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Therapeutic approaches to social work in residential child care settings: Literature review

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Therapeutic approaches to social work in residential child care settings

Literature review

Professor Geraldine Macdonald and Dr Sharon Millen
Institute of Child Care Research, Queen's University Belfast

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Written by Professor Geraldine Macdonald and Dr Sharon Millen

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Social Care Institute for Excellence
Fifth Floor
2–4 Cockspur Street
London SW1Y 5BH
tel 020 7024 7650
fax 020 7024 7651
www.scie.org.uk

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Executive summary

Children leaving care have notably poorer outcomes than comparable children in the general population, and children in residential care are among the most vulnerable.

In 2007, the Children Matter Taskforce in Northern Ireland commissioned a regional review of residential child care (RRRCC). Following the recommendations in the RRRCC, children's homes across the region are piloting six 'therapeutic approaches' to work with children and young people:

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

Aims of the review

To date, information about the therapeutic approaches has not been collated in one document. Furthermore, while it seemed that the approaches shared a number of underlying features, this had not been explored systematically.

As part of an evaluation of the six therapeutic approaches, the Institute of Child Care Research was asked to undertake a scoping review of the approaches. The aims of the review were to:

- Describe the origins, content and evidence base of the models.
- Analyse the similarities and differences between them.

The review also considered the extent to which each model makes clear its 'theory of change'. At its core, a theory of change spells out how the core components of an intervention (inputs) bring about changes in staff behaviour and organisational processes or culture (outputs) and why or how these changes are thought to benefit children and young people (outcomes).

Key findings

1. There are underlying similarities between the approaches

All the approaches provide a way of thinking about the challenges of working with children with a range of social, emotional and intellectual difficulties. Each provides a framework whose constituent theories are intended to help staff to understand:

- How trauma impacts on children and young people.
- How and why their ways of coping might be maladaptive.
- How and why agencies and staff respond in ways that are not always helpful.
- How they might change. Each emphasises the importance of helping staff develop the knowledge and skills necessary to help those they care for.

The approaches share similar underpinning concepts (see Table 1). With the exception of Social Pedagogy, the significance of trauma and attachment in the lives of children is a feature of all the models in use within the trusts, although trauma and attachment have a more prominent place in some models than others (for example, the theory of attachment is particularly strong in Sanctuary, CARE, ARC and the MAP models). Both theories are used to help staff better understand why children (and staff) behave and relate in the ways they do and provide a conceptual scaffold that can help them think how best to intervene or support children and young people.

Table 1: Underpinning concepts

	Sanctuary	ARC	CARE	MAP	Resilience	Social Pedagogy
Attachment theory	✓	✓	✓	✓	✓	
Trauma informed	✓	✓	✓	✓	✓	
Competences		✓	✓		✓	✓
Neurodevelopmental/ biopsychosocial	✓		✓	✓		✓

The absence of trauma and attachment from most formulations of Social Pedagogy does not mean that these concepts do not feature in the training provided to staff using this approach, or in the expectations of practice. Indeed, material on resilience and attachment are among the background papers provided in the staff training pack. It reflects Social Pedagogy's focus on what society wants for its children and what helps promote their welfare and full potential.

Another similarity between the Sanctuary, CARE, ARC and MAP models is their emphasis on creating an environment that is trauma-informed and aims to be therapeutic, supportive and attentive to the individual needs of children, so as to maximise their chance of healing and growth. In particular, the Sanctuary and CARE models take a full-systems approach to creating a therapeutically beneficial environment. Both these models focus on providing training to all staff at every level within the organisation, with the help of a guiding set of principles. While all models recognise the biopsychosocial nature of development, Sanctuary, CARE, MAP and Social Pedagogy explicitly address this in descriptions of their approach.

The approaches also share similarities in terms of the changes to the way staff work in the homes using these approaches (see Table 2). These include the use of non-confrontational approaches to working with young people, 'modelling' positive behaviours and skills and aiming, where possible, to increase the involvement of the young person with their family.

Table 2: Staff behavioural change

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

2. There are currently few studies looking at the effectiveness of the approaches. Those that were found modest positive impacts but lacked robust study designs.

This part of the review aimed to look at effectiveness studies with a control or comparison group. However, despite an extensive search, only two studies of this kind were identified that examined the effectiveness of the Sanctuary and CARE models. Both studies were carried out by the developers of the models.

In the evaluation of Sanctuary, the authors reported some improvements in Sanctuary youth after six months, compared with young people in standard residential care. They did better in relation to their use of effective strategies to cope with tension; performed better on the verbal aggression scale of the Social Problem Solving Questionnaire; and

evidenced a greater sense of control over their lives, compared with youth in standard residential care, where scores stayed roughly the same. However, the differences related only to a subscale in three measures out of the seven used (Rivard et al, p 86).

An evaluation of CARE conducted in 2006 found that CARE training improved staff knowledge of core concepts and led to intention to change practice in key areas. However, the sample size for this study was small, representing only half of those trained, and relied on self-reports of the people who took part. Outcomes for children and young people were not explored as part of the study.

The lack of strong evidence available for the models does not mean that they are ineffective, but does highlight the importance of adding to the evidence base for these approaches.

3. Implementing the models requires organisational change, which can be challenging

The review also searched for studies that examined the models from the point of view of the experience of key stakeholders, particularly staff and young people. Such studies are important in making sense of the findings of outcome evaluations, as well as being important in their own right.

We found one study that examined the implementation of the Resilience model, some reports from ‘change agents’ who had been responsible for implementing the Sanctuary model and a report on the findings of the English pilot projects in Social Pedagogy.

The studies highlighted:

- the challenges of effecting change in top-down hierarchies and the importance of effective leadership
- the fact that effecting change and securing people’s participation takes time
- problems caused by staff turnover
- the impact of continual organisational change
- the difficulties posed by entrenched and risk-averse organisational cultures
- with regard to Social Pedagogy – more general differences in the organisation of social care services in the UK compared with Europe.

Some useful practices for surmounting these challenges included:

- participatory work groups which plan and guide the implementation
- flexible approaches to rule-setting within homes
- managerial recognition of the contribution of workers to the lives of young people
- development of a culture that rewards young people's successes.

The models at a glance

Children and Residential Experiences (CARE)

Origins: CARE originated in 2005 in the USA. 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: 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.

Model of Attachment Practice (MAP)

Origins: The Model of Attachment Practice 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 youths and their families at the Maples Adolescent Treatment Centre has been particularly influential.

Core components: MAP draws on attachment theory and research on neurodevelopment to help staff 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 staff to help children and young people learn more adaptive and pro-social ways of relating and behaving.

Sanctuary model

Origins: The Sanctuary model was developed in the USA. 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 – which stands for safety, emotion management, loss and future. The model includes a set of practical tools that reinforce the language and philosophical foundations of the model.

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.

ARC (Attachment, Self-regulation and Competency)

Origins: The ARC framework was developed at the Trauma Center at Justice Resource Institute in Brooklyn, MA. Dr Tom Teggart introduced this approach to one of the Intensive Support Units in Northern Ireland. It has since 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
- managing their own effectiveness
- providing a consistent response to children's behaviour and by establishing 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:

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

Resilience model

Origins: The Resilience model used in the Southern Trust was developed as an action research project by Dr Stan Houston with staff in one residential care home. It drew particularly on a model of resilience articulated by Daniel and Wassell (2002).

Core components: Essential to the fostering of resilience is a secure base where the child feels a sense of belonging, good self-esteem and a sense of self-efficacy. The Resilience model aims to promote at least one secure attachment, to cultivate a safe environment and provide children with a range of social supports. It seeks to develop self-esteem by fostering children's talents and interests.

Theory of change: This model shares many of the features of ARC. Essentially it believes that it is possible to boost children's resilience by providing a protecting network and a strengths-based approach to intervention. This, in turn, should improve outcomes for children.

Social Pedagogy

Origins: Social Pedagogy has a long history as a recognised discipline in Europe. It aims to promote children's social functioning, their inclusion, participation, social identity and social competence. In June 2007 the Department for Education and Skills (DfES) (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 is 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.

Review methodology

A protocol for the review was agreed in consultation with the relevant managers in the health and social care trusts, the Department of Health, Social Services and Public Safety (DHSSPS) and the Social Care Institute for Excellence (SCIE).

The review looked at papers that described the therapeutic approach, examined process and implementation or reported the findings of an effectiveness study.[1] It included only studies that had included children and young people aged eight to eighteen years of age in residential care settings, including secure settings and mainstream residential schools that provide accommodation for pupils for more than 295 days a year.

A systematic search strategy was used to identify relevant literature. The search identified 25,026 citations. After removing duplicate citations and those that were clearly irrelevant, hard copies of 1,537 citations were either retrieved or scrutinised online. Those that failed to meet one or more of the inclusion criteria were excluded, leaving 38 papers that informed this review.

[1] We defined 'effectiveness studies' as those with a comparison or control group.

Introduction

In 2007, the Children Matter Taskforce in Northern Ireland commissioned a regional review of residential child care. Improving outcomes for children in care was a key aim, and the review reiterated the importance of enhancing the skills, confidence and job satisfaction of residential care staff, as a means of improving the care of children in children's homes.

Prior to the completion of the review, the five health and social care trusts had begun to pilot a range of systematic changes in the way that staff approached the care of looked-after children in residential care, including a range of 'therapeutic approaches' to residential child care. The regional review endorsed this development with the recommendation to promote therapeutic approaches within residential care. Each trust has adopted a different approach (see Table 3).

Table 3: Models used within the five health and social care trusts

Trust	Name of model/approach
Belfast	Social Pedagogy
Northern	Children and Residential Experiences (CARE)
South Eastern	Sanctuary
Western	Model of Attachment Practice (MAP)
Southern	Resilience model and Attachment, Self-regulation and Competency (ARC)

The introduction of an explicit model of care, championed by the heads of homes and delivered in collaboration with a whole staff team, has much to recommend it in terms of the existing evidence regarding how best to improve the quality of care. However, at the time these approaches were piloted, information about their underpinning evidence-base had not been collected in one place. Nor was it clear to what extent –while conceptually distinct – they did or did not embody similarities in practice. As part of an evaluation of the six therapeutic approaches, the Institute of Child Care Research was asked to undertake a scoping review to describe the origins, content and evidence base of the six therapeutic approaches/models being used in Northern Ireland.

Background

Children looked after

Children leaving care have notably poorer outcomes than comparable children in the general population, faring less well in their physical, educational, social and economic wellbeing. The traumatic pre-care experiences of many looked-after children heighten their risk of developing mental health problems (Meltzer et al, 2004) and evidence indicates that children and young people in public care have higher levels of mental health need than those living at home, although they may not describe them in these terms (Mullan et al, 2007; McAuley and Davis 2009). Further, mainstream child and adolescent mental health services appear not to be meeting their needs (Taggart and Menary, 2005), an issue that was highlighted in the Bamford review of mental health and learning disability services in Northern Ireland (Bamford, 2006).

A majority of looked-after children experience abuse or neglect before coming into care and many have had problematic attachments with their birth parents or other carers. Children in residential care are the most vulnerable among looked-after children, often having experienced multiple placements. Older children often find themselves in residential care, either because they cannot be contained elsewhere, or because they cannot cope with the demands of family life, or because their behaviour is too challenging.

The range of difficulties is illustrated in Sinclair and Gibb's study of 223 young people in residential care (Sinclair and Gibbs, 1998a and 1998b). Seven out of ten young people had been excluded from school or were frequent truants; one third had engaged in self-harm or attempted suicide; and six out of ten had been involved in delinquency. At least four out of ten had been involved in violence to others, had run away from home or from care, or put themselves at risk through sexual behaviour. Over half had previously been in foster care and a similar proportion had had previous episodes in residential care. Twelve years on, there is evidence that the needs of children in residential care are, if anything, more complex. Despite a variety of government initiatives to improve the quality of care and outcomes for looked-after children, improvements are proving hard to secure (NSPCC, 2009).

Residential care in Northern Ireland

Northern Ireland places a higher percentage of children and young people in residential care than other UK jurisdictions (13 per cent compared with 11, 10 and 5 per cent in England, Scotland and Wales, respectively) (Children Order Statistical Bulletin 2007/2008). As of 30 June 2009, there were 54 residential homes for children in Northern Ireland. Forty-two of these were statutory homes providing 312 places, equivalent to 7.2 places per 10,000 of the population under 18 years. The remaining 14 were independent homes located in four of the five trusts (none in the Western Trust). The independent homes provided 74 places, half of which were in five homes in the Belfast Trust (Regulation and Quality Improvement Authority, 2010).

On 31 March 2009, there were 2,463 looked-after children in Northern Ireland. This is an increase of 1 per cent from 2008, and a fall of 2 per cent since 2004. Table 4 details the distribution of children and young people in residential care across the five trusts on 31 March 2008.

Table 4: Children looked after by age and gender as of 31 March 2008[2]

Trust	Under 1		1-4		5-11		12-15		16+		Total		
	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	All
Belfast[3]	6	8	43	45	103	80	99	77	73	58	324	268	592
Northern	4	6	38	36	92	76	80	76	49	49	263	243	506
South Eastern	8	4	48	36	87	79	80	87	64	60	287	266	553
Southern[4]	0	0	0	0	64	61	55	42	30	32	180	176	356
Western	0	0	0	0	73	67	66	71	44	46	211	215	426
Northern Ireland	24	25	182	182	419	363	380	353	260	254	1,265	1,168	2,433

Source: Children Order Statistical Bulletin 2007/2008

Many studies bear witness to the very positive relationships developed between children and staff in care homes (Triseliotis et al, 1995; Sinclair and Gibbs 1998; Anglin, 2004). However, there remains considerable room for improvement in the experiences of children in public care that would help improve their life chances as adults.

What works in residential care?

The answer to the question 'What works in residential care?' depends on the purpose for which it is being used. Many of the early studies of residential care have limited value in the current policy context. However, researchers are generally in broad agreement about the characteristics of children's homes that provide good quality care (Berridge and Brodie, 1998; Sinclair and Gibbs, 1998). This is not necessarily the same as an effective home, but it is certainly a prerequisite. Homes that provide good quality care are those where:

[2] Source: **www.nspcc.org.uk/inform** 0 represents a zero or a cell count less than 4 in order to avoid personal disclosure. In addition, where a zeroed cell cannot be deduced from the totals, the next smallest cells will be zeroed. For this reason some row or column totals may not tally.

[3] Belfast HSC Trust did not provide the clarification requested regarding respite cases.

[4] Figures for the Newry and Mourne locality of the Southern HSC Trust exclude children looked after for respite.

- heads of home have a clear remit and sufficient autonomy to pursue it
- heads of home are clear how the home should be run
- there is a consensus among the staff and between the staff and the head of home about how it should be run.

