycho-education programme, and also outreach programmes to help stay in contact with, and offer support to, young people who have recently left care in order to enable them to continue with relationships they had formed during their stay in a home.
- *CARE:* Attempts to involve parents in various social activities within the home, to build relationships with staff and young people, were considered a key component of the model. Some home managers within the Northern Health and Social Care Trust felt that, in order to successfully implement the model

and sustain it long term, it was essential to practise the CARE principles within their own staff team.

- *Social pedagogy:* It was suggested that training days for therapeutic crisis intervention, restorative practice, attachment, resilience and Social Pedagogy should be held together as one training event, based on the principles of social pedagogy. It was felt that there were many similarities between the approaches. A few staff thought that a DVD outlining the theories and practices of the social pedagogy approach would be useful, both to remind themselves of the various aspects of the approach and to increase their knowledge base.
- *ARC:* Other suggested resources included more manuals and other literature to read relating to ARC.
- *MAP:* It was suggested that more research into the model would be useful, with the aim of creating a pack that people could pick up, which would illustrate how to relate to young people in certain situations and give practical examples of this.

### 4.6.2 Desired long-term changes through implementation of the models

Respondents were asked about how they hoped the models would develop in the future. Themes identified throughout the trusts included:

- all staff in each trust practising the model consistently, with each staff member working from the same knowledge base
- the models being rolled out to other workers within the trust, such as field workers, and to staff within the education system
- the appropriate placement of young people within homes so that the therapeutic environment is not disrupted for other young residents due to an inappropriately placed young person
- improvements in the quality of contact and better communication between workers and young people
- young people becoming more responsible for themselves and for decisions concerning their wellbeing
- more emphasis on improving relationships with parents as well as with the young people
- the models being expanded upon in order to facilitate all potential situations within residential child care
- the successfully integration of young people into the community, equipped with all of the skills required to live a stable and healthy life and to be able to communicate and solve problems for themselves.

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# Appendices

## A1 The models at a glance

### A1.1 Overview

The models being implemented in each trust are as follows:

- South Eastern Health and Social Care Trust – Sanctuary model
- Northern Health and Social Care Trust – Children and Residential Experiences (CARE) model
- Belfast Health and Social Care Trust – social pedagogy
- Southern Health and Social Care Trust – Attachment, Regulation and Competency (ARC) model
- Western Health and Social Care Trust – Model of Attachment Practice.

### A1.2 Sanctuary model

***Origins:*** The Sanctuary model was developed in the United States. The principal architect describes it as a whole-system approach to creating a system that can effectively meet the needs of traumatised children.

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

***Theory of change:*** The Sanctuary model is complex, with no explicit 'theory of change' or 'logic model'. The implicit theory of change appears to be as follows: by bringing staff to a shared understanding of trauma and its effects, and providing them with a language with which to communicate that understanding, staff can bring about the changes in organisational behaviours, structures and processes needed to address the detrimental effects of trauma.

### A1.3 Children and Residential Experiences (CARE) model

***Origins:*** CARE originated in 2005 in the United States. It aimed to develop a competency-based curriculum to help residential care staff establish practices that would improve outcomes for children.

***Core components:*** CARE focuses on two core areas of competence. One is organisational and focuses on improving leadership and organisational support for change. The second focuses on enhancing consistency within and across team members in how they think about, and respond to, the needs of the children in their care.

***Theory of change:*** CARE hypothesises that by improving their understanding of trauma and its impact on development, staff will be able to enhance interactions with children by:

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

Enhancing staff child interactions is thought to help children develop more positive perceptions about themselves and their relationships and interactions with staff. This, in turn, contributes to improvements in children's social and emotional wellbeing.

### A1.4 Social pedagogy

***Origins:*** Social pedagogy has a long history as a recognised discipline in Europe. It aims to promote children's social functioning, social identity and social competence, and their social inclusion. In June 2007, the Department for Education and Skills (England and Wales) proposed the piloting of social pedagogy with a view to exploring its effectiveness.

***Core components:*** It is difficult to identify 'core components' *per se*, as the main features of social pedagogy are based more on values than empirical data, and reflect different approaches to children and different cultural histories of social interventions. However, the relationship between child and pedagogue is important and good communication essential. This relationship is viewed more collaboratively or democratically than the hierarchical approach usually found in children's homes. So-called 'ordinary tasks or events' provide opportunities to foster development, and social pedagogy blurs the dividing line between the personal and the professional, while also recognising the private.

### A1.5 ARC (Attachment, Self-Regulation and Competency)

***Origins:*** The ARC framework was developed at the Trauma Centre at Justice Resource Institute in Brooklyn, MA. It was first introduced in Northern Ireland into one of the Intensive Support Units, and since that time has been rolled out to other homes.

***Core components:*** ARC is described as a flexible framework that enables practitioners to choose from a 'menu' of sample activities and interventions. These are organised around one of three domains: attachment, self-regulation and competency. Traumatised children are helped to (re)build healthy attachments by helping carers to:

- tune into children and better understand their behaviour and emotional responses
- manage their own affect
- provide a consistent response to children's behaviour and establish routines and rituals that promote a sense of safety.

***Theory of change:*** There is no explicit theory of change within ARC. Implicitly, it appears to hypothesise that outcomes can be improved by (a) providing staff with a

theoretical framework for thinking about child development and how things 'go wrong', (b) targeting those factors thought to derail normal development and (c) working with children, their families and carers to help remedy deficits.

### A1.6 Model of Attachment Practice (MAP)

***Origins:*** MAP is under development within the Western Health and Social Care Trust. The trust is drawing on a range of sources, including work within foster care and residential care. A Canadian project for conduct-disordered youth and their families at the Maples Adolescent Treatment Centre in Canada has been particularly influential.

***Core components:*** MAP draws on attachment theory and research on neurodevelopment to help staff to understand children's behaviour and what it means. It encourages staff to consider themselves as 'actors' rather than 'observers' and to recognise the implications of the emotional demands placed on them in their work with children. Other core components are the importance of authoritative parenting and attunement.

***Theory of change:*** MAP's implicit theory of change is that by enabling staff to view children's behaviour through the conceptual lens of attachment theory, they can better understand the meaning and causes behind behaviour. The resulting changes in their attitudes to children and young people will enable them to form better relationships, which in turn will enable them to help children and young people learn more adaptive and prosocial ways of relating and behaving.

## A2 Sanctuary model – South Eastern Health and Social Care Trust

### A2.1 Understanding of how the model was selected

Within the South Eastern Health and Social Care Trust, three home managers and six residential child care workers were interviewed. As a whole, workers were unsure of the exact details of how Sanctuary was chosen to be implemented within the trust. However, a small number of staff reported that the head of Lakewood Secure Unit attended a conference in the United States at which Sandra Bloom – the Sanctuary programme developer – was speaking. After some discussion and consideration of other therapeutic models by service managers, it was felt that the Sanctuary model would be an appropriate choice to implement within the Lakewood centre in particular. Subsequently, when trusts were asked to formally choose a model to pilot, Sanctuary was chosen by the South Eastern Health and Social Care Trust as it was already being implemented at Lakewood, and was considered most suitable to meet the needs of young people in residential child care within the trust.

### A2.2 Experience of implementing a therapeutic approach

Initial reactions to the introduction of the Sanctuary model varied considerably between groups of staff in terms of grade/experience. The majority of home managers said that they were positive from the outset, but residential child care workers were more likely to say that they were initially apprehensive about the model.

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

These preliminary apprehensions among residential care staff appeared to result from being less involved in the information-gathering and decision-making stages of the process. Some support staff initially resisted getting involved as they did not think that they needed to, but they were reassured by home managers that it was essential for *everyone* to take part in order successfully to create a therapeutic community within the residential setting.

Once they started to implement the model for themselves – using the language and understanding the model in practical terms – staff reported that it had empowered them in their role as residential child care workers.

### A2.3 Experience of the training process for the Sanctuary model

Training for the Sanctuary model was phased in, and included everyone who worked within residential child care – from cleaners and cooks up to those holding senior management posts. This non-hierarchical approach appeared to be a significant selling point – especially for home managers. Many of those interviewed said that it had indeed broken down barriers right across the bureaucratic hierarchy. In general, the initial training received from the programme developers was found to be very useful.

> 'The trainers were excellent, they made people get involved in it ... you couldn't say "I'm opting out of this", like at the community meeting[4], …. You had to participate. So in their own way they were teaching us in that first training: look you need to participate in this, otherwise it's not going to work.' (HoH 5)

Home managers felt that, overall, the introduction of the model within the trust had been particularly well organised, which had greatly facilitated further training and implementation of the model within homes. All staff members were able to attend the training, and this was deemed another significant factor in the model's successful implementation.

