The place of residential care in the English child welfare system

Research report

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Introduction

This rapid review of the literature on residential care for looked-after children aims to:

- describe *the **use of residential care for children*** within the child welfare systems of England and other relevant countries;
- review the ***evidence on children's outcomes*** from residential care;
- review the ***quality of the evidence and identify gaps in the evidence base*** in order to inform future research priorities.

The use of residential care for children

There has been an overall decline in the use of residential care for children in the developed world since the 1980s because of concerns about the lack of attachment in young children, and the risk of abuse. Significant international differences remain, however. English-speaking countries tend to place only a small proportion of their looked-after children in residential care compared with mainland Europe (6% in Australia v. 54% in Germany).

These variations suggest differences in attitude. Is residential care predominantly a last resort, to be used only in the absence of a family alternative and for the shortest time possible, or should it be the placement of choice in many cases? This depends, in part, on the extent to which the state is engaged in supporting families and whether a residential placement is seen as a means of sharing parental care on an ongoing basis, or as a last resort whilst a permanent alternative is being sought. Interestingly, there is evidence that some children and young people do not necessarily agree that residential care should be a last resort and may prefer it to a family placement.

These fundamental differences in approach inevitably influence the way that residential care operates, in terms of the type of settings that are developed, the way they are staffed and the children they take. Some countries operate a wide range of models, with a blurring of boundaries between fostering and residential placements, or between secure and open provision. England is relatively limited in the types of provision; other countries, such as Denmark, Germany and France, make much more use of part-time, respite and shared-care arrangements, with parents still actively involved in the child's care.

One result of a decline in residential care is that it is almost exclusively used for children deemed unable to live in a family. This is usually because of behavioural problems arising from past abuse or neglect, but is sometimes compounded by difficulties within the care system: children often experience a number of failed foster placements before being considered for residential care. The US have 'residential treatment centres' that

take children with a range of behavioural and emotional problems, but the word 'treatment' is rarely found in the English literature on children's residential care. There has, instead, been a growth in 'therapeutic' placements, although there is no formal definition of this. The need for treatment for troubled and traumatised children deserves more recognition, and it could be argued that it is unrealistic to expect children to receive the right help in an establishment staffed largely by poorly trained and paid staff, and where they are intended to stay for the shortest time possible, as tends to be the case in England.

The residential care population

Although information is collected in England about looked-after children and their outcomes, this does not fully differentiate between placement type. From the information that is available for the year ending March 2013, we know that children's homes accommodate mainly teenagers, with more boys than girls and that placements are short, with only 19% of placements lasting longer than a year. Whilst the proportion of looked-after children in residential care appears to have stabilised at about 9%, out of area placements are not reducing and placement stability seems to be worsening. Three-quarters of the children had experienced previous placements (six or more for 31% of the children) suggesting problems either in assessing needs or in matching children to suitable placements.

It is important to question the factors that contribute to problems experienced by children in residential care. We do not know the extent to which children's problems are caused by:

- pre-care experiences;
- the trauma of being removed from home and missing their family;
- a history of placement breakdown;
- inadequate care within the residential setting.

Factors such as peer violence, unsupportive staff – or poor quality food – have been associated with children displaying more problems. It is essential that staff have the skills to understand why a child behaves in a particular way and to respond without assuming that there is something 'wrong' with them. Given the prevailing message that such a placement is a last resort, children may see themselves as too damaged or difficult for a normal life and adopt a negative identity as 'victim' or 'trouble-maker'.

How does residential care operate?

How each home operates will depend on its purpose. This could be to provide:

- care and upbringing;
- temporary care;

- emergency/ roof over head;

- preparation for long-term placement;

- assessment;

- treatment;

- a bridge to independence.

It appears that the proportion placed in residential care for 'care and upbringing' is small in the UK compared to other European countries. The purpose of the establishment is key to how staff see their role, how children perceive themselves and the engagement of parents, but there is evidence that some homes' Statements of Purpose are so vague as to be meaningless.

One important factor is the *ethos* of the home. In countries with a tradition of social pedagogy, the 'feel' of the living space is crucial, and one Danish study describes attempts to establish a sense of 'hominess', using measures such as staff doing paperwork at the kitchen table rather than an office. The children did not necessarily buy into the idea: they knew it was a 'job' for the staff, and looked for other indications that they were really cared about. Although the context is very different in England, making it difficult to directly import social pedagogy, there are examples of approaches that mirror some of its concepts, such as the Life Space approach, which uses everyday crises to help children learn new ways of thinking, feeling and behaving. Whatever the model of care, the quality of the relationship between staff and children is key but may be adversely affected by poor training, lack of a theoretical framework and short placements.

We know that many children end up returning to their families when they move on from care, and even if they do not, they will have a psychological need to make sense of the relationship. Yet in England, *work with the family* is likely to centre on whether the child can return home and be undertaken by the social worker or other community-based professionals. It is likely to decline or cease altogether if the child is not returning home. Elsewhere, there is an expectation that ongoing 'family work' will take place whatever the care plan and that residential staff will be directly involved in it.

The ability of the *workforce* to provide good quality care is central, and some claim that the qualification framework in England is flawed because neither the competency-based approach of a National Vocational Qualification (NVQ) nor social work training equip care staff for the task. Staff in some other countries receive a much higher level of training, and have higher status and more autonomy as a result. Studies of job satisfaction in the UK suggest that staff would like to be more involved in therapeutic work, aftercare, family contact and relationships outside the home rather than the behaviour management and process-driven work that can predominate.

Residential care in England is provided by a *mixed economy* of local authority, private

and voluntary sector agencies.[1] This seems to be universal in the developed world, although some countries do not allow homes to be run for profit. In England, private provision is on the increase and some have expressed concern about whether this will compromise standards because of the drive to have 'heads on beds'. This concern is evident elsewhere. For example, one study showed that state-run homes in Ontario had a better trained and more stable workforce but were less likely to accept children with behaviour problems because they did not rely on filling beds for their survival. In Sweden, practitioners were worried about whether they could trust the claims made in the 'glossy brochures' of the providers when making a placement, and there is concern that active marketing by providers, 90% of which are private, risks the market being led by supply rather than demand.

Although children's homes are subject to regulation and inspection, the challenge is to assess the *quality of care* as well as compliance with basic standards. Does the 'glossy brochure' reflect the true nature of the work that goes on, and how does this support improved outcomes? The final version of Ofsted's new inspection framework from April 2015 will focus more on children's experiences than was previously the case (Ofsted, 2014).

Outcomes from residential care

The evidence base on outcomes from children's residential care is undermined by a number of methodological weaknesses and evidence gaps, including:

- Limited 'controls' to enable one to attribute differences in outcome between children in residential care and their peers in family-based care to their setting rather than to the fact that these two groups are very different.

- Limited contextual information that can help to explain positive or negative outcomes from residential care, such as the quality of provision.

- A focus on a narrow range of mainly negative outcomes from residential care, while we know from research in other children policy areas (e.g. early years) that a wide range of outcomes is needed to understand how policy and practice can effectively intervene to support children's wellbeing and life chances.

- Very limited evidence collected directly from children with experience of residential care and their parents.

Notwithstanding these methodological weaknesses, the consistency of some of the findings from studies from different national contexts enables us to draw some conclusions about outcomes from residential care, albeit rather tentative.

First, a number of studies found that 'residential care as usual' does not seem to be effective in dealing with the problems children face when entering a home. 'Care as

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[1] See DfE reports on how to improve the functioning of the market in children's homes (forthcoming).

usual' seems mainly defined by what it is not, that is: it does not have a clear purpose; the service delivery is not guided by a theoretical underpinning; it is not evidence based and outcome focused; it is not staffed by well-qualified professionals who receive adequate training and support. Children in this type of care are not placed there based on a robust assessment of their needs and the kind of placement that can effectively meet these needs; they are typically placed in 'residential care as usual' because everything else has failed.

Second, it seems that residential placements are needed in some cases. An extensive review of residential care in the US concluded that for some children, residential care is needed and can be beneficial. One of the studies reviewed found that a third of children in residential care could have been placed in home-based care, but two-thirds had risk factors that required a placement in a restrictive residential setting. More generally, even when studies found that residential care did not seem to be associated with expected improvements, the conclusion was not that residential care should not be used, but that the decision to place a child in a (particular type of) residential placement should be based on a robust assessment of his or her needs and how these needs can be best met, and that the quality of residential care had to improve.

Third, the positive outcomes from some of the specialist and evidence-based residential programmes reviewed support the view that rather than eliminating residential care, what needs to be eliminated is 'bad' practice, and residential services should be reconfigured so that they can effectively meet the needs of children who, for a range of reasons, need a residential placement.

What works for whom and how

There is very limited evidence available on 'what works' in residential care, in particular the more robust type of evidence that links the process and structural features of a residential placement with outcomes for children. In England, we have no evidence to answer even the most basic question of what a residential home leading to positive outcomes for children should look like in terms of: staffing levels, qualifications, pay and working conditions, and inspection ratings (i.e. we do not know if children's outcomes are better in homes with high ratings than in those with lower ratings). This is in contrast with other children's policy areas, where this data has been available for a number of years and has informed policy and practice decisions relating to service improvement. Similarly, while widely validated instruments, based on researcher observations, have been developed in other children's policy areas to assess the processes that determine the quality of a setting (e.g. staff-child interactions), we could not identify any such instruments from the literature on children's residential care.

There is an even bigger gap in relation to evidence on 'for whom' residential care works, both in the international literature and the English evidence base. We could not find a single nationally representative English study carried out in the past ten years directly

linking children's characteristics with quantitative outcomes from different types of residential care placement.

Bearing in mind these methodological difficulties, the evidence presented below on 'what works' in residential care must be interpreted with caution.

- A residential placement should be part of a continuum of care, with a sophisticated system for identifying which children may benefit from different types of residential placement at some point in their care journey. Two evidence-based approaches for assessing needs were identified in Sweden (Multifunctional Treatment in Residential and Community Settings – MultifunC) and the US (Child and Adolescent Needs and Strengths – CANS). The evidence indicates that it is also very important for the residential care to be linked to services and support before and after a residential placement.

- Positive relationships between staff and children and between children themselves are often mentioned in the literature as important to ensure good outcomes from residential care. However, the evidence on the links between relationships and outcomes for children is very limited: this could be largely due to the absence of robust measures to assess the quality of the staff-child interactions in residential care.

- Families' involvement is linked to positive outcomes for children. Here the evidence is more robust, as a number of studies have measured the link between, for example, frequency of parental visits and child outcomes. Furthermore, studies that have compared outcomes from residential programmes that place considerable emphasis on working with parents (e.g. by providing family therapy) with those that do not, found that the former resulted in better child outcomes in the short and longer term.

- A residential placement should aim to provide a 'normal' environment. 'Normal' has been conceptualised and measured in a number of ways in the literature, with positive children's outcomes associated with: small 'family-like' settings; homes providing leisure and academic activities and support; the availability of good food; and last, but not least, safe settings, i.e. free from violence and abuse.

- Hallmarks of good quality in residential care often mentioned in the literature include: a home with vision and purpose; strong leadership; highly skilled, motivated and qualified staff. However, we found very few studies that tried to link these features with children's outcomes.

The evidence on 'for whom' residential care is not sufficient to draw even tentative conclusions.

Children's experiences and views

As adults, we have a responsibility to make decisions about children's best interests, but should never forget to ask what they think. Although the range of opinions is vast and inevitably based on personal experience, surprisingly consistent themes emerge – not necessarily about 'what works' – but about what matters to children.

Many of the children's perceptions mirror those of policy makers and practitioners: information about the purpose of the placement, the quality (and genuineness) of relationships with staff, the importance of family and the need for a comfortable and homely environment.

There are some important differences, however. They place much greater significance on the relationships within the group of children than is always recognised by adults, sometimes feeling threatened by, or in competition, with each other. Children also express very mixed opinions about the value of the 'specialist' support they have received within the placement, demonstrating that one size definitely does not fit all.

There is also ample evidence that children do not always feel that they can talk to staff, or be heard, and that this can lead to their trying to achieve change through running away or otherwise disrupting their placement. Not only are children able to describe the reality behind the rhetoric, they do not always agree with the rhetoric itself. Most importantly for the purpose of this review, they do not necessarily agree that residential care should be a last resort.

Moving towards evidence-based policy and practice

As we have seen, there are some major gaps in the English evidence base on children's residential care which leave some key questions unanswered, including:

- What are children's experiences and outcomes from children's homes in England?

- What are the broader experiences and outcomes of children in residential care beyond the more typical narrow focus on pathologies and problems?

- To what extent can we attribute differences in outcome between children in residential care and their peers in family-based care to their setting, rather than to the fact that these two groups are very different?

- What are the features of English residential homes that can help to explain positive or negative outcomes from residential care and 'what works' (and does not work)?

- Which children are most (or least) likely to benefit from different types of residential placement?

- What do children and their families think about residential care?

While the fact that children in residential care are very different from looked after children in other types of placement will make any research looking at comparative outcomes

challenging, a sophisticated design and an adequately resourced research programme can fill the evidence gaps outlined above. A feasibility study will be required to fully scope out the methodological options and costs, but we believe that in order to produce robust evidence to answer the questions above the research programme will need to include:

- A longitudinal quantitative study to collect evidence on a wide range of children's outcomes and experiences before, during and after a residential placement, and the characteristics of these children.

- The longitudinal study will need to include a comparison group, i.e. children who have not experienced residential care but who are as similar as possible to children who do – this would enable one to assess with a certain degree of confidence the extent to which differences in outcomes are due to the home rather than to children's characteristics, and experiences before and after a residential care placement.

- The collection of comprehensive data on the features of residential placements linked to effective practice, including: processes (e.g. quality of staff-child interactions, leadership, interagency working); structural features (e.g. facilities, staff levels, qualifications, working conditions); and any specialist support that children and their families receive.

- The ability to link data on children's outcomes and characteristics with data about the features of children's homes to answer the question of 'what works for whom and how'.

Options for obtaining data on children's experiences and outcomes include:

- Use of administrative data on children's health, education and income collected from central government departments and local data from children's social services.

- Use of data from the New Life Study, a longitudinal study that will follow up a very large sample of UK children into adulthood.

- A dedicated longitudinal survey of looked-after children, including a sufficiently large group of children with experience of residential care.

Options for collecting data about the quality of residential placements include:

- Linking Ofsted ratings on children's homes with children's outcomes from the administrative and/or survey data sources described above.

- Linking data from the DfE Census of the Children's Home Workforce with children's outcomes from the administrative and/or survey data sources.

- Developing instruments for comprehensive quality assessments of residential settings, which can then be linked to children's outcomes obtained from the administrative and/or survey data sources.

At the moment the English evidence base on residential care does not allow one to answer the key question of 'what works for whom and how'. Not knowing what works in residential care means that a great deal of money could be spent on services that may be ineffective or even harmful. The consequences of getting it wrong in this policy area can be very negative both in terms of children's lives as they grow up, but also in terms of long-term costs to society. It would therefore make sense to explore the feasibility and costs involved in improving the quality and comprehensiveness of the evidence base on residential care, so that policy makers and practitioners can have access to the kind of evidence base that has been available for over a decade to their colleagues in other children's policy areas.

Conclusions

There is no simple answer to the question of 'what works' in residential care, partly because of gaps in the evidence but also because we first need to answer the more fundamental policy question, 'what is residential care for?'

The most pressing need is to clarify *which children will benefit* from a residential rather than a family placement and at what point in their care journey. At the moment, it is predominantly but not exclusively used for older or more troubled children within the care system, three-quarters of whom have a history of failed placements behind them. There are a number of problems with this approach. Firstly, it does not reflect the evidence described earlier that some residential care can achieve positive results in the right circumstances. Secondly, it does not reflect the views of children, some of whom say that the idea of living in someone else's family is uncomfortable for them. The 'last resort' rhetoric also gives a negative message to society – and to the children themselves, who may struggle to retain a positive sense of who they are and what they can achieve. The fact that residential care in England is not, in policy terms, defined as a permanent placement also affects the way it is used. If residential units are only a stopgap until children can be moved on to a family, what are they actually meant to do with them while they are there?

Because of the lack of clarity about the purpose of residential care, it is difficult to develop suitable provision. The care system will inevitably contain a proportion of children with complex needs as a result of their experiences. They require either therapeutic support or specific treatment that is unlikely to be available in a mainstream placement. The challenge is to develop *a continuum of services* that can meet each child's assessed needs, whether in a family or a residential setting. Although there has been a growth of children's homes adopting the title 'therapeutic', the lack of an agreed definition makes it difficult for local commissioners to evaluate the claims. There is also a major gap in provision for children with disorders that require more than a therapeutic milieu. The idea of a continuum also needs to extend to the way services are delivered, with less rigid barriers between types of setting, more family involvement and more continuity in interventions before, during and after placement.

No type of home, however well-conceived, will work unless day-to-day practice is of a high *quality*. Formal programmes and interventions are important, but even more important are the people who are delivering them. Whilst specialist and therapeutic placements are needed, *all* staff should be able to develop relationships with the children they care for based on an understanding of what will help them to deal with abuse, loss and trauma. Whenever children are asked, they say it is the staff who make the difference. This is not reflected in the status, pay or training that residential care staff in England receive, and there is no agreed conceptual framework that supports staff to work together. This is not to denigrate the work that is done: children are overwhelmingly positive about the staff who look after them, but this may be based on personal commitment and qualities rather than a proper framework of support.