Homes with these characteristics appear to have less staff turnover, less delinquent behaviour among residents and to elicit more positive accounts of the home by both staff and residents. In a study of children who go missing from residential and foster homes, Wade and Biehal (1998) found that rates differed from 25 to 71 per cent across the children's homes in their study. Wade and Biehal asked a small number of children why they went missing. Among the reasons the children gave were bullying and intimidation, being unsettled or insecure in the placement, and 'a general lack of confidence and sense of disempowerment among residential staff' (p 197). The factors listed above appeared to mitigate this behaviour.

Scoping review – methodology

Protocol

A protocol for the review was agreed in consultation with the relevant managers in of the health and social care trusts, the DHSSPS, and the commissioners of the work, SCIE. Inclusion criteria were set in relation to the types of paper or study, the participants involved and the types of intervention.

Inclusion/exclusion criteria

Types of studies included

- Papers or other publications describing any of the therapeutic models, their theoretical and/or empirical origins and their subsequent development.
- Papers or other publications describing the 'theory of change' underpinning each model (see below for more information on the theory of change).
- Outcome studies providing evidence of the effect of each model, irrespective of study design, with the exception of Single Case Designs.
  It was agreed that judgements on effectiveness would be based on studies with comparison groups, where these existed.
- Studies examining process and implementation issues of each of the six models.

Types of participants included

- Children and young people aged eight to eighteen years of age, in residential children's homes, including secure settings, characterised by measures of physical restraint, for example, locked doors, bars and walls. Children in secure settings may have committed an offence or need extra protection provided within these settings.
- Children could be in homes designed to provide short-term or long-term care.
- Children in mainstream residential schools that provide accommodation for pupils for more than 295 days a year.

Children in the following settings were excluded:

- Residential provision designed to meet the needs of children with a disability or health need; learning disability, drug or alcohol addiction; or serious mental illness was excluded.
- Semi-independent supported lodgings/hostel accommodation (i.e. halfway houses) that help those children aged 16 years and over prepare for independent living.
- Foster care or adoptive placements.
- Hospitals or residential family centres.
- Settings where children are living with their parents, relatives or foster carers.

Types of interventions included

The types of interventions to be reviewed are the six interventions listed below:

- ARC model
- CARE practice model
- Model of Attachment Practice
- Resilience model
- Sanctuary model
- Social Pedagogy

Only publications describing these models of intervention, exploring their implementation or assessing their impact were included. Studies relating to other models or approaches were excluded.

Types of outcomes

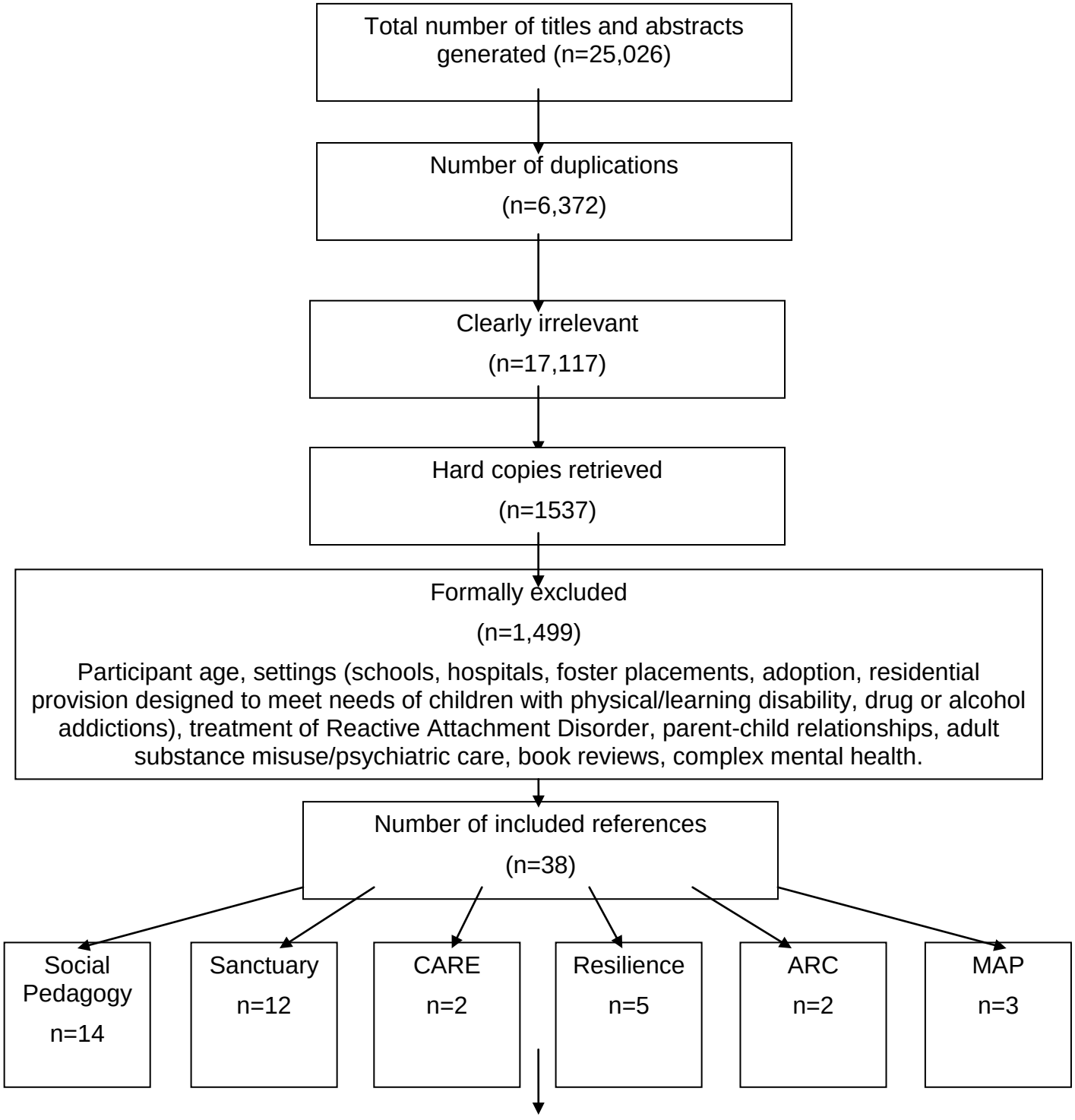
Outcomes of any description used in impact studies were included in the review

Search strategy and study selection

A systematic search strategy was used to identify the relevant literature (see Appendix 1). The search identified 25,026 citations which were independently reviewed by two researchers against the inclusion criteria above. After removing 6,372 duplicate citations, the researchers screened for ‘clearly irrelevant’ citations and eliminated a further 17,117. In order to make judgements on the eligibility for inclusion of the remaining 1,537 citations, hard copies were retrieved or scrutinised online. Of these 1,499 were excluded on the grounds that they failed to meet one or more of the inclusion criteria, i.e. participant age, settings (schools, hospitals, foster placements, adoption, residential provision designed to meet the needs of children with physical/learning disability, drug or alcohol addictions), treatment of Reactive Attachment Disorder, parent-child relationships, adult substance misuse/psychiatric care, book reviews, complex mental health. There were no significant disagreements

and differences were resolved by discussion. The flow chart on the next page provides an ‘at a glance’ account of this process. Of the remaining 38 papers included in the review, most were at a level of describing the models rather than providing evidence of their effectiveness (see later sections of the report). Other papers – not represented in the flow chart - were identified through searching reference lists of included articles and websites established by model developers.

Figure 1: Quorum flow chart



***** While no citations dealt explicitly with MAP, we included nine papers that seemed to be of direct relevance to the development of this model within the Western Trust.

Origins and content of the models used within the trusts

Introduction

In this section we outline the origins, underpinning assumptions and core components of each model, as described by the people who developed them. We then consider to what extent each model makes clear its 'theory of change'.

At its core, a theory of change spells out how the core components of an intervention (its 'inputs') bring about changes in staff behaviour and organisational processes or culture (the 'outputs') and why or how these changes are thought to benefit children and young people ('outcomes').

Lipsey (1993, p 11) identified the following as minimal elements of an 'intervention theory' or theory or change:

1. A clearly articulated problem definition, spelling out what the problem is, its aetiology (if possible), those it affects and the likely consequences in the absence of intervention.
2. Specification of the essential components of the intervention; the frequency, duration, and 'quantum' thought necessary to bring about change, and how this can be delivered.
3. The means whereby the intervention brings about change, including any important sequencing of events or relationships between component parts, any mediating variables that might explain differential responses to the intervention, such as individual differences, timing, method of delivery.
4. Specification of expected outputs and outcomes, and the interrelationships between them.

A theory of change might also seek to specify the likely influence of

- environmental factors – such as social conditions or facilities
- implementation issues – such as the ways in which the delivery of an intervention might influence its impact, for example staff skill levels
- chance variations that occur in any research programme, including variability in staffing, external events and measurement.

Children and Residential Experiences (CARE)

Origins: CARE originated in 2005 in the USA. It resulted from a partnership between Cornell University, the South Carolina (SC) Association of Children's Homes and Family Services, the Duke Endowment and the SC Department of Social Services. The aim was to develop 'a competency-based curriculum', based on research evidence and best practice (they consulted with some 100 residential care staff about the competencies required for their work) that would help residential care staff establish practices that would improve outcomes for children.

Holden – the principle architect of CARE – and her colleagues have described CARE as a 'multi-component programme designed to build the capacity for residential care organisations and staff to provide a research evidence informed practice model to the children in their care' (Holden et al, 2010, p 133). This practice model was introduced to SC homes in 2006 and 2007.

Core components: The CARE curriculum focuses on two areas of competence. One is organisational and is concerned with improving leadership and organisational support for change. The second emphasises the importance of enhancing consistency within and across team members in the ways in which they think about, and respond to, the needs of children in their care. In developing consistent practice, CARE draws on evidence from a number of issues relevant to the development and the wellbeing of children in residential care, namely:

- strengthening attachments
- building competencies
- adjusting expectations to account for children's developmental stage and trauma history
- involving families in children's care and treatment
- enriching the environment.

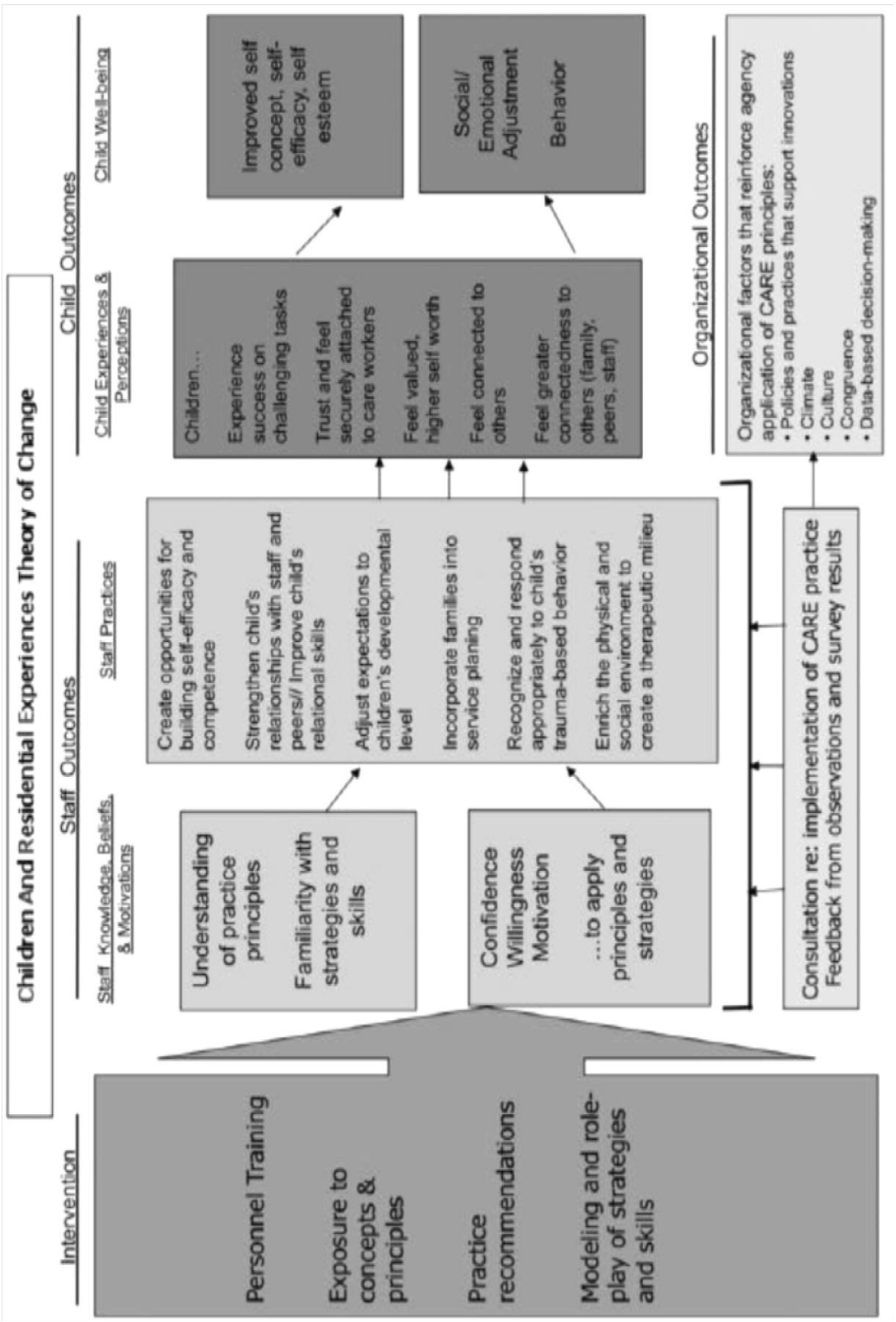
Guiding principles: Drawing on the available evidence, CARE's training curriculum is organised around these six guiding principles (Holden et al, 2010, pp 136–139):

1. *Developmentally focused* – Residential care provides an opportunity to enhance children's chances for normal development. Because looked-after children have often experienced trauma and life events, they may need additional support and 'healing experiences' in order to overcome the resulting impediments to their development. Staff need to be mindful of how best to facilitate and encourage children's normal development. They are taught that children learn best when tasks are difficult for them to do alone, but achievable with assistance (Vygotsky's theory of the *zone of proximal development* – Vygotsky, 1978). Staff learn how to enhance children's developmental competencies by i) teaching skills that are missing or maladaptive; ii) creating opportunities for children to practice these skills with adult assistance, and iii) adapting the environment so that children can succeed.