In general, the residential child care workers found the training interesting, although they felt that there was a lot of information to take on board during the training sessions. Most felt that, following the initial training, further reading was necessary in order fully to understand the model.

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[4] Community meetings provide an open forum for discussion of emotions and feelings. They take place daily and are attended by staff and young people.

> 'It was an awful lot to take on board at the beginning. … [W]e introduced it slowly and they did have a timescale for introducing community meetings and then safety plans[5] and things like that there and it was step by step. It wasn't rushed and it was done properly so it was.... Sometimes we went after we came off shift and that was the difficult part....' (Registered child care worker [RCCW] 7)

Quite a number of home managers felt that it was essential to maximise the use of existing skills from within their staff team. One home manager spoke of how they thought that it was much more beneficial and efficient to allow staff to receive training and then for them to practise their skills (such as complementary massage therapy) with the young people themselves, instead of bringing people in from outside the unit to provide this. They thought that the fact that staff had already formed relationships with the young people meant that the young people were likely to benefit more from the treatment.

### A2.4 Factors that help or hinder implementation

***Cultural setting:*** One of the main challenges in implementing the Sanctuary model was the resistance of staff and young people to participation in community meetings. The Sanctuary model recommends that community meetings should take place every morning, with attendance from both workers and young people. Their purpose is to provide an opportunity to discuss openly how each person is feeling on that particular day and, if necessary, a chance to nominate someone to help them with any ongoing issues they are facing. Despite the overall enthusiasm for the model, there was a consensus that it needed to be contextualised in order to maximise its potential within Northern Ireland. The community meetings were a particular focus of this, and in one home the language was changed within the psycho-educational programme in order to make it more user friendly.

> 'During our initial Sanctuary training the facilitators would have been very prescriptive that you have to use this form of words: How are you feeling today? What are your goals for today? Who can help you? I think people felt very cynical that that just wouldn't work in Northern Ireland with our kids from West Belfast, Derry you know ... there is a varied engagement from the kids, but I think a lot of them find it very difficult to engage....' (HoH 6)

***Important factors in creating a therapeutic community:*** Integrating the language of the model into daily work and teaching the new terminology to young people were also regarded as a challenge. However, one home manager reported that, as staff gradually started to see the changes that the model was making, they were encouraged to use the new language more and more, and in turn the young people also started to buy-in to it.

[5] Safety plans consist of five individually devised steps that a person can implement if they feel they need 'time out' to regulate their feelings and emotions.

Sustained enthusiasm for the model very much depended on the extent to which it was implemented within each unit and the number of staff that became involved in in-house Sanctuary training. The importance of everybody 'buying in' to the model was emphasised, as most respondents felt that there needed to be consistency throughout the unit in order for the therapeutic community to evolve.

> 'Most of the work is done in the psycho-education groups.... The key workers are supposed to … follow it up afterwards in individual sessions ... with their key children. ... but that's up to each individual how much they want to involve themselves.' (RCCW 7)

Another issue that was commonly mentioned was that the majority of young people refused to wear their 'safety plans' pinned to their clothing on a daily basis. Furthermore, some staff reported that they did not wear theirs because the young people tended to pull these when workers had them pinned to their clothing. However, despite the plans not being pinned to people's clothing, home managers emphasised the importance of safety plans and how effective they had been when young people and staff had been able to implement and follow these steps.

As a whole, staff from short-term units found it more difficult than those in long-term units to successfully implement the model with young people, due the limited time available to them.

> 'A long-term unit I think has an easier job because the kids get used to the way the staff do [things] but [here] … every two to three months they are leaving and if it takes you five or six weeks to get used to this system you are only here for another few weeks and then you are away, so I think the kids are more resistant than the staff.' (HoH 6)

### A2.5 Job satisfaction and improved practice of individuals and teams

The majority of respondents felt that the implementation of the model had had a very positive impact on practice. In particular, it had enabled staff to think through a situation before reacting and had allowed workers to be more reflective and insightful about their own emotions and their views on those of others.

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

However, many respondents emphasised that it will take time for people to fully 'buy in' to the model as it requires a significant change to a person's way of thinking and approach to practice.

Around half of workers also spoke of how they were now able to use the model as a therapeutic assessment tool, which they could use to review a young person's life from birth until present, in order to identify key factors and determine what, if any, psychological support is required for the young person.

One staff member clearly stated that the implementation of the Sanctuary model had created a safer working environment for staff and this was seen as a major benefit.

> 'It is all about connecting with the self, the safety, emotional loss and future and that's what we use in the daily working in the unit. And I think ... the most positive thing I see is the safety aspect as regards to the staff because they now believe that they are being looked after. They are being recognised to be in danger. Whereas before, it's your job, get on with it as I said.' (RCCW 9)

More generally, respondents felt that they were valued and the importance of their was work recognised. One home manager suggested that the implementation of Sanctuary might help improve staff retention, as the more therapeutic way of working provided by the model had formalised/professionalised the role of residential child care workers. The majority felt that the tolerance of workers had increased as they were now more understanding of certain situations concerning young people.

> 'I think tolerance has increased, I mean of staff understanding that's it's not the young person's fault that you do maybe have to tell them the same thing ten times before they actually remember to do it....' (HoH 1)

On the whole, it was felt that the psycho-education element of Sanctuary was particularly beneficial to young people, although one worker voiced their concerns about delivering this as they were not trained to do so.

The general consensus among staff in all groups was that the model had not been implemented long enough to identify significant differences in outcomes for young people. However, quite a number of workers were able to identify individual cases in which they felt that an improvement was evident (see Example 1).

**Example 1**

'I can give you an example of one young fella I'm looking after here ... who came here and … was extremely angry, obstructive and we fought with him for three months until we decided, like we need to change here. We need to change our attitude here, rather than fight to keep him in. Let's start taking him out. Let's start explaining to him. Let's try and build insight. And it worked to the extent where I had him over in for Boxing Day in my home. I am extremely fond of him and proud of him I have to say and he would say, he would mention Sanctuary to me you know and … he came in and helped, we have a guy in the unit who did all the safety plans and we did little cartoon characters along with him for individuals and he helped him make those all up. So he is actually investing in that.' (RCCW 9)

### A2.6 Strategy for the maintenance and development of the model

***Regular refresher training days:*** Respondents were unanimous that refresher training days – delivered at least biannually – were needed to keep the model alive. Again, the importance of having everyone 'on board' was emphasised. One home manager said

that they had learned that, by rotating staff who attend core meetings and other Sanctuary-related events, it enabled more people to get involved from within the units.

> 'The five-day TCI [therapeutic crisis intervention] training was great but it is the annual refresher training that has embedded it into our practice ... it's the annual refresher that has made it become part of our systems and I worry for Sanctuary that there is a very significant bit missing there that it will never fully embed unless we are going back every six months or every twelve months to be refreshed and reminded about it ... apart from the refresher training, I don't see an ongoing cost. Once the model's in, the model's in. You know, there's no physical stuff you're given here ... it's concept, it's meetings, it's behaviours, it's practices, it's things that once you do them, you do them.' (HoH 6)

Several respondents mentioned other resources that were thought necessary to sustain the model. These were (a) a resource pack (including CDs and DVDs for the psycho-education programme), (b) designated time to read the literature relating to the model and (c) ensuring that all staff were practising Sanctuary in their daily work. A suggestion made by one of the residential child care workers was the introduction of outreach programmes in order to stay in contact with and offer support to those who had recently left care, and enable young people to continue with relationships they had formed during their stay in a home.

### A2.7 Desired long-term changes through implementation of the model

In response to probes about what would be needed to bring about long-term changes through the implementation of Sanctuary, respondents were unanimous in saying that all staff would need to use the same theoretical framework, consistently, within all homes throughout a trust on an everyday basis.
Respondents also felt that staff needed to be made more aware of staff safety protocol issues so that everyone was aware of what help was available to them.

## A3 CARE model – Northern Health and Social Care Trust

### A3.1 Understanding of how the model was selected

Three home managers and seven residential child care workers were interviewed within the Northern Health and Social Care Trust. The majority of home managers displayed a good understanding of how and why the CARE model was chosen for use within the trust. All respondents reported that a number of information days were held, which looked at alternative approaches such as social pedagogy and Sanctuary. These sessions were attended by a small number of staff from each home. The senior management team then met on a number of occasions to discuss the suitability of each model for residential child care within the trust. The authors of the CARE model were then invited from Cornell University, USA, to present the CARE model in detail. This model was subsequently selected by senior managers, who felt that it would best meet the needs of young people in residential care within the Northern Health and Social Care Trust.