If the new Quality Standards and Inspection Framework are effective, they could form the basis of a *quality framework* that would allow child outcomes to be tracked across placement type. This will be particularly useful if a broader range of provision is developed. At some point we will need to know, for example, whether children with a conduct disorder benefit from an expensive therapeutic placement or do just as well in a good home 'as usual'. We need a robust system of data collection to enable this evidence to be gathered and analysed systematically. Ways of achieving this have been suggested in the report and are in development elsewhere. Without such comprehensive evidence, there can only be a partial answer to the question of 'what works'.

Whilst outcomes are extremely important, so are children's experiences. However it is done, the ongoing process of asking children about their experiences is essential if we are genuinely interested in raising standards.

1 Introduction

1.1 Aims of the report

This rapid review of residential care for looked-after children was commissioned by the Department for Education (DfE) to look at what is known about 'what works' in residential care, what its role should be in ensuring the best outcomes for children who use it, and to identify priorities for future research.

One of the aims of the review was to provide a description of **the place of residential care** within the child welfare systems of England and other relevant countries, including an attempt to explain any differences. Key questions were:

- Is there an explicit national/ local residential care strategy and what is its purpose within the overall approach to looked-after children?
- How does this relate to other types of provision, such as foster care, placement at home, in-patient psychiatric care, or custody?
- Are there other types of residential care that differ from the English model? For example, settings with resident staff that bridge the gap between fostering/ residential placements, or 'semi-secure' provision?
- Who are the providers of residential care and how much does it cost?
- What are the levels of use, duration of stay, size of homes and the reasons for any variation (e.g. reflecting different models of residential care, children's needs)?
- How do the homes operate (e.g. in terms of parental involvement, provision of education and treatment, staffing levels and skills, children's participation and advocacy?
- Is the quality of residential care assessed and, if so, how? Is this information used to support commissioning decisions and service improvement?
- What types of children are cared for within residential settings and is this for negative or positive reasons (e.g. no alternative available or placement best suited to the child's needs)?

Another key aim was to review the evidence about the **impact of residential care** on children, both domestically and internationally, and any evidence about the elements of residential care that contribute to its effectiveness. Key questions explored included:

- What is the short term impact during their placement, such as physical and mental health, criminal activity, substance abuse, educational attainment, school exclusion/absence rates and NEET (not in education, employment or training) status?
- What are the longer term outcomes following the placement or in adult life, such as employment status, imprisonment, housing or health?

- How do these short- and long-term outcomes compare to other types of placement?

- What are the needs and/or circumstances of children who are most likely to do better in residential care than other types of placement?

- Are there types of residential care, such as therapeutic or secure settings, or private versus public provision, that achieve 'better' outcomes than others? If so, for which children?

- Is there any correlation between factors such as cost, duration of stay, staffing levels, staff skills and qualifications, inspection and other quality ratings, users' involvement and outcomes for children?

- What are the views and experiences of children, and parents, about residential care?

Finally, the **quality of the evidence base** was reviewed with a view to making proposals about the implications for the future development of residential care in England:

- Can we answer the question of 'what works' for which children and in which types of establishment? To what extent is evidence on the impact of residential care based on robust evaluation designs, including a counterfactual, that can isolate the impact of residential care by controlling for other factors that affect children's outcomes?

- If there are major gaps in the domestic evidence, what can we learn from international studies – e.g. how to construct a counterfactual, what are the short- and longer-term child outcomes that should be measured, what are the features of residential care or different types of provision associated with different outcomes for different children?

- To what extent are international exemplars of good practice transferable e.g. is there sufficient evidence on implementation to make an initial assessment of their suitability for the English context?

It was recognised that the findings would be complex, because neither residential care itself nor the children it serves are homogeneous. As well as differences in the types of provision, there can be intangible variations between establishments that appear to be similar. Factors such as leadership and unit culture are cited as making a considerable difference to the quality of care (Clough et al, 2006). It is also very difficult to measure outcomes, particularly where children experience many moves during their care career: how can we attribute a 'successful' outcome to one placement rather than another – or to the many other events in the child's life?

1.2 Policy context

There has been ongoing concern about the safety and quality of children's experiences in English residential care since a number of abuse investigations in the 1980s and a steady decline in its use. In 2010, the government initiated the Children's Homes Challenge and Improvement Programme to raise the standard of care by sharing effective practice across the sector and driving improvements in commissioning, quality and care planning. The statutory framework was also revised and updated, including the Children's Homes Regulations and the National Minimum Standards (NMS), to place more emphasis on the quality of relationships rather than operational processes (Department for Education, 2011).

Subsequently, the particular vulnerability of children in residential care to child sexual exploitation was highlighted (Office of the Children's Commissioner [OCC], 2012) and Edward Timpson, Children's Minister, announced a package of reforms in June 2013 to improve children's residential care in England. The first set of regulatory changes was delivered in 2014 and intended to make sure that children's homes were located in safe areas, and that local authorities were effectively safeguarding children at risk of going missing.

The House of Commons Education Committee (2014) considered the proposed reforms and concluded that, whilst they were welcome, there was more to be done. Their recommendations included measures to improve placement stability and the development of a national strategy for care provision, aiming to 're-position residential care as a positive choice for the right children and young people in the right circumstances' (p. 13). The Government responded that, whilst there would be no attempt to define at a national level what homes should look like, work was being undertaken to develop quality standards, and to examine the skills and qualifications of the workforce.[2]

New Children's Homes Regulations and quality standards came into force in April 2015.[3] They aim to address the fact that:

> *existing regulations for children's homes were insufficiently focused on outcomes and overly focused on process;*

> *there was a disconnect between the regulations and the National Minimum Standards which make up the regulatory framework; and*

> *the concept of 'minimum' standards was unhelpful in driving up quality (Department for Education, 2014a: p. 7).*

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[2] http://www.publications.parliament.uk/pa/cm201415/cmselect/cmeduc/305/30504.htm

[3] http://www.legislation.gov.uk/uksi/2015/541/contents/made

The quality standards will have regulatory force and set out higher aspirations and a greater focus on child outcomes than was previously the case with the NMS. They address the quality and purpose of care; the voice of the child; education; enjoyment and achievement; health and wellbeing; positive relationships; protection of children; leadership and management; and care planning. Against each of the standards will be a description of the underpinning requirements needed to meet the standard, and these will provide the evidence for Ofsted inspectors to reach a judgement and to take enforcement action if necessary. Reflecting the regulatory change, a revised framework for the way that Ofsted inspects children's homes will be in operation from April 2015, placing more emphasis on children's experiences and progress (Ofsted, 2014).

The Department for Education has also set up the Children's Social Care Innovation Programme to allow new approaches to be trialled, including innovative ways of delivering residential care (Department for Education, 2014b).

This renewed focus is set to continue, and it is hoped that this report will stimulate debate, not just about what a 'good' children's home looks like but about the place of residential care within the future English child welfare system.

1.3 How the review was carried out

We reviewed the international academic and grey literature published between January 2004 and December 2014. The search strategy is described in Appendix 1: in total 172 items were included in the review. The criteria used for screening relevant sources of evidence are described below.

- We focused on residential care for looked-after children, and research focusing (exclusively) on the following was excluded: residential treatment for substance abuse or psychiatric illness; custodial settings for young offenders; residential special schools; homes specifically for disabled children.

- We included evidence relevant to policy and practice with the potential for transferability to the English context, and the following were excluded: studies mainly focusing on testing psychological theories/models and very theoretical studies with no/limited implications for practice; studies with no/limited transferable lessons because from very different contexts (e.g. orphanages in developing countries) or too specific to be transferable.

- We only included research evidence (and excluded practice guidance) and focused mainly on more methodologically robust studies, particularly for studies focusing on outcomes and impact from residential care, and the key influences on the effectiveness of residential care (the methodological criteria used to select these studies are described in the relevant chapters).

- In this report we have provided a number of examples of residential care models and programmes, which were selected in two ways. First, we selected examples that illustrate different ways of conceptualising children's residential care and its purpose in different international contexts. Second, we looked for 'promising' practice, that is, practice with some evidence that it works. A systematic review of evaluations of residential care programmes was beyond the scope of this rapid review, but in selecting (non-English) examples, we focused on those with the strongest evidence base.

1.4 Report outline

The following three chapters are primarily descriptive. Chapter 2 considers how residential care is used in England and elsewhere and its place within child welfare systems. Different models of residential care are described, including the interface with specialist settings providing treatment or secure care. Chapter 3 looks at the residential care population, including what we know about their identified needs and how these are assessed. Chapter 4 examines how residential care operates in practice: what it aims to do and how it goes about it, including what we know about the workforce.

We then move on to an examination of the 'hard' evidence on 'what works for whom and how'. Chapter 5 reviews the findings from studies about the outcomes of residential care, from the short-term impact on children whilst in placement to the medium- and longer-term outcomes once they have left. Chapter 6 looks at the question of 'what works' and 'for whom' based on the available research evidence, but also on descriptions within practice literature.

Chapter 7 presents children's views and experiences, which are an important additional source of evidence against which to evaluate the strengths and weaknesses of existing residential provision. Chapter 8 looks at the strength of the English evidence base overall, including gaps and suggestions for future research.

We offer our conclusions in Chapter 9, suggesting that there are fundamental policy questions to be answered about the place of residential care before the sector can move forward.

2 The use of residential care for children

This chapter looks at the overarching question of the role of residential care within children's services in England and elsewhere. It begins with a description of the international policy context and the impact that this has had on placement patterns, with residential care commonly seen as a last resort. This has raised questions about its purpose, and different models of care that have emerged as a result are described. Finally, the links between 'mainstream' residential care and treatment or secure provision are considered.

2.1 International policy

In countries facing extreme poverty, and with large numbers of abandoned or orphaned children to care for, the model of large institutions is still prevalent. The emphasis is inevitably on meeting children's basic needs for food and shelter. This is not to denigrate the efforts of the staff to provide as good a quality of care as possible (see, for example, Hosie, 2007). Nevertheless, we know that care in large, impersonal institutions can cause lifelong damage to children's emotional development because of their need for secure attachment and a sense of being 'cared-about', not just 'cared-for'.

This recognition, combined with revelations of physical, sexual and emotional abuse in some homes, prompted participants[4] at the second international conference on Children and Residential Care to agree a number of principles in the Stockholm Declaration (2003) including that institutional care should only be used as a last resort and as a temporary response. This approach was endorsed by the Human Rights Council of the UN General Assembly, which in 2009 produced guidelines for the alternative care of children. These stated that:

> ...alternative care for young children, especially those under the age of 3 years, should be provided in family-based settings. Exceptions to this principle may be warranted in order to prevent the separation of siblings and in cases where the placement is of an emergency nature or is for a predetermined and very limited duration, with planned family reintegration or other appropriate long-term care solution as its outcome (United Nations General Assembly, 2009, Para 21).

These international statements created a clear expectation that governments should replace their residential care provision and create family alternatives. This approach has been adopted by most of the developed world, with dramatic reductions in the use of residential care and the development of family placements, primarily foster and kinship care. This is usually evident within the legislative or policy context. For example, in Italy National Law 149 (2001) ruled that large institutions should be closed or transformed into smaller units by 2006; residential care was a last resort; and that if residential care was

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[4] 600 individuals from governments, civil society and the research community from 71 countries.

used as a temporary measure, it could not last longer than twenty-four months unless endorsed by the courts as being in the best interests of the child (Carrà, 2014; Licursi et al, 2013). Licursi suggests, however, that in poorer parts of Italy such as Calabria, this aspiration has not been achieved. As expectations have grown about the need to protect children, services have been established to intervene in family life, and the number of children in care has increased dramatically. Carrà reports a 30% increase in the care population across Italy since 1998/9 and, in spite of an increase in the use of foster care, many children remain in some form of residential care.

The picture is similar in Spain, where legislation in 1987 and 1996 stipulated that children should be brought up in a family environment.

> ...residential care ceased to be a measure for the upbringing of children without a home, to become a temporary care measure pending the definitive solution of family reunification or fostering (Bravo and Del Valle, 2009: p. 44).

Again, the authors describe the difficulty in implementing this goal given increasing need and a severe shortage of foster placements alongside a growing recognition that many children had more complex problems than could easily be managed in a family setting.

2.2 Comparative use of residential care across developed nations

The difficulties in making valid international comparisons are well documented. For example, Gilbert (2012) describes problems in:

- the way rates are calculated, whether as a snapshot of the numbers of children in care on a single day or the total across the year;

- what is counted as an out-of-home placement, with variations in the inclusion of young offenders, those placed at home and kinship placements;

- what the numbers and trends signify, whether care is readily used by families as a supportive service or seen as a coercive measure, and whether children are adopted from care.

Whilst acknowledging these difficulties, Ainsworth and Thoburn (2014), recently undertook an analysis of available data across developed and transitional economies. Their findings reveal striking differences in placement patterns.

Table 1: Rates of residential placement

Country	% of children in care in a group-care placement
Australia (2011)	6
England (2010)	14
USA (2009)	15
Spain (2007)	21
Scotland (2009)	23
Sweden (2008)	27
Denmark (2007)	47
Italy (2007)	48
Germany (2005)	54
Japan (2005)	92

Adapted from Ainsworth and Thoburn, 2014: p. 18.

The authors noted that English-speaking countries had both the lowest rates of care overall, and the lowest use of residential placements.

2.3 The purpose of residential care

The fact that there are such significant variations suggests differences in attitude towards the place of residential care within a developed child welfare system. This raises fundamental questions about the purpose of residential care. Is it to provide:

- a (temporary) refuge for children until a better alternative is found?
- a home where children can be brought up as an alternative to family life?
- a therapeutic setting where children receive treatment for problems caused by adverse life experiences? (Whittaker et al, 2014).

or should there be a range of residential care models to meet different needs?

The message from the Stockholm Declaration and the UN guidance is that residential care is a last resort, to be used only in the absence of a family alternative and for the shortest time possible. In spite of some resource difficulties, most countries report a reduction in their use of residential care. For example, Bullock and Blower (2013) compared placement patterns in studies undertaken in 1980 and 2010 and reported that residential placement of new children entering care in England had declined from 46% to 2%. The paradigm appears to be that it should be used only until a 'proper' home can be identified.

This is not universal, and some European countries, notably Finland, Germany and Denmark, continue to use residential care as the placement of choice in many cases. They have interpreted the call for 'deinstitutionalisation' as a move away from large,

impersonal to smaller group settings, where children can receive individual attention and feel at 'home'.

Petrie et al (2006) suggest that these differences are rooted in wider socio-political belief systems, with the US and England being neo-liberal (minimising the role of the state and relying on market forces); Nordic social-democratic countries (with universal services and the state assuming greater responsibility); and conservative, such as Germany (the state provides services as a safety net for those who cannot provide for themselves). Also recognising these different models, Gilbert (2012) suggests that child welfare systems are either orientated towards child protection (e.g. US, Canada, UK), or family service (continental Europe). Depending on this stance, abuse can be seen as the behaviour of malevolent parents, or as dysfunction stemming from psychological difficulties, marital problems and socio-economic stress – and amenable to therapeutic intervention. In the family service model, there is an emphasis on prevention and the aim of a placement in care is to support parents, not to replace them. There will be more use of 'voluntary' care, more shared parenting (with children living at home part of the time) and less emphasis on permanency.[5] Gilbert (2012) notes that these disparate conceptual frameworks may be beginning to merge, with increasing concern about child protection in some Nordic countries and more emphasis in England on family support. To counterbalance this, in England, there is an increasing drive towards speedier permanency planning and adoption that is lacking in the rest of Europe, where ongoing parental involvement is taken as a given. This is supported by the fact that adoption from care is not an option in Sweden, Finland and Denmark (Bowyer and Wilkinson, 2013). Different attitudes to the autonomy of the family versus state intervention are noted by Pitts (2011: p.19): 'life is more "social" and less familial in Finland'. This is coupled with a greater trust in 'experts' and the quality of provision, and less 'politicisation' of child welfare and youth offending.

Interestingly, there is some evidence that children and young people do not necessarily agree that residential care should be a last resort. For example, children in children's homes interviewed by Sinclair and Gibbs (1998) stated, by a ratio of three to one, that they would choose residential over foster care, even those who had experience of both. This has been confirmed elsewhere:

> *Many respondents felt they could not relax in foster homes, partly because it was someone else's house but mainly because they were wary of carers usurping the role their own parents should have been taking. They often felt that the carers' own children were given preferential treatment, leaving them feeling alienated … Residential care, on the other hand, was seen as less intense. One could blend into the background more easily in a unit than in a family and there were always a wealth of different adult personalities and perspectives (Barry, 2001: p. 13)*

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[5] In England, each child should have a permanence plan by the time of their second looked after review 'to ensure that children have a secure, stable and loving family to support them through childhood and beyond' (Department for Children, Schools and Families, 2010).

2.4 Models of residential care

These fundamental differences in approach inevitably influence the way that residential care operates, in terms of the type of settings that are developed, the way they are staffed and the children they take. A traditional model of children's homes in England up to the 1980s was to admit children to an Observation and Assessment centre to assess their needs and determine where they should best be placed in the longer term – or whether they could return home (Bullock and Blower, 2013). For those who were to remain within the care system, many were placed in a 'family group home' with resident house parents. This model is much less evident in England now, and many other countries have also reconfigured their provision. What does residential care look like now?