2. *Family involved* – Because a child's identity (in terms of race, ethnicity and culture) is inextricably tied to their family, involving a parent or other significant adult is a vital component in planning for the child's return to the community. This accords well with the legislative requirement of the Children (Northern Ireland) Order 1995 to work in partnership with families.
3. *Relationship based* – Good quality attachments and nurturing care experiences are necessary for children to be able to form meaningful relationships (Maier, 1991). Positive relationships between children and staff (or carers) enable children to feel safe, to learn to trust and be able to gain assistance to overcome barriers and problems they face. In other words, they enhance resilience. Good attachments with staff maximise staff influence in helping children learn a range of important interpersonal skills (Masten, 2004).
4. *Competence centred* – This refers to the combination of skills, knowledge and attitudes that children need in order effectively to negotiate the challenges of daily life. Staff are encouraged to help children become more competent at managing both their environment and learning new skills.
5. *Trauma informed* – Research suggests that children's development is adversely effected by trauma, such as neglect, abuse and violence (Bloom, 1997). CARE teaches staff to take into account the impact of a child's trauma on all interactions, activities and expectations. CARE stresses the importance of establishing and maintaining a safe, non-violent culture in which children can learn adaptive ways of coping with stress.
6. *Ecologically oriented* – A caring and supporting environment provides the wherewithal for children learn how to look after others and themselves. In an environment where there are caring adults who will show their belief in the child's abilities and strengths, a child is motivated to learn and the more the environment can be enhanced to motivate the children to participate in activities and relationships, the better the child's opportunities for growth and development (Benard, 2004).

Theory of change: Figure 2 details the logic model underpinning CARE. At its core is the argument that by engaging staff at all levels of the agency and providing them with intensive training around the above six principles, all of which are based on research relating to child development, that one can create the conditions for a service that can improve children's wellbeing. The conditions provide for a cohesive approach to care, in which staff learn how to enhance their interactions with children and provide an enriched environment which, together, create a more therapeutic milieu. When the six principles are realised and maintained, children develop more positive perceptions of themselves and others and, ultimately, these lead to improvements in their social and emotional wellbeing and in their behaviour (Holden et al, 2010, pp 134–135).

Figure 2: The Children and Residential Experiences: theory of change (reproduced from Holden et al, 2010, p 134) – see below.


Children And Residential Experiences Theory of Change
Intervention
Staff Outcomes
Staff Knowledge, Beliefs, & Motivations
Staff Practices
Child Outcomes
Child Experiences & Perceptions
Child Well-being
Organizational Outcomes
Personnel Training
Exposure to concepts & principles
Practice recommendations
Modeling and role-play of strategies and skills
Understanding of practice principles
Familiarity with strategies and skills
Confidence
Willingness
Motivation
...to apply principles and strategies
Create opportunities for building self-efficacy and competence
Strengthen child's relationships with staff and peers// Improve child's relational skills
Adjust expectations to children's developmental level
Incorporate families into service planing
Recognize and respond appropriately to child's trauma-based behavior
Enrich the physical and social environment to create a therapeutic milieu
Children...
Experience success on challenging tasks
Trust and feel securely attached to care workers
Feel valued, higher self worth
Feel connected to others
Feel greater connectedness to others (family, peers, staff)
Improved self concept, self-efficacy, self esteem
Social/ Emotional Adjustment
Behavior
Organizational factors that reinforce agency application of CARE principles:
• Policies and practices that support innovations
• Climate
• Culture
• Congruence
• Data-based decision-making
Consultation re: implementation of CARE practice
Feedback from observations and survey results

Model of Attachment Practice (MAP)

Origins: The Model of Attachment Practice (MAP) is a model being developed within the Western Trust. At its core is the application of knowledge, evidence and experience derived from working with children with attachment difficulties. It takes a developmental approach to attachment, drawing on other relevant research concerned with neurodevelopment and the importance of authoritative parenting. The following account draws on the information available from the trust (in the form of training material) and the wider literature on attachment and neurodevelopment.

Core components: In developing the model, the trust has drawn on a range of sources, including work within foster care (IFCO, 2006). One of the projects most influential in shaping MAP has been a Canadian project for conduct-disordered youth and their families, undertaken at the Maples Adolescent Treatment Centre in British Columbia. The centre seeks to avoid strategies that emphasise control and containment of challenging behaviour. Such strategies are thought to undermine young people's already frail attachments to adults and trigger power struggles that pre-empt their ability to develop a sense of responsibility for their actions. Instead, staff use empathy and conflict resolution strategies that aim to strengthen relationships and promote individual and family development.

Attachment relationships – Attachment theory hypothesises that it is through attachment relationships that we develop 'mental representations' of others and the self. These 'internal working models' contain expectations about:

- other people's behaviour
- how loved, accepted and socially effective the self is
- the availability, emotional interest and concern of others, especially our caregivers (Bowlby, 1979).

Many looked-after children have experienced care from carers who appear 'emotionally unavailable' to them (Moses, 2006). As a result they are less able to see themselves as loveable or worthy, or to see other people as emotionally available and caring. This impairs their ability to trust others or to form healthy relationships, with all that follows.

The rationale for attachment-based interventions is therefore that giving children the opportunity to establish **good** close caregiving relationships provides a means of addressing the problems associated with poor attachments (Keck and Kupecky, 1995; George and Soloman, 1996). The general premise underpinning the therapeutic dimension of residential child care is that all interactions in the environment have the potential to be a 'corrective' emotional experience for children with insecure attachments. Such supportive relationships create a milieu where young people feel safe, secure and have the potential to grow (Moses, 2006).

Neurodevelopmental perspectives – Neurodevelopmental perspectives suggest that post-natal brain development is significantly shaped by the experiences that infants have with their primary carer. The stimulation provided by nurturing relationships effectively 'sculpt' the brain, causing neurons to 'fire', neural circuits to form, followed by the complex neural networks that set the framework for a child's sense of self and others, and their ability to build and sustain social relationships (see Sullivan and

Lasley, 2010). Maltreatment, or any experience that results in prolonged stress, can bring about changes in the brain that can result in difficulties in later life (Perry, 2006 and 2009).

When a child experiences threats to their wellbeing, a cascade of neuronal activity moves through the different brain areas to reach the cortical areas where this sensory information and threat are interpreted and a response activated. The brain is thought to store these memories and patterns of neuronal input that are associated with threat, in order that it might in future be able to react in an immediate and uninterrupted way (see Hanson et al, 2010).

Understanding how children's responses may have been shaped by maltreatment, including neglect, is thought to help staff respond sensitively and appropriately to challenging or unhelpful behaviour, and to provide opportunities for new, positive experiences that may help to reverse the adverse consequences of early childhood adversity (Cicchetti and Rogosch, 2001; Moses, 2006; Gunnar and Quevedo, 2007).

Parenting style – MAP also draws on the research on parenting style (Baumrind, 1967 and 1991) and attunement (Rees, 2011). Like parents or other caregivers, residential care workers need to be **attuned** to the children in their care. Attunement requires a degree of self-awareness and is a skill that can be taught (Bakermans-Kranenburg et al, 2003; Doughty, 2007; Stewart-Brown and Shrader-McMillan, 2010). **Empathy** is essentially the ability to see things from another's point of view and the feelings which accompany this, and to be able to communicate this understanding. **Authoritative parents** have a warm, understanding relationship with a child and a high level of involvement that provides a clear rationale for parental discipline. This style of parenting has been identified as effective and appropriate (Baumrind, 1991). Authoritative parents set clear standards for conduct and use disciplinary methods that are supportive rather than punitive. This encourages children to be self-regulated and cooperative (Darling, 1999).

Guiding principles – The seven principles underpinning MAP have been compiled from the research underpinning the above theoretical concepts:

1. All behaviour has meaning.
2. Early and repeated experiences with primary caregivers set a foundation for our internal working models of relationships with self and others. These can change but it takes considerable time and repeated opportunities for 'unlearning and/or relearning'.
3. Biological legacies (our cognitive and physical capabilities, for example) are integral to our experience and contribute to our internal working models. Staff need to understand their impact for behaviour and children's limitations.
4. Internal working models develop in the context of relationships and experience. They are constantly under review on the basis of experience.
5. Interpersonal relationships are a process of continuous, reciprocal, and unavoidable interplay between each person's internal working models and those of others. Staff need to understand the consequent implications of

emotional demands placed on them and the need for change in staff behaviour.

6. We understand ourselves in relation to others. Our sense of self includes our sense of how others view and respond to us.
7. Enduring change in an individual's behaviour occurs only when there is change in their internal working models supported by change in the system.

The model has formulated a number of rules and strategies (see Table 5) which were adapted from the report *Looking after children who hurt* (IFCO, 2006).

Theory of change: Because of its stage of development, the theory of change underpinning MAP is less well articulated than some other approaches. Figure 3 reproduces the trust's 'ideal model'. The implicit theory of change appears to be that by enabling staff to view children's behaviour through the conceptual lens of attachment theory, and incorporating knowledge of brain development, they can better understand the meaning and causes behind behaviour, particularly challenging or dysfunctional behaviour. This improved understanding, together with knowledge of what works in effective parenting, can bring about changes in their attitudes to children and young people and they will be better able to form good relationships with them. In turn, these will enable staff to help children and young people learn more adaptive and prosocial ways of relating and behaving. Training, team meetings, good supervision and leadership are the means by which these changes are brought about and sustained.

Figure 3: Ideal map model

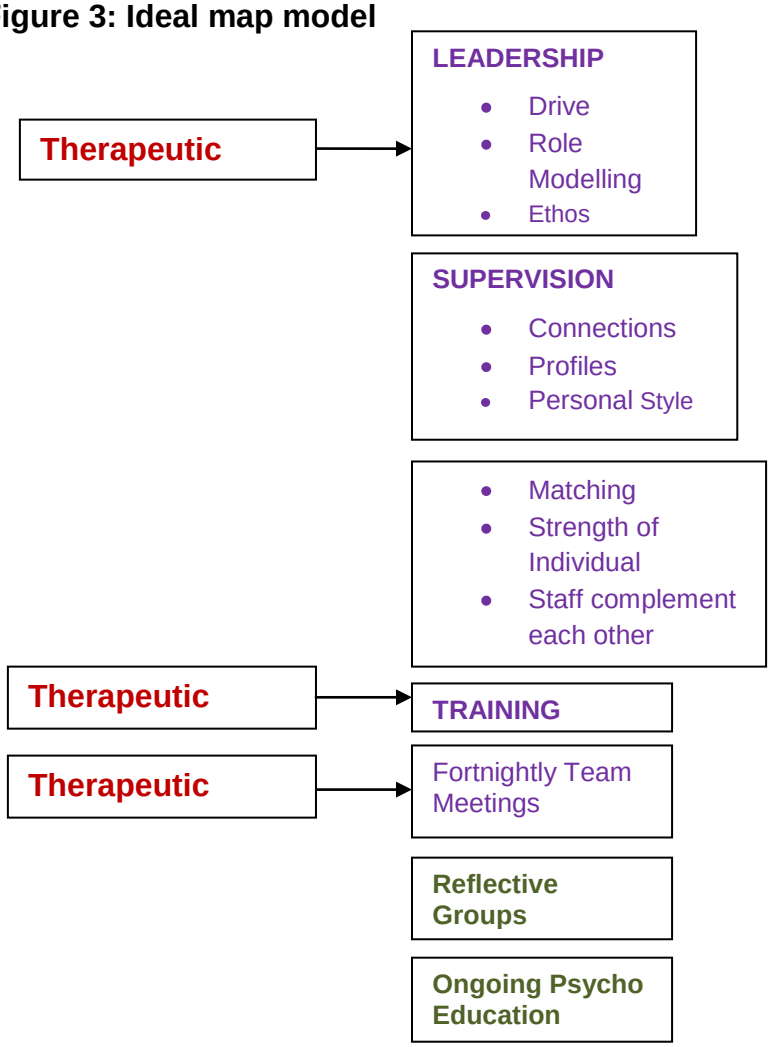


Table 5: MAP rules and strategies for carers

	Rule	Why?	Strategy
1	Don't try to teach.	Because traumatised children's brains are not wired up to understand complicated sequencing and concepts.	Model and practice behaviours, with the focus on accentuating the positive and making it fun.
2	Work out the child's emotional age and try to bond based on where they are.	In order to be able to attune to the child, the carer needs to know their emotional age to be able to develop appropriate strategies.	Take account of the child's emotional age when doing activities such as hand games, painting, board games etc. Do exercises that encourage direct eye contact.
3	Know your own attachment issues.	We all have attachment histories and patterns. It is important to understand how we were parented. Children in care will feed into difficulties/vulnerabilities from a carers own life.	The carer/staff member should think about how they were parented. If a child is making the carer angry and defensive, then they have won and the carer is not there for them.
4	Have firm boundaries and do not treat children with attachment difficulties the same way you would treat your own children	Confrontation doesn't work with children with disordered attachments. Do not use confrontation as it only escalates problems.	Confrontation doesn't work with children with disordered attachments. Do not use confrontation as it only escalates problems.
5	Take back control.	For a child with an attachment disorder, giving up control is frightening. To be a therapeutic carer you need to be in control.	Therapeutic caring means giving up your own control baggage. Take control without confrontation or lecturing. Move the child into your world with questions and try to take power back.
6	Look after yourselves.	For children to be alright, carers need to be alright and confident beyond survival of a shift.	Find and get support from therapists and others who understand the issues. Use supervision and team meetings to address the issues. Training about attachment disorders, what to do and not do is important. Leadership and supportive team are vital.
7	Draw them into your world.	Children's behaviour is often designed to provoke or create mayhem. It is designed to confirm that they are bad and unlovable, so chose your battles carefully and let others go. Recognise that the child will project their feelings on to you. This is good in that as the carer you will get a sense of their feelings, distress, anger and fear. However it is also hard as it will make you feel bad. Recognise these feelings and put them in the right place.	Don't take behaviour such as spitting, swearing and aggression personally. Take and be in control, don't get drawn into their world. Use of humour can be used appropriately to respond to these behaviours.

The Sanctuary® model

Origins: The Sanctuary model was developed in Philadelphia, USA, originally in an acute inpatient adult psychiatric setting for adults who had been traumatised as children (Bloom, 1994, 1997, 2000 and 2003). It has since been adapted for a wide variety of settings such as youth justice, domestic violence shelters, substance-abuse treatment centres and schools, as well as residential treatment settings for children (Bloom, 2005). The principal architect, Sandra Bloom, describes it as follows:

> *The Sanctuary model is not a specific intervention but a full system approach focused on helping injured clients recover from the damaging effects of interpersonal trauma. Because it is a full system approach, effective implementation … requires extensive leadership involvement in the process of change as well as staff and client involvement at every level of the process (Farragher and Yanosy, 2003).*
>
> Bloom and Yanosy Sreedhar, 2006, p49

Sanctuary is underpinned by a range of assumptions about trauma and its impacts (Bloom, 1994). A core assumption is that children in residential care have experienced trauma in a variety of forms, including maltreatment and disrupted attachments. Trauma can cause post-traumatic stress reactions in otherwise well-adjusted individuals; when it occurs early in life it can adversely affect children's physical, psychological, intellectual and moral development. The coping skills of traumatised individuals can become maladaptive, and their behaviour can appear irrational or inexplicable. Children whose attachments are disrupted may be unable to modulate arousal or control their aggression. They may be less able to problem solve or form stable relationships. Exposure to repeated traumas may result in learned helplessness and increase the risk of developing a range of secondary problems (Bloom, 1994).