A number of home managers were aware of the close links between CARE and the therapeutic crisis intervention model (developed by the same programme developers). The fact that the same trainers from Cornell University had previously delivered training sessions on therapeutic crisis intervention within the trust was felt to be an influencing factor. Residential child care workers were less informed of this process, but as a whole they understood that senior management had considered alternative models and that CARE was deemed to be best suited for use.

One home manager described feeling shocked when informed that all homes within the trust would be implementing the same model, as they felt that it would be more advantageous if various units within the trust adopted different models, so that the specific needs of young people could be catered for.

### A3.2 Experience of implementing a therapeutic approach

An initial response reported by almost all respondents was that the CARE model was essentially 'good social work practice', with some valuable new components added, such as how to work with children suffering from trauma. It was widely agreed that CARE provided a good framework for practice and consistency within units throughout the trust. Most respondents felt enthusiastic about it and acknowledged that it provided good therapeutic objectives and ways in which to achieve good therapeutic outcomes.

There was also, however, some initial scepticism from a minority of workers regarding the model and its usefulness. A small number of Band 6 and 7 workers felt that it was 'too basic', while a few who had been in residential child care for a long time were somewhat resistant to changing their way of practice.

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

Over time, as staff became more familiar with CARE, those who had expressed initial scepticism could recognise its potential and it was largely welcomed within the trust.

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

### A3.3 Experience of the training process for the CARE model

In the first instance, a small number of staff, from each home, were chosen to attend a conference delivered by the programme developers, which looked at the various components of the model in detail. This was followed by a further two-day course in order to prepare these same individuals for their role as CARE trainers or 'champions'. Subsequently, all members of staff attended a five-day introductory training session delivered by the 'champions'. Half of the staff team from each home attended training at one time, with the remaining staff being trained a few weeks later. It was explained that

whole staff teams were not able to be trained together due to staffing requirements within the homes.

However, some nominated CARE champions were not comfortable with delivering in-house training to other members of staff, as they felt that they were not able to present the information as effectively as the programme developers.

> 'No matter how much I read the stuff, the quality of my training ... does not compare to, you know, Martha who basically has done all the research and written the book.... So, I don't think that since the initial training it has been as good.' (RCCW 10)

Respondents in the trust observed that it was unusual for staff to see all senior management involved in the training process, from the director down (*cf* Sanctuary). This was welcomed and seen as emphasising the importance of the model.

All respondents were satisfied with the structure of the training and in general felt that learning about the model in its entirety before attempting to implement it prepared and enabled them to do this most effectively. Practical activities were found to be most beneficial and enjoyable, as staff were able to participate and interact with one another.

### A3.4 Factors that help or hinder implementation

***Placement panels:*** One factor that was widely thought to have facilitated the implementation of the model, particularly the therapeutic environment within the homes, was the introduction of a placement panel to help better place children according to their needs. However, home managers emphasised that this service could be further improved and needed to be consistent in approach while allowing the CARE model to guide the decision-making process.

> '[W]e have a placement panel, which didn't happen before ... [so] we're not getting inappropriately placed children who are overtly violent and disruptive, which ... totally destroy a therapeutic environment … it's a planned admission …, they get visits and then they get overnights and there's none of this just dropping a bomb in….' (RCCW 10)

***Language and terminology:*** Almost all staff were unfamiliar with the language of the CARE model. In particular, longer-serving members of staff reported feeling threatened by the new terminology, and resisted change. The rigidity was seen as a significant challenge for the home managers. In an attempt to overcome this, home managers tried to encourage staff by introducing case scenarios within team meetings, as a means of reviewing the use of the CARE model. They felt that this also helped to keep the model alive and allowed opportunities for individuals to ask questions and become more familiar with the new language.

***Further training:*** Another commonly reported issue that hindered implementation was the need for further training. In particular, the high turnover of staff in residential child care was seen as a problem, as there was reportedly a significant number of new staff who had not yet been trained in CARE.

The fact that field workers had not received any training was widely considered to be a drawback, as this led to a perceived lack of consistency and continuity between residential and field social work practice. This was most evident when residential staff attempted to promote family contact and develop family relationships for young people.

> 'So you could be sitting around a LAC [looked-after children] review and ... you are coming from a CARE perspective, which is involving the family, which is promoting contact where it's safe and appropriate, and you have field social workers who historically know there were problems in that family, not so keen to promote more contact and working the child back home whereas we would see that as what we are attempting to do….' (HoH 4)

***Suitability of the CARE model for children with learning and behavioural disabilities:*** Quite a few workers were of the view that within any home there is a range of young people with different needs, which they felt could not all be addressed fully using CARE as a stand-alone model. In particular, it was thought not to be applicable to young people who had learning and/or behavioural difficulties such as those with autism spectrum disorder or attention deficit hyperactivity disorder. It was widely accepted that in these circumstances, the model needed to be supplemented with a different kind of intervention, such as a behavioural approach[6], in which prosocial behaviour is reinforced (rewarded) by methods such as star charts in order to best meet the needs of the child.

***Suitability of the CARE model for younger children:*** The majority of workers agreed that the CARE model was more suited to younger children as they were more compliant through partnership with staff than older children. Most home managers felt that perhaps the model was too flexible or 'soft' to be implemented effectively with individuals aged 15 years or over.

> 'A lot of children coming through now ... 15, 16 where really they are out of control of their parents because they're linked into drugs ... and I am not sure that CARE sits well with that. Yes a child coming into care maybe 12, 13 where there is room for a relationship. A child 15 or 16 is difficult to form a relationship with.' (HoH 4)

***Other challenges to practice:*** A few residential child care workers reported feeling disempowered due to the change in emphasis from sanctions to natural consequences. Particular difficulties were identified when a young person did not respond to any attempts at interaction made by staff. Another area of concern was with children who did not buy in to the model but instead tried to abuse its flexibility. This disheartened

[6] Behavioural approaches recognise the extent to which a great deal of our behavioural repertoire is learned, and on that basis can be unlearned (and new behaviours learned) by reorganising the costs and benefits of behaving in certain ways, such that prosocial behaviour is reinforced and antisocial or dysfunctional behaviour is weakened or 'punished', which in behavioural terms, simply means anything that reduces the likelihood of the behaviour recurring, for example withdrawing attention.

some workers, resulting in them reverting back to former methods of practice such as 'firefighting' techniques:

> 'So you know the CARE model kind of says it is a very caring approach. When you have a young person who is very defiant and really refusing to do pretty much anything, it can be very difficult and your hands get tied if there's rules and regulations you have to abide by to enforce things such as school attendance. So those kind of limitations can be frustrating.' (RCCW 6)

In general, CARE was viewed as more successful when implemented with a new group of young people who were unfamiliar with former methods of practice. The overall consensus was that it was not conducive to all situations and at times needed to be supplemented with other approaches.

***Number of young people in a home:*** Almost all respondents felt that in order to implement CARE successfully and spend sufficient time building an individual relationship with each child, either more staff or smaller units were required, with units of six being better, but those with four being ideal.

### A3.5 Job satisfaction and improved practice of individuals and teams

All staff found that the new approach challenged their way of thinking about practice. A few respondents said that it allowed them to think more constructively about potential contributing factors relating to challenging situations before addressing the young person. This more objective approach also enabled a large majority to understand better why a child was behaving in a certain way instead of interpreting the behaviour as a personal attack specifically directed at them, as it provided the theory behind pain-based behaviour and trauma. As a result, these workers felt more motivated to facilitate the young person's living experience within the home and strived to help them to learn new things and enjoy their experience as much as possible.

In particular, many staff found the 'zone of proximal learning'[7] component to be particularly beneficial for young people, as it enabled individual goals to be realistically tailored for young people to achieve. This sense of achievement in turn resulted in the young person feeling more confident.

> 'There always is pressure … about young people not achieving, not getting the same GCSEs [General Certificates in Secondary Education] as other kids ... and in residential units about them having more negative outcomes ... we need to look at where their zone of proximal development is and we need to sort of lower it at times to what our expectation might be so that they can learn to feel success and to feel good about themselves and to encourage, I suppose, self-esteem.' (HoH 10)

[7] Zone of proximal development or learning is a term coined by psychologist Lev Vygotsky to mean the range of challenge in which a learner can progress because the task is neither too hard nor too easy.

Most home managers found the model to be a useful tool for supervision as it provided structure and encouraged the use of reflective practice.

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

***Perceived change in children's behaviour since implementation of the model:*** Workers within the Northern Health and Social Care Trust repeatedly stated that there was a significant reduction in the number of recorded incidents of physical aggression since implementation of the model.

> 'Measurable outcomes are the huge decrease in recorded incidents of physical aggression. I mean, they're a fraction of what they used to be, because we're taking a different approach.' (RCCW 10)

In addition, a small number of workers described how the CARE model enabled them to realise that young people were able to learn from staff modelling good social conduct. It was also recognised that as a result of improved relationships between staff and young people, peers were encouraged to also form better relations with workers, which was considered to be a significant benefit.