Although it is difficult to be precise because of variations in terminology, the following types of child welfare residential placement are evident in the international literature.

Table 2: International models of residential care

	Type of provision	Description	Country*
1.	Reception facilities/ children's shelters	Serve as emergency and/or assessment placements for children entering care	Denmark; Germany; France; Spain; Italy; US
2.	Respite/part time homes	Used to provide either a planned/emergency service for families struggling to cope but child does not live there on a permanent basis	Denmark; Germany
3.	Care for babies and very young children	Establishments specifically for very young children, sometimes with parents also resident. Used either to assess family functioning or to enable permanency planning.	Sweden; Spain
4.	Family group care	Live-in couples (sometimes with their own children) who provide ongoing care for a small group of children, supported by paid staff. These may be stand-alone homes or on a campus with several such homes and shared support services.	US; Denmark; Germany; Israel; Italy; Netherlands
5.	Group care/children's home	These may be generic, for children of mixed ages and needs, or specialist, for children with specific characteristics such as unaccompanied asylum seekers or ethnic groups (e.g. Aborigine or Torres Strait children in Australia). They are staffed by youth workers/ social pedagogues/ educators/ care staff. As with family group care, these may be stand-alone homes or on a campus with several such homes and shared support services.	England; US; Denmark; Germany; France; Canada; Spain; Italy; Australia; Finland; Israel; Netherlands

	Type of provision	Description	Country*
6.	Specially commissioned provision for single children	Where children cannot safely be placed with their peers, or where no suitable establishment can be identified, a specific placement may be created.	England; Australia
7.	Therapeutic/ high support units	For children with complex needs who cannot be cared for in mainstream settings, and who need a range of specialist support, such as therapy or on-site education. They have a higher ratio of staff per child and offer a therapeutic milieu.	England; Spain; Denmark; Norway; Germany;
8.	Residential treatment centres	For children requiring clinical intervention for specific disorders, particularly conduct disorder. May also take children who are not in the care system	US; Netherlands; Finland; Spain
9.	'Semi-secure' placements	Open settings but where there is some restriction on the child's movements	Finland; Netherlands
10.	Secure care	Locked establishments taking children who are deemed to be a risk to themselves or others and/or who have committed offences.	US; England; Sweden; Australia; Netherlands; Germany
11.	Supported accommodation in preparation for independence	Accommodation for older adolescents who are preparing to live independently. They may live in groups, with resident or non-resident staff offering support.	Italy; Spain; England; Australia; Germany

Notes: * This list is not exhaustive because of gaps in the evidence

See Bowyer and Wilkinson, 2013; Bravo and Del Valle, 2009; Courtney and Iwaniec, 2009; Francis et al, 2007; Hamilton-Giachritsis and Browne, 2012; Harder et al, 2013; Licursi et al, 2013; O'Sullivan and Breen, 2008; Otimi et al, 2009; Pitts, 2011; McLean et al, 2011; Rodríguez, 2013; Whittaker et al, 2014.

Not all types of provision are offered in all countries but some have a much wider range than others, particularly Germany and Denmark. England is relatively limited, primarily offering only 5, 6, 7, 10 and 11 from the above list. This is a relatively rigid model. Children are either in care – or not; in a foster *or* residential placement with distinct regulatory boundaries; in a secure *or* open setting. These distinctions are less evident in many European countries, where boundaries are more blurred. For example, Harder et al (2013) describe the following type of home in Germany:

> *...the concept of parent model residential groups, which is based on the idea that a couple (one of them being a professional) raises a group of children, shows that the differentiation makes the lines between residential and foster care blur (p. 208).*

Other countries such as Denmark, Germany and France, make much more use of part-time, respite and shared care arrangements (Boddy et al, 2009). Although there is no reason why this cannot happen in England, the regulations state that children in short-term placements of over 17 days or for more than 75 days in a 12-month period are considered to be looked after; this may be a deterrent to some parents (DCSF, 2010). One local authority in England did offer respite residential provision for children at risk of entering full-time care and the evaluation reported a reduction in family stress (Dixon and Biehal, 2007). Interestingly, some looked-after children told the Children's Rights Director that, had this been available, it could have prevented them from permanent removal (Morgan, 2011) and the Innovation Programme in England is enabling further trials to take place, such as the 'No Wrong Door' approach in North Yorkshire (Department for Education, 2014b). Boundaries are also more permeable in terms of the way establishments operate in some other countries. For example, residential staff may undertake work with parents in the community, or families may take part in activities within the establishment (Boddy et al, 2013).

Establishments specifically designed to cater for emergencies, or to take children when they first enter care, are not part of the mainstream system in England in the way that they are elsewhere. Children entering care for the first time will usually be placed in foster care, even if they clearly have a high level of need. This begs the question whether they are being set up to fail. However, the SAFE house establishment created in the US to assess the needs of children when they first entered care did not prove any more effective than foster care, and was more expensive (DeSena et al, 2005).

The other type of setting that has largely disappeared in England is that of large institutions operating within a campus model, such as the old Barnardo's village. These do still exist elsewhere: for example Youth Villages in Israel (Grupper, 2005; Burnstein, 2007) Boys' Towns in the US (Allen and Vacca, 2011) and the Kinderhaus in Germany (Benjamin, 2006). The latter is particularly interesting in that it provides a range of different services within a multi-story building, such as small 'family' units, education for children not managing in mainstream school, a mother and baby unit and a residential family intervention project. Children are said to be actively involved in decision making and there is a well-developed children's council. There are a number of calls from around the world, particularly the US, to 'bring back orphanages', on the basis that large establishments allow siblings to be kept together, their size enables a range of services to be provided, and children with complex needs are not being served well by the current system (Allen and Vacca, 2011; Frampton, 2011). Others urge caution about this 'nostalgia' for orphanages, claiming that large institutions are expensive and do not produce good outcomes (Freundlich et al, 2006).

At the other end of the spectrum are homes caring for one child, sometimes within a permanent facility, at other times in temporary accommodation rented specifically for the purpose. There has been concern in the past about the potential isolation and loss of liberty experienced by such children, although in England they do have to be registered

and inspected (Commission for Social Care Inspection, 2007). Six per cent of homes now appear to be used for this purpose (Department for Education, 2014c) but there does not seem to have been any examination of the experiences and outcomes of this particularly vulnerable group.

One result of the development of family-based care has been that residential care in many countries is now almost exclusively used for children deemed unable to live in a family. This is usually because of behavioural problems arising from past abuse or neglect but sometimes compounded by difficulties within the care system: these children often experience a number of failed foster placements before being considered for residential care. Has the process of 'deinstitutionalisation' gone too far? Commenting on the situation in Australia, which has the lowest use of residential care in the developed world, Ainsworth and Hansen (2005) write:

> *The dream – no more residential care – has gone disastrously wrong. One consequence of the attempt to do without residential care programmes rather than transform them into residential education and treatment facilities is that there is a crisis in foster care in NSW and every other Australian State and Territory. This crisis has to a large extent been created because many foster carers are exhausted and disillusioned by the placement, or more accurately misplacement, of children and youth who by virtue of unmanageable behaviour should not have been placed in a regular home environment (p. 197).*

They go on to describe a worrying picture whereby such children are placed in rented rooms and supervised by untrained staff, referred to homeless accommodation, or allowed to deteriorate until they are picked up by the youth justice system. The Australian government organised a national summit to consider the problem and identified a mismatch between the traditional model of children's homes and the needs of the children now requiring such care (McLean et al, 2011). They concluded that there was a need to develop 'therapeutic' provision, which they defined as:

> *Therapeutic residential care is intensive and time-limited care for a child or young person in statutory care that responds to the complex impacts of abuse, neglect and separation from family. This is achieved through the creation of positive, safe, healing relationships and experiences informed by a sound understanding of trauma, damaged attachment, and developmental needs (in section: Definition of Residential Care).*

There have been similar developments elsewhere, including England, where a number of providers are now offering therapeutic placements. There is no formal definition of this, and no separate category of registration to guide those seeking to identify suitable placements for troubled children. The Royal College of Psychiatrists and others have attempted to develop some consensus about what constitutes a 'therapeutic community' and have established the Community of Communities:[6] a quality improvement and

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[6] http://www.communityofcommunities.org.uk/

accreditation programme for providers. It covers both adult and children's settings, however, and there is no requirement for providers to participate.

This growing interest in therapeutic models links to the 'social pedagogical' approach operating in parts of Europe, notably Denmark and Germany, where a distinct profession of social pedagogues work with children to support every aspect of their development. The aim is to achieve the best 'upbringing' for the child; not to care for them until someone else can take on the task (Bengtsson et al, 2008). The pilot to introduce social pedagogy into a number of children's homes in England, considered in more depth later in the report, encountered a number of problems, but perhaps this was inevitable given the different beliefs about what residential care is for (Berridge, 2013; Berridge et al, 2011).

2.5 How do children's homes fit with other types of provision?

Children with similar backgrounds and needs can be found in residential care, psychiatric units or the secure estate, and for some children, their pathway may be somewhat arbitrary, depending on which agencies are involved and the way the child's distress has manifested itself. Some have argued that social care agencies leave troubled children to be picked up and dealt with by the youth justice system (see House of Commons Justice Committee, 2013: pp.14-18) and there are calls for youth courts to have the power to refer children whose offending is due to unmet welfare needs for assessment and intervention by children's services.[7] For those children who are in care, some may act their distress in ways that lead to involvement by mental health services, or through increasingly risky behaviour or criminality. This can lead to admission to a 'welfare' secure placement or the intervention of youth justice agencies and possible detention in a custodial setting under criminal law. Evidence for these pathways is largely anecdotal due to a lack of research, but we do know that looked-after children and care leavers are overrepresented within our secure estate (HM Inspectorate of Prisons, 2011).

2.5.1 Secure care

In England, there are two pathways into secure care: children detained under S25 of the Children Act 1989 because they are likely to abscond and pose a risk to themselves or others ('welfare' route) or children subject to a remand or sentence through criminal justice legislation. Secure Training Centres and Youth Offending Institutions provide placements just for those who have been detained within the criminal justice system, but Secure Children's Homes may take children through either route. Only a small number of children are subject to 'welfare' secure placements (the reasons for which are complex – see Mooney et al, 2012) and the numbers of children placed because of their offending has also declined dramatically in England: 211 children were resident in Secure

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[7] http://www.michaelsieff-foundation.org.uk/content/Youth-court-to-acquire-Family-Court-Powers.pdf

Children's Homes in England on 31 March 2014 (Department for Education, 2014d). This has led to considerable instability in the sector: secure children's homes are costly to operate and cannot afford to function with empty beds (Mooney et al, 2012). Following a review by Deloitte, the Minister for Children has just announced the government's intention to work with others to develop a system for the national commissioning of welfare secure beds.[8]

There is considerable unease about depriving children of their liberty, and conflicting views about whether it is in children's interests. Studies undertaken in Scotland (Creegan et al, 2005; Roesch-Marsh, 2014) and Northern Ireland (Regulation and Quality Improvement Authority, 2011) suggest that there are more effective ways of tackling children's 'risky' behaviour. The children were often trying to communicate their distress through their actions and hoping that adults would engage with that rather than exerting control. Where children were not detained, it was often found that intensive support services could manage their behaviour in the community.

Again, the question of whether, and under what circumstances, it is justifiable to place children in locked settings is an issue that other countries have grappled with. It is expressly forbidden in Finland although they do have the authority to impose some restrictions on children's freedom of movement and have a number of 'special care' units within the context of treatment (Francis et al, 2007). In the Netherlands, it used to be the case that children with conduct disorders could be detained in 'correctional', i.e. youth justice, facilities but in 2008 the government created a new type of secure establishment specifically within the child protection system. This is designed for children with severe internalising and externalising behaviour problems, and funding is dependent on providers offering evidence-based interventions (Boendermaker, 2008). Given that the age of criminal responsibility is higher in other European countries than it is in the UK, they have to develop alternative responses for children who are displaying aggressive or antisocial behaviour other than a 'correctional' response. There is also a more permeable boundary between 'secure' and open provision, with some units being described as semi-secure: a category that does not exist in England (Harder et al, 2013).

The situation in Finland is of particular interest. Because of their more 'social' culture, children who have committed what would be classed as a criminal offence in England are instead considered to be in need of treatment: something must have gone wrong with the child's development and socialisation. This has led to a large number of children being placed in mental health units. Whilst Finland is often congratulated on its extremely low numbers of children in custody, others have questioned whether hospital detention, with

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[8]
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/411387/ET_letter_to_ADCS_LGA.pdf

its lack of due process in decision making and no clear discharge date, is equally problematic and an infringement of children's rights (Francis et al, 2007; Pitts, 2011).

2.5.2 Treatment

This brings us to the second major source of residential care: that of treatment. Interestingly, this is a word rarely found in the English literature on children's residential care, but it is very prevalent in the US, where much of the available literature, including that on outcomes, refers to 'residential treatment centres'. Indeed the term is often used interchangeably with 'residential care'. It is difficult to make direct comparisons with the English context because of the lack of definition or regulatory framework that determines how such centres will operate:

> *...it is difficult to describe what unites these diverse programs or describe succinctly what constitutes the "treatment" in residential treatment. Indeed, the most commonly used current definition of residential treatment centers consists of little more than the statement that they are inpatient facilities that are not licensed as hospitals and offer mental health treatment for mentally disturbed children (Leichtman, 2006: p. 286).*

It is left to individual states as to how – or whether – they will monitor their operation. In some states, such as New York, they are part of the child welfare system (Dale et al, 2007). Both the Child Welfare League of America and the American Association of Children's Residential Centers have attempted to establish some commonality and to set standards. Leichtman (2006) suggests that the central tenets of residential treatment should be the use of the life experience in a therapeutic fashion, sometimes referred to as 'milieu' therapy, and 'marginal' or Life Space interviews. These have much in common with the model of a therapeutic community described earlier.

The reality may be somewhat different. Although many of the children referred to treatment centres share the characteristics of those that are in residential care elsewhere, they are not necessarily all in the care system. In the US, parents may make direct referrals and pay for the treatment themselves or claim via their medical insurance. This has led to concerns about breaches of human rights, with accounts of children being collected in the middle of the night without their consent or any legal process and being taken to establishments where the standard of care may be unacceptable and outcomes untested.

> *Programs are often reported to maintain a severe and rigid approach to discipline and activities of daily living that would be protected as 'rights' of youth in licensed inpatient mental health facilities are framed as 'privileges' in many of these programs. For example, a number of programs forbid contact with parents both initially (sometimes lasting for months) and when youth are not complying with program rules. It is not unusual for youth residents to be involved in monitoring and disciplining their peers – a particularly questionable practice since all youth sent to the program presumably have special challenges themselves (Friedman et al, 2006: p.297).*

Of particular concern are the 'wilderness' programmes, which have attracted considerable media attention. Evaluations of such programmes suggest that they are not an effective solution to adolescent behaviour problems and may be actively abusive (Behar et al, 2007).

The need for treatment for troubled and traumatised children deserves recognition. Studies have repeatedly demonstrated a high level of unmet mental health need amongst the residential care population (Ford et al, 2007), and it could be argued that it is unrealistic to expect them to receive the right help in an establishment staffed largely by poorly trained and paid staff, operating without any theoretical framework and where they are intended to stay for the shortest time possible. This dilemma has been discussed in Spain, where child protection services operate a number of establishments for children with a conduct disorder, referred to variously as 'intensive education' or 'socialisation' units. The Spanish Ombudsman has questioned why children with a clinical diagnosis are not cared for by health agencies and criticised the lack of regulation or defined status of the establishments (Rodríguez, 2013). There are also calls for clarity in the US (Lieberman, 2009) and Canada (Ninan et al, 2014) about who can be treated, using what methods, by which staff, how long for, how treatment will link with community support and expectations about family involvement.

Many countries also have specific residential treatment for children with substance misuse disorders: again something not found in England. In fact, facilities specifically designated as providing treatment for any type of mental health problem are extremely scarce, with only 1264 inpatient beds within the NHS in July 2014.[9] There are many calls for this to be increased. The nearest equivalent is the growth of 'therapeutic' homes, but again, the lack of a distinct registration category raises doubts about their credentials, in spite of the fact that there are high-quality establishments within the sector. Although not the subject of this report, there have also been initiatives to develop specialist or treatment fostering schemes. For example, some children with particularly challenging or offending behaviour may be placed within Multidimensional Treatment Foster Care (MTFC). The interface between 'ordinary', 'therapeutic' and 'treatment' provision would benefit from a system of classification based on consistent criteria.

2.6 Conclusion

The rapid move away from the use of residential care has been prompted by genuine concerns about children's best interests rather than conclusive research evidence about its ineffectiveness. We know that children who cannot live at home should be in alternative settings where they are safe, but also where their emotional as well as physical needs can be met. This has led to uncertainty, however, in defining the purpose

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[9] http://www.bbc.co.uk/news/health-28255930

and shape of the residential care that should remain. There is no international consensus about this, with some countries seeing it as having a continuing role as an important service to support, rather than replace parents, whilst others see it as a temporary measure until the child can move to a permanent home. In response to this uncertainty, a variety of different models have developed, but without any agreement about the 'right' type of care for children with different types of need. Assessment models are emerging in some countries to support decision making, described later in the report, but are not in use in England. Neither is there comprehensive research to guide practitioners. Particular gaps include:

- how best to establish the needs of new entrants;
- the best way of protecting children who pose a risk to themselves and others;
- the differences between mainstream placements, those described as therapeutic and treatment;
- the benefits/risks inherent in different models of care.