Core components: The Sanctuary model combines trauma theories (Bloom, 1997), an 'enhanced therapeutic community philosophy' (Bloom, 1997) and the strategies commended by Friedrich (1996) to address post-traumatic symptoms, unhelpful coping strategies and disruptions to children's development (Rivard et al, 2003):

1. *Trauma theories* – A trauma-informed community recognises our inherent vulnerability to the adverse effects of trauma and organises system-wide interventions aimed at mitigating these (Bloom, 2005). Sanctuary recognises that trauma can arise from discrete events and the impact of cumulative and less tangible experiences such as poverty. A trauma-informed culture can make sense of children's behaviour and, by using trauma-specific approaches, can help children to recover or 'heal' (Bloom, 2005).
2. *Enhanced therapeutic community philosophy* – Like the individuals they aim to help, organisations and the staff within them can misapply survival skills and produce dysfunctional (defensive) ways of behaving. This can result in environments that

exacerbate children's problems. Sanctuary therefore addresses the need for systemic level change (the so-called 'parallel process'). It has adopted a set of values ('seven commitments'), based on UK therapeutic community standards, to help individuals and organisations avoid trauma-reactive behaviours and to develop the organisational context necessary to provide a therapeutic environment for children (see Gatiss and Pooley, 2001; Bloom, 2004). The seven principles are:

- Commitment to non-violence: building and modelling safety skills.
- Commitment to emotional intelligence: teaching and modelling affect management skills.
- Commitment to inquiry and social learning: building and modelling cognitive skills.
- Commitment to shared governance: creating and modelling civic skills of self-control, self-discipline and administration of healthy authority.
- Commitment to open communication: overcoming barriers to healthy communication, reducing acting-out, enhancing self-protective and self-correcting skills, teaching healthy boundaries.
- Commitment to social responsibility: rebuilding social connection skills, establish healthy attachment relationships.
- Commitment to growth and change: restoring hope, meaning, purpose.

3. *The Sanctuary toolkit* – This refers to a portfolio of skills designed to help teams and individual staff members work more effectively, particularly in difficult situations. They include community meetings, team meetings, safety plans, psycho-educational groups and SELF – a framework that equips staff and children with a non-technical language that provides a more helpful perspective on the recovery process. SELF stands for safety, emotion management, loss and future. Victims of traumatic and overwhelming life experiences may have difficulty staying **safe** (refers to physical, psychological, social and moral safety); they may find **emotions** hard to manage; may have suffered many **losses** (including feelings of grief and personal loss) and may struggle to envision a **future** for themselves. SELF provides the organising framework for planning, community conversations and decision-making.

   SELF sets the scene for the deployment of a range of cognitive-behavioural and psycho-educational interventions that, together, can address the symptoms of trauma and help children acquire the skills of accurately processing information, problem-solving, self-regulation and anxiety management, identifying and discriminating feelings, increasing self-efficacy, and using feedback from others (Rivard et al, 2005, p 84). Bloom and her colleagues point to evidence that support

these approaches as the best available to address the needs of children with post-traumatic stress disorder (PTSD) or PTSD related symptoms (Friedrich 1996; Rivard et al, 2005; Cohen et al, 2009).

Implementing Sanctuary requires a commitment from senior staff. Staff at all levels are encouraged to examine shared assumptions, goals and existing practices, to analyse their structures and functioning, and provide a forum for constructive criticism, discussion and change. Workers are encouraged to meet twice daily to provide structure to their therapeutic day and to reinforce the social norms of the community. Democratic participation is regarded as a prerequisite for providing the context in which children (and staff) can learn to modulate emotional arousal in ways that do not interfere with problem solving and good decision-making. Collaboration between staff and children is encouraged and the shared framework and common language facilitate this. Children are included in psycho-educational groups that familiarise them with SELF language and enable them to develop their own self-management skills. Bloom argues that, as a direct result, staff become more interested in what these children have experienced and how much their history has shaped their present behaviour (Bloom, 2003).

The Sanctuary model is explicit about the outcomes that should be observable when it is successfully implemented (Bloom, 2008). Anticipated changes include:

- reduced violence (physical, verbal and emotional)
- a systemic understanding of the impact of trauma and abuse with implications for response
- less victim-blaming and judgemental responses
- clearer and more consistent boundaries and higher expectations
- earlier identification and confrontation of perpetrator behaviour
- improved ability to articulate goals, and create strategies for change
- better understanding of re-enactment behaviour and resistance to change
- a more democratic environment
- improved outcomes for children, staff and the organisation as a whole.

Theory of change: The Sanctuary model is a complex one with no ‘theory of change’ or ‘logic model’ presented by its architects. Rather, it provides a rationale for each of the component strands or parts. The theory of change appears to be that by introducing organisational changes that position staff on the ‘same page’ (in terms of their understanding of trauma and its effects on individuals and organisations) and providing a shared framework and language with which to communicate that understanding, staff can critically appraise organisational practices and facilitate change in their behaviours, structures and processes. Having done this, and equipped with a set of evidence-based interventions that are logically connected to the trauma and the organisational frameworks that underpin it, residential care staff are better able to help children and young people recover from the detrimental effects of trauma and develop the skills they need for adult life, including relationships and decision-making skills.

ARC (Attachment, Self-regulation and Competency)

Origins: The ARC framework was developed by Margaret Blaustein and Kristine Kinniburgh when both worked at the Trauma Center at Justice Resource Institute in Brooklyn, MA (Blaustein and Kinniburgh, 2007). Dr Tom Teggart, consultant clinical psychologist in the Southern Trust, introduced this approach to one of the Intensive Support Units in Northern Ireland, before it was rolled out to other establishments.

Core components: The model developers describe ARC as a strengths-based and component-based framework designed to deal with the problems and vulnerabilities that result from overwhelming stress (trauma) in children's earliest experiences of care (Kinniburgh et al, 2005).

ARC is not a model *per se*, but a flexible framework which enables practitioners to choose from a 'menu' of sample activities and interventions built around ten building blocks or key treatment targets, organised around one of the three domains: attachment, self-regulation and competency (see Table 6).

Table 6: Building blocks of ARC

Attachment	Self-regulation	Competency
Caregiver affect Management (1)	Affect identification (5)	Developmental tasks (8)
Attunement (2)	Affect modulation (6)	Executive functions (9)
Consistent response (3)	Affect expression (7)	Self-development (10)
Routines and rituals (4)		

ARC aims to help children actively explore and integrate their past experiences into a more comprehensive understanding of themselves which, in turn, will enable the young person to engage more effectively with their present (Kinniburgh et al, 2005).

The attachment domain – This domain targets the care-giving system with whom it is important to engage and work. This may be biological parents or significant others, including residential care staff. The four building blocks in this domain are designed to build or re-build healthy attachments between traumatised children and their caregivers, and create a safe environment for healthy recovery. They include helping caregivers to recognise and regulate their own emotions (modelling and depersonalising); helping children and carers learn how to 'tune in' to each other's cues and respond appropriately; improving carers' ability to respond consistently and appropriately, and developing routines targeted at key trouble spots such as transitions.

The self-regulation domain – Traumatised children are often unable to regulate their emotions. Some learn to cope with overwhelming stress by disconnecting from their feelings, lacking awareness of the connection between specific emotions and body states (Cook et al, 2005; Kinniburgh et al, 2005). They tend to internalise responsibility for the trauma they have experienced, which predisposes them to feelings of shame,

isolation and other negative feelings in response to daily events. Emotions expressed by others may be misinterpreted as negative or threatening. ARC aims to help children learn accurately to identify and express affect (in themselves and others) by giving them a language for emotional experience, for building connections between their feelings and triggering stimuli and for sharing their experiences with others in a safe and appropriate way.

The competency domain – Children who have experienced trauma often have impairments in:

- interpersonal competency, making it difficult for them to develop secure attachment relationships, peer relationships etc)
- intrapersonal competency (awareness of internal states, development of positive self-concepts etc)
- cognitive competencies (executive function skills, language development etc)
- emotional competencies.

ARC aims to build developmental competence in children by drawing on what we know about the qualities that foster resilience. Staff undertake individual assessments of the developmental competency needs of children, then work with them to build their executive functioning skills (with the help of teachers, mentors and caregivers) and foster their self-development in areas such as planning, impulse control and social skills.

Theory of change: There is no explicit theory of change within ARC. Implicitly it appears to hypothesise that outcomes can be improved by:

- providing staff with a theoretical framework for thinking about child development and how things 'go wrong'
- targeting those factors thought to derail normal development
- working with children, their families and carers to help remedy deficits and build competencies.

Resilience model

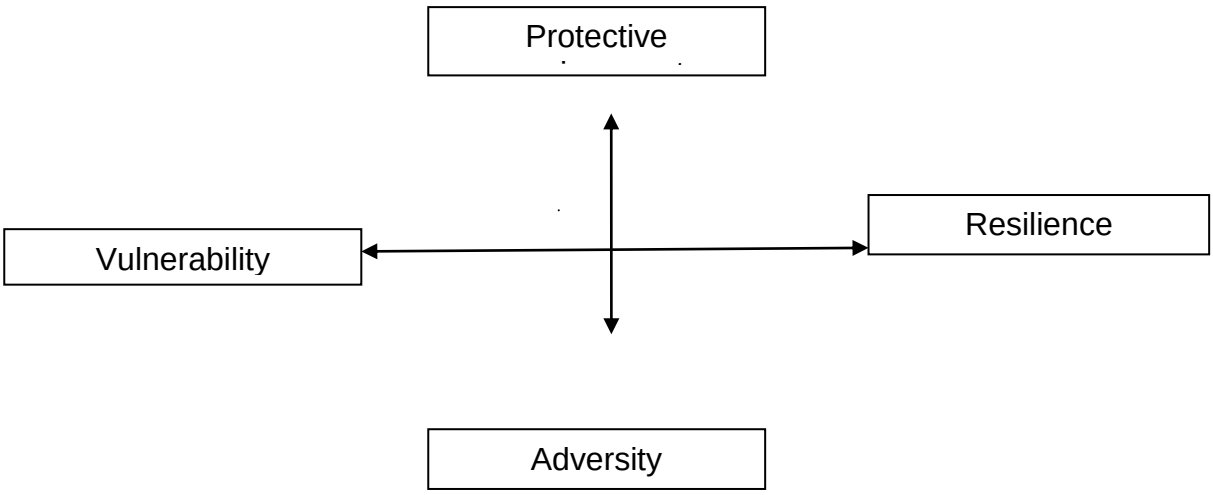
Origins: The Resilience model was developed as an action research project by Dr Stan Houston with colleagues at one residential children's home in the Southern Trust. The impetus for their work was the recognition of high levels of mental health needs among looked-after children, and a desire to move away from approaches that appeared to 'pathologise' children, towards one that emphasised their strengths and the potential inherent in resilience building strategies (Houston, 2010).

Resilience research is located predominantly within an ecological model in which the child's functioning and behaviour are viewed as a function of multiple relationships and influences within and across a number of interacting systems. These include the individual (biological system), family, school, peers, neighbourhood and the wider society. While genetic factors play a role in resilience, the quality of interpersonal

relationships and the availability of support networks are also important (Masten and Powell, 2003; Daniel and Bowes, 2010).

A child's degree of **intrinsic** resilience can be considered as falling somewhere on a continuum with 'vulnerability' at one end and 'resilience' at the other. A range of factors will influence where on this continuum a child might be located, and their influence will change with age and stage (Werner and Smith, 1992; Daniel and Wassell, 2002). But resilience is also influenced by **extrinsic** factors within the family and wider community. These can be a source either of protection or adversity.

Figure 4: The dimensions provided by a resilience framework (Daniel et al, 1999)



Although pointers to resilience may be present these have always to be taken in the context of an individual child's situation. Children who appear to be coping well with adversity, may, internally, be feeling very stressed (Daniel and Wassell, 2002; Daniel, 2003).

Core components: The definition of resilience used in the study was 'normal development under difficulty conditions' (see Fonaghy et al, 1994). The sources for staff training used in this approach drew primarily on the handbook by Daniel and Wassell (2002). Figure 4 provides Daniel and Wassell's framework for the assessment of risk and protective factors within a child's social and emotional environment. The framework provides a basis for developing plans to increase protective factors and thus boost a child's resilience. These centre on developing self-esteem and self-efficacy 'through supportive school environments, cultural activities and sporting pursuits'.

While drawing on a range of sources, Daniel and Wassell's model was used to provide residential care staff with theory and a practice template for enhancing resilience across six domains of experience:

- secure base
- education
- friendships
- talents and interests
- positive values
- social competencies.

Daniel and Wassell's model was used to inform six stage 'action research' cycle of work with staff (see Table 7).

Table 7: Stages for building resilience (Houston, 2010, p 359)

Stage	Description
Assessment	Staff were provided with a checklist of factors to use in appraising young people's needs under each of the above domains.
Goal Setting	Staff were encouraged to identify concrete, specific goals for each of the young people, for the group more generally and in relation to the home. Goals targeted one or more of the above six domains specifying which of a young person's emotional, behavioural, cognitive or social dimensions should be addressed.
Planning action for goal achievement	
Implementation	Drawing on knowledge, skills and values from the model, staff introduced specific interventions directly involving the young person or the systems surrounding them.
Evaluation	This centred on the extent to which an improvement had been effected in the identified domain, identifying the interventions that had helped, enabling and constraining factors.
Initiating another action research cycle	

Key practices included the use of a weekly planner to ensure regular attention to all six domains, plus motivational interviewing and force field analysis. Force field analysis entails examining the factors that support change and those that resist it, and identifying ways of strengthening those that are supportive, while weakening those that get in the way of change (see Lewin, 1951). Daniel and Wassell's model provided the focus for the resilience building work and a conceptual framework to link with other theories such as attachment, mastery and autonomy. The action research provided a method for structuring reflection and action. (Houston, 2010, p 359).

Theory of change: Aside from Daniel and Wassell's model, there is no well-articulated theory of change for the Resilience model. An implicit theory of change appears to be that by enhancing staff knowledge of resilience, helping them to reflect on their work and facilitating an explicit cycle of assessment, goal setting, planning and implementation it may be possible to boost children's resilience. This, in turn, should enhance the likelihood of better long-term outcomes. The means of achieving this is by providing a framework for intervention that focuses on potential areas of strength within the young person's whole system.

Social Pedagogy

Origins: Social Pedagogy is a discipline whose origins some attribute to the German philosopher Paul Natorp (Stephens, 2009):

> The social aspects of 'education' and the 'educational' aspects of social life constitute this science [Social Pedagogy].
>
> Natorp, cited in Stephens 2009, p 344

According to Hämäläinen (2003) Social Pedagogy aims to promote people's social functioning, their inclusion, participation, social identity and social competence. It focuses on the difficulties people may have in managing their lives and integrating in society (Bohnisch, 1997) and has historically focused on socially marginalised groups (Stephens, 2009). In relation to children, it reflects how a given society thinks about their upbringing, about the relationship between the individual and society, and how it supports its disadvantaged or marginalised members.