Overall staff felt (a) that both the young people and workers had become more relaxed as a result of implementing the model and (b) that children both recognised and appreciated these changes. Most home managers had adopted the CARE principles to enable them to manage their staff team more effectively, while others felt that it created a more balanced and measured way of working with colleagues.

> 'I think the young people are much more relaxed, I think the staff team generally are much more relaxed in that they don't really feel, it's not they don't feel obliged but there is a genuine kind of feeling that people care about each other now you know in relation to the children.' (HoH 4)

In general, then, despite having initial apprehensions, almost all staff felt that the change from sanctions to natural consequences allowed the young people to learn through reflecting on their own behaviour rather than through punishment. This method was credited with a significant decrease in recorded incidents and what one respondent described as 'power struggles' between staff and children (that is, 'bad' behaviour → use sanction → worse behaviour → more severe sanction and so on).

> 'Even though we knew on reflection it wasn't working because the kids were getting sanctions every week. Day in, day out, you know, there was no change. It wasn't making them go to school, no matter how mean to them you were or how much money you took off them. They still didn't have what it took to be able to manage some of the

> tasks we were asking them to do and CARE sort of changed, I feel, staff's attitudes, definitely mine with regards to that, which means you have to think more about why these kids can't achieve this, so what is it that we need to do?' (HoH 10)

There was a general consensus that the introduction of the model improved and professionalised practice by providing consistency and congruency throughout the trust. Prior to its implementation, each home had been working in isolation and had developed their own culture and way of working.

### A3.6 Strategy for the maintenance and development of the model

In keeping with the model, all respondents felt that it was very important to involve parents in various social activities within the home, as building relationships was considered to be the key component in successfully implementing CARE.

> '[P]arents have been involved the whole way down the line. We do things like projects and bring the parents in and involve them in it and maybe have barbecues and things and there is a photographic exhibition that's going on at the minute.' (HoH 7)

***Regular refresher training days:*** Everyone said that further training was needed to keep workers up to date with practice and the language used, and to allow staff teams time to reflect on their practice outside the unit. In general, a refresher day for all staff twice a year was thought to be sufficient. Nearly all home managers said that they had more opportunities than residential workers to discuss issues relating to the model in various forums, and that it was important that other workers were given more opportunities to further their learning. Furthermore, it was largely felt that staff should be encouraged to use the language of the model when writing up looked-after children reports and monthly synopses, in order to help embed the new terms into everyday practice. Overall, it was agreed that everyone involved in residential child care needed to be proactive in implementing the model in order to maximise its success.

***Financial implications of training:*** It was commonly reported that money for refresher training needed to be ring-fenced in order to maintain the successful implementation of the model. One home manager specifically referred to the need for good therapeutic resources outside the unit so that, on leaving residential care, young people suffering from severe attachment issues might continue to receive any necessary help, such as psychotherapy.

**Example 2**

'We have a young person who is just not managing mainstream school at all at the minute and so I think in that way CARE has allowed me to practise differently with support from the staff, but that's a thing a lot of staff still struggle with.

With this young person we were pretty much forcing her, saying that she had to be doing something as a part of her placement and .. .it wasn't good really whenever you looked at it. She just wasn't able ... and she was using aerosol as the way to cope.

She was in tears. She went down to school and came back and she wanted to do well because she has good relationships with staff in here and she wanted to please us, and you could see that she wanted to achieve what our expectations of her were but really couldn't do it. And it wasn't that she was unwilling to do this, she wasn't able, she really wasn't. And before we probably would have had a different attitude to her, and then we realised "Right, okay, we'll work this one to one, we'll see if this young person lacks motivation or is unwilling". But now she learns one to one and is enjoying it, succeeding, doing really well.

So it showed us it is still this issue with relationships and being with peers and lack of confidence around it, it's not like people say "Because she's lazy, she wants to lie about here all day". But it was in fact CARE allowed us to reflect and lower the expectation and we realised that this was the change that this child needed in order for them to succeed and achieve and I suppose that's how we'd lead her forward so she's able to do that in a small group and then in a larger group.' (HoH 10)

### A3.7 Desired long-term changes through implementation of the model

It was generally felt that the model needed to be further developed in order to deal with other circumstances within residential child care such as learning and behavioural difficulties.

A large number of respondents were also keen to see the model rolled out to other services within the trust, such as to field workers and to staff within the education system. Overall, staff wanted the implementation of the model to better enable young people to move on from residential care, with the knowledge and confidence to take opportunities that were available to them and to enjoy a full life.

> 'I would like to be able to see that maybe people that we're working with now with this model, the changes we've been able to provide for them, the opportunity for learning that they have been able to take on, to be able to hold on to that and then implement that when they move on from here because when they move on from here there's very little, it is fairly difficult.' (RCCW 6)

# A4 Social pedagogy approach – Belfast Health and Social Care Trust

## A4.1 Understanding of how the model was selected

Within the Belfast Health and Social Care Trust, four home managers and nine residential child care workers were interviewed.

The home managers were more generally knowledgeable than the residential child care workers about how the social pedagogy approach was selected for implementation within the trust. They reported that a member of the training team from the South and East Belfast Trust became interested in social pedagogy while researching it for a postgraduate qualification. She and a colleague then attended conferences on social pedagogy in England. When the introduction of therapeutic approaches was announced, the worker then 'pitched' social pedagogy to the senior management team, and it was chosen to be implemented within the homes in the Belfast Health and Social Care Trust.

None of the residential child care workers was sure as to how exactly the decision was made to opt for social pedagogy. One home manager said that they were not consulted or aware of any consideration of alternative models but were informed that the trusts in Northern Ireland would be implementing different models, with the Belfast Health and Social Care Trust using the social pedagogy approach. Other home managers reported that social pedagogy was chosen as the most suitable approach because there was already a level of experience and enthusiasm for it within the trust, it was similar to their way of practising and complemented other models that they were already using.

When asked, quite a few residential workers had difficulty describing the approach in their own words. Others described it in general terms as a very practical way of building relationships with young people and/or a model that gives permission to develop a more meaningful relationship between the adult and young person while encouraging adults to see themselves more as equals in the relationship with the young person.

Social pedagogy was felt to encapsulate much about how a good parent or adult should treat a young person. Some perceived it as a method for promoting inclusiveness for young people, while encouraging more involvement of young people in decision making and also promoting a more relaxed environment. A small number described it as social teaching in its widest sense, where teaching does not have to take place within a formal setting, and felt that it fitted very well with group living and with the whole purpose of residential living.

## A4.2 Experience of implementing a therapeutic approach

The social pedagogy approach was initially piloted in two homes and later introduced in another two homes within the trust. The pilot homes received an information session from an external trainer, after which the staff team in one of the pilot homes started to

research the approach further. Training was then organised through ThemPra[8], with the pilot homes receiving their training first.

***Initial reactions and organisational change:*** Overall, the introduction of social pedagogy was viewed positively by both residential child care staff and home managers. They hoped that it would be a new way to enhance their practice, empower them and provide a direction in which to work. Most were ready for the challenge and felt that the approach was best suited to them because it encompassed much of what they were already practising.

However, there was some apprehension from a few residential child care staff who feared that the training would replicate that of other models in which they had recently been trained. Others feared that it would not be resourced or supported after the initial training, while a small number saw it as a significant challenge to learn a new approach and successfully implement it. A few members of staff were very sceptical about the introduction of the approach, which they felt would mean the eradication of all rules and regulations and greatly resisted this.

> 'I am always interested in finding out about new ways to enhance your practice so in that way it was good but my only reluctance was: is this another thing now that is being thrown at us and is it going to be followed through properly? … It all sounded great in theory but it was whether that was followed through on.' (RCCW 33)

Home managers reported feeling particularly enthusiastic about the introduction of social pedagogy within their home for reasons such as it provided an opportunity for homes to become less rigid. In hindsight, however, one home manager felt that there was such enthusiasm and momentum about getting social pedagogy introduced that managers almost neglected to bring their teams along with them in the process.

### A4.3 Experience of the training process for the social pedagogy approach

***Satisfaction with structure of training:*** In general, staff were positive about the training content and its structure. All of the staff members from both pilot homes attended these sessions together. They received eight days' training in total, comprising two days a month for four consecutive months. This enabled the staff teams to go back and reflect on what they had learned and focus on certain aspects of the approach before attending the next training session. The other two homes in which the approach was later introduced received similar training, consisting of six days in total.

There was reportedly some initial apprehension from Band 5 workers as to whether they would be able to keep up with the training as well as the qualified staff, but as the training commenced these fears were soon alleviated.