3 The residential care population

Given the changing shape of the residential care sector, it is inevitable that there will also have been changes in the population of children that it serves. In this chapter, we explore placement patterns in an attempt to understand how many children are placed, in which types of residential care and for how long. We then examine the evidence about the children's profiles and their identified needs, and how these needs are assessed.

3.1 Placement patterns

Although information is collected in England about looked-after children and their outcomes, this does not fully differentiate between placement type. Increasingly detailed analyses about children in residential care have been undertaken by the DfE in the format of the Children's Homes Data pack (Department for Education, 2014c). To summarise key points for the year ending 31 March 2013:

- 9% of looked-after children were in residential care;
- the average age of children in children's homes was 14.7;
- only 19% of placements in residential care lasted longer than a year, with an increasing proportion lasting less than 30 days (35%);
- more boys (64%) were placed in children's homes than girls, particularly younger boys under the age of 12;
- for 25% of children in children's homes, this was their first placement, but 31% had had six or more placements;
- 45% of children in children's homes lived within the local authority, but 31% lived outside *and* more than 20 miles from home;
- 95% of children in children's homes outside the local authority boundary were in private or voluntary provision.

Whilst the proportion of children in residential care appears to have stabilised (see previous data packs), placement stability seems to be worsening and distance from home is not reducing.

While most countries do collect data, it is insufficiently consistent to allow meaningful comparisons. For example, the US publishes data on the proportion of children under 12 in residential care, but not older children.[10] It does appear that there are very different patterns, however. For example, a study of children in residential care in Lombardy, Italy, in 2009 found that the proportion of boys and girls was similar until the age of 14, when boys began to predominate; 70% of children stayed more than six months and 12% for

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[10] Child welfare outcomes in the US, http://cwoutcomes.acf.hhs.gov/data/overview

over three years (Carrà, 2014). In Italy, responsibility for data collection is devolved and Lombardy also collects useful data on whether the children are in voluntary care (80%), the amount of parental contact they have during placement, and where they go on leaving the placement.

There is a presumption that residential care is a service for older children and adolescents and this is supported by the English data, although the 11% of boys and 5% of girls aged 11 or under must not be forgotten (Department for Education, 2014c). The age range in other developed countries is more variable, and Hamilton-Giachritsis and Browne (2012) report a surprisingly high number of children under the age of three in residential care in Western Europe. It also appears that there are differences in the age at which children enter care, with English-speaking countries admitting far more children under the age of five than continental Europe, where there are more adolescent entrants (Bowyer and Wilkinson, 2013). It is more difficult, however, to establish how this relates to the age at which they are placed in residential care. To what extent is it a placement of choice when they are first admitted and the extent to which is it a last resort, following disruption? Sinclair et al (2007) found that half of those in children's homes in their English study were 'adolescent graduates', following a breakdown in one or more family placements and half were 'adolescent entrants', who had been admitted straight to residential care from home. It is also of note that the age at which children must leave residential care is different, with some countries allowing them to remain until their early 20s: for example, in Denmark this is set at 23.

Cameron (2011) found that placement stability was much higher in Hungary, Spain, Denmark and Sweden than in England, where nearly half of the study sample had four or more placements. Just 18% of children in England had had one placement, compared with 34-45% in the other countries. Harder et al (2013) described concern about placement stability in Germany, when one in seven children were found to have experienced more than one placement breakdown: a figure that other countries would find low. The findings of Olsson et al (2012) suggest that the Danish picture may be more complicated than Cameron suggests. In their study, specifically of teenagers, 44% had experienced at least one placement breakdown, particularly in the early months and if there were other teenagers in the placement. The authors suggest that teenagers require particularly good care planning, including contingency arrangements, to protect them from the harm caused by unplanned moves. Even where a placement is unsuitable, sudden disruption means that a better alternative may not be available and the child may feel rejected.

In Australia, there is increasing recognition that the pattern of multiple failed placements in foster care before placing in residential care is flawed. In a summary of the Australian research literature on placement disruption, Osborn and Bromfield (2007) state that a subset of children in care experienced ongoing and severe placement disruption, with an average of 11 placements during their time in care and five placement breakdowns over

the previous two years. The factors that were thought to predict placement disruption were:

- children with experience of early trauma and abuse;
- gender, with boys four times more likely to experience disruption than girls;
- placements located in the countryside;
- a history of six or more placement changes;
- mental health problems (e.g. conduct disorder);
- hyperactivity;
- longer time in out of home care.

One study claimed that it was possible to differentiate between 'unstable' and 'stable' children based on whether they had experienced two or more breakdowns in the previous two years due to their behaviour. If so, consideration needed to be given to specialist provision rather than trying yet another mainstream placement (Delfabbro and Barber, 2003).

At the opposite end of the scale is the problem of children who are admitted to residential care on a temporary basis but not moved on. In most countries, residential care is intended to be just such a short-term measure. James et al (2012) looked at whether it was being used as the intended 'stopgap' or not in the US, and tried to identify the factors that were associated with length of stay. They found that one-third of their sample had stayed less than six months, one-third between six months and a year, and the remaining third between one and three years. The factors associated with longer placements were chronic health problems and a higher number of previous placements. Surprisingly, behavioural problems and the goals of the placement did not seem to make a significant difference to how long they stayed. The average age of the children was only 10.7 and the authors suggest that there needed to be more rigorous examination of the justification for placing them in residential care.

3.2 Children's profiles

The catalogue of problems that children in residential care across all nations are said to demonstrate is daunting. For example, Bath (2009) cited: attachment disorders; an impaired ability to trust; trauma-related symptoms; education problems; intellectual disability; neuro-developmental problems; mental illness and aggression. This is an account of the situation in Australia:

The difficult and disturbed children and young people to whom we are referring are predominantly aged between 10 and 17 years, of either gender, whose activities range from disruptive and delinquent acts through to serious aggressive and violent behaviours. These behaviours are often linked to mental health (including self harm) and substance abuse problems arising in many instances from abuse and neglect. These children and young people invariably demonstrate an inability to live peaceably with others, either their immediate family or foster carers. They rarely

attend day school as they have usually been suspended or expelled. A history of multiple disrupted foster care placements is commonplace. They are so alienated from others that without effective intervention to steer them to an alternative outcome they face long-term unemployment and homelessness, with the potential to drift into a life of social isolation, adult crime and poverty (Ainsworth and Hansen, 2005: pp. 195-196).

This level of disturbance seems to be supported by English data. Recent government statistics suggest high level of emotional and behavioural difficulties: 38% of children in children's homes have a statement of special educational needs; 62% have clinically significant mental health difficulties; 74% were reported to have been violent or aggressive in the last six months (Department for Education, 2014c). Berridge et al (2012) found that half of the residents in their study of children living in a sample of 16 children's homes had special educational needs; their mental health needs were six times the rate of the wider population and they had very significant behaviour problems, including offending behaviour. A comparative study of mental health disorders in the UK suggested that looked-after children were about five times as likely to have a mental disorder as their peers. This was even greater for those in residential care than in foster or kinship care, with 61% reported to have a conduct disorder as opposed to 32% and 26% respectively (Ford et al, 2007). The findings were based on survey data, however, rather than reports from clinicians or direct screening.

In a French study, diagnostic interviews were conducted with 183 adolescents in residential care (Bronsard et al, 2011). The findings indicated that just under half had at least one psychiatric disorder. Anxiety disorder was the most prevalent (28%), followed by 'psychotic symptoms' (19%). Conduct disorder was evident in 15% of the children, as was major depression. The incidence of disorders was much higher amongst girls (65%) than boys: nearly half of the girls had an anxiety disorder and over a quarter had major depression. Behavioural issues were therefore less of an issue that 'internalising' problems.

This was also the case in two studies of children in Spanish residential care, undertaken in 2002 and 2006 (Bravo and Del Valle, 2009):

...problems of anxiety or feelings of unhappiness and depression emerged as the most common, at least 65% of children's home residents presenting (according to the care worker's criterion, rather than a diagnosis) a problem of this type; conflict-related problems, such as the use of violence, criminal behaviour, substance use and running away, accounted for 35% of the sample. At that time, then, there was clearly greater prevalence of problems related to personal suffering than to conflict or aggression (p. 46).

Other studies have looked at ADHD (Casey, 2008); suicide risk (Duppong Hurley et al, 2014) offending behaviour (Darker et al, 2008) and language impairment (Hagaman et al, 2010; McCool and Stevens, 2011).

One factor that emerged from the social pedagogy pilot in English children's homes was the claim that 'our children are worse' than those in Nordic countries (Cameron, 2014).

The fact that the threshold for entering care is relatively high in England, and that more children are placed in family settings, could lead to a high concentration of troubled children in residential care. In a small-scale study of children in five European countries, Cameron did not find any evidence that entrants to care were significantly different in terms of their family background, but the English system offered the children less stability, with a much higher proportion experiencing four or more placements. This would seem to support the findings of another comparative study across England, Germany and Denmark (Petrie et al, 2006). Children in residential care in England were more likely to be out of education and/or employment, and at greater risk of teenage pregnancy and of engagement in criminality, but this could not be explained by differences in the characteristics of the children themselves. The authors concluded that the key explanatory factor was the professionalisation of the workforce, and therefore how well-equipped they were to care for the children.

This links to an important question – and one not always asked – about the factors that contribute to problems experienced by children in residential care. Some will relate to the child's previous experiences or individual characteristics, but others may be due to the trauma of being removed from home, or the quality of the care they are receiving. Using an extensive database developed in Israel to monitor children's progress, combined with an examination of the way each residential unit functions, Attar-Schwartz explored the factors associated with children's psycho-social problems (2008), school functioning (2009) and runaway behaviour (2013). In relation to the children's characteristics, the findings suggest that struggling to come to terms with a painful history, being in statutory rather than voluntary care and having poor-quality parental contact all contributed to a child's difficulties. The quality of the care they received also made a difference, however. Establishments where there were high levels of peer violence, unsupportive staff – or poor quality food – were all associated with children displaying more problems. The author calls for a more ecological approach that considers the child in context in an attempt to understand their behaviour:

> In that context, the care system needs to consider the functioning and self-fulfillment of the children as part of its 'parental' responsibility, instead of focusing exclusively on psychopathologies, difficulties and 'survival' (Attar-Schwartz, 2008: p .245).

This is supported by a study of children where a secure placement was being considered in Scotland because of 'out-of-control behaviour'. While managers were concerned with risk, social workers were trying to understand the behaviour in terms of past abuse, but the children were attempting to communicate their *current* unhappiness with their placement or family relationships (Roesch-Marsh, 2014). Similarly, McLean et al (2012) found that those working with children displaying challenging behaviour had six different theories about the origin of the behaviour, and therefore six different sets of ideas about how it should be tackled. Some thought the behaviour was a deliberate strategy for the child to get what they wanted; others that it was learned behaviour seen as 'normal' by the child because of their background, or that it was a response to constant change and

instability. Depending on this stance, solutions included measures such as prosocial modelling of good behaviour, firm boundaries or trying to provide a secure relationship. There was a risk that the different beliefs held by people working with a child could lead to an incoherent response.

The importance of being able to understand why a child behaves in a particular way is also described in a study by Ferguson et al (2011) of residential workers' ability to recognise 'reactive attachment disorder', which is characterised either by hypervigilance or indiscriminate friendliness in children who have been abused. Particular strategies are needed to help such children as they are at risk of developing conduct disorders. The authors found that less than half the workers were able to recognise the classic symptoms.

3.3 Assessing and understanding needs

This raises questions about the way children's difficulties in residential care are assessed and understood. The methods used in research studies are primarily screening tools designed to identify pathology, or reports from carers. In England, the assessment framework designed for children in need (Department for Education, 2013) is intended to be holistic, as is the Strengths and Difficulties Questionnaire for looked-after children.[11] Usually, it is the difficulties that get reported, however, not the strengths.

Although in a very specific context, Block et al (2006) describe the use of a strengths-based assessment model with gay, lesbian and bisexual young people in residential care. This approach enables children to tell their story and identify the ways they have coped with the challenges in their lives. It can be a tool for empowering them rather than dwelling on the negatives. Given the prevailing message that placement in residential care is a last resort, there is a risk that children will see themselves as failures: too damaged or difficult for a normal life. This message can be compounded by the media. Clackson et al (2006) undertook an analysis of media reports in Scotland and found several references to 'homes from hell'. They described one example where the headline 'Scandal of Free Pop Trip for Teen Bad Girls' referred to a trip to a concert taken by some teenage girls, none of whom were looked after because of behaviour problems, and where funding had come from their normal holiday allowance.

Jansen (2010) suggests that the two roles offered to children in residential care are that of 'victim' or 'troublemaker' and that this can present risks to their development. Calheiros et al (2014) undertook a study to compare the ways in which professionals and the children themselves defined their needs. The professionals categorised children

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11 http://www.sdqinfo.com/

according to levels of risk, whereas the children identified the most important aspects of their lives as the quality of their placement, social and family relationships and education.

We need to develop a more sophisticated understanding of a child's inherent problems and those that are a reaction to the environment in which they find themselves. Various commentators have noted the risk of 'peer contagion' when troubled children are placed together (see Barth, 2005) but relationships with staff are also key. Berridge et al (2012) wrote:

> *The overall conclusion from our periods of observer participation was that the residential homes were comfortable environments but retained some unnecessary institutional features. Yet more important than physical environment are the interpersonal interactions and we were disappointed, in our assessments, that only about half the homes provided a consistently warm and caring environment throughout the day and across the staff group. In two of the ten homes staff were rather detached: young people also sensed this and told us in interviews (p. 91).*

There is a distinct possibility that some of the difficult behaviour assumed to be an intrinsic characteristic of children in residential care is a product of the placement and the research evidence for this is discussed in Chapter 5, when we look at impact and outcomes.

3.4 Conclusion

Residential care is only used for a small proportion of looked-after children in England, and this now seems to have stabilised at around 9%. As could be expected given the preference for family placements, the children tend to be older and more troubled, with evidence of considerable placement instability. Attempts to establish these children's needs indicate a higher incidence of mental health disorders than in the general population and, where data exists, than in children in foster care. What we do not know, however, is the extent to which children's problems are caused by:

- pre-care experiences;
- the trauma of being removed from home and missing their family;
- a history of placement breakdown;
- inadequate care within the residential setting.

The fact that residential care is seen as a last resort may also lead to feelings of social exclusion, with children adopting the negative identity of 'victim' or 'trouble maker'.

We need to have methods of assessing children's needs that identify strengths as well as difficulties and do not unnecessarily pathologise them. This information should then be used to identify the right type of provision in a more sophisticated way than is currently the case. Although there have been some attempts to identify which children are least

likely to settle in foster care, this is a long way from an evidence base that could be used to make individual placement decisions.

4 How does residential care operate?

This chapter offers a more detailed picture of how residential care operates, including what it aims to do and the different aspects of day-to-day practice that are meant to contribute towards these goals. The following chapter will then consider the research evidence linking these factors to children's outcomes. Of particular importance are unit 'culture' and the quality of relationships between staff, children and their families. At a more structural level, we also examine the qualifications and skills of the workforce, the impact of the 'market' in residential care and the difficult issue of assessing quality.

4.1 Purpose and ethos

Although the different types of residential establishment that can exist were described earlier, this did not tell us how they operate in practice. Various authors have likened life in a children's home to a 'black box' of poorly understood elements, making generalisation difficult (Knorth et al, 2008).The first fundamental difference will arise according to the purpose of the placement: Rowe et al (1989: p.132) identified the following possible placement aims, which seem equally valid today:

- care and upbringing;
- temporary care;
- emergency/ roof over head;
- preparation for long-term placement;
- assessment;
- treatment;
- bridge to independence.

They found that the main aims of residential placement in the children studied were primarily temporary, with only 14% there for 'care and upbringing'. Twenty-five years on, this proportion is likely to be even less.

> In the USA and to a lesser extent Australia and the UK, the proportion placed in residential care for 'care and upbringing' is small and even when it is the aim, it will be with respect of children who did not enter the establishment until at least aged 10 and usually well into adolescence. More children in European countries have 'care and upbringing' as a major purpose of residential care, although this is often associated with maintaining links with birth family members (Ainsworth and Thoburn, 2014: p. 22).

The purpose of the establishment is key to how the staff see their role, how children perceive themselves and the engagement of parents. Each home in England should have a Statement of Purpose, setting out its aims and objectives and the types of children that it can accommodate. This should include the home's ethos and theoretical approach (Department for Education, 2011). Every child placed should also have an individual Placement Plan describing the part that the home will play in meeting their

needs (DCSF, 2010). So, at least in theory, everyone should be clear why a particular child has been placed and what to expect. Berridge et al (2012) found that some Statements of Purpose were so vague as to be meaningless, such as providing a 'secure base' or being 'child-centred'. Similarly, descriptions of the home's theoretical framework were either based solely on behaviour management, or absent altogether.