Every child matters (DCSF 2003) and more recently *Children matter* (DHSSPS 2007) highlighted the need for reform within the early years/social care workforce, and in particular referred to the need to consider models used elsewhere in Europe. Social Pedagogy is the discipline that underpins most work with children and young people in Europe.

> Social Pedagogy provides a theoretical and practical framework for understanding children's upbringing. It has a particular focus on building relationships through practical engagement with children and young people using skills such as art and music or outdoor activities. It provides the foundation for training those working with children in many other European countries. In a residential care setting, it brings a particular expertise in working with groups and using the group as a support.
>
> DfES 2007, p 58

In June 2007 the former Department for Children Schools and Families (DCSF) (England and Wales) proposed the piloting of Social Pedagogy with a view to exploring its effectiveness.

Core components: Social Pedagogy draws on concepts and models from sociology, psychology, education, philosophy, medical sciences and social work in order to address culturally specific social problems through educational means (Hämäläinen, 2003). It is seen as a distinct area of care operating at three connected levels; the

development of theory, the formulation of policy, and the training and education of workers (Petrie et al, 2002). Social Pedagogy embraces a holistic approach to residential child care, attending to a child's mind, body, feelings, sociability and creativity. The essence of social pedagogic practice is the relationship between the pedagogue and the young person, whereby the latter can develop their life skills safely and without the fear of rejection (Bengtsson et al, 2008).

> The pedagogical approach rests on an image of a child as a complex social being with rich and extraordinary potential, rather than as an adult-in-waiting who needs to be given the right ingredients for optimal development … For pedagogues there is no universal solution, each situation requires a response based on a combination of information, emotions, self-knowledge and theory.
>
> Children's Workforce Development Council 2006
> (cited in Them Pra Presentation)

Key principles of Social Pedagogy – Petrie (2006) identified nine key principles of Social Pedagogy:

1. A focus on the child as a whole person, and support for the child's overall development.
2. The pedagogue seeing themselves as a person, in relationship with the child/young person.
3. Children and the pedagogue are viewed on the same level, not existing on separate hierarchical domains.
4. Pedagogues are encouraged constantly to reflect on their own practice and to apply both theoretical and self-knowledge to the demands of their work.
5. Pedagogues are practical; their training prepares them to share in activities of children's daily lives.
6. Children's peers and family are an important resource and pedagogues should foster and make use of this group.
7. Pedagogy builds on an appreciation of children's rights, which extend beyond policy or legal requirements.
8. There is an emphasis on teamwork and an understanding of the contribution of others in socialisation, for example, parents and members of the community.
9. The relationship between the pedagogue and the child is significant, and inherent in this is the importance of communication and listening.

These principles provide opportunities for learning, enable children to empower themselves. This is a holistic process creating a balance between head (cognitive knowledge), heart (emotional and spiritual wellbeing) and hands (practical and physical skills). It also aims to strengthen health sustaining factors resulting in holistic wellbeing.

The relationship – The relationship between pedagogue and child is a particular feature of pedagogy. Achieving the right relationship is necessary, though not sufficient, for success. The pedagogue needs to have a genuine interest in helping a young person develop all of their abilities and use their opportunities for development. The pedagogue facilitates this by creating task-based situations to allow the young person to determine whether they possess certain skills and how they can develop, differentiate and deepen them. The nature of the interpersonal interventions will depend on both the institutional context in which the social pedagogue works and this in turn will depend on the socio-political context in which the institution is located (Badry and Knapp, 2003).

Because of the emphasis on personal relationships, workers need to be skilled at maintaining a proper balance between the personal and professional. The pedagogic role can be split into three dimensions (three 'Ps'): the professional, personal and the private. The private pedagogue sets the personal boundaries of what is not shared with others and should therefore not be part of the relation with a child in care. The personal pedagogue represents what the worker offers to the child – the rapport built up between the worker and the child. Positive relationships between worker and child provide an example of what positive relationships are about. A key message is that workers will have an impact on a child's life regardless of how little time they spend with them and therefore there is a responsibility on each of us to ensure that that is positive rather than a negative impact. Training emphasises the importance of finding explanations for a child's behaviour in order to intervene effectively.

Expectations of staff – Petrie (2007) compared the level of qualifications held by social pedagogues in England, Denmark and Germany. Whereas in England, one third of workers held a medium level qualification, including the NVQ Level 3 and a further third held either no qualification or none that was relevant to their post, staff in Germany were almost equally divided between those with medium and those with high-level qualifications in pedagogy and related fields. Given investment in the area, the level of qualifications is likely to be much higher in Northern Ireland.

Comparison of models

An important question for this review was the extent to which the six models differ in terms of underpinning concepts, core components and implementation. In this section we examine the differences and similarities across the approaches.

Models, frameworks or approaches?

The language used to describe the six interventions differs with regards to whether they constitute a 'model', a 'framework' or 'an approach'. Some use all three terminologies. Some describe themselves as a model, but the approach and content vary considerably across settings and countries (Social Pedagogy). Some move between the language of framework and model (Sanctuary, for example) and others between framework and approach. With the exception of CARE, none provides an explicit 'logic model' or theory of change, although a sympathetic reading indicates an implicit theory of change within each. Further, 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.

One could spend considerable energy determining the conceptual status of the approaches, but to do so would achieve little. All provide a way of thinking about the challenges of working in residential care settings with traumatised children who, as a result of their pasts, have a range of difficulties in their social, emotional and intellectual development.

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

- how trauma impacts on children and young people
- how and why their ways of coping might be maladaptive,
- how and why agencies and staff respond in the ways that they do, not all of which are adaptive
- how they might change.

Each places an emphasis on the importance of helping staff develop the knowledge and skills necessary to help those they care for, and on the techniques that might help.

Models articulate the inter-relationships of their component parts and the pathways of change embedded within them. Where these currently do not exist, it may be that, in time (or if asked), programme developers will articulate a logic model or explicit theory of change. In the following sections, we use the term 'model' in the looser sense of 'approach' or 'programme'.

Similarities between the models

This section highlights explicitly articulated features of the models that are presented as an integral component or defining characteristic. Readers may instinctively feel that we have missed an element within a model with which they work, because it is something that they use or see as part and parcel of the approach. This is because we are making

formal comparisons among definitional or key descriptive components. Something that does not appear in a table with a 'tick' against it may nonetheless be form part of the 'delivery' of the model.

Underpinning concepts

Table 8 summarises the commonalities across the models in respect of four key concepts: attachment, trauma, competence and development as a biopsychosocial phenomenon. Attachment theory refers to the importance explicitly afforded to attachment theory by each model. Models that are explicitly based on an understanding of trauma are categorised as 'trauma informed'. 'Competencies' refers to those models that highlight the importance of developing particular competencies in children and young people, and 'neurodevelopmental/biopsychosocial' indicates those models that **specifically** address the biopsychosocial aspects of human development, particularly brain development.

Table 8: Underpinning concepts

	Sanctuary	ARC	CARE	MAP	Resilience	Social Pedagogy
Attachment theory	✓	✓	✓	✓	✓	
Trauma informed	✓	✓	✓	✓	✓	
Competences		✓	✓		✓	✓
Neurodevelopmental/ biopsychosocial	✓		✓	✓		✓

With the exception of Social Pedagogy, the significance of trauma and attachment in the lives of children are features of all the models in use within the trusts, although each has a more prominent place in some models than others (for example, the theory of attachment is particularly strong in Sanctuary, CARE, ARC and MAP models). Both theories are used to help staff better understand why children (and staff) behave and relate the ways they do and provide a conceptual scaffold that can help them think how best to intervene or support children and young people.

The absence of trauma and attachment from most formulations of Social Pedagogy does not mean that these concepts do not feature in the training provided to staff using this approach, or in the expectations of practice. Indeed, material on resilience and attachment are among the background papers provided in the staff training pack. It reflects Social Pedagogy's focus on what society wants for its children and what helps promote their welfare and full potential.

Another similarity between the Sanctuary, CARE, ARC and MAP models is their emphasis on creating an environment that is trauma-informed and aims at being therapeutic, supportive and attentive to the individual needs of children, so as to maximise their chance of healing and growth. In particular the Sanctuary and CARE

models take a full-systems approach to creating a therapeutically beneficial environment. Both these models focus on providing training to all staff at every level within the organisation, with the help of a guiding set of principles (see above). While all models recognise the biopsychosocial nature of development, Sanctuary, CARE, MAP and Social Pedagogy explicitly address this in descriptions of their approach.

Key model components

(See Table 9.) One would expect overlap between the concepts underpinning a model and its key components. What Table 9 highlights is the greater common ground between the models in regard to providing a nurturing environment, building attachment (even it this is not a major conceptual feature) and helping young people develop competence in a range of areas, including the practical, social and emotional.

Children in residential care often have deficits in competencies due to the high levels of trauma they have experienced, and these models aim specifically to address these deficits according to the needs of each individual child. ARC, CARE, Resilience and Social Pedagogy make particular reference to the concepts of competency. The aim of building competency in **executive functions** and **social skills** is a key similarity between the ARC and CARE models. More generally, the importance of helping children develop a range of competencies is recognised (more or less explicitly) in each of the models.

All models appear to work towards promoting resilience, though MAP and Sanctuary talk primarily of the things that contribute towards resilience, such as 'self-efficacy' or coping skills.

Table 9: Key model components

	Sanctuary	ARC	CARE	MAP	Resilience	Social Pedagogy
Create a nurturing culture	✓	✓	✓	✓	✓	✓
Build Attachments	✓	✓	✓	✓	✓	✓
Build Competencies	✓	✓	✓	✓	✓	✓
Building resilience		✓	✓			

Likewise, there is clearly overlap between 'staff behaviours' and aspects of each model, for example, family involvement could be included in one of the earlier tables (see Table 10). 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.

Table 10: Staff behavioural change

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

Key distinctions

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

Both MAP and Sanctuary emphasise the importance of working with families, but CARE is the only model that includes the involvement of a young person's family in their care, planning and treatment as a core principle.

Some elements are only found in respect of one model. Examples include:

- The development of shared terminology (SELF framework) in the Sanctuary model.
- Increased 'democratic participation' by young people in the Sanctuary model.
- The use of motivational interviewing, weekly planners and force field analysis in resilience model.

Just a different way with words?

The apparent ‘convergence’ of the six models begs the question of whether it matters which one is used? There may be merit in the argument that it is providing staff with ‘a framework’ within which to think about their work that matters, rather than a particular framework. Staff who can think analytically about their work, who can better understand children’s behaviour and critically appraise their own actions and those of others, and who can draw on their understanding to act in the best interests of children, are likely to be better at their job than those who have no such framework. They are also likely to have more job satisfaction and, particularly when whole staff teams are trained in that framework, more likely to behave consistently – something we know children value. But whether the particular model matters or not is an empirical question and, as we shall see in the next section of this overview, there is little empirical data with which to begin to tease this out.

Evidence-base for the therapeutic approaches in use in Northern Ireland

As anticipated, we did not expect to find a large literature of the effectiveness of any of the models. We found some studies that assessed the impact of Sanctuary and CARE, although it is important to note that both studies were conducted by the developers of the models. We also found some papers that described or discussed the key 'lessons learned' about the process of introducing a therapeutic approach into residential children's homes. We begin this section with a consideration of the studies available on the evidence of the effectiveness of each of the six models.

Effectiveness of the models

In order to establish a causal link between an intervention and changes in staff behaviour and outcomes for children, one needs to eliminate competing explanations, or at least minimise their plausibility as an explanation. Other things happen in children's lives: they mature; the mix of children changes with changes in group dynamics; they form relationships with others that make a difference to their behaviour and wellbeing. New leadership can make an immense difference to organisational culture and staff behaviour.

One way of ruling out competing explanations for changes that one expects to follow from a particular intervention is to compare the outcomes for participants with those of another, comparable group, who do not experience it. Although not impossible, experimental studies (for example, randomised controlled trials) are difficult to do in residential child care. The inclusion criteria for this part of the review therefore stipulated outcome studies with either a control group or a comparison group of some kind.

Despite such a low threshold, few studies were of this kind, **or any other,** were identified in what was a very extensive search. No comparative evaluation of any of the models has been carried out, and no impact evaluations of any of the models have been conducted in Northern Ireland (a process evaluation of the resilience model is reported below). A pilot study of the effectiveness of Sanctuary was reported in 2005 by Rivard et al and we describe this next.

Sanctuary

In 2005, Rivard et al reported the preliminary findings of the implementation and short-term effects of incorporating Sanctuary within residential treatment programmes for young people. The study used a comparison group design with measurement at baseline, and 3 and 6 months after staff were trained and the model implemented. The evaluation was conducted in 2001.

The authors piloted the Sanctuary model in four residential units that volunteered to participate in phase 1 of the project. During this time the staff training protocol and manual was developed and piloted. Four additional residential treatment units were randomly selected to implement the Sanctuary model later the same year. Eight other units, providing the standard residential treatment programme, served as the 'usual services' comparison group. Participants consisted of all young people for whom full,

informed, written consent was obtained from custodial agencies, legal guardians, parents and youths. The staff sample comprised those staff who worked in the programmes and who voluntarily elected to participate in surveys and focus groups through a similar consent process. Substantial attrition occurred after baseline as young people were discharged through the usual operations of the programme. Eighty-seven youths completed all three phases of data collection.

The authors report data on implementation, youth outcomes and 'therapeutic community outcomes'. Table 11 sets out the outcomes and associated measures.

Table 11: Overview of outcomes and measures used by Rivard et al, 2005

Outcome domain	Measures	Authors
Implementation	Consultants process notes	N/A
	Periodic reviews of Sanctuary Project Implementation Milestones (observable criteria)	N/A
	Qualitative data on staff perceptions	N/A
	Focus groups on the challenges in implementation	N/A
Youth outcomes	Child Behaviour Checklist	Achenbach 1991
	Trauma Symptom Checklist	Briere 1996
	Rosenberg Self-Esteem Scale	Rosenberg 1979
	Locus of Control Scale	Nowicki and Strickland 1873
	Parent and Peer Attachment Inventory (Peer form)	Armsden and Greenberg 1987
	Youth Coping Index	McCubbin et al 1996
	Social Problem Solving Questionnaire	Sewell et al 1996
Therapeutic environment outcomes	Community Oriented Programs Environment Scale (COPES) Measures three dimensions of programme environments: i) Relationship Dimension: Involvement scale, support scale, Spontaneity scale ii) Personal Growth Dimension: Autonomy Scale, Practical Orientation Scale, Personal Problems Orientation Scale, Anger and Aggression Scale iii) System Maintenance Dimension: Order and Organisation Scale; Programme Clarity Scale	Moos 1996

Therapeutic community outcomes

The authors report no differences in therapeutic community outcomes between the two groups at baseline and during the two waves of measurement until the final measurement point. At this point, using independent t tests they report significant differences between the groups on four subscales of the Community Oriented Programs Environment Scale (COPES) and in the total COPES score, favouring the Sanctuary homes.