A number of staff found the all-day training to be very intense but informative, as it covered the various underpinning theories and the numerous components and

[8] ThemPra Social Pedagogy Community Interest Company provides personal and professional development courses in social pedagogy.

techniques relating to the approach as well as some practical tasks. The practical activities seemed to be the most popular way of learning for the majority.

> 'Thought the training was really great and got really involved in the practical activities which afterwards were very thought provoking. It was really well structured and planned; it was enjoyable but serious too. There was a lot of theory but also a lot of practical/physical activities, which created a lot of variety.' (RCCW 3)

Both home managers and residential child care staff felt that they could identify with various aspects of the approach, which were similar to other models they were using and also put a name to some existing aspects of their practice. A lot of staff stated that they had learned new skills, and as the training progressed became more confident that they would be able to implement the approach successfully and felt re-energised by this. Residential social workers emphasised how beneficial it was to have home managers at the training so that all staff were familiar with the new way of working.

> 'It was stuff that you already knew but it made you think again and reflect and the reasons why I was here and what the purpose of my job was and what we were looking to achieve. It was quite intense – six days' training – delivered in a very good style.' (RCCW 27)

Some, but not all teams, trained together. A large number of respondents said that training the whole team together was very beneficial as it helped them to bond. Others felt that the most valuable part of the training was the fact that they were trained alongside staff from another children's home, as they were able to get to know each other and discuss common everyday issues that they were encountering, but in different settings.

> 'Being with another children's home was really good too who were doing the same job but in a different environment and culture in their own home so there were a lot of similarities but also a lot of differences that we could take on board and discuss things with the other group.' (RCCW 3)

However, some of the more negative points made regarding the training by a number of staff were that there needed to be much more follow-up and more support for staff who were attempting to implement the approach. They felt that six or eight days' training was not sufficient to equip them to become social pedagogues. Others reported that as part of the training process, social pedagogues were meant to visit each of the homes and observe staff in practice and demonstrate exactly how things should be done, but this had not yet happened.

Another point, which was reiterated by a number of staff from the more recently trained homes, was that their entire staff team did not get to attend the training together. These respondents felt that those who had missed out felt resentful because of this. Those who attended the training tried to share what they had learned, but found this to be difficult as much of the training involved practical tasks, which the workers needed to be

part of in order to learn from them. The reason for these staff teams not being trained together was that the maximum size of each training session provided by ThemPra was 16.

### A4.4 Factors that help or hinder implementation

One of the factors emphasised by respondents as important for the successful implementation of social pedagogy was reflective practice, on both a team and an individual basis. One residential worker described how the use of reflective practice enabled their team to realise that they had to approach the younger and older age groups using different methods of pedagogic practice. Others stated that the use of reflective practice was a very effective way of communicating with other team members without being judgemental. One home manager encouraged the introduction and use of reflective practice for 10 minutes at the end of each handover to discuss openly how the shift went and what worked and didn't work so well for individuals.

> 'It has also reinforced for me the importance of having the time to reflect because if you don't have that you could go back and do the same thing again that maybe wasn't the best thing in the first place.' (RCCW 27)

Other factors thought to facilitate implementation included staff being familiar with the underlying principles behind some of the components of the approach and focusing on forming and maintaining relationships with the young people.

Factors considered to hinder implementation of the approach included the resistance of the young people to new ways of practising and their lack of understanding of the purpose of the change, which was to try to teach them basic problem-solving skills and to empower them to take more control of their own lives.

As indicated above, staff from homes in which a number of workers missed out on the initial training felt frustrated and less able to implement the approach because not all of the team understood what social pedagogy was about. Similarly, new staff members had since started working within homes but had not yet received any training, which was also considered a hindrance. One home reported having as many as five new untrained members of staff. Some homes attempted to deliver their own training to these new staff with some success.

> 'It would be positive if only all of our team got to do the training, which was a real negative as so much of social pedagogy is practical throughout the training and to bring that back is difficult; yes you can bring back the theoretical aspect of it but you've missed out when you've missed out on what we did.' (RCCW 27)

The lack of training for field workers was seen as a significant drawback. As both residential and field social workers were working towards the same goals, it was felt that this would be made much easier if there was consistency in approach. Social pedagogy involves working alongside the young person and including them in decisions regarding themselves, so that they can have some control over issues concerning them. A number of staff stated that attempts to normalise a young person's life as much as

possible can often be prevented through the looked-after children process or decisions taken in the field.

Another drawback to implementation was the realisation that some components, such as the Common Third[9], were not as effective with the older age group as with the younger age group. Respondents suggested that within Northern Irish culture, older children want to be seen to be independent and are often out doing their own thing; they are not really interested in engaging in activities with staff members.

A number of staff members also said that they found it extremely difficult to fully implement the social pedagogy approach due to the risk-averse environment within the trusts and social service systems. This conflicts with the social pedagogic approach, which encourages staff to allow young people to take age-appropriate life steps to be able to expose themselves to a certain amount of risk in order for them to learn how to protect themselves and to develop.

### A4.5 Job satisfaction and improved practice of individuals and teams

Overall, the introduction of social pedagogy had resulted in a number of positive changes to daily practice, such as a greater emphasis on children's emotional wellbeing, which had helped staff to become more aware of how young people were feeling and how to help them to cope with their emotions.

It had also led staff to rethink the ways in which they worked with young people within the home. They had tried to make their interactions less formal and to see young people more as equals, while also creating opportunities for conversation in more subtle ways. Efforts had been made to create a more relaxed, homely environment within the residential homes. Workers had also changed the language used within the homes, such as no longer referring to the home as a 'unit' but instead using the word 'home', and some young people as a result had started to use these new terms. This in turn had encouraged them to invest more in their relationships with staff, as they now saw their home as more of a shared living environment rather than a workplace for staff.

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

It was widely agreed that social pedagogy had allowed staff to be more reflective, more open as a team; more relaxed and freer in their methods of practice. It had also helped

[9] The concept of the 'Common Third' is central to social pedagogic practice and is about using an activity to strengthen the bond between social pedagogue and child and to develop new skills.

them to step back from certain situations instead of reacting immediately. One residential worker described how, instead of immediately lecturing the young person on the potential risks of their behaviour, she now used her relationship to let them take the lead when they are ready to tell their story, and to draw their own conclusions from the situation. From that she felt that she can then work towards the right course of action, and others also found this method to be a real success. Another staff member described how social pedagogy helped her to distinguish and separate her relationship with the young people and her statutory social work responsibility, which she felt had become somewhat intertwined within residential work.

**Example 3**

'So the big changes will be in how the quality of the contact that staff have with young people and how we now look at our time in terms of spending either more time with those children that need it, or encouraging the older ones who don't need your immediate support about how to be more independent in the community. And that's about just about using our time better. One of our young people, for example, has a scooter and it's not working at the moment. He crashed into a car and damaged the front of the scooter. Now we're trying to get the balance right. We want to encourage him to take ownership of getting the thing fixed and get mobile again. From our point of view we should be prompting independence for him, getting around the town.

One of the biggest things with looking after children, they have always been taxied to and from places, school, etc. We have a young person with a moped, do you know, which in itself presents its own risks, but provides some independence and at 17 years of age that's what he should be aiming for, so he will be able to go to his own appointments, his own work schemes, contact on his own without a member of staff having to be present and then that allows for workers to be there more for those children who need serious therapeutic support on a daily basis. And that's what the training highlighted for us, about us adapting to meet the needs of the children rather than the children adapting to fit into the unit where it would be so easy to hide behind policies and procedures and quote risk assessments and stuff rather than actually saying: "Right, how can we enable these children to do A, B and C in a safe and secure way?".' (HoH 2)

One of the main changes in practice relates to the issue of sanctions, and how difficult situations are handled. Instead of automatically issuing a sanction, staff now tried to negotiate an appropriate sanction with the young person, in the belief that if the young person had more ownership of the sanction, they were more likely to complete it and to learn from it. This change had created a better understanding of the purpose of rules for some of the young people. However, a more negative change to young people's behaviour was the fact they often used the new approach to try to get their own way within the home.

Social pedagogy had provided many more tools for staff to use in practice, and freedom in which to use them. It had also provided Band 5 staff with more of a sense of equality and purpose, and had motivated some to become more creative, both as a team and as individuals, as to how they worked with the young people. Respondents felt that these changes had improved practice. Some also reported that the use of the Common Third technique had allowed staff to better connect with the young people and to share a common interest or skill, while others had noticed young people growing in confidence because they were being given the support to develop skills and increase their independence and responsibility for themselves.

### A4.6 Strategy for the maintenance and development of the model

***Regular refresher training days:*** All respondents said that in order to sustain the approach, and for it to be absorbed by staff, regular refresher training days were needed for all workers. Others felt that support mechanisms should be put in place to enable staff to set aside allocated time to meet and discuss issues in order to keep the approach ongoing.