There have been a number of attempts to describe the ethos or 'feel' of different homes. In an English study, Berridge et al (2012) found:

> *Despite the reasonably comfortable décor, several of the homes seemed to us to retain unnecessarily institutional features. In at least three homes, when the telephone rang a bell sounded loudly through the home; in contrast, in some other units, staff had overcome this by carrying cordless phones to avoid the constant clamour and interruption. In another, certain lights constantly went on and off when they detected movement ... A few homes had visible 'health and safety' posters and collections of young people's leaflets on display, on issues such as nutrition and healthy eating or sexual health. While important, these would not usually be displayed in a family home and reinforce an institutional feel (p. 40).*

In some homes, staff spent nearly all their time in the office, with children hovering around the door hoping for attention. Whilst some staff sought children out when they came on duty to ask how they were, others went straight to the office to find out from the log book.

In countries with a tradition of social pedagogy, the 'feel' of the living space is crucially important. Højlund (2011) undertook an ethnographic study in a group of homes in Denmark that strove to establish a sense of 'hominess' for the children. This is seen as something to be aspired to in Denmark – where they still see residential care as a long-term option. They believe children should receive pedagogical/psychological therapy, but in the context of a normal day-to-day life. The homes tried to instil 'hominess' in a number of ways: by burning candles, baking buns, showing physical affection and joining in activities with the children. They also organised the home to make it as much like a normal family as possible, always having a male and female staff member on shift, not using terms such as 'being on duty' and not having an office within the home. If staff needed to do paperwork, they did it at the kitchen table. A constant source of discussion for staff was: 'would you do that at home?' Staff wanted the children to feel that they were in a place where they could stay for the rest of their childhood, particularly as some had experienced a number of previous placements: 'here the children can put down roots'. The children did not necessarily buy into the idea that this was their home, however. They knew it was a 'job' for the staff, and looked for the blurring of the boundaries, such as staff inviting them home or bringing in their own children, to indicate that they were really cared about. Højlund concluded that 'hominess' is perhaps an unattainable ideal, but that there are valid reasons for trying to achieve it.

The concept that homes need to be as normal as possible is questioned by Ward (2006). Whilst accepting that children do need to be supported towards an 'ordinary' life, this

should not be at the expense of tackling the emotional and psychological needs that any child in residential care will inevitably have. If staff accept children's troubled behaviour as normal, they are doing them a disservice. Instead, Ward advocates a 'special' approach to everyday living, which uses the opportunities for learning and development that residential care presents. This is similar to the concepts within social pedagogy, on which there is extensive literature that will not be covered here, although the pilot to introduce it into residential care in England is discussed later in the report. This approach provides the theoretical underpinning for much of the residential care provided in parts of Europe, particularly Denmark and Germany (Petrie et al, 2006). Homes using a pedagogical approach may not be labelled as 'therapeutic' because they are embedded in mainstream practice rather than being reserved for specialist settings. They are, however, concerned with the active task of 'upbringing' rather than just accommodating children and complying with regulations.

Although the context is very different in England, making it difficult to directly import social pedagogy, there are examples of approaches that mirror some of its concepts: for example, Cameron and Maginn (2009) argue the need for the care system to parent children, rather than just to care for them, and propose a Pillars of Parenting model for children in residential care. The Life Space approach, which uses everyday crises to help children learn new ways of thinking, feeling and behaving, and the 'milieu' therapy that is an integral part of therapeutic communities, are also actively engaged with supporting troubled children to develop and overcome their difficulties. In their observational study of three English children's homes, Petrie et al (2006) concluded that, in spite of the fact that the staff had no training in pedagogy, they were demonstrating many of its features through:

> *...the physical environment, the social relations between adults and children, the way young people's skills and participation in daily life are valued and the extent to which children's integration in the local community is fostered (pp. 146-147).*

4.2 The importance of relationships

If staff are to take on the task of parenting rather than care taking, the quality of their relationships with the children is key, yet not a lot is known about what supports good relationships. Practice guidance offers lists of the qualities that a good worker should have, but evidence about how this translates into positive interaction is somewhat lacking. Kendrick (2013) suggests that, when residential care works well, children describe it using the metaphor of a family. They may describe staff members as 'like a sister' and the establishment as 'my house'. When children and staff in children's homes were asked about their experiences of physical restraint, it could have both a positive and negative effect on relationships.

> *Young person: And like when that guy, Jimmy, came in there, he was like holding me in a like, you know it was like a fatherly way or something, making sure I was safe and that.*

Interviewer: And that feels?

Young person: Like he's caring for me (p. 82).

Yet there is some ambiguity about the nature of these relationships. Steckley (2012) describes children who seemed to provoke crises where they would be restrained in order to be 'held' by staff. The experience of being touched can play an important part in children's development, in helping them to regulate their emotions and to feel safe, but staff may be anxious about physical contact in case they are accused of abuse.

The issue of establishing boundaries within relationships is complex (Pemberton, 2009). There is also the tricky question about what happens to relationships when children leave.

I would say to [a new resident] don't tell [staff your] personal business, don't trust them, that they know too much about you. As soon as you leave they're not your friends, you're not allowed back (young woman quoted in Petrie et al, 2006: p. 118).

Berridge et al (2012) described many instances of positive and sensitive interactions in staff's work with children, including physical affection and general warmth, friendliness and approachability. This was not universal, however, and there were instances of children being ignored or being exposed to staff's complaints about their working conditions.

Petrie et al (2006) looked at differences in the way residential workers approached their task across England, Germany and Denmark. English children's homes were usually smaller, but fewer staff took on a 'key worker' role than their counterparts; they were less likely to adopt an empathetic approach to the children and more likely to refer to procedures. It was difficult to identify whether these differences could be accounted for by differences in training, or the wider societal context in which residential care operates. Relationships were adversely affected by the fact that English placements tended to be shorter. It was also the case that the personality of the individual care worker was important: some workers just seemed to have the capacity to form supportive relationships with children. The authors commented, however, that this may not be enough in itself and cannot be relied upon as a substitute for training.

4.3 Unit 'culture'

Ainsworth and Fulcher (2006) describe the need to establish a 'culture of care' that provides living, learning, treatment and supervisory support for children in residential care. The factors that shape culture are complex, ranging from structural factors, such as the design of the building, staffing and the policy context, through working practices, team functioning and shared values.

McPheat and Butler (2014) question how far residential care settings are 'learning organisations'. In spite of a number of inquiries revealing shortcomings, change in the sector has been slow. Why is this?

...Organisations learn through a change in culture. However, achieving a change in organisational culture is a significant task. Organisational culture represents the norms for those that work within an organisation and can be described as the way things are done and the patterns of delivery systems that exist. Each organisation can be viewed to have a 'cultural web' which consists of the taken-for-granted assumptions of an organisation and the physical manifestations of organisational culture (p. 242).

Managers and practitioners were asked by survey to rate their establishment according to these measures of a learning organisation: team learning; shared vision; mental models; personal mastery; systems thinking; celebration of success; innovation; learning from mistakes; human potential; shared knowledge; trust; learning from others. The findings indicated that, whilst many aspects of a learning organisation were present, particularly a shared vision and mental models, there were differences between the views of managers and other practitioners. Most significant were the findings that many staff did not feel supported to take risks nor encouraged to develop innovative practice; mistakes were not used as learning opportunities and a culture of blame was felt to exist.

The importance of involving staff in transformational change is described by Hatter and VanBockern (2005). Managers had decided to introduce a new working model, Circles of Courage, to their residential programme, but embarked on a comprehensive implementation plan that involved all staff and children in recognition that it was important that: 'the model was not simply the mantra of management' (p. 42).

Questions of culture and a shared vision may extend beyond the walls of the home, and it is important that all agencies supporting a child can work together. McLean (2012) interviewed a range of practitioners and carers about their experiences of collaborating to meet the needs of children with challenging behaviour in Australia. The findings were worrying:

Each group experienced their understanding of challenging behaviour as incongruent with those of other groups. Furthermore, 'other groups' practice frameworks and approaches were viewed as inferior, inaccurate, inappropriate, inflexible and largely ineffective. 'Others' approaches to behaviour were seen to hinder attempts to help young people by being too punitive, by lacking clarity or focus or by being based on insufficient understanding (p. 480).

Problems were compounded by power imbalances, weaknesses in information exchange and decisions about resources, with those directly caring for the child having the least voice.

4.4 Working with families

Statements about working in partnership with parents are present throughout child welfare policy, but little is known about how this is interpreted in practice within residential child care. In England, work with the family is likely to centre on whether the child can return home and be undertaken by the social worker or other community-based professionals. If it is decided that the child will be permanently placed outside the family, work with the family is likely to diminish or cease altogether. The language is usually about the child having 'contact' with family members, whereas the expectations elsewhere often go much further. In continental Europe and Israel, there is an expectation that 'family work' will take place and that residential staff will be directly involved in it. There is evidence of change in this direction within the US:

> *Historically, when a young person was placed in a residential facility … The family worker was separate from the facility staff. Concerned with different issues, they competed with and blamed each other – if they even talked to each other. Now it is more common to see residential staff directly involved in working with families (Garfat, 2011: p. 7).*

Boddy et al (2013) argue that there is a need to go 'beyond contact' and look at ways of actively involving parents in their children's lives. We know that many children end up returning to their families when they move on from care and, even if they do not, they will have a psychological need to make sense of the relationship. They suggest that parental involvement is less challenging when children are in residential care rather than a family placement. The fact that more children are in this placement option in Denmark, France and the Netherlands, combined with a better-qualified workforce and much lower rates of legally enforced removal from home, gives residential staff the opportunity to work constructively with parents. Parents were encouraged to parent 'at a distance' or on a part-time basis, and were often actively involved in decision making and the child's everyday life.

Klap (2008) describes the work of a family rehabilitation centre in Finland providing residential care for children aged 12 or over. The tasks of the children are defined as:

- resolving issues of maltreatment;

- forming at least one close relationship;

- improving lost self-esteem and maturing emotionally/ socially;

- making peace with the family.

Parents are actively involved in this process and work with staff from the centre even if the child will not be returning home. They attend a series of family meetings but are also invited to take part in recreational activities, along with the child's siblings.

Grupper and Mero-Jaffe (2008) also use the term 'rehabilitation' in relation to family relationships rather than where the child will live. They argue that parents were historically seen as 'part of the problem' for children in residential care and therefore

ignored. Israeli policy determined to tackle these negative attitudes towards parents because they felt that it was in the children's best interests. The authors evaluated a programme which aimed to improve the relationships between parents, children and residential staff. It was hoped that this would not only improve the child's adjustment and self-esteem but also raise parents' awareness of their child's needs and enable a trusting relationship to develop between staff and parents. The approach included dynamic workshops for parents within the home, family days and summer camps for the children and their parents together. The findings were positive: the divided loyalties previously experienced by the children were reduced; parents became more confident and competent, and staff felt more positive about them (see also Burstein, 2007).

The call for greater family involvement is also evident in more 'child protection' oriented systems, where parents were traditionally blamed. Ainsworth (2005) describes the factors that support parental engagement and says that homes need to structure themselves in a different way. The first step is to adopt a different value system. Instead of seeing parents just as the perpetrators of harm there needs to be recognition of the psychological and environmental stresses that have caused their problems in coping. The role of staff is not to be the parents' therapist but a 'parent educator, trainer, and supporter'.

It goes without saying that children should be active participants not only in their own care, but also in the way their establishment operates. This right was fought for in Germany in the 1970s and 1980s, when the residents of residential care protested against the impersonal and repressive nature of their institutions, supported by academics, students and practitioners; this led to widespread reform. In England, the right to participation and advocacy are enshrined in the Children's Homes Regulations, and inspection activity ensures that arrangements are in place. Mechanisms may include involvement in staff recruitment, unit meetings, the use of complaints procedures, user surveys, suggestion boxes and so on. A detailed exploration of these is beyond the scope of this report. It is likely, however, that the ability of children to be meaningfully involved will depend on many of the factors described above relating to the culture and ethos of the home, and the quality of relationships between staff and young people.

4.5 Management and staffing

The ability of the workforce to provide good-quality care is central. It does not matter how strong the theoretical model is if staff are not equipped to deliver it. There have been calls to raise the qualification levels of residential care staff in line with those in much of Europe, particularly those employing social pedagogues. In these countries, many staff are better qualified and the profession has higher status. Petrie et al (2006) undertook detailed comparisons of the residential workforce in England, Belgium (Flanders), Denmark, France and Germany. The study confirmed that the English workforce had the lowest level of qualifications, and that most of the training was focused on 'care work', such as a level three NVQ in Caring for Children and Young People, or social work, as opposed to the specialist focus on children's upbringing provided by social pedagogy.

Although the training differed across the European countries, it was usually a minimum of three years and at degree level. A qualification in pedagogy could lead to a range of jobs within children's services and it meant that there was a coherent approach and shared vision across the workforce. In contrast, English staff had a disparate range of qualifications and lacked a common language. Contrary to popular conception, however, Petrie et al did not find that the higher level of qualification in Europe was reflected in higher rates of pay.

A comprehensive survey has just been undertaken of the children's residential workforce in England (Thornton et al, 2015). Key findings were that:

- 92% of staff and 90% of managers had attained the required level 3 or level 5 qualification or were working towards this;
- 1% of staff were being paid at or below the National Minimum Wage and 11% were being paid less than the Living Wage Rate, all in the private sector;
- Privately run homes paid less per hour than local authority homes;
- Over half of all managers (54%) said that they found it difficult to recruit, particularly in the private sector;
- Local authority homes tended to have a larger number of places than privately run homes, but occupancy rates were similar;
- Local authority run homes tended to have a higher number of staff on average (15) compared to privately run homes (11);
- Staff in privately run homes tended to work longer hours on average.

4.5.1 Staff perceptions of the job

A number of studies have looked at staff morale and job satisfaction in the UK. Surveys across the four nations showed that more than three-quarters were 'satisfied' or 'very satisfied' with their job and that staff morale was generally thought to be 'OK' or 'high' amongst at least two-thirds of respondents (Mainey and Crimmens, 2006). Staff described their main tasks as a mixture of procedural (care planning), supportive (showing concern) and supervisory (keeping order). They would have liked to be more involved in therapeutic work; aftercare, family contact and relationships outside the home:

We are policing the unit rather than offering care (p. 35).

Proper therapeutic training would help me. We're just managing the behaviour instead of looking at the root causes (p. 79).

Petrie et al (2006) also found high levels of commitment across residential staff in England, but confirmed a greater emphasis on procedural and behaviour management tasks amongst English staff, as described above. English staff were much more likely to report that they had to deal with violence from residents than their counterparts in Germany and Denmark. Winstanley and Hales (2008) undertook a survey of 87 members

of staff in three children's homes to ascertain levels of aggression and violence. Respondents reported that, in the preceding year, 64% had been assaulted (56% more than once) and 72% had been threatened. The authors tried to ascertain whether there were any differences amongst the staff to explain different levels of aggression towards them.

The common assumption that, with appropriate training and/or practical on-the-job experience, staff will be better equipped to handle escalating aggression is not borne out by the results of this investigation. Whether qualified or not, staff experienced similar levels of both assaults and threatening behaviour. Similarly, staff with lower levels of experience did not experience a higher level of assault or of threatening behaviour. Nor were differences in age or in sex found to be a significant issue (p. 108).

4.5.2 Staff attitudes and skills

There clearly needs to be much more examination of the causes of violence. For example, it could be that training and qualification *do* make a difference – if they are the 'right' training and qualifications. The critique of the qualification framework in England by Petrie et al (2006) is supported by Smith (2005), who writes about the development of a course in Scotland specifically designed for residential care staff. He suggests that neither the competency-based approach of an NVQ nor social work training equip them for the task. Gharabaghi (2010) describes the mandatory training that residential workers received in Ontario: a Ministry-approved crisis intervention technique; first aid/CPR; the use of fire extinguishers; workplace health and safety, and safe food handling. Beyond that, there are no formal requirements. In a study of additional in-service training, Gharabaghi found that this rarely included relational work, residential/therapeutic milieu or collaborative problem solving. He argues that this would reduce the use of ineffective strategies in working with children, who often reported 'arbitrary control' and 'random consequences'. In another Canadian study, Gharabaghi and Phelan (2011) found that none of the residential care staff interviewed were able to describe the theoretical concepts underpinning their work, and did not see theory as important. Instead, they saw their job as promoting 'positive behaviour', or compliance, amongst the children, and often used rewards and consequences to achieve it such as points or level systems. Even recreational activities were often framed as rewards for good behaviour. Yet the authors claim:

When we force youth to act responsibly by imposing punishments and rewards, we can get them to attend school, stop swearing, avoid alcohol and drugs, and be less aggressive. However, these behaviours disappear as soon as the controls are removed, usually within a week of leaving the program (p. 76).

One model designed to support staff and develop their skills has been to provide external consultancy from a mental health practitioner. Evans et al (2011) describe the complexities of trying to do this in one unit. Possible barriers include staff feeling under-

confident, being put off by the use of 'jargon', and practical problems such as the availability of the consultant or a lack of 'peace and quiet' in which to talk.