Youth outcomes

The authors report a similar pattern for youth outcomes, with no differences between the groups at baseline or 3 months but differences on three measures at 6 months. Two of these differences relate to subscales of measures. Sanctuary youth improved more than those in standard residential care on the subscale of the Youth Coping Index that measures 'the degree to which young people adopt coping strategies that exacerbate interpersonal tension and conflicts, and adopt appraisal strategies which minimise the significance of the problem or make the issue larger than it is' (McCubbin et al, 1996, p 586; Rivard et al, 2007, p 86). They also did better on the verbal aggression scale of the Social Problem Solving Questionnaire. The other difference was in relation to the Nowicki-Strickland Locus of Control Scale where Sanctuary model youth evidenced a greater sense of control over their lives, compared with youth in standard residential care, where scores stayed roughly the same.

Given that the authors used seven youth outcome measures and two measures of 'therapeutic community outcomes', there is a distinct sense of 'data dredging' and 'selective reporting' here. In addition, the analysis **may** also have focused on the wrong unit of analysis, i.e. the individuals rather than the homes.

These few positive findings have been interpreted by the authors as offering promise that full implementation may yield greater youth benefits. They note that some of the most important lessons learned concerned the need to support implementation efforts with more intensive onsite technical assistance and to incorporate the use of brief behaviour checklists as part of the regular programme operations (see below). This upbeat interpretation of these pilot results need also to be tempered by the fact that the researchers included the programme developers.

CARE

The only empirical research currently available in relation to CARE is from surveys conducted at four agencies in South Carolina where the CARE model was implemented in 2006. Again, the studies were conducted by research teams that included the programme developers.

The surveys examined staff knowledge of the core concepts of CARE before and after training, their reactions to the training and their intention to modify their practice according to the CARE principles (Holden et al, 2010). Just over one half of the staff who participated in the implementation of CARE completed the surveys (54 per cent, n=41 respondents). We do not know what the remaining half thought, so the results provided need to be read with that in mind. Researchers assume that missing data such as these result in bias, though in what direction we can't know (non-responders might

be very satisfied or very dissatisfied, and everything in between). The results were as follows.

Knowledge

Before training, respondents correctly answered an average of 52 per cent of items (SD=13 per cent) on a 25-item test designed to examine their understanding of CARE's core concepts and the practice approaches and skills taught. This increased to 75 per cent post-training (SD=14 per cent). An ANOVA test suggested that this increase was statistically significant ($F = 118.6$; $p < .001$). Staff who participated from all four agencies demonstrated gains in knowledge, with staff from one agency evidencing a more marked gain than those from the other three. No data regarding individual agencies are provided. The authors argue that improvement may have been greater had participants not been asked to prepare for training by reading the CARE student workbook beforehand. We cannot tell from this kind of study.

Reactions to the CARE training

It was hypothesised that the chances of participants applying their knowledge would depend on how they perceived the relevance of what they had learned and the extent to which it was supported by the agency. Overall, respondents' reactions to the CARE training were positive. In the post-test survey, 90 per cent of the 41 respondents said they understood what they had learned and planned to use it. They rated the training highly and said their agency was 'definitely supportive' of what they had learned.

Intent to change practice

Intent to change is a strong predictor of behaviour change (Davis, 2003). The study assessed participants' intention to change their practice in response to the training by means of a 22-item survey (with a five-point Likert scale) asking how frequently staff used a variety of practices (pre-test) and how often they intended to use those practices in the future (post-test). An example item from the scale is 'Decrease number of rules by changing them into expectations'. The difference between how respondents' rated their practice behaviour before training and what they said they intended to do afterwards was deemed to reflect their 'intention to change'.

The researchers averaged ratings of pre-training behaviour and post-training intentions across survey items for each respondent (means = 3.4 and 4.5, respectively). Using repeated measures ANOVA the analysis indicated statistically significant differences across all four sites ($F (1, 35) = 140.5$; $p < .001$).

Strength of evidence

Such small-scale surveys provide no more than suggestive indicators of staff satisfaction and intentions to adopt the new practices they have learned. The evidence is weak because:

- it relies on staff self-report, rather than measures of actual behaviour change
- only half of the participants' responded
- there is no comparison group.

Conclusions about the impact of training on practice is, therefore, purely speculative. At best the existing evidence suggests that CARE can have a positive impact on staff knowledge, their motivation to change, and their intention to use new skills. To this extent, it provides **some** support for the underpinning theory of change, but nothing more.

We found no report of a study of the effectiveness of CARE on outcomes for children. At the time of writing, the authors of CARE are planning a quasi-experimental study to explore its impact, but this has yet to be completed. This matched comparison design will establish a year long baseline that will provide an opportunity to test the effectiveness of this approach. Lessons learned from the implementation of CARE in residential children's homes are reported below.

MAP

To date there has been no empirical study of the effectiveness of the Model of Attachment Practice (MAP). The model has been developed in Northern Ireland, with influence from a variety of sources (for example, programmes in Maples Adolescent Treatment Centre, Canada), as well as drawing from the theories of attachment, neurodevelopment and parenting styles to inform it's training and practice.

ARC

We found no reports of evaluations using a control group or comparison group have been carried out on the ARC. Blaustein and Kinniburgh state that preliminary data from pilot studies indicate that 'ARC leads to a reduction in post-traumatic stress symptoms in children, a decrease in anxiety and depression, and increased adaptive and social skills' (Blaustein and Kinniburgh, 2006). They make specific reference to a pilot study using the ARC framework to reduce failed or disrupted adoption placement, but no reference to a study focused on residential care. We were unable to find the paper on adoption that was said to be 'in preparation' in Blaustein and Kinniburgh, 2006.

Resilience model

The only study on this model identified was Houston's action research on the Resilience model was also designed as a pilot study. It focuses largely on the process of introducing the model and the reactions and experiences of staff and children, and is discussed in the next section.

Social Pedagogy

We found no reports of any evaluation of Social Pedagogy. Comparative data from inter-country comparisons are reported in the next section. Carpenter and his colleagues at the University of Bristol are currently conducting an study of the introduction of this approach within a sample of residential children's homes in England.

Studies of process and implementation

The large literature on organisational change testifies to the many challenges facing anyone wishing to introduce new ways of working. Organisations are complex systems. Interventions aimed at improving outcomes for children and young people in residential care are complex interventions.

As well as studies exploring what effects such interventions have on outcomes, it is important to understand how they are experienced by staff, young people, families and other key stakeholders. If interventions do not 'work' as intended, an exploration of the process of implementation is key to understanding why this might be. What obstacles prevent the role out of a programme or make it unacceptable to key actors? Why does it work in some places or for some people, and not others? Is the programme really being implemented as it was designed? If not, why not and does this matter?

These and other important questions can be answered as part of an effectiveness study, but more often they are separately explored in studies of process and implementation. Indeed, given the cost of rigorous evaluations, it is sensible to have answers to some of these questions before embarking on an outcome study. We found some studies of this kind in relation to the six models, though – again – far fewer than we had hoped.

CARE

In the study reported in the previous section, Holden and colleagues include reflections on the process of implementing the CARE practice model in some twenty agencies in and outside of the United States (pp 139–140). They produce anecdotal evidence which they interpret as suggesting that CARE is a thoughtful and useful tool for use in children's residential care (Holden et al, 2010), highlighting the following as of particular significance in securing 'buy in' from staff throughout the agencies:

1. *Leadership support and engagement* This facilitated the integration of CARE principles into day to day work, to an extent that even in agencies whose staff had yet to receive training, many of the principles were already successfully incorporated as a result of leaders modelling the required practices.
2. *Participatory and active work groups* The implementation team regard these groups as having been 'essential in providing continuity throughout the implementation process' (p 140). These groups are responsible for planning and guiding the implementation, including making decisions about who is trained, when they are trained, who will become agency trainers, what needs to be changed within the organisation, how to go about making such changes, and how to handle people who are reluctant to engage.

SANCTUARY

A number of papers identified in the search describe the process of implementing Sanctuary. Bloom 2003 describes the introduction of Sanctuary in five different settings in America. Each account is provided by the change agent for that establishment. Two

of the five relate to residential treatment programmes for children and adolescents, and a third describes the process of implementing Sanctuary in a group home for disturbed adolescents. The first two say little about what was learned in the process, but rather describe what was done. The third goes further.

Brian Farragher writes about the process of implementing Sanctuary at the Julia Dyckman Andrus Memorial Children's Center in Yonkers, in New York (known as 'Andrus'). The centre serves about 150 children, 73 of whom were in the centre's residential programme at the time, while the remainder attended a day treatment setting. The vast majority of the children and young people at Andrus were 'victims of serious childhood trauma'. Farragher is Director of Campus Programs, and writes from the perspective of a leader trying to introduce change. The introduction of Sanctuary involves, among other things, the identification of a core team, not dissimilar to the 'working groups' in CARE. Farragher notes the importance of modelling the behaviours that one wants to foster:

> '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, 2003, p 179

In order to prove his willingness to be the democratic and participatory leader that Sanctuary requires (and he wished to provide at Andrus) Farragher had to sit back and 'wait patiently for their participation'. He also describes the process of reconciling the apparently contradictory roles of being a leader and part of the core group.

Farragher's 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' (179). The other lessons that Farragher chose to highlight was the importance of discussing the uses and misuses of power and the synergies between the values and interpersonal behaviours of staff, how they treat young people and what they expect of them.

David McCorkle describes the introduction of Sanctuary into Hawthorne-Cedar Knolls, which comprises three residential programmes for children and adolescents in Westchester County, New York, owned by the Jewish Board of Family and Children's Services. The children, aged 11 to 17 are described as having 'a wide variety of emotional and behavioural problems', with the majority having been exposed to 'severe violence, multiple placements, and a great deal of loss. Many are involved in the juvenile justice system' (p 181). McCorkle's account is descriptive rather than analytic, detailing some of the core principles and approaches within Sanctuary and how these were implemented. What is important to McCorkle is that Sanctuary 'helped ... refocus on our moral purpose wherein we have open and honest group discussions about making a difference in the lives of the children we hope to help'. His lessons learned are more to do with learning the value of a cooperative group, rather than about implementation.

Kelly Nice-Martini describes the implementation process at the Community Residential Rehabilitation (CRR) group in Wilkes-Barre, Pennsylvania, where she is programme

director. CRR is described as ‘a small residential facility for ten troubled adolescent boys and girls’, most of whom are involved with child protection services, have a range of psychiatric diagnoses, a history of multiple placements, serious family difficulties and a lack of trust in adults. Young people are said to be more likely to act out their problems than talk about them, which they find difficult. They usually spend around six months at CRR.

Nice-Martini describes the shift from a predominantly behavioural approach to the Sanctuary approach (although one might take issue with their interpretation of a behavioural approach). She describes the ‘light bulb’ moment of realising that perhaps children failed to comply with their requests because they did not how, rather than simply out of defiance, and the change this brought about in how staff spent their time (not fighting for ‘control’, for example), their attempts to understand, rather than control, children’s behaviour, and how – as a team – to bring about changes. The training made sense, it made them more patient, and impacted positively on their relationships with young people. She describes other changes, and reports the impact that these have had on children’s behaviour.

Lessons learned

While Nice-Martini’s contribution is largely descriptive, she highlights some of the challenges that faced her and her colleagues in introducing Sanctuary. She notes that while the results of the changes they have made ‘are tangible’ they are ‘difficult and challenging to maintain’. It requires a lot of self-discipline from staff who have constantly to reflect on the behaviours and values they are modelling to young people. This is particular so 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 realise how vital it is for us all to be consistently on the same page.
>
> Nice-Martini, 2003, p 186.

Resilience

The starting point for Houston's study was a recognition that, while there is a growing consensus about the importance of promoting resilience, little is known about ‘the opportunities and barriers facing professional carers’ when they try to introduce resilience-based interventions in residential care settings:

> Bureaucratic professional cultures and risk dominated forensic discourses sometimes militate against strength-based interventions (Gilligan 2004).
>
> Houston, 2010, p358

Houston opted for an action research model that was designed to facilitate reflection and action among the staff group, and to explore the challenges to implementing change. Staff were encouraged to reflect on the model that was introduced, and on what helped or hindered their attempts to reorient their practice towards a focus on resilience. Houston highlights three particular tensions that emerged during the work. The first was how to balance responses focused on risk with those focused on the young person's needs. The second was the balancing act required on the part of staff between care and control. The third was managing the personal and the professional.

Staff identified those factors within the organisation that enabled them to intervene effectively and those that constrained them from achieving their desired outcomes. Examples of the former are: a flexible approach to rule setting within the home; managerial recognition of their contribution to the lives of young people; a culture that rewarded young people's successes and provided a pervasive sense that the home was a secure base for them. The importance of theory informed therapeutic care and the centrality of relationship-based social work were also found to be essential in promoting resilience within the young people. Houston summarises this as a person-centred culture.

Factors cited as getting in the way of change included 'a top-down set of organisational imperatives' (p 365); a risk averse performance culture that lacked resources, challenges associated with trying to parent under the strictures of organisational mandates and the pressures arising from continuing organisational change. It was this that 'problematised the sharp dichotomy between care and control' (p 365). Houston is careful to point out that these things did not prevent resilience-building, but they did make it very difficult at times. What was remarkable was how the staff implemented organisational imperatives yet kept to person-centred ways of doing so. Young people themselves brought other another set of influences from within themselves and their lives, most notably 'the vagaries of mood and emotion … (which) sometimes produced a sense of lassitude and unwillingness to engage in the resilience work' (p 365). These changes could be triggered by events or relationships outside the home, as well as within the home. For Houston the challenges in shifting practice come from needing to balance care and control, the personal and the professional and psychology and state parenting (p 366). His analysis is, however, an optimistic one. His study demonstrates the possibility of change in circumstances that are not entirely supportive (in the larger legal and bureaucratic context). Staff were proactive in identifying possibilities to 'rework' agency systems and structures, including the system's statutory requirements, so that they became more supportive of their endeavours to build on Daniel and Wassell's domains. The action research process provided a space and a structure for this work, and by moving through a cycle of reflection and action, the participants grew in confidence and developed a stronger theoretical and therapeutic approach to their work, which was accompanied by an enhanced sensitivity to the issues faced by young people in their care. It also helped them develop a consensus within the team as to how to approach issues (Bullock et al, 1993).

Social pedagogy

Although no outcome evaluations of Social Pedagogy were identified, there is a sizeable literature describing and explaining it, and comparing the approaches adopted

in different countries and different settings. In the UK, the work of the Thomas Coram Research Unit (TCRU) accounts for the bulk of research on Social Pedagogy, most of which is also descriptive and comparative (across countries).