Visits from highly trained people or qualified social pedagogues were also widely requested in order to help staff improve their practice and to progress further with using the approach, as well as to attend and support the practitioners' network to give it direction. A few staff thought that a DVD, outlining the theories and practices of the social pedagogy approach, would be useful both to remind themselves of the various aspects of the approach and to increase their knowledge base.

***Physical environment:*** A small amount of funding was requested by one home manager to carry out some minor decorating within the home to make it look and feel more homely. They also requested funding to buy some equipment such as musical instruments so that staff can demonstrate and share skills with young people and teach them new things, which in turn could increase confidence and promote self-esteem.

***Staffing levels:*** A number of staff also felt that if a home was at full capacity, extra staffing would be extremely useful to enable time to be spent with the young people and to maintain a settled environment within the home in order to maintain the approach.

### A4.7 Desired long-term changes through implementation of the model

The long-term changes desired by staff, as a result of implementation of the model, included improvements in quality of contact and better communication between workers and children as well as young people becoming more responsible for themselves and for decisions concerning their wellbeing.

> 'I would like it to get to the stage here where it is being implemented and recognised and young people are benefiting from having more sort of involvement in what happens in their lives and through the use of skills and stuff perhaps the young people go on to have more kind of positive outlook in terms of whether it is employment or relationships or whatever it is for them, you know even just confidence in day-to-day living and stuff.' (RCCW 13)

# A5 ARC model – Southern Health and Social Care Trust

## A5.1 Understanding of how the model was selected

In the Southern Health and Social Care Trust, four home managers and eight residential child care staff were interviewed.

Home managers reported that, initially, the Intensive Support Unit (ISU) had been implementing components of the ARC model before it was rolled out to the other homes. The trust's consultant clinical psychologist had been working with this unit since it opened approximately eight years ago.

In June 2009, the programme developers of ARC (Kinniburgh and Blaustein) were invited to Northern Ireland to present the model at a two-day conference. This was open to all social workers as well as other organisations such as VOYPIC (voice of young people in care). The entire staff team from the ISU were able to go to this, as initially the model had been intended for use exclusively within this unit. Due to staff resources, only three workers from other residential homes were able to attend.

During their stay, the programme developers also visited the ISU and demonstrated putting the theory into practice using a case study that staff found to be very beneficial. Based on this groundwork within the ISU and advice from the consultant clinical psychologist, the two heads of service (short-term and long-term) then chose ARC as the most suitable therapeutic model for residential child care within the Southern Health and Social Care Trust.

Residential workers from the ISU had some knowledge of how the model was selected; however, those from other units were unaware of the process and whether any alternative were considered.

## A5.2 Experience of implementing a therapeutic approach

***Initial reactions and organisational change:*** Most residential workers said that they were apprehensive about being trained in another model because they felt that it might overburden them, but when they learned more about ARC they were enthusiastic about it.

> 'I think initially people are, they see something new and they see a big booklet and they initially go "oh God"…. But once it is broken down and explained to us, everyone seems to be in agreement that it's a good one to work from.' (RCCW 20)

After learning about the model, most staff could see its potential and how it could benefit young people in residential care, but thought its usefulness depended very much on each young person's circumstances. Overall, staff felt that some components of ARC reflected what they were already practising, and complemented existing models such as therapeutic crisis intervention and restorative practice, with ARC simply providing more tools for their 'toolkit'.

### A5.3 Experience of the training process for the ARC model

***Initial two-day introductory training:*** Those who were able to attend the two-day conference found it informative and interesting, but staff from outside of the ISU felt that there was too much information to retain in a two-day session, as this was their first exposure to the model.

> 'I think part of it was very heavy and it was very hard to really stay focused on because it was so intense, I suppose we had no, I certainly had no knowledge of ARC before we went to this training and I kind of came away, it was a lot to take in.... And then that was so long ago and to be honest I wasn't going to that training thinking we're going to be implementing this.' (RCCW 24)

In early 2010, the model began to be phased into homes throughout the trust, with the consultant clinical psychologist due to visit units on a fortnightly basis to provide in-house training for workers. This is still an ongoing process, with one home manager stating that their in-house training was to commence in April 2011.

> '[The consultant clinical psychologist] - he would have done about five sessions on introducing the model ... and explaining what the [main headings] meant and sort of giving examples that were applicable to the young people here.... It's early days I suppose, CCP's [consultant clinical psychologist] been involved with the staff team for approximately 12 months. They find the consultations … useful.' (HoH 9)

Each home was asked to nominate two members of staff to attend meetings with the consultant clinical psychologist and a principal practitioner, to train to become 'ARC champions' and form part of a working group to relay the information back to the rest of the team.

Most home managers and residential child care staff felt that the implementation of ARC was still very much a work in progress and that it would take time in order to fully integrate it into everyday practice.

> 'I would say that both myself and the team here don't yet have our final grasp on ARC and it is a work in progress and progress has been made.' (HoH 17)

> 'There certainly hasn't been enough to be at the evaluation stage, would be my initial point, … I suppose it's just the time that's in it, in that you know staffing ratios and that are different now given cutbacks and all, and so training time has also felt the impact of that and at present we have staff off on sick leave and things like that. The amount of money we have to spend with children has been decreased as well. So with all these constraints and then being given more information, it does feel like more

> pressure you know as a worker but I know that's not the intention, it's just the culture at the moment.' (RCCW 15)

### A5.4 Factors that help or hinder implementation

***Effective roll-out of training:*** A commonly reported issue by home managers was the fact that it was extremely difficult to get staff together on a regular basis to receive in-house training on the model. Quite often these training sessions had to be cancelled due to events occurring within the unit, resulting in the staff training becoming fragmented.

> '[T]raining *per se* hasn't happened the way we would all have liked it to happen and we haven't had all the staff team in on any given day when [the consultant clinical psychologist] covered the area of attachment or he's looked at, you know, childhood development – all the things that are relevant to the ARC model, so not all of them have had the opportunity to be there ... you would need a person with the knowledge of [the consultant clinical psychologist], who knows ARC very well, coming to your unit more than half a day a fortnight and sometimes you even have to cancel that.... I would say truthfully … it's probably only been once a month.... And I've had to cancel sessions or he's had to cancel sessions, so it's been a bit bitty in that regard.' (HoH 8)

There was a general consensus that field workers should also be trained in ARC in order to facilitate further the implementation of the model. However, at least one home manager thought that they were not really interested, being focused largely on getting 'all the paperwork they have to do done', and, until prioritised within the trust, this was unlikely to change.

***User-friendly documentation:*** During the course of the interviews, a shorter, more concise 'user-friendly' document outlining the model was written and distributed by C the consultant clinical psychologist and his colleagues and it was widely agreed by staff that this would greatly facilitate their learning.

***Relationships with young people:*** Many workers emphasised that in order for ARC to have a successful impact on young people it needed to be practised very subtly, so that the young people did not realise that it was being implemented. The need to build a strong relationship with the young person was also largely emphasised.

> "You have 14- and 15-year-olds coming into care and you have an expectation that they have the ability to form attachments, to think things through in a logical format, to come up with good ideas, but …, these kids don't know how to have a relationship, full stop. And in many ways you have to allow them to regress to a very young age in order to help them develop and you are re-educating them, but if you do that in a very subtle way you manage to get there. If you do it in a very overt way, they will

> consider you as condescending, patronising and fight against you.' (HoH 12)

***Emotional impact on staff:*** A concern of another home manager was that the implementation of the ARC model forced staff to reflect on their own lives, leaving some feeling exposed and vulnerable. Another stated that it took a long time to form secure attachments with young people and therefore they felt that there was insufficient time to properly implement ARC in a short- or medium-term unit. One member of staff also felt that Band 5 workers appeared to struggle more than qualified social workers when implementing the model.

***Language and terminology:*** The unfamiliarity of the language associated with the model was another commonly reported drawback.

> '[T]he first block is "caregiver affect management" ... that's very wordy and the term "affect" is very sort of psychological whereas in social work we talk about emotions and feelings and that sort of thing, more everyday language. So I suppose that would be the main sort of challenge that springs to mind is the language of the model ... caregiver affect management really means being in control of your own feelings when you're working with young people.' (HoH 17)

### A5.5 Job satisfaction and improved practice of individuals and teams

***Changes in practice:*** Those who had been trained within the Southern Health and Social Care Trust had started to integrate ARC into their reports and logs, and felt that it provided a structure that made it easier for others to see what stage a young person was at and to note improvements.