Although the studies of the workforce have suggested that job satisfaction is relatively good, this does not necessarily translate into staying in the job and turnover is reported to be high (Colton and Roberts, 2007). They identified the reasons for a high level of staff turnover as negative perceptions about residential care and the 'bad press' it receives; views about the challenging nature of the children; and human resource issues such as heavy workloads, and low pay and status. There are some indications that a lack of permanent staff has a detrimental effect on stability within homes, with greater trouble and disorder occurring when temporary staff are on duty (Fagan, 1997).

An important factor in enabling staff to do a good job has been identified as 'leadership'. Hicks et al (2009) undertook a study of the manager's role in a number of English children's homes. They found that:

> ...of primary importance was achieving a team dynamic which worked consistently, over time, and which was able to operate within the manager's preferred approach. This was a necessary prerequisite to putting in place consistent, goal-oriented ways of working with young people's social, emotional and educational development (p. 833).

Where this was in place, staff had higher morale and there was evidence that children's behaviour was better so that they had fewer school exclusions and criminal convictions. The authors concluded that we need to know more about the fit between training, care standards, inspection and actual practice. It was clear from their study that an understanding of the way that groups operate is essential but may be lacking from the procedural framework.

The importance of management is supported by inspection findings:

> A common feature of children's homes that stay at adequate or become inadequate is weak management capacity. In a sample of children's homes that had been judged adequate for two inspections or more in succession, management weaknesses were central to their failure to improve ... There is also an emerging pattern of managers being required to manage more than one home at a time. On occasions, inspectors have noted that this can result in a decline in quality, for example through a lack of effective supervision arrangements, and to low morale. (Ofsted, 2013: p. 25).

4.6 Providers and the 'market'

Residential care in England is provided by a mixed economy of local authority, private and voluntary sector agencies and ways of improving the functioning of the market are the subject of separate reports. Concern about the role of the market is particularly acute

for children with very specialist needs and there have been calls from the Association of Directors of Children's Services for regional or national commissioning.[12] This is now being actively considered for children requiring a 'welfare' secure placement. [13] One of the difficulties for commissioners lies in determining the cost of placements, but there have been questions both about the methodology for calculating these and the importance of linking them to children's needs and outcomes if they are to be meaningful (Beecham and Sinclair, 2007; Holmes, 2014; Ward et al, 2008).

Detailed data on children's home providers is available in both the recent data pack on children's homes (Department for Education, 2014c) and the workforce survey (Thornton et al, 2015) and is not repeated here. Key findings of relevance to this report are:

- 60% of children in children's homes are in private and 4% in voluntary provision;
- Children's homes were disproportionately located in certain areas of the UK, and this did not match the population being placed;
- 6% of homes were registered for just one child;
- There is no clear link between whether a home is private, voluntary sector or local authority run and the quality of provision;
- 81% of managers said that their home provided long-term care;[14]
- The proportion of homes saying that they provided therapy, treatment or education was much higher amongst private and voluntary than local authority providers.

A mixed economy of provision seems to be universal in the developed world, although the balance differs, with a number of countries, such as Italy, not allowing homes to be run for profit, and religious organisations are still the main providers of non-state care in some places. Private provision is increasing in England, and some have expressed concern about whether this will compromise standards. Gillen (2008) expresses particular alarm about the entry of private equity firms into the market. Because their prime purpose is to generate profits, there is a risk that they will close non-profitable homes regardless of the needs of the children, and the withdrawal of a major provider from the market in 2007 necessitated unplanned moves for a number of children. Gillen (2008) reports ex-employees as saying that they were pressured to accept referrals for children who were not suitable because of the drive for 'heads on beds'.

Similar concerns about the private sector have arisen in Ontario where, according to Gharabaghi (2009), over half the children in residential care were said to be placed in

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[12] http://www.cypnow.co.uk/cyp/news/1149113/alan-wood-backs-national-commissioning-childrens-home
[13] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/411387/ET_letter_to_ADCS_LGA.pdf
[14] defined as 'caring for children until they are prepared and ready for "leaving care" support'.

such provision. Funding was on a per diem basis and centrally controlled by the Ministry of Children and Youth services, based on the intensity of the service offered. This resulted in:

> ...decisions that favor the financial needs of the business over the service needs of children and youth. This is most apparent in the speed at which beds are filled, allowing for minimal time for clients to adjust to the departure of a peer or to prepare for the arrival of new client. It is also apparent in the compromises around matching clients often made ... in order to fill a bed (p. 172).

State-run homes in Ontario were actually more expensive, the workforce was better qualified and had higher salaries and more training opportunities, and staff turnover was lower (Gharabaghi, 2009). In spite of this, they were more likely to refuse to accept children with behaviour problems because they did not rely on filling beds for their survival. The result was that the most challenging children were placed in the private sector, in spite of the lower level of resources at their disposal.

Concerns have also been expressed in Sweden, where Forkby and Höjer (2011) stated that about 90% of residential homes are privately operated. In a study of practitioner decision making, they found that placement in residential care was seen as a risky, 'last resort' decision: it was hard to find the right unit, they were expensive and the media were hostile towards such decisions. There was also a lack of evidence about the quality of homes, and whether the claims made in the 'glossy brochures' of the providers could be trusted. Instead, they relied on colleagues and inspectors to try to get an accurate picture:

> One robust measure of quality ought to be the results of earlier placements and the ability of care providers to produce evidence of good results. However, several informants – social workers, managers and representatives from caregivers – declared that promises of good results from residential units would, almost invariably, be judged with suspicion. Indeed, any such claims made by a care provider could have a contradictory effect in that they could be perceived as unreliable or irresponsible, and as exclusively interested in the profit to be derived from the sale of care (p.165).

The pattern in Sweden is unusual in that there has been an *increase* in the use of residential care since the early 1980s for new entrants to care aged 13-17 (Sallnäs, 2009). Sallnäs suggests that this may be, in part, because of active marketing by providers, with little restriction on the opening of new homes and a market that risks being led by supply rather than demand.

There has been no research comparing the outcomes for children cared for in the private sector with other types of provision, and we do know that private homes are just as likely to receive positive inspection ratings (Department for Education, 2014c). Nevertheless, there are worries about whether market forces alone can be relied upon to provide the right places with the right services in the right location. In a recent analysis of the children's homes market and the use of out-of-authority placements, based on data collected from 15 local authorities, Munro et al (2014) highlighted the complexity of the

market, the variability of supply and demand across the country: they also emphasised the need for the children's homes market to be considered within the wider context of the 'whole system'.

4.7 Assessing quality

Children's homes are subject to regulation and inspection, and all developed countries have systems for this, but often at a local level. The challenge is to assess the *quality* of the intervention. The home may have an excellent policy on children's participation, but how is this implemented in everyday practice? Does the 'glossy brochure' reflect the true nature of the work that goes on? The intentions of Ofsted's new inspection framework from April 2015 are clear. Inspectors will:

- track the experiences of children and young people in order to evaluate the quality of practice, care and management and the difference this makes to the lives of children and young people;

- take into account children and young people's starting points, their abilities, any barriers to participation and the length of time they have been living in the home;

- expect to see ambition for children and young people and the positive contribution of the home to the development of secure and permanent plans for their futures;

- investigate how the staff: understand each child or young person's starting point; measure success; know they are making a positive difference to children and young people's lives (Ofsted, 2014: p.5).

This will require direct observation of the interaction between staff and children, and discussions with children and their families if appropriate.

Approaches to assessing quality within specific units may include self-evaluation, service user assessment, independent inspection, and/or the use of specific tools to measure interventions. For example, Bastiaanssen et al (2012) developed a tool to measure the quality and nature of interventions amongst staff caring for children with behavioural problems in the Netherlands. Although the children were receiving a range of therapeutic services, the authors described the everyday engagement between staff and children as being an important element of the care: a form of 'therapeutic parenting'. In an attempt to understand more about this, the authors devised a self-administered questionnaire for staff to categorise their interventions with children according to: control, warmth/support and autonomy granting. This was related to the type of child behaviour they were responding to, whether internalising (withdrawal, anxiety) or externalising (rule breaking, aggression). The findings suggested that the tool was effective in distinguishing between different types of staff intervention, with controlling interventions being used more with

externalising behaviours. The authors acknowledge, however, that important dimensions are missing from the study: the characteristics of individual workers, which is likely to influence how they interpret children's behaviour, and the link between interventions and treatment goals. This issue of staff competence in delivering interventions is increasingly recognised within evaluations: claims are made about the effectiveness of a particular programme, but outcomes may vary according to the people delivering it (see Duppong Hurley et al, 2006).

Lee and McMillen (2006) acknowledge the need to provide evidence about the effectiveness of residential care and suggest that this should come from a mixture of outcome studies and the development of quality indicators. Whilst some individual programmes have developed their own, there needs to be a consistent set of outcome measures across the sector if they are to enable placing authorities to choose between settings and to develop an evidence base about 'what works', and for whom. Lee and Barth (2011) present a set of 'reporting standards' that would better differentiate the range of establishments within the term 'group care' in the US. In the absence of these descriptions, there is a risk of over-generalisation and a dismissal of group care as ineffective. Lee and Barth propose a classification model based on factors ranging from the outcomes that the establishment is aiming to achieve and the children with whom it will work, the methods it will use, to the staff it will employ and how it will relate to the external world. Some elements of this relate to the Statement of Purpose that all English homes should have, but is more comprehensive and specific.

Whilst consistent ways of measuring quality and classifying types of residential care provision are important for those choosing placements, they could also provide evidence at a macro level. Israel has implemented a national database that fulfils the multiple purposes of regulation, assessment, follow-up and continuous improvement of quality of care: the RAF system. It contains standardised 'tracer' information about each child's needs, such as low achievement at school. It then tracks the inputs and outputs that have been provided, and the outcomes for the child. This information is linked to the licensing and inspection of the establishment and is used to drive improvement (Zemach-Marom, 2011).

4.8 Conclusion

We do not normally see the role of residential care in England as being to 'bring children up': their stay is intended to be temporary. This leads to potential confusion as to whether this is the child's 'home' and how staff and children should relate to each other. This is in contrast to social pedagogical models, where staff have a clearer remit and are supported by a theoretical framework. Whilst societal differences mean that social pedagogy cannot be introduced without modification, its concepts present an opportunity to reflect on the purpose of residential care in England and to examine whether staff have been offered an adequate theoretical framework within which to practice.

It is also unclear how parents fit into the transitory nature of our current arrangements: even if they see the child regularly, there may be little active involvement with them on the part of residential staff. This has in contrast to practice in some other countries, where some form of family work has been found to be crucial, regardless of the child's care plan.

Given these uncertainties, it is particularly important that each unit has a vision about its purpose and ethos, supported by effective leadership. It could be argued that homes that achieve this do so in spite of, rather than because of, the framework within which they are operating. Staff are not well paid, and some argue that the current training and qualification framework do not equip them for the job. Care staff may also be frustrated about a lack of opportunity to engage in meaningful work with the children they care for and their families if their role is seen as essentially one of behaviour management.

The existence of a competitive market for the provision of residential care has led to an inconsistent supply of homes that may not match demand, and a degree of scepticism about what is on offer. Within this context, it is important that reliable and consistent ways of assessing quality are developed so that there is objective evidence about how well it is likely to meet a particular child's needs.

There is much that we do not know about day to day practice in our children's homes. For example:

- the respective perceptions of social workers, residential staff, children and families about the purpose of residential care;

- the extent to which staff are guided by theoretical approaches, and how these are translated into practice;

- the extent and nature of family work undertaken whilst children are in residential care;

- the ways in which staff and children relate to each other and the impact this has on children's experiences and outcomes.

Ways of systematically collecting this missing evidence are suggested in Chapter 8, which would not only support better decision-making but would allow new ways of working to be tested.

5 Outcomes from residential care

In this chapter, we review the evidence on outcomes for children who are placed in residential care. We first discuss short-term outcomes, which relate to experiences and behaviour while in a residential placement; we then look at the medium term, that is, outcomes at the point of leaving residential care and in the following year; lastly, we look beyond the first year to explore long-term outcomes.

While we review a number of English studies, most of the evidence on outcomes (particularly medium- and long-term ones) comes from other countries, as the evidence base in England is very limited. As discussed earlier, in considering the international evidence one must bear in mind variations in contextual factors, that is: the size and profile of the residential care population, the purpose of residential care and approaches to residential care which may be rather different from those in England.

The other issue to consider in relation to the findings in this chapter is the methodological difficulties associated with assessing outcomes from residential care, difficulties that were noted by virtually every study we reviewed.

First, some of the studies reviewed only focused on children in residential care, for example, by assessing outcomes at entry and then again at exit and/or post-exit. This type of study can provide an indication of whether progress was made towards the improvements expected when a child is placed in a setting. However, it cannot provide conclusive evidence of whether and the extent to which (positive or negative) outcomes can be attributed to residential care, because we do not know what would have happened to these children if they had not been in residential care (i.e. in another type of placement or at home). This is what is known as the 'counterfactual', i.e. data from a comparable control or comparison group of looked-after children who were not in residential care.

Second, while a number of the studies reviewed had a counterfactual, for this to be effective those included in the control or comparison group must be as similar as possible to those in the residential group in relation to their needs and the circumstances that affect the outcomes of interest. Given that children in residential care are very different from children in other types of placement (e.g. in terms of placement history, reasons for being in care, behaviour problems, age, gender) and that these differences have a great influence on the outcomes considered when looking at a placement's effectiveness, one can immediately see the methodological difficulties faced by researchers in this field. Statistical controls are applied to deal with this problem, which is known as 'selection bias'. However, often the data is not sufficiently comprehensive and sophisticated to control for the complex interplay of factors that affect these children's lives. Selection bias is particularly an issue for studies comparing children in residential care versus foster/kinship care: it is less problematic when comparing different types of residential placements.

Third, studies typically have very limited contextual information that can help to explain positive or negative outcomes, for example, to explore the extent to which outcomes can be linked to the quality of provision.

Finally, studies on children's residential care typically focus on a narrow range of mainly negative outcomes, in contrast with research in other children's policy areas (e.g. early years, schools) where a wider range of outcomes is explored, as this is considered necessary to understand how policy and practice can intervene to support children's wellbeing and life chances. Furthermore, in the studies reviewed, evidence on outcomes came primarily from service providers and very limited evidence seems to be collected directly from children and their parents, which is again in contrast with research in other children's policy areas, where much of the data (e.g. on outcomes, views and experiences of services, aspirations and expectations) is collected directly from children and their parents.[15]

The implications of these methodological weaknesses are briefly discussed when presenting the findings, while Appendix 2 provides detailed information about the contextual and methodological issues one needs to bear in mind when considering the findings from this chapter.

5.1 Short-term outcomes

Short term outcomes relate to children's experiences and behaviour while in a residential placement.

A study of residential homes in England (Berridge et al, 2012) collected baseline and then follow-up data on outcomes some 6-8 months later. Among those who were still in the same residential placement, there was little change in behaviour problems, risky behaviour, likelihood of going missing, and drug and alcohol misuse. While the pattern of school attendance improved slightly, there was no evidence of improved academic performance. This study did not include a comparison group, so we do not know what the outcomes would have been if the children had been in another type of placement (or at home). Furthermore, the sampling approach used for the study does not seem sufficiently robust to provide generalisable estimates beyond the homes included in the research, data were collected directly from a small number of children (59), and a lot of the analysis relied on administrative data provided by the homes.

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[15] See for example, the DfE-funded longitudinal studies such as the Longitudinal Study of Young People in England https://www.education.gov.uk/ilsype/workspaces/public/wiki/LSYPE and the Study of Early Education and Development http://www.seed.natcen.ac.uk/?_ga=1.179477092.1773907856.1421744850, and also the Millennium Cohort Study which is also partly funded by DfE http://www.cls.ioe.ac.uk/page.aspx?&sitesectionid=851&sitesectiontitle=Welcome+to+the+Millennium+Cohort+Study.

Other studies in this area have tended to focus on concerns discussed earlier about the greater risk of abuse, 'peer contagion' in relation to offending behaviour and more recently concerns about sexual exploitation of children in residential care.

A study of abuse (by adults) or neglect in settings among children in care in the UK (Biehal et al, 2014) estimated that there were 250-300 reported and confirmed cases of abuse or neglect a year in residential care, that is 2-3 confirmed cases per 100 children, compared with an average of less than one (i.e. 0.80-0.88) per 100 children in foster care. The researchers also found that when allegations in foster care were substantiated, well over half of children were permanently removed from the placement, while very few children were removed from residential placements, and, reviews to assess care planning needs were rarely held following a confirmed case of abuse or neglect. The authors conclude that despite the confirmed allegations of abuse: 'In most respects, therefore, life went on much as before' and that residential staff need better training and support given the very challenging circumstances in which they operate (p. 15). It should be noted that the study focused on officially reported cases and therefore it is unlikely to reflect the actual level of abuse. Furthermore, the authors say that the findings on residential care should be treated with caution because the number of substantiated cases that were followed up in residential care was small (i.e. 24) and a quarter were from two units characterised by a culture of physical coercion and compliance.

A study of physical abuse (by adults) in the Netherlands (Euser et al, 2014) found overall higher levels of physical abuse among looked-after children compared with Biehal et al (2014), probably because their research was not confined to allegations that were officially recorded, but abuse reported by children in a (confidential) survey. However, as in the Biehal study, Euser et al also found higher levels of abuse in residential care (304 per 1000 adolescents) compared with foster care (164 per 1000 adolescents). Their conclusion echoes one of the key recommendations from the Biehal (2014) study: residential homes are violent environments where groups of children with very challenging behaviour live under one roof, and staff are not adequately trained to operate in such difficult circumstances.