A comparative study carried out by TCRU indicated that children in residential care in Denmark and Germany reported better outcomes and quality of life than their counterparts in England. This study also indicated that those in residential care in England were, when compared to their Danish and German counterparts, more likely to be out of education and/or employment and at greater risk of teenage pregnancy and/or engagement in criminal activity (Boddy et al, 2009). Better life chances were associated with a smaller more stable and professionalised workforce, and a reflexive, child-centred approach to work with children

In Denmark, all pedagogues held a high-level relevant qualification compared with only one fifth of equivalent staff in England. In Germany, staff were almost equally divided between those holding medium- and high-level qualifications related to pedagogy. Workers in Denmark were more likely than their English counterparts to report that they responded to young peoples' difficulties by listening (see also Cameron, 2004).

Staff turnover, recruitment and retention caused greatest concern in England, least concern in Denmark. Their findings suggest that country of origin and care entry characteristics accounted less for statistically significant variations in outcome indicators than staff characteristics accounted for this (Boddy et al, 2009). This is an interesting finding, given that the outcomes for young people in Northern Ireland are similar to the UK but the workforce is generally better qualified.

Following a recommendation in *Care matters: Time for change* (DfES, 2007) a number of pilot programmes were established based on practice in Europe. These programmes recruited social pedagogues who had been trained in Europe to work in residential child care settings in England alongside staff, managers and young people. The intention was to encourage, within each setting, a discourse regarding the differences and similarities between the English and European approaches and to promote learning about Social Pedagogy by working with it on a daily basis. In an attempt to assess whether the social pedagogic approach could be introduced widely, the programme set out to recruit children's homes that represented some of the diversity of residential child care homes in England.

Cameron et al (2010) outline the preliminary findings of the pilots. The homes recruited to the pilot represented homes from the public, private and voluntary sectors and followed four 'models' (called 'groups' in the report by Cameron et al, 2010). These were:

Group 1 – four children's homes employing staff who were recruited to 'standard posts' but who had been trained as social pedagogues in other countries. The authors describe this as 'low-level input' or 'low-dose' social pedagogy.

Group 2 – comprised eight homes where staff were recruited to posts of a specified social pedagogue job description. The expectations on these staff were that they work with other staff and young people, as social pedagogues – a somewhat higher 'dose'.

Group 3 – comprised six homes in which the managers were asked to recruit social pedagogues (as in Group 2) but for two thirds of their working time. The remaining third was set aside for these staff to advertise social pedagogy to local agencies/organisations involved in children's lives.

Group 4 – comprised comparison homes drawn from the same providers in Groups 1 to 3 (Cameron et al, 2010, p 3).

Staff in Groups 2 and 3 were asked to commit to a two-year employment period to support the evaluation of the project. The study was designed to reproduce 'ordinary' conditions of recruitment and employment, in order to address the DCSF's concern as to whether the social pedagogic approach could be rolled out in England.

Results of the pilot projects

The authors note a generally positive response to the Social Pedagogic approach, with some pedagogues described by managers as role models for other staff. Particular reference is made to their modelling the importance of relationship building in making assessments of a young person's needs, and how a pedagogical approach brings a unique knowledge base on shared everyday life in the residential setting. However, a number of problems were also noted:

- Social pedagogues are typically better qualified that residential care workers in England. This can lead to a 'mismatch of expectations around pay'. If one was to move to a 'social pedagogic' trained workforce this would have a number of implications for training, salaries and the organisation of work.
- Staff teams in Europe are less hierarchically organised, with a more diverse range of responsibilities (p 7). This flows from a more democratic and citizen-based ethos. Social pedagogues operating with a more limited role and in a hierarchical organisation than that to which they were used to, found this difficult. In the pilots. Some pedagogues disagreed with observed practices, but had no avenues to discuss or contest these.
- Practical arrangements, such as the time constrained nature of 'handover' was also problematic. Social Pedagogues expected time for reflection and analysis, applying theory and finding a way forward. They found handover times too short and too 'procedurally oriented' (p 8). Similar challenges were found in relation to team meetings.
- In several cases, the 'distractions' of financial considerations undermined the application of a Social Pedagogic model. Where homes were catering for very few children, the imbalance of staff to young people also undermined this approach, which was felt to be too 'top heavy'.
- Some of the 'benefits' described in the pilot projects, were as much to do with 'outsiders coming in' as with their particular approach. The report talks about the benefits of 'challenge to established practices'.

- The fragmented nature of service provision also presented problems. Cameron et al report that the sheer number of specialists involved with looked-after children mean that there is ‘a more reduced space for action and contribution from the residential worker than, for example, in Germany’ (p 9). An interesting discussion of this, and other issues, can be found in Coussée et al (2010).

Conclusions

What works in therapeutic models of residential care?

Common to each of the approaches introduced with the five trusts are:

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

These assumptions are undoubtedly reasonable, and not necessarily new. What is new is the framework established within each model and the ways in which each operationalises these – and other – principles or beliefs. Is there evidence that these are the hallmarks of effective residential care? Is there evidence that any model makes a difference in respect of improving children's lives? Is there evidence that one model is better than another?

Taking seriously what we know of what counts as good evidence, the answer to questions about the effectiveness of the models is, at the moment 'we don't know'. There are few studies designed to rule out competing explanations for change over time, or that explore the differences between the implementation of a model and standard residential care. Those studies that exist are conducted by, or in conjunction with, programme developers. There is an inherent conflict of interest in these studies and a bias in favour of the model/intervention in question (for a contrary view, see Sherman and Strang 2009).

No studies have examined the views of children and young people.

If we were to drill down into particular aspects of the models, such as their use of social learning theory or cognitive behavioural therapy, we could provide a strong evidence base in support of individual components. But this would not be true of all components, and –importantly – these models are more than the sum of their parts. They are complex social interventions designed to change organisational culture, and the ways in which staff think and act. Their ultimate goal is to improve outcomes for children who spend time in residential children's homes, whether long-term or short-term, or in whatever circumstances that brings them into care. Their effectiveness in doing any or all of these things is unknown. Moreover, there is a disjuncture between the enthusiasm for these approaches within the literature, and the available evidence.

That said, the thrust of these models resonates with findings from earlier research on residential children's homes in the UK (see Clough et al, 2006; Sheldon and Macdonald, 2009) and with the views of children and young people about what is important to them (Who Cares, 1993; Morgan, 2004). It is important to learn from the social experiment currently under way in Northern Ireland. As this review emphasises, there is a large gap in our knowledge of 'what works' that has yet to be filled.

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Appendix 1: Papers relevant to each of the six models

CARE

Authors	Title	Source
Holden 2009	*Children and Residential Experiences: Creating conditions for Change.*	SS
Holden et al 2010	Children and Residential Experiences: A Comprehensive Strategy for Implementing a Research-Informed Program Model for Residential Care.	SS
The following references are cited in Holden 2010. They either underpin the model or are cited in the evaluation		
Barth 2005	Residential care: From here to eternity.	
Benard 2004	Resiliency: What we have learned.	
Maier 1991	Developmental foundations of youth care work.	
Masten 2004	Regulatory processes, risk, and resilience in adolescent development.	
Vygotsky 1978	Mind and Society: The development of higher mental processes	

ARC

Authors	Title	Source
Blaustein and Kinniburgh 2007	British Psychological Society. Briefing Paper	SS
Kinniburgh et al 2005	Attachment, Self-Regulation, and Competency: a comprehensive intervention framework for children with complex trauma.	*SS*
The following reference was obtained from sources other than search strategy.		
Blaustein and Kinnibugh 2010	Treating Traumatic Stress in Children and Adolescents: How to foster resilience through attachment, self-regulation and competency	*Web search*

Resilience

Authors	Title	Source
Daniel, B 2003	The value of resilience as a concept for practice in residential Settings. *Scottish Journal of Residential Child Care, 2, 1, 6-15.*	SS
Daniel et al 1999	'It's just common sense isn't it?' Exploring ways of putting the theory of resilience into action. *Adoption and fostering, 23,* 3, 6-15	SS
Daniel and Bowes 2010	Re-thinking harm and abuse: insights from a lifespan perspective	SS
Houston 2010	Building resilience in a children's home: results from an action research project.	SS
Masten 2004	Regulatory processes, risk, and resilience in adolescent development.	SS
The following references were obtained from sources other than search strategy.		
Daniel and Wassell 2002	*Assessing and Promoting Resilience in Vulnerable Children I (Adolescence).*	Houston 210
Daniel et al 1999	*Child Development for Child Care and Child Protection Workers.*	QUB library
Werner and Smith 1992	*Overcoming the odds: High-risk children from birth to adulthood*.	QUB library

MAP

MAP is a model in development and no papers directly address it. The references are to those studies that seem particularly salient to this model.

Authors	Title	Source
George and Solomon 1996	Representational models of relationships: links between caregiving and attachment.	SS
Gunnar and Quevedo 2008	The neurobiology of stress and development.	SS
Moses and Barlow 2006	A new, unified treatment approach for emotional disorders based on emotion science.	SS
The following references were obtained from sources other than search strategy.		
Baumrind 1991	The influence of parenting style on adolescent competence and substance use.	Cited in Darling 1999
Bowlby 1979	The making and breaking of affectional bonds.	Book
Darling 1999	Parenting style and its correlates.	Retrieved from ERIC digest
IFCO 2006	Looking after children who hurt. www.hopeforhealingtrauma.com/docs/looking_after_children_who_hurt.pdf	
Keck and Kupecky 1995	Adopting the hurt child.	Book
Perry 2006	Applying Principles of Neurodevelopment to Clinical Work with Maltreated and Traumatised Children.	Reference
Perry 2009	Examining child maltreatment through a neurodevelopmental lens: clinical application of the Neurosequential Model of Therapeutics.	Reference

Sanctuary

Authors	Title	Source
Bloom 1994	The Sanctuary Model: Developing Generic Inpatient Programs for the Treatment of Psychological Trauma.	SS
Bloom 2000	Creating sanctuary: Toward the evolution of sane societies.	SS
Bloom 2003	The Sanctuary Model: A trauma-informed systems approach to the residential treatment of children.	SS
Bloom 2005	The Sanctuary Model of organizational change for children's residential treatment.	SS
Bloom et al 2003	Multiple opportunities for creating sanctuary.	SS
Bloom and Yanosy 2008	The Sanctuary Model of Trauma-Informed Organisational Change.	SS
Farragher (undated)	Leading the Sanctuary Change Process.	SS
Farragher and Yanosy 2005	Creating a trauma-sensitive culture in residential treatment.	SS
McCorkle and Yanosy 2007	When Loss Gets Lost: Using The S.E.L.F. Model To Work With Losses In Residential Treatment.	SS
Rivard et al 2003	Assessing the implementation and effects of a trauma-focused intervention for youths in residential treatment.	SS
Rivard et al 2004	Implementing a framework for youths in Residential Treatment.	SS
Rivard et al 2005	Preliminary results of a study examining the implementation and effects of a trauma recovery framework for Youths in residential treatment.	SS
The following references were obtained from sources other than search strategy.		
Abramovitz and Bloom 2003	Creating sanctuary in a residential treatment setting for troubled children and adolescents.	Website
Bloom 2004	Neither Liberty Nor Safety: The Impact Of Fear On Individuals, Institutions, And Societies, Part II.	http://www.sanctuayweb.com/
Bloom and Farragher 2011	Destroying Sanctuary: The crisis in human service delivery systems.	Website
Cohen et al 2009	Practice Parameter for the Assessment and Treatment of Children and Adolescents with Posttraumatic Stress Disorder	Cited in a paper
Gatiss et al 2001	Standards of practice for working with children and young people in a therapeutic community setting.	http://www.sanctuayweb.com/

Social Pedagogy

Authors	Title	Source
Bengtsson et al 2008	Introducing Social Pedagogy into Residential Child Care in England.	SS
Boddy et al 2009	Working at the 'Edges' of Care? European models of support for young people and families.	SS
Cameron 2004	Social pedagogy and care. Danish and German practice in young people's residential care.	SS
Cameron et al 2010	Implementing the DCSF pilot programme: The work of the first year.	SS
Coussée et al 2010	The Emerging Social Pedagogical Paradigm in UK Child and Youth Care: Deus Ex Machina or Walking the Beaten Path?	SS
The following references were obtained from sources other than search strategy.		
Badry et al 2004	Pädagogik – Grundlagen und Sozialädagogische Arbeitsfelder. Munich: Luchterhand (cited in **www.nla-schwiz.ch/Download/wunderbarer-stolperstien-oder-effektices-sprungbrett.pd**	
Department for Children, Families and Skills 2007	Care Matters: transforming the Lives of Children and Young People in Care. **www.education.gov.uk**	
Eichsteller 2009	Social Pedagogy in Britain –further developments. http://www.social-pedagogy.co.uk/	
Eichsteller and Holthoff 2008	Social Pedagogy Training Pack.	Thempra training
Hämäläinen 2003	The concept of social pedagogy in the field of social work.	SS
Jackson 2006	The role of social pedagogy in the training of residential child care workers.	SS
Kornbeck 2002	Reflections on the exportability of social pedagogy and its possible limits.	SS
Petrie et al 2001	The potential of Pedagogy/Education for the work in the children's sector in the UK.	SS
Petrie et al 2002	All-round friends.	SS
Petrie et al 2005	Pedagogy – a holistic, personal approach to work with children and young people across services,	SS
Petrie et al 2009	Pedagogy – a holistic personal approach to work with children and young people across services.	SS
Smith and Whyte 2008	Social education and social pedagogy: reclaiming a Scottish tradition in social work.	SS
Stephens 2009	The nature of social pedagogy: an excursion in Norwegian territory.	SS
Petrie et al 2006	Working with Children in Care: European Perspectives.	QUB library

Appendix 2: Search strategies

Search strategy – CARE

DATABASE	SEARCH TERMS	RESULTS
Social care online	"children and residential experiences"	1
ChildData [includes 'children in the news']	"children and residential experiences"	0
Cinahl	"children and residential experiences"	3
Cochrane library	"children and residential experiences"	0
British nursing index	"children and residential experiences"	1
HMIC	children and residential experiences	0
Medline	children and residential experiences	1
NHS EED	"children and residential experiences"	3
PsycInfo	"children and residential experiences"	19
PsycArticles	"children and residential experiences"	1
Social services abstracts	"children and residential experiences"	0
IngentaConnect	"children and residential experiences"	0
ISI web of knowledge	children and residential experiences	117
	TOTAL	**146**