> 'When young people transfer from here to different units, the other units will have a very good understanding of the young person before they meet them ... because they're trained in the same sort of language and the same framework, you know, so when we're recommending how young people's therapeutic needs should be met they're sort of hitting the ground running in the longer-term units whenever they receive those young people...." (HoH 17)

Almost all staff felt that ARC provided them with a framework for practice and a better understanding of the needs of young people.

> "It helps in explaining what we are doing and why we are doing it with our young people because you can link it to … the different stages of the ARC ... you can refer to your handbook and look for ideas and if you are getting baffled or confused about where a kid is at or whatever, to refer back to the framework helps you put it into perspective, so it gives you a good tool to work from as well and I think that has been helpful ... it helps us to formulate better

> when young people are going through difficult times and understand it in a therapeutic context....' (HoH 12)

Quite a few residential workers described how ARC helped to explain young people's behaviours by providing them with a better understanding, which enabled staff to focus more on young people's feelings.

> 'One of our young people here could not understand how a very, very negative relationship with his mother could have any impact on how he's feeling now, you know what I mean, so it helped us to open up discussion about their feelings and where they originate in development so it's helpful in that way.' (HoH 21)

A small number also reported that ARC taught them how to deal with stressful situations more effectively.

> 'I find that when a situation is too hard for me now, I am going to need to get a little help here, you know, or, I am the trigger, get me out, get somebody else in…. I think it has helped me in that way ... in the past maybe I would have wanted to stand my ground and argue my point but that's not worth it....' (RCCW 21)

In addition, one home manager described how he found it beneficial to use ARC concepts during supervision sessions with staff.

> 'Obviously I have to support them and people's natural reaction when they've been physically attacked is not to be empathetic with the person who is assaulting, so in supporting those staff I've also been referring to ARC and helping them understand some of the behaviours of the young people, that it's not, you know, personally directed towards them as people: it's as a result of the traumatic experiences that they have had….' (HoH 17)

***Perceived change in children's behaviour since implementation of the model:*** A small number of staff noticed improvements in young people, which they attributed to the implementation of the ARC model (see Example 4).

**Example 4**

'With a young girl, it was very obvious on her admission that she had no self-esteem and part of ARC looks at self-esteem and tries to build it up, you know it reinforces the importance of kids having self-esteem and living off their self-esteem.... Staff have been using ARC with that young girl and it seems to have made a difference to her. She is now recognising the importance of herself and that she's not, you know, she's gotta look after herself, the way she was behaving before she came here she didn't see any benefit or any importance to herself or her self-worth, you know, she had been abused ... and she's only in here since December, a very short time.' (HoH 9)

### A5.6 Strategy for the maintenance and development of the model

The main emphasis here was on building up a strong relationship with the young person in order to sustain the model long term. One-on-one trips out with the young person and key worker were thought to be a good way of forming a bond, initially.

Regular training for all staff including 'bank' staff and field workers was also greatly emphasised, while around half of home managers stated that having smaller units would allow the model to be implemented more effectively.

> 'Ideally ,I would think it should be four, if you are doing that type of work and you want to give these kids that sense of attachment and security and stability then you need very high staff ratios because they will literally drain you emotionally as well. They become incredibly emotionally draining. It's not just the fact that you are having to deal with issues and you are physically on the go for 24 hours, emotionally they will suck you dry.' (HoH 12)

Other suggested resources included more manuals and other literature to read relating to ARC.

> 'We have one book for all the staff, and one manual, and the manual is different, because it's labelled all differently and … when we refer from a consultation report it's to the manual but you're reading the book so even the fact that there's two different books can be confusing.' (RCCW 15)

### A5.7 Desired long-term changes through implementation of the model

Aspirations for the future included the successful integration of the young person into the community and for them to be able to sustain a stable and healthy life. One residential worker described how she hoped that each young person would eventually have their own work file, which documented their progress during their stay in care.

> 'I would like, if we were able to achieve through using it, having an individual work file, where you could see particular gaps or difficulties in development in attachment issues that each young person had could be documented, worked on, reviewed and progressed, moved on, you know what I mean and gone over again so that when a young person is leaving here, they can see what has, what has all this talking been about and whatever happened with that problem that I had, so they would have it to look back on and we would have it to learn from them with our next young person….' (RCCW 15)

# A6 MAP model – Western Health and Social Care Trust

## A6.1 Understanding of how the model was selected

In the Western Health and Social Care Trust, three home managers and eight residential child care workers were interviewed. The majority of staff agreed that MAP somewhat differed from other models or approaches in that it had not yet been written up as a therapeutic model and had been designed and developed organically within the trust.

In general, residential child care staff were not aware of the details of how the model was chosen. One worker did explain that, prior to the initiative, MAP had been informally piloted in one of the trust's children's homes and was found to be a success, so they thought that this had perhaps influenced the decision.

Home managers reported that they had no input into the decision-making process regarding the best therapeutic model to implement; however, they described how nominated staff members from each home attended meetings where alternative approaches were presented and discussed. MAP was presented by the programme developers Paul Harvey and Dr Adrian McKinney and this was attended by service managers and senior service managers who held a discussion and decided that MAP should be implemented within residential child care settings throughout the Western Health and Social Care Trust.

## A6.2 Experience of implementing a therapeutic approach

***Initial reactions and organisational change:*** It was largely agreed that, initially, opinion varied regarding the implementation of the MAP model. There was some criticism that needed to be dealt with gradually, specifically regarding the perceived loss of authority and control because of less emphasis on sanctions. However, after starting to implement the model, the vast majority of both home managers and residential child care workers felt positive as they could see its potential benefits.

> 'I think people are definitely coming round to it. I still see ... people struggling with their own value base and about being a bit more open-minded about stuff of what we can restrict here and what we can't…. But I do feel that ... we have come to a really good place, definitely do ... [the workers] still felt that they were the boss but needed to realise that shouting at them doesn't work as they still do the behaviour. We need to provide the child with some sort of safety and gain their trust so that they can feel that they can talk to us without getting yelled at all the time.' (RCCW 23)

## A6.3 Experience of the training process for the MAP model

All staff interviewed received fortnightly in-house training on MAP from a senior practitioner within the trust, and a clinical psychologist visited homes on a monthly basis where he would talk about strategies relating to MAP. Staff from all of the pilot homes

reported attending the one-day training event that introduced the model, led by the programme developers. However, the majority of staff felt that they needed more formal training on MAP.

> 'There was some answers there, but one day ... we were wanting more than a day and I didn't get it ... you know that initial training package I thought was, it was ok. It was four and a half/five out of ten. I wouldn't have given it an eight. But I'm not faulting the people, the delivery; I think I'm faulting more the idea that it was a one-day thing. I think if you're gonna change an approach to lives, it's not like a wee therapy session....' (RCCW 31)

Others also attended a training event in January 2011 hosted by a clinical psychologist who deals with trauma and attachment problems.

> '[H]e was like a wee breath of fresh air. And it just made you think ... we actually are doing what [he] is saying, you know. And it's not rocket science; it's just looking at your approach differently … not barging in and shouting and screaming ... you're actually taking a step back and thinking: "right, well as [the consultant clinical psychologist] would say 'let's figure this out'"... I thought he was fantastic.' (RCCW 30)

Most of the staff stated that MAP was discussed during changeover meetings and used during supervision.

> 'When asking staff about particular incidents … I would ask what strategies or techniques they used and sometimes they find it hard to explain or even remember but when I mention MAP it's as if a light bulb is turned on and they are able to explain the event and any strategies used when they relate it to MAP.' (HoH 13)

### A6.4 Factors that help or hinder implementation

Taking a more child-centred approach to practice was considered by quite a few to facilitate the implementation of MAP.

> 'A more child centred view and realising that they are not your children, that's another thing that would have come up, you know – "If that was my child I wouldn't be letting him do that, let him get away with that" – but he's not your child.' (RCCW 29)

Another factor that one worker felt helped the implementation of the model was the age of the young person when entering residential care. They felt that young people aged 15 years or over were more open to forming relationships with staff, aiding the implementation of MAP, whereas those aged 12 to14 years were described as being more difficult to bond with.

One factor thought to seriously hinder the implementation of MAP was that there was no manual written as yet – staff were given a folder containing a collection of academic articles relating to attachment; it was therefore felt that it was hard to fully implement the model. Only a small number of staff felt that reading the folder provided was particularly useful.

> 'This is the problem with this whole process is that I've been asked to implement something that doesn't exist in its finished form.' (HoH 16)

One residential child care worker felt that the programme developers had not been given the time that they deserved to fully develop the model by the trust.

Lack of consistency in practice was another hindrance raised by the majority of respondents.