Hayden (2010) carried out a study in England to explore whether children's residential care is criminogenic, i.e. 'whether this type of care helps to provide the conditions that produce crime and criminality' (p. 461). Based on the empirical research carried out for this study and other research reviewed, the author concludes that as violence, conflict and offending behaviour are common in residential homes, there is a risk that they reinforce offending behaviour and this is why they are used as the last resort. However, this can become a vicious circle, i.e. the more they are used as the last resort, the higher the risk factors. A number of methodological issues need to be taken into account when considering these findings. The study did not include a comparison group nor any statistical controls, so we do not know the extent to which these findings reflect the characteristics of the children investigated, rather than the fact that they were in residential care. The study was based on 60 children in homes in one county, therefore

they cannot be generalised to the English residential care population. The data were collected from a very small number of children (46), while a lot of the analysis relied on administrative data of incident records, police call outs and offending.

The US based study by Ryan et al (2008) found that residential home placements were associated with a significantly higher risk of delinquency, compared with foster home placements. These effects emerged even after controlling for variables known to be associated with delinquency, including age at placement, ethnicity, gender, and previous placement instability. However, the author mentioned that the data available to control for selection bias was limited. Furthermore, it was possible that these results partly reflected the fact that reporting of youth offending is more common in residential homes than in foster care. Similarly, an international review of therapeutic residential treatment has raised doubts about the validity of the evidence that residential care is criminogenic (Whittaker et al, 2014). There is a risk, however, that children may be inappropriately caught up in the criminal justice system as a response to challenging behaviour or minor offences in their placement: behaviour that would not have prompted police involvement if they lived in a family setting (Schofield et al, 2014).

The Office for the Children's Commissioner inquiry into sexual exploitation (OCC, 2012) estimated that one in five children in care were sexually exploited. A separate figure is not provided for residential care but it is noted that as the most vulnerable children are placed in residential care and can often be isolated because they are placed outside their local authority, very high-quality standards of care are required to ensure that these children are kept safe, while many residential care staff are poorly trained and unsupported. It should be noted that this was not a research study; it was based on evidence submissions that do not comply with the standards required to make quantitative evidence generalisable – i.e. it was not collected using tested and standard instruments that minimise subjectivity and it was not collected from a statistically representative sample.

An international review of sexual abuse (by staff, other adults and peers) in residential care involving 66 studies (Timmerman and Schreuder, 2014) concluded that while sexual abuse is not 'an incidental phenomenon' within residential care, providing reliable and comparable estimates of prevalence is very difficult because of differences in definitions and methodology.

5.2 Medium-term outcomes

In this section we look at the medium term, that is, outcomes at the point of leaving residential care and in the following year.

The study of residential homes in England mentioned above (Berridge et al, 2012) found that among children who had left the placement, half had returned home (with half of this group having reached the transition from care age), while a quarter moved to another

residential placement and the remaining children went into foster care. Less than half of the moves were planned and a third of leavers moved because the placement had been disrupted, in some cases because they had assaulted staff. These findings need to be interpreted with caution given the methodological weaknesses noted above.

An extensive review of US-based studies (Lee et al, 2010a) found that on a number of measures (persistence of sexualised behaviour, placement stability, length of time out of care and likelihood of living at home post-discharge) children in residential homes did less well than their peers in foster placements. Differences were particularly marked when comparing children in residential homes with those in multi-dimensional treatment foster care (MTFC).[16] It should be noted though that the fact that MTFC is voluntary while children may not necessary have agreed to go into residential care, could partly explain more positive outcomes from MTFC. The review included 99 studies; limited information was provided on their methodology and robustness, but the authors identified some common weaknesses of the research reviewed (e.g. providing little context about the programme, relying mainly on data collected from residential care providers), and it is not clear how far the studies could control for differences between children in residential and family-based care which could explain different outcomes.

Interestingly, a study of a residential home in Israel (Shechory and Sommerfeld, 2007), where residential care is the norm for welfare children and foster homes are rarely used, also found negative outcomes from residential care, with a prolonged stay associated with high levels of anxiety and depression. However, it should be noted that this was a very small study based on 68 children from one residential home.

A number of studies show that more specialist residential care is associated with more positive results than those discussed above. For example:

- Looking at the US Residential Treatment Centres (RTCs) for children requiring intervention for specific disorders, Lee et al (2010a) found that while 70% of children entered RTC from a more restrictive[17] setting, 94% moved to a less restrictive setting, including 45% who returned home. The study also found that children who entered an RTC had had an average of three placements in the previous six months, compared with an average of 0.5 placement changes in the year after leaving the RTC. It should be noted though that these were 'before and after' studies without a comparison group.

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[16] MTFC is an evidence-based licensed programme developed in the US which provides an intensive intervention for children aged 3-17. Foster carers and the birth family receive intensive support and training to enable children to build on their strengths and address their difficulties. Children receive skills coaching to help them improve life and relationship skills and problem solving abilities.

[17] The restrictiveness of a setting is a common outcome measure in US research; it relates to how 'restricted' children's movements are. Typically foster and kinship care is less restrictive than residential care; within the latter, the most restrictive settings are the equivalent of English secure homes, and some therapeutic programmes, whilst not in secure settings, set a number of restrictions on children's movements.

- Another review (Hair, 2005) also found a number of positive outcomes for children placed in RTCs, including completion of the programme, achievement of the desired emotional and behavioural changes, and a move to a less restrictive setting. The author noted the methodological weaknesses of the studies reviewed (e.g. difficulties in controlling for selection bias, limited evidence on the placement context), but also noted that the consistency of some of the findings means that some tentative conclusions can be drawn from recurrent research messages.

- A meta-analysis of 27 studies from North America, Western Europe and Australia, which focused on residential treatment programmes (Knorth et al, 2007), found that after a period in this type of setting, children on average improved their psychological functioning, with medium and even large effect sizes. This study also found that residential treatment seemed to achieve better results than home-based treatment with the same very problematic group, except in the case of multi-dimensional treatment foster care (MTFC) which seemed more effective than residential treatment programmes. The total sample for this meta-analysis was large (2,345 children), with three-quarters of the sample coming from quasi-experimental studies including a comparison group. However, the study had some limitations, for example: it did not assess longer term outcomes, which tend to be less favourable; and the analysis did not include some important predictors (e.g. the nature and severity of the problems that children and their families were facing).

- A more recent meta-analysis of 27 studies from North America and Western Europe exploring the effectiveness of therapeutic interventions (De Swart et al, 2012) found that children reacted positively to treatment and improved their psychological wellbeing. However, effectiveness was linked to whether or not the treatment was evidence based, i.e. with research showing its (potential) effectiveness. Evidence-based treatment (in or outside residential care) was found to have a more positive impact than 'care as usual' (i.e. with no evidence-based treatment), and evidence-based treatment in residential settings, particularly cognitive behaviour therapy, uniquely accounted for the effectiveness of residential care. The authors conclude that providing what they define as 'regular' group care to children who have serious developmental and behaviour problems does not seem to have a positive effect and could even increase the problems. The sample for this meta-analysis was very large (17,000 children) and only studies using quasi-experimental and experimental designs (i.e. including a comparison and control group respectively) were included. However, the positive findings could partly reflect the fact that studies showing positive effects are more likely to be published than those showing no effects; studies of moderate (rather than exclusively) high quality were included; and, there were also some technical issues affecting the analysis (see Appendix 2).

- Effectiveness was also found for programmes that while not providing a specific treatment are nevertheless evidence based. For example, the US-based Boys Town Family Home programme includes five key components: teaching skills;

building healthy relationships; supporting religion and faith; creating a positive family environment; and, promoting self-determination. The review by Lee et al (2010a) of 99 studies found that only two studies (both involving children in Boys Town Family Homes) showed more positive outcomes for those in residential placement compared with foster care: the former were more likely to return home after discharge and less likely to have multiple placements than their peers in foster care.

However, adopting a particular theoretical and/or an evidence-based approach per se does not seem sufficient to lead to positive outcomes for children. We identified a number of studies of specialised programmes that did not result in the intended outcomes; this could be because the approach was not implemented as intended, the model simply did not work or was not cost effective. For example:

- A study of a Dutch secure home (Harder et al, 2012), which used both a social competency model aiming to reduce problem behaviour by enhancing competence skills, and a motivation for treatment model which assumes that treatment motivation can be improved, found rather inconclusive results in relation to outcomes. When young people in the study left the unit, they did not show significant changes in their competence skills, although there was a small increase in 'treatment motivation' possibly indicating that young people were likely to take action in future to deal with their problems.

- A study of secure children's homes in England and Wales (Justice Studio, 2014) highlighted that some of these settings' features reflected the evidence base on effective residential care, which is discussed in the next chapter. However, the report provides little convincing evidence that these homes operate as intended and result in positive changes for children who are placed there.

- Safe Homes is a US short-term group care programme for children aged 3-12 developed to improve stability for children when they are first placed in care. The evaluation (De Sena et al, 2005) found that that while outcomes for children significantly improved, a comparison group of children in foster care had comparable or better outcomes on most of the variables explored (i.e. number of placements, placements with siblings and placements in the community after discharge), while the cost of foster care placement was significantly lower than that of the Safe Homes.

5.3 Long-term outcomes

There is far less evidence on long term outcomes, i.e. beyond the first year after leaving residential care.

Using a sample of children from the 1970 British Birth Cohort Study who had been in care, with measures of outcomes collected at age 16 and 30, Dregan and Gulliford (2012) found that compared with foster care, residential care was associated with poorer

outcomes, including depression, life satisfaction, self-efficacy, addiction and criminal convictions. While the authors say that part of the differences between the two groups may have been due to lack of data to control for pre-care differences, it is unlikely that the differences were entirely due to selection bias, and it is likely that they could be explained by the quality of the placement and care pathways post-discharge. While the analysis relied on a very robust longitudinal data set which has been widely used for analysis of child development and outcomes, it includes very limited data to enable one to contextualise the findings on outcomes from residential care, that is the extent to which these differences are due to differences between the characteristics of children in residential care and their peers in other types of placement, and/or to the quality and features of the residential care these children experienced.

Evidence from the US shows that compared with children in foster placements, those in residential homes were more likely to be arrested and less likely to be in post-secondary education, with differences more marked when compared with children in multi-dimensional treatment foster care (MTFC) (Lee et al, 2010a) – the limitations of this review were noted earlier.

A similar picture emerges from Swedish research (Vinnerljung et al, 2008), which found that on a range of long-term measures (e.g. mental health problems, criminality, teenage parenthood, educational attainment and reliance on welfare benefits), a residential placement was associated with more negative outcomes than foster care, while the most negative outcomes were associated with secure units. The study was based on a large sample (over 1,000 children), but the variable used to control for selection bias was described by the author as being rather crude and there was no information on the quality and features of the placements, which could contribute to explain differences in outcomes between residential and foster care. Also the study relied on administrative data and no data were collected directly from children.

There is some evidence to suggest that the positive medium-term outcomes discussed earlier in relation to specialist residential care are sustained in the longer term. Lee et al (2010a) found that the Boys Town Family Home programme resulted in positive long-term outcomes, with children who attended the programme having more positive educational outcomes (e.g. more schooling, high school graduation) compared with their peers who were accepted for the programme but never enrolled.

The Treatment Family Homes (TFHs) is another US family-style and community-based programme staffed by specially trained married couples (Family-Teachers) who live in the home and provide structured supervision in daily living and treatment activities. An evaluation of this programme (Ringle et al, 2010), found that 83% of young people in their 20s (followed up five years after leaving) and 90% of those in their 30s (followed up after 16 years) had obtained high school education, with a longer period in TFHs (ranging between 18-24 months) increasing the chances of obtaining this level of education. It should be noted that this study did not include a comparison or control group, so we do

not know what outcomes these children would have had if they had been in another type of placement.

5.4 Conclusion

The evidence base on outcomes from children's residential care is undermined by a number of methodological weaknesses, with the English evidence being particularly weak, much weaker than the evidence available to inform other children's policy areas in England, for example, early years and schools. The main methodological weaknesses and evidence gaps the review identified include:

- Limited and sometimes lack of 'controls' to enable one to attribute differences between children in residential care and their peers in family-based care to their setting rather than to the fact that these two groups are very different (e.g. in terms of placement history, reasons for being in care, behaviour problems, age, gender), and that these differences have a great influence on the outcomes considered when looking at the impact of a placement.

- Limited contextual information that can help to explain positive or negative outcomes from residential care, for example, to explore the extent to which outcomes can be linked to the quality of provision.

- A focus on a narrow range of mainly negative outcomes from residential care, while we know from research in other children's policy areas (e.g. early years, schools) that a wide range of outcomes is needed to understand how policy and practice can effectively intervene to support children's wellbeing and life chances.

- Very limited evidence seems to have been collected directly from children with experience of residential care and their parents. This is again in contrast with research in other children's policy areas in England, where much of the data (e.g. on outcomes, views and experiences of services, aspirations and expectations) are collected directly from children and their parents.

- In England in the past decade, there has not been a large-scale study with a methodologically sound design that has provided robust evidence on the likely effects on children of the increasing reliance on family-based care and the use of residential care as the 'last resort'.

Notwithstanding these methodological weaknesses, the consistency of some of the findings from studies from different national contexts enables us to draw some conclusions about outcomes from residential care, albeit rather tentative.

First, a number of studies found that 'residential care as usual' does not seem to be effective in dealing with the problems children face when entering a home. 'Care as usual' seems mainly defined by what it is not, that is: it does not have a clear purpose;

the service delivery is not guided by a theoretical underpinning; it is not evidence based and outcome focused; it is not staffed by well-qualified professionals who receive adequate training and support. Children in this type of care are not placed there based on a robust assessment of their needs and what kind of placement can effectively meet these needs; they are typically placed in 'residential care as usual' because everything else has failed.

Second, it seems that residential placements are needed in some cases. In 2002, Fonagy et al concluded that:

> *…there is no empirical evidence either for or against the use of residential and day treatment facilities. However, there is a clinical consensus that the severity and complexity of some disorders … may require access to in-patient and day-patient treatment units (quoted in Bullock 2006: p. 77).*

Some years later, an extensive review of residential care in the US (Lee et al, 2010a) also concluded that for some children, residential care is needed and can be beneficial. One of the studies reviewed found that a third of children in residential care could have been placed in home-based care, but two-thirds had risk factors that required a placement in a restrictive residential setting. More generally, even when studies found that residential care did not seem to be associated with expected improvements, the conclusion was not that residential care should not be used, but that the decision to place a child in a (particular type of) residential placement must be based on a robust assessment of children's needs and how these needs can be best met, and that the quality of residential care must improve.

Third, the positive outcomes from some of the specialist and evidence-based residential programmes reviewed support the view that rather than eliminating residential care, what needs to be eliminated is 'bad' practice, and residential services should be reconfigured so that they can effectively meet the needs of children who, for a range of reasons, need a residential placement. The questions of the features of an effective residential placement and the children who are most likely to benefit from (different types of) residential care are addressed in the next chapter.

6 What works for whom and how

In this chapter, we first review factors associated with the effectiveness of residential care, that is, what processes and structural features of a children's home have been found to be associated with positive outcomes for children. We then discuss the evidence on which children are most likely to benefit from (different types) of residential care.

Much of the evidence reviewed in this chapter comes from other countries, and variations in contextual factors (size and profile of the residential care population, the purpose of residential care and approaches to residential care) must be born in mind when considering the extent to which findings are relevant to the English context. The methodological challenges discussed earlier in relation to assessing outcomes also affect research trying to assess what works: finding associations between specific features of residential care and outcomes for children requires very sophisticated data, which were not available for many of the studies we reviewed.

The implications of the limitations of the studies presented are briefly highlighted, while further information on the studies' methodologies and their limitations can be found in Appendix 2.

6.1 What works

The evidence shows that the key ingredients of residential care linked to positive outcomes for children can be classified under four broad headings:

- residential care seen as part of the **continuum of care** where a child's needs are regularly assessed and monitored and this information is used to decide which services a child needs; part of this continuum of care may include a residential placement with the type and length of placement being determined by the child's needs;
- **positive relationships** in the homes between children and staff and between the children themselves;
- **working with families** before, during and after the residential placement and involving children and their families in decisions about children's lives while they are in a residential placement;
- providing **a 'normal life' environment** where children feel safe and have access to the same range of support, activities and opportunities as their peers.

The literature also highlights the **hallmarks of good quality**, i.e. the structural features a home requires to deliver effective residential practice. These hallmarks of quality fall into four broad categories:

- clarity of vision and purpose for the setting;
- leadership with a clear plan for implementing the vision;

- staff with the skills, qualifications, experience and motivation to implement the vision and to deliver effective residential practice;
- good interagency working.

The evidence on the features of effective residential practice and hallmarks of good quality are discussed in the rest of the section.

6.1.1 A continuum of care

There is a growing consensus that residential care should be seen as part of a continuum of care which is needs-led rather than service-led, and with regular assessment and monitoring to ensure that children's needs are met. While effective assessment and planning are important for all decisions affecting looked-after children, it has been argued that they are particularly important in relation to decisions to place children in residential care, because: 1) these are the most vulnerable children in the care system; 2) there are variations in the quality and purpose of residential placements; and 3) residential care is a very expensive option and one needs to ensure that this money is well invested to maximise benefits for children (Whittaker et al, 2014).