Search strategy – Sanctuary

DATABASE	SEARCH TERMS	RESULTS
Social care online	Sanctuary and “residential child*”	7
	Sanctuary and “looked after children*”	0
	Sanctuary and “children in care*”	0
ChildData [includes ‘children in the news’]	Sanctuary and residential child*	0
	Sanctuary and looked after children*	0
	Sanctuary and children in care*	0
Cinahl	Sanctuary and “residential child*”	12
	Sanctuary and “looked after children*”	12
	Sanctuary and “children in care*”	68
Cochrane library	Sanctuary and “residential child*”	0
	Sanctuary and “looked after children*”	0
	Sanctuary and “children in care*”	0
British nursing index	Sanctuary and residential child*	0
	Sanctuary and looked after children*	0
	Sanctuary and children in care*	9
Econlit	Sanctuary and residential child*	0
	Sanctuary and looked after children*	4
HMIC	Sanctuary and residential child*	0
	Sanctuary and looked after children*	0
	Sanctuary and children in care*	0
Medline	Sanctuary and residential child*	0
	Sanctuary and looked after children*	0
	Sanctuary and children in care*	0
NHS EED	Sanctuary and residential child*	0
	Sanctuary and looked after children*	0

	Sanctuary and children in care*	0
PsycInfo	Sanctuary and “residential child*”	34
	Sanctuary and “looked after children*”	30
	Sanctuary and “children in care*”	67
PsychArticles	Sanctuary and “residential child*”	0
	Sanctuary and “looked after children*”	0
	Sanctuary and “children in care*”	1
Social services abstracts	Sanctuary and residential child*	2
	Sanctuary and looked after children*	1
	Sanctuary and children in care*	0
IngentaConnect	Sanctuary and residential child*	2
	Sanctuary and looked after children*	0
	Sanctuary and children in care*	5
ISI web of knowledge	Sanctuary and residential child*	4
	Sanctuary and looked after children*	0
	Sanctuary and children in care*	3
	TOTAL	**254**

Search strategy – Attachment

DATABASE	SEARCH TERMS	RESULTS
Social care online	attachment and "residential child"	15
	attachment and residential child*	37
	attachment and "looked after children"	77
	attachment and looked after child*	78
	attachment and "children in care"	605
	attachment and children in care*	14
ChildData [includes library and 'children in the news']	attachment and "residential child"	0
	attachment and residential child*	0
	attachment and "looked after children"	0
	attachment and looked after children*	0
	attachment and "children in care"	0
	attachment and children in care*	0
Cinahl [plus and British nursing index]	attachment and "residential child"	1629
	attachment and residential child*	3
	attachment and "looked after children"	8

	attachment and looked after child*	8
	attachment and “children in care”	44
	attachment and children in care*	45
Cochrane library	attachment and “residential child”	0
	attachment and residential child*	1
	attachment and “looked after children”	0
	attachment and looked after child*	1
	attachment and “children in care”	0
	attachment and children in care*	3
Econlit	attachment and “residential child”	56
	attachment and residential child*	56
	attachment and looked after children*	57
	attachment and looked after child*	57
	attachment and “children in care”	491
	attachment and children in care*	491
HMIC	attachment and residential child	1
	attachment and residential	1

	child*	
	attachment and “looked after children”	0
	attachment and looked after child*	0
	attachment and “children in care”	9
	attachment and children in care*	9
Medline	attachment and residential child	1
	attachment and residential child*	1
	attachment and looked after children	1
	attachment and looked after child*	1
	attachment and children in care	4
	attachment and children in care*	4
NHS EED	attachment and “residential child”	1
	attachment and residential child*	1
	attachment and “looked after children”	0
	attachment and looked after child*	2
	attachment and “children in care”	5
	attachment and children in care*	5

PsycINFO	attachment and “residential child”	35
	attachment and residential child*	35
	attachment and “looked after children”	29
	attachment and looked after child*	29
	attachment and “children in care”	751
	attachment and children in care*	1172
Social services abstracts	attachment and “residential child”	0
	attachment and residential child*	29
	attachment and “looked after children”	0
	attachment and looked after child*	89
	attachment and “children in care”	0
	attachment and children in care*	73
IngentaConnect	attachment and residential child	9
	attachment and residential child*	22
	attachment and looked after children	16
	attachment and looked after child*	16
	attachment and children in	164

	care	
	attachment and children in care*	263
ISI web of knowledge	attachment and residential child	40
	attachment and residential child*	90
	attachment and looked after children	19
	attachment and looked after child*	23
	attachment and children in care	789
	attachment and children in care*	1123
PsycArticles	attachment and “residential child”	49
	attachment and residential child*	70
	attachment and “looked after children”	200
	attachment and looked after child*	351
	attachment and “children in care”	24
	attachment and children in care*	39
	TOTAL	**9371**

Search strategy – Competency

DATABASE	SEARCH TERMS	RESULTS
Social care online	competency and “residential child”	2
	competency and residential child*	2
	competency and “looked after children”	6
	competency and looked after child*	6
	competency and “children in care”	52
	competency and children in care*	52
ChildData [includes library and ‘children in the news’]	competency and “residential child”	0
	competency and residential child*	0
	competency and “looked after children”	0
	competency and looked after children*	0
	competency and “children in care”	0
	competency and children in care*	0
Cinahl [plus and British nursing index]	competency and “residential child”	343
	competency and residential child*	343
	competency and “looked after children”	767
	competency and looked after child*	832
	competency and “children in care”	7
	competency and children in care*	8
Cochrane library	competency and “residential child”	0
	competency and residential child*	0
	competency and “looked after children”	0
	competency and looked after child*	0

	competency and “children in care”	0
	competency and children in care*	0
HMIC	competency and residential child	1
	competency and residential child*	1
	competency and looked after children	0
	competency and looked after child*	0
	competency and children in care	1
	competency and children in care*	1
Medline	competency and residential child	1
	competency and residential child*	1
	competency and looked after children	0
	competency and looked after child*	0
	competency and children in care	0
	competency and children in care*	0
NHS EED	competency and “residential child”	0
	competency and residential child*	0
	competency and “looked after children”	0
	competency and looked after child*	0
	competency and “children in care”	1
	competency and children in care*	2
PsycINFO	competency and “residential child”	18
	competency and residential child*	18
	competency and “looked after children”	4
	competency and looked after child*	4
	competency and “children in care”	177

	competency and children in care*	219
Social services abstracts	competency and “residential child”	0
	competency and residential child*	8
	competency and “looked after children”	0
	competency and looked after child*	3
	competency and “children in care”	0
	competency and children in care*	6
IngentaConnect	competency and residential child	0
	competency and residential child*	0
	competency and looked after children	0
	competency and looked after child*	0
	competency and children in care	19
	competency and children in care*	22
ISI web of knowledge	competency and residential child	3
	competency and residential child*	5
	competency and looked after children	1
	competency and looked after child*	1
	competency and children in care	121
	competency and children in care*	140
PsycArticles	competency and “residential child”	1
	competency and residential child*	1
	competency and “looked after children”	51
	competency and looked after child*	38
	competency and “children in care”	2
	competency and children in care*	2
	TOTAL	**407**

Search strategy – Resilience

DATABASE	SEARCH TERMS	RESULTS
Social care online	resilience and “residential child”	24
	resilience and residential child*	36
	resilience and “looked after children”	56
	resilience and looked after child*	56
	resilience and “children in care”	6
	resilience and children in care*	463
ChildData [includes ‘children in the news’]	resilience and “residential child”	0
	resilience and residential child*	0
	resilience and “looked after children”	0
	resilience and looked after child*	0
	resilience and “children in care”	0
	resilience and children in care*	0
Cinahl	resilience and “residential child”	453
	resilience and residential child*	453
	resilience and “looked after children”	2
	resilience and looked after child*	2
	resilience and “children in care”	8
	resilience and children in care*	8
Cochrane library	resilience and “residential child”	0
	resilience and residential child*	0
	resilience and “looked after children”	0
	resilience and looked after child*	0
	resilience and “children in care”	0

	resilience and children in care*	4
British nursing index	resilience and “residential child”	25
	resilience and residential child*	25
	resilience and “looked after children”	24
	resilience and looked after child*	25
	resilience and “children in care”	2
	resilience and children in care*	2
HMIC	resilience and residential child	1
	resilience and residential child*	1
	resilience and looked after children	1
	resilience and looked after child*	1
	resilience and children in care	3
	resilience and children in care*	3
Medline	resilience and residential child	0
	resilience and residential child*	0
	resilience and looked after children	0
	resilience and looked after child*	0
	resilience and children in care	1
	resilience and children in care*	1
NHS EED	resilience and “residential child”	0
	resilience and residential child*	0
	resilience and “looked after children”	0
	resilience and looked after child*	0
	resilience and “children in care”	2
	resilience and children in care*	2
PsycInfo	resilience and “residential child”	9
	resilience and residential child*	9

	resilience and “looked after children”	7
	resilience and looked after child*	7
	resilience and “children in care”	143
	resilience and children in care*	218
PsycArticles	resilience and “residential child”	49
	resilience and residential child*	49
	resilience and “looked after children”	56
	resilience and looked after child*	44
	resilience and “children in care”	1
	resilience and children in care*	2
Social services abstracts	resilience and “residential child”	0
	resilience and residential child*	27
	resilience and “looked after children”	0
	resilience and looked after child*	64
	resilience and “children in care”	0
	resilience and children in care*	52
IngentaConnect	resilience and residential child	6
	resilience and residential child*	12
	resilience and looked after children	6
	resilience and looked after child*	0
	resilience and children in care	72
	resilience and children in care*	96
ISI web of knowledge	resilience and residential child	7
	resilience and residential child*	24
	resilience and looked after children	6

	resilience and looked after child*	6
	resilience and children in care	222
	resilience and children in care*	312
	TOTAL	**745**

Search strategy – Social Pedagogy

DATABASE	SEARCH TERMS	RESULTS
Social care online	Social Pedagogy and “residential child*”	0
	Social Pedagogy and “looked after children*”	0
	Social Pedagogy and “children in care*”	0
ChildData [includes ‘children in the news’]	Social Pedagogy and “residential child*”	0
	Social Pedagogy and “looked after children*”	0
	Social Pedagogy and “children in care*”	0
Cinahl	Social Pedagogy and “residential child*”	3
	Social Pedagogy and “looked after children*”	155
	Social Pedagogy and “children in care*”	1
Cochrane library	Social Pedagogy and “residential child*”	0
	Social Pedagogy and “looked after children*”	0
	Social Pedagogy and “children in care*”	0
British nursing index	Social Pedagogy and “residential child*”	5
	Social Pedagogy and “looked after children*”	1
	Social Pedagogy and “children in care*”	11
Econlit	Social Pedagogy and “residential child*”	43
	Social Pedagogy and “looked after children*”	47
	Social Pedagogy and “children in care*”	160
HMIC	Social Pedagogy and residential child*	1
	Social Pedagogy and looked after children*	0
	Social Pedagogy and children in care*	0
Medline	Social Pedagogy and residential child*	1
	Social Pedagogy and looked after children*	0
	Social Pedagogy and children in care*	0
NHS EED	Social Pedagogy and residential child*	0
	Social Pedagogy and looked after children*	0

	Social Pedagogy and children in care*	1
PsycInfo	Social Pedagogy and residential child*	3
	Social Pedagogy and looked after children*	2
	Social Pedagogy and children in care*	4
PsycArticles	Social Pedagogy and residential child*	55
	Social Pedagogy and looked after children*	68
	Social Pedagogy and children in care*	69
Social services abstracts	Social Pedagogy and residential child*	9
	Social Pedagogy and looked after children*	6
	Social Pedagogy and children in care*	5
IngentaConnect	Social Pedagogy and residential child*	3
	Social Pedagogy and “looked after children*”	1
	Social Pedagogy and children in care*	7
ISI web of knowledge	Social Pedagogy and residential child*	1
	Social Pedagogy and looked after children*	1
	Social Pedagogy and children in care*	10
	TOTAL	**673**

Search strategy – Self regulation

DATABASE	SEARCH TERMS	RESULTS
Social care online	Self regulation and “residential child”	1
	Self regulation and residential child*	1
	Self regulation and “looked after children”	1
	Self regulation and looked after child*	1
	Self regulation and “children in care”	40
	Self regulation and children in care*	40
ChildData [includes library and ‘children in the news’]	Self regulation and “residential child”	0
	Self regulation and residential child*	0
	Self regulation and “looked after children”	0
	Self regulation and looked after children*	0
	Self regulation and “children in care”	0
	Self regulation and children in care*	0
Cinahl [plus and British nursing index]	Self regulation and “residential child”	2132
	Self regulation and residential child*	1
	Self regulation and “looked after children”	912
	Self regulation and looked after child*	966
	Self regulation and “children in care”	5
	Self regulation and children in care*	6
Cochrane library	Self regulation and “residential child”	0
	Self regulation and residential child*	0
	Self regulation and “looked after children”	0
	Self regulation and looked after child*	0

	Self regulation and “children in care”	0
	Self regulation and children in care*	0
HMIC	Self regulation and residential child	0
	Self regulation and residential child*	0
	Self regulation and looked after children	0
	Self regulation and looked after child*	0
	Self regulation and children in care	0
	Self regulation and children in care*	0
Medline	Self regulation and residential child	0
	Self regulation and residential child*	0
	Self regulation and looked after children	0
	Self regulation and looked after child*	0
	Self regulation and children in care	0
	Self regulation and children in care*	0
NHS EED	Self regulation and “residential child”	0
	Self regulation and residential child*	0
	Self regulation and “looked after children”	0
	Self regulation and looked after child*	0
	Self regulation and “children in care”	2
	Self regulation and children in care*	4
PsycINFO	Self regulation and “residential child”	3
	Self regulation and residential child*	3
	Self regulation and “looked after children”	1949
	Self regulation and looked after child*	1851
	Self regulation and “children in care”	50

	Self regulation and children in care*	85
Social services abstracts	Self regulation and “residential child”	0
	Self regulation and residential child*	1
	Self regulation and “looked after children”	0
	Self regulation and looked after child*	2
	Self regulation and “children in care”	0
	Self regulation and children in care*	2
IngentaConnect	Self regulation and residential child	-
	Self regulation and residential child*	-
	Self regulation and looked after children	-
	Self regulation and looked after child*	-
	Self regulation and children in care	-
	Self regulation and children in care*	-
ISI web of knowledge	Self regulation and residential child	-
	Self regulation and residential child*	-
	Self regulation and looked after children	-
	Self regulation and looked after child*	-
	Self regulation and children in care	-
	Self regulation and children in care*	-
PsycArticles	Self regulation and “residential child”	-
	Self regulation and residential child*	-
	Self regulation and “looked after children”	-
	Self regulation and looked after child*	-
	Self regulation and “children in care”	-
	Self regulation and children in care*	-
	TOTAL	**8,058**

Children leaving care have notably poorer outcomes than comparable children in the general population, and children in residential care are among the most vulnerable.

In 2007, the Children Matter Taskforce in Northern Ireland commissioned a regional review of residential child care (RRRCC). Following the recommendations in the RRRCC, children's homes across the region are piloting six 'therapeutic approaches' to work with children and young people:

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

Social Care Institute for Excellence
Fifth Floor
2–4 Cockspur Street
London SW1Y 5BH
tel 020 7024 7650
fax 020 7024 7651
www.scie.org.uk