> 'One of my challenges would be coming up against maybe another staff member who doesn't fully understand it or maybe doesn't believe in it. I think, when you're making decisions on the floor and you're ... keeping MAP in your mind, and how you're going to make that decision, some people that you work with might want like a black-and-white approach, you know, "no they're getting sanctioned" bla bla.' (RCCW 29)

It was also reported by a few that MAP did not recognise that young people often presented with physically aggressive and defiant behaviour, which resulted in an unsettled home, an increase in incidents and more emphasis on child protection and therefore less emphasis on MAP.

In general, respondents thought that the model could not be applied in a situation where the young person was under the influence of drink or drugs, where the only the approach to take was to ensure the safety of all concerned. In such a circumstance, one residential care worker suggested that on the following day, instead of punishing the individual, one should take them for a long drive so that they can relax and hopefully talk about anything that is bothering them.

### A6.5 Job satisfaction and improved practice of individuals and teams

***Change to practice:*** The majority of staff felt that MAP facilitated practice in many ways. Attachment was considered a core element of practice by many, and was useful to understand the background and history of a young person in order to try to make sense of their behaviour. It also provided a framework for staff that enabled them to look at their existing skills and to deal with incidents in a different way – usually in a restorative way, resulting in much less conflict. The fact that workers felt empowered to admit that they could have done things differently previously in their practice was considered to be a real learning curve. In general, it allowed staff to become more reflective.

> 'I suppose a good way of explaining it is that everything is not always what it seems – there is always something behind the behaviour and we need to try and understand

> what it is. It is almost like reprogramming the young person – to teach them that you can trust adults, we will show love, and give them a firm attachment so that they can carry this through their life. Attachment is a fundamental building block for everyday life.' (RCCW 23)

Staff unanimously reported a reduction in conflict within the home as a result of the model, and improved relationships between workers, young people and their families, with all those involved treating each other with more respect.

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

Increased contact between young people and their families was considered by the majority to be a significant benefit of the new way of practising.

> 'There's things that's been happening here in the last six months that we never thought would be able to happen. More contact [with families], which resulted in calmer children and happier children.' (RCCW 29)

A main change to practice was that sanctions were not issued as often, and an alternative approach that focused more on using the relationship with the child to resolve issues was considered to be much more effective in improving both relationships and behaviours of young people. One worker commented that staff and young people seemed much calmer since the introduction of MAP, with staff having more energy to invest in productive things. Another talked about the changes to her ways of dealing with challenging situations.

> '[T]here's a few staff here who it just sort of rolls off, they're very good at it ... but then there's somebody like me that has to sort of, take that step back and keep thinking right, come on, stop it, you can do this, you know you can deal with this the right way rather than jump in and make a whole hames (mess) of it, you know, 'cause that's all it takes – the wrong word to the wrong person and you have created a nightmare.' (RCCW 30)

Some staff provided examples to help illustrate the benefits of using the model for practice (see Examples 5 and 6).

**Example 5**

'Well we have a 17-year-old here who was in and out of secure [care]. When she came to us, she came to us from secure. She wasn't here very long when she was back in secure again. So she's now with us and hasn't been in secure for what, the guts of a year now. Her relationship here with us is, well we still have our difficulties with her, and she has her difficulties with us, but the relationship building with her is as plain as the nose on your face. You know, she feels wanted, she feels part of this home, she feels that we actually do care for her because we talk to her, we listen to her, we don't sanction her, we don't threaten her with secure or we don't call the police if something happens, if she absconds or if, say, she's out and is drinking or taking drugs.... No, we make sure she's safe and we sit down the next day talk to her ... she's been to see her mummy in England ... three or four weekends, whereas before that would have been totally unheard of, 'cause she'd have been in secure or she would have been running all weekend ... and I think that that's down to us, a different approach with her, and I think the outcomes are good.' (RCCW 30)

**Example 6**

'You know, genuinely being there, and this whole attachment thing, it did help. If we'd have sanctioned every night he came back late I wouldn't even have gotten into the room to chat to him, you know, "keep me pocket money, bang [denotes the young person slamming their bedroom door], get out, I'm away out the night again", you know, it'd have been a cycle of that there, there'd be no getting in through the door and sitting down and chatting to him. Whereas this gave us that opportunity to get in there. It sounds quite wishy washy but it was real in that situation.' (RCCW 31)

However, a few home managers pointed out that there were some instances where young people had to learn the consequences of their inappropriate behaviour, for example if a young person has broken a window 'it is not normal behaviour and there is a consequence for the behaviour they have to pay' ( HoH 13). Another home manager said that the only time they sanctioned young people was when they thought they were spending their pocket money on drugs, in which case they would withhold it:

> 'We would spend the pocket money with them – that's really the only time we would sanction. We deal with things on the hoof, in the house, as they happen and then sometimes after they happen, when a period of calm has occurred.' (HoH 16)

Quite a few staff felt that MAP simply provided labels for what they were already doing. It was generally felt that MAP was not a stand-alone model for residential child care practice and only formed part of the toolkit required.

> 'TCI [Therapeutic crisis intervention] sits well along side it and … PSNI [Police Service of Northern Ireland] … have to be contacted when certain situations get out of control. MAP is not an adequate method to use in these circumstances ... MAP is a child-friendly way of doing things – it doesn't cover everything.' (HoH 16)

***Perceived change to staff:*** An increase in staff morale and confidence levels was reported by a significant number of workers, with a perception that sick leave had dropped, with fewer confrontations taking place between staff and young people. An example given by one member of staff highlights some of the complexities associated with a less confrontational approach.

> 'When you remove the confrontational things, it gives a chance to get in there, to lie on the sofa and watch TV if they're not at school; to try and understand why they're not at school and what they feel about school and what's going on in their head, as opposed to the door being closed and staff as such, there's, most of them, myself included, confidence wise, you develop more, more confident in what you do, and you know what you're doing is right and it improves practice....' (RCCW 31)

***Perceived change in children's behaviour since implementation of model:*** The overall view of staff was that young people had become more relaxed as a result of the implementation of the MAP model, with one worker highlighting the fact that the number of incidents within their home had reduced dramatically.

> 'When they go out they know not to fear coming back now as they won't get shouted at, but I think this has been very beneficial as if we ring them now they are more likely to pick up and tell us that they are safe. We need to remember that some of these young people may never have had boundaries or structure and it takes a while to pick that up.' (RCCW 23)

### A6.6 Strategy for the maintenance and development of the model

Respondents thought that it would be useful to have regular refresher training sessions outside the unit, and longer training sessions, as well as formal training for new staff and field workers. Other resources included money for training, an established workforce and ways of keeping experienced members of staff (such as creating opportunities for promotion that do not include weekend work and sleepovers). It was also thought that more research into the model should be carried out, with the aim of creating a pack that people could pick up, which would illustrate how to relate to young people in certain situations, and give practical examples of this.

It was also thought to be beneficial to discuss progress and share experiences with staff from other homes within the trust:

> 'Space to sit down away from here, 'cause ... the amount of team meetings you come into and it's going grand, but if you get called out for three phone calls during that and the wee ones are up and they're banging the door, so although we're looking at it during the team meeting, you're not getting the time and space plus as I'd say, the five-day thing ... if there's new research going on, to be kept up to speed on what's going on; … and if you'd different practitioners from other places too, just to share, share their experiences, 'cause we're talking about ours at the minute but if we could even look at this place down the road that's doing it as well that, say if there were some speakers from England they came over and talked about their experiences, just to share, give as big a picture as possible.' (RCCW 31)

The majority also felt that a smaller number of beds per home would help maintain the benefits of the model. One worker suggested that family support workers, employed to work alongside the residential home, would be of great benefit in building relationships between the family and the home.

### A6.7 Desired long-term changes through implementation of the model

Long-term aims for the model included providing young people with a secure base that they could carry through to adulthood and apply in various life situations; and an opportunity to make positive changes to a young person's life and equip them with the required tools to enter into employment or to start a family of their own.

More emphasis on improving relationships with parents, as well as with the young people, was another common aspiration.

> 'I'd like to see an increase in the understanding of that whole idea of what lies behind the behaviour, that it's about parents as well as children, about their history with social services and how to make that less conflictual ... I would hope that ... our fieldwork colleagues would gain an understanding that we're living in a building here with an open door. That when they put a child in here, that it may remove the risk from their desktop, but it won't lessen the risks that the young person experiences.' (HoH 16)

Another worker described how she would like to see students trained in the principles of the model while at university.

**MAY 2012**

Residential child care is an important component of the looked-after children system in Northern Ireland. The 2007 Regional Review of Residential Child Care (RRRCC) proposed a number of options for improving the skill mix of staff within the residential care sector.

One of the proposals was the adoption and promotion of 'therapeutic approaches' to residential child care. This report presents early findings from an evaluation of therapeutic approaches to residential child care in Northern Ireland.

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