Two of the more sophisticated approaches we have identified for assessing needs and deciding if and what type of residential treatment[18] a child is more likely to benefit from are described below:

- Child and Adolescent Needs and Strengths (CANS) is a theory-based model developed in the US. It relies on large clinically informed databases to determine which children are more likely to benefit from (which types) of residential treatment. CANS provides a comprehensive list of problems a child may be facing (e.g. psychosis, depression, anxiety, eating disturbance), and recommendation to residential treatment (including of a particular type) is based on the combination of the number and type of problems identified. Research has found that children who met the model thresholds benefited more from residential treatment than those who fell below those thresholds (Whittaker et al, 2014).
- Multifunctional Treatment in Residential and Community Settings (MultifunC) is a model developed in Scandinavian countries to enable practitioners to establish 'what works for whom'. The programme: is based on an extensive review of the evidence of the effectiveness of different types of intervention; aims to develop individualised programmes to support children with multiple and complex problems; targets individual as well as environmental factors; and includes integrated aftercare in the community. The programme is currently being evaluated, and although the initial results show that it can be successfully

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[18] It should be noted that there are differing interpretations of the concept of treatment and different definitions (Whittaker, 2005).

implemented, the results on treatment effectiveness are not yet available (Whittaker et al, 2014).

Other data in the literature rely on less sophisticated measures but nevertheless show the importance of adequate planning. For example, a Swedish longitudinal study (Lindquist, 2011) analysed the association between the anticipated length of the residential placement at the time of entry with outcomes for children, with expected duration being considered a minimum requirement for the placement to be considered 'planned'. The study found that:

- planned placements (i.e. with expected duration) reduced the risk of placement breakdown by 11 percentage points;
- unplanned placements were associated with higher use of legal force in placing children, termination of the placement at short notice, and subsequent placement within another residential facility;
- children with a planned placement were less likely to be convicted of a crime and to be imprisoned between the ages of 20 and 24, although there was no association with educational achievement and reliance on welfare benefits.

The author argues that there could be two reasons for the association between planned residential placement and positive outcomes. First, a plan for the placement may act as a motivator for the children. Second, unplanned placements could reflect the inadequacy of social services to meet children's needs (Lindquist, 2011).

The length of placement also relates to planning although the evidence here is mixed, probably reflecting the fact that its influence needs to be considered in combination with the purpose of placement, the model of working and its quality:

- The Swedish study mentioned above (Lindquist, 2011) found that, unlike planned length, how long the placement actually lasted was not associated with any of the outcomes explored (placement breakdown and disruption, criminal behaviour, educational achievement and reliance on welfare benefits).
- One of the largest British studies exploring outcomes for looked-after children (Dregan and Gulliford, 2012) found that a longer stay in residential care was associated with lower levels of wellbeing in adulthood, although the authors recognised that this finding could be explained by the poor quality of the placement rather than its length.
- Hair's review of RTCs in the US (2005) found that positive outcomes were associated with a shorter stay in residential treatment, including research suggesting that short and repeatable residential treatment periods may be better at supporting treatment benefits in the longer term than a 'once and for all cure'.
- An evaluation of Treatment Family Homes (Ringle et al, 2010), another US-based programme, found that a longer period in these homes was associated with the likelihood of achieving high school education. The authors argued that this result was supported by other evidence indicating that a longer placement can help to support school performance, provided that the setting places high importance on

educational achievement and has a focus on educational skills and school performance.

Placement instability could also be seen as reflecting poor planning (e.g. placement breakdown, unplanned moves), and is again associated with negative outcomes. For example, a study of British children who were in care in the 1970s and 1980s (Dregan and Gulliford, 2012) found that multiple placements were associated with extensive disadvantage in adulthood in most of the outcomes explored (e.g. depression, life satisfaction, self-efficacy, addiction and criminal conviction). While this result related to both children who had been in foster/kinship care, as well as those with experience of residential care, as discussed earlier, the latter are more likely to experience multiple placements. However, it should be noted that there is also evidence that multiple placements could reflect 'managed' moves to meet a child's needs (Whittaker et al, 2014).

Ofsted's study (2011) of the 'best' children's homes in England (i.e. those that received an outstanding rating six times for three consecutive years) found that a key feature of these homes was a good understanding of children's needs and, through meticulous planning, ensuring that children's individual needs were met and children were involved in the planning process. It should be noted that the study did not link the homes' features with outcomes; in other words it did not attempt to prove that certain features were associated with positive outcomes for children. Furthermore there was insufficient information available to judge the robustness of the methodology used in this study.

Finally the evidence shows that a continuum of care includes providing post-placement support to ensure that gains made during the residential placement are sustained, although there are methodological challenges in disentangling the effects of what happened in the placement from the effectiveness of the aftercare support. As we have seen, MultifunC includes integrated aftercare. Lee et al (2010a) reported that in a study of an RTC in the US which resulted in very positive outcomes (e.g. move to less restrictive placements, fewer placement disruptions, reduction in psychological problems), most children (86%) had received some kind of aftercare support to maintain the improvements made during the placement. Hair's (2005) review of RTCs in the US found that, in addition to family involvement, post-discharge functioning was associated with the provision of aftercare services (e.g. therapy, special education, advocacy for school and employment). The importance of aftercare is also highlighted by Whittaker et al (2014) in their review of therapeutic residential treatment.

6.1.2 Relationships in the homes

As discussed in Chapter 4, establishing good relationships between staff and children is considered very important. However, there is limited evidence linking the quality of relationships in a home with children's outcomes, and it comes mainly from small-scale studies.

An approach that places a strong emphasis on relationships is social pedagogy, which is widely used in continental Europe in residential care (as well as other children's services). Relationship is at the heart of this approach, with a strong emphasis on listening and communicating, and practitioners seeing themselves in a relationship with the child and trained to share many different aspects of a child's life (Cameron et al, 2011). This approach was piloted in 18 children's homes in England in 2009-2011. The evaluation, which compared outcomes for children in these homes with those from homes which did not employ a social pedagogue, found no differences between the two groups. However, the evaluation also found significant challenges in implementing the approach, which, together with a relatively short timeframe for the evaluation (18 months), could explain the results. Furthermore, although children in the 'social pedagogy' and comparison groups were different in relation to characteristics that could affect the outcomes examined, this difference does not seem to have been taken into account in the analysis. The evaluators concluded that there was some evidence that this approach might be successfully implemented in England (Berridge et al, 2011). And indeed, the pilot has resulted in considerable interest in social pedagogy which is now being piloted in a number of areas (e.g. Essex, Hackney, Staffordshire, Derbyshire and Walsall), and is being introduced in foster care (e.g. the Head Heart Hands demonstration programme) and in some degree courses (Bowyer and Wilkinson, 2013).

The Ofsted study (2011) of outstanding children's homes mentioned above also found that a defining feature of these homes was the meaningful and secure relationships that children had developed with staff and with each other (but note the methodological issues relating to this study discussed above).

The study by Harder et al (2012) of secure homes in the Netherlands found that a positive relationship with the care worker was associated with children's high satisfaction with the placement, and that children seemed to prefer staff with a clear focus in relation to activities and goals. It should be noted though that the study relied on a very small sample (22 children) and suffered from high attrition between data collection waves.

A study of children in residential care in Portugal (Mota et al, 2013) found that higher levels of communication and trust in peer relationships were associated with the development of self-esteem and coping. The authors concluded that provision of emotional support by peers would seem particularly important for children in residential care, given that they were very likely to have insecure and chaotic relationships with their families. The sample in this study was somewhat small (109 children) but the study design was sound.

6.1.3 Working with families

There is a growing body of evidence on the positive effects on children of family involvement while children are in residential care, and even very 'modest' levels of

involvement (e.g. parental visits) seem to be associated with positive outcomes for children across different child welfare systems.

Attar-Schwartz (2009) found that in Israel, better quality and more frequent visits by parents were associated with better psychological outcomes for children in residential homes. The study was based on a large sample (4,420 children), with some data on the characteristics of the settings, although it relied just on administrative data, which could only explain a small part of the variance in psychological condition.

Hair's (2005) review of RTCs in the US found that family involvement throughout the treatment was associated with positive short-term outcomes (e.g. programme completion, achieving treatment goals), as well as longer-term ones (e.g. moving to a less restrictive setting, reduction in psychological problems and antisocial behaviour, improved family functioning).

The extensive review of residential care in the US by Lee et al (2010a) found that children who received family therapy were eight times more likely to go back to their families at the end of the placement. They also reported the findings of a randomised experiment in the US with children placed in a family-centred programme, which included elements of family preservation and multi-systemic therapy to promote problem-solving skills, family participation in decision making, family functioning and a range of residential and community-based services. Compared with children who received 'care as usual', children in the family-centred programme had significantly shorter lengths of stay and were more likely to be reunited with their family when they left the programme (49% compared with 19% in the 'usual care' group). Almost twice as many children who received the family-centred intervention were stable at both 6 and 18 months post-discharge compared with the usual care group.

The international review of therapeutic residential care by Whittaker et al (2014) also found that family involvement was associated with positive outcomes for children, particularly when it involved working with families prior to and following the placement, as well as during it.

A study in Israel (Davidson-Arad and Klein, 2011) found that children in residential care with a sibling reported higher wellbeing than those in care alone, although sibling care did not seem to be associated with self-esteem and sibling closeness. It should be noted though that the study only included adolescents (aged 12-14) and we do not know if the results would apply equally to other age groups. The study also suffered from a low participation rate, with a high proportion of children not cooperating with the research.

The concept of involvement goes beyond parents' visiting children in a residential placement and taking part in family therapy; it also includes parents and children having a say in decisions that affect children's lives while in the placement. This is an area that is rarely explored in research focusing on outcomes. We did not find any quantitative measures of children's involvement (e.g. in the running of a home, in their care planning)

in the many studies on outcomes that we reviewed, and even broader commentary on this (e.g. from qualitative research) was rare. This could partly reflect the fact that on the whole, residential care, including most of the various specialist programmes and approaches, does not place a great emphasis on children's involvement. A notable exception is social pedagogy mentioned above; this approach builds on an understanding of children's rights that goes beyond legislative requirements and procedures. A key aim of this approach is:

> Empowerment or promoting active engagement in one's own life and within society, and as such is fundamentally concerned with children's rights and developing the skills for living in a democracy. (Cameron et al 2011: p. 14).

However, the evaluation of the programme that piloted this approach in England did not suggest that children in the pilot felt more involved and participated more actively in decision making than children in the comparison group, although, as noted earlier, social pedagogy did not seem to have been well implemented in this pilot (Berridge et al, 2011).

6.1.4 A 'normal life'

There are many references in the literature to the fact that residential settings should aim to ensure that, as far as possible, children should have a 'normal life', with 'normal' conceptualised and measured in a number of different ways.

A common measure of 'normality' explored in the literature, which is also a key feature of some residential programmes, is having a family-like environment:

- A study of residential homes in Israel (Attar-Schwartz, 2009) has shown that children in small, family-like settings had fewer problems at school than children in larger homes, possibly indicating that intimate environments can better support children's development, school performance and adjustment. However, the author was not able to control for selection bias, i.e. this result could simply reflect the fact that children with fewer problems were more likely to be placed in these homes.

- The review of 99 US studies by Lee et al (2010a) found that only two studies, both involving children in Boys Town Family Homes, showed more positive outcomes for those in residential placement compared with foster care; family living is a key feature that distinguishes the programme from other types of residential care, with trained married couples (Family Teachers) running these homes (Whittaker et al, 2014).

Other research has also highlighted the importance for children in residential care of having access to the same academic and recreational facilities and opportunities as their peers. For example, a study of residential homes in Israel (Attar-Schwartz 2008, 2009) found an association between facilities in the home and outcomes:

- In homes that provided more after-school activities (both leisure and academic activities), children had lower levels of psychological difficulties and fewer problems with school functioning;
- Better physical conditions (e.g. recreational facilities) were also associated with fewer problems at school;
- Children in homes that provided better food (in terms of amount and variety) had fewer lower levels of psychological difficulties possibly reflecting:

…the symbolic value of food extending beyond its nutritional value. Food can transmit a sense of security, of warmth, and a feeling of homeliness for children, especially those lacking secure environments in their childhood and simultaneously having to cope with an unnatural, institutionalized setting (Attar-Schwartz, 2008: p. 243).

Supporting children academically (as parents typically do) has also been found to be associated with positive outcomes, not only because of the direct effect that this support can have on children's school performance, but also because doing well at school can increase children's self-esteem and confidence (Attar-Schwartz, 2009; Hair, 2005; Hayden, 2010; Ringle et al, 2010).

Last but not least, 'normality' means feeling safe: as well as being a fundamental right, feeling safe is associated with better outcomes. For example, the study of residential homes in Israel mentioned earlier (Attar-Schwartz, 2008) found that in homes with lower levels of peer violence, children had lower levels of psychological problems. This finding was not related specifically to children being the victims of violence, but to being in an environment where violence was common, which could create a feeling of insecurity regardless of whether one was directly affected by it or not.

6.1.5 Quality hallmarks

When looking at the hallmarks of good quality, that is the structural features of a home associated with effective residential practice, the evidence is very limited as we identified very few studies which had explored hallmarks of quality in relation to children's outcomes.

Clarity of vision and purpose for the setting was highlighted by Ofsted as one of the key defining features of outstanding homes (Ofsted, 2011), and is often mentioned in the literature about residential care practice (e.g. Clough et al, 2006; Courtney and Iwaniec, 2009). A clearly stated purpose and theoretical and/or research underpinning also characterise the specific residential programmes and models discussed earlier (e.g. social pedagogy, MultifunC, the Boys Town Family Programme). However, when it comes to 'care as usual', the vision and purpose of the setting are seldom measured in a quantitative way, probably reflecting the fact that these are rather nebulous and ill-defined (see e.g. Berridge et al, 2012).

Leadership and management of care homes have been found to be associated with children outcomes (Hicks et al, 2009) and were also highlighted by Ofsted (2011) as a

key feature of outstanding homes. However, this evidence is very limited compared, for example, with research on the impact of leadership in schools and early years settings, where instruments have been developed to measure leadership quality and its association with children's outcomes.[19]

Staff skills, qualifications, training and attitudes are believed to be closely linked to the effectiveness of residential care. Some of the approaches and programmes described above were fairly prescriptive about staff requirements, which were high compared with England. For example, typically social pedagogues train for three or four years at degree level, and a fundamental aspect of this approach is 'reflective practice', that is

> *…practitioners assess their work in the light of theory and self-knowledge and on this basis, make decisions about taking the work forward, according to the best interests of children and young people. (Cameron et al, 2011: p. 15).*

The MultifunC programme mentioned earlier involves extensive training for residential staff who, in Scandinavian countries, have higher qualification levels than in England (Whittaker et al, 2014). However, again we did not find any evidence that even the easiest-to-measure staff characteristic, i.e. qualifications, were measured to assess whether qualification levels are associated with children outcomes; as has been noted elsewhere (De Swart et al, 2012), this is a major gap in the current evidence base. And it is again in contrast with research in early years, where staff qualifications are closely monitored and where degree-level qualifications have been found to be associated with better outcomes for children.[20]

Hair's (2005) review of RTCs in the US concludes that quality improvement in residential care requires:

- supervision that provides intellectual stimulation, individual consideration and inspirational motivation;
- role clarity, job satisfaction and development opportunities;
- a climate that encourages 'provider-consumer' relationships;
- quality assurance standards reinforced through ongoing training and supported on a daily basis by managers.

Finally good interagency working is seen as important in providing a continuum of care and holistic care – residential care staff must work effectively with professionals outside

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[19] See for example the evaluation of Children's Centres https://www.gov.uk/government/publications/evaluation-of-childrens-centres-in-england-ecce and the longitudinal study on the Effective Provision of Pre-School, Primary and Secondary Education (EPPSE) http://www.ioe.ac.uk/research/153.html.

[20] See for example the evaluation of Children's Centres https://www.gov.uk/government/publications/evaluation-of-childrens-centres-in-england-ecce and the longitudinal study on the Effective Provision of Pre-School, Primary and Secondary Education (EPPSE) http://www.ioe.ac.uk/research/153.html

the settings who support children before, after and during a placement. This is again a hallmark of quality mentioned in the practice literature (e.g. Clough et al, 2006; Courtney and Iwaniec, 2009), but rarely measured in research and linked to outcomes to establish if and the extent to which effective multiagency working makes a difference to outcomes for children.

6.2 Which children benefit from residential care

Having reviewed the evidence on 'what works' in residential care, we now turn to the question of 'for whom it works', that is, is residential care more or less effective depending on children's characteristics and circumstances? The variations in the level of use of residential care across different countries, which range from less than 10% to more than half of looked-after children placed in residential homes (see Chapter 2), indicate that thresholds for admitting children to residential care vary considerably. However, the evidence available on which children are most (and least) likely to benefit from residential care is limited and not very conclusive.

6.2.1 Children's demographic characteristics

The Swedish study discussed earlier which, established an association between planned placements and positive outcomes (Lindquist, 2011), found that this association was stronger for boys than girls. As this gender difference was found by other research, the author speculates that this result could indicate that boys may be more negatively affected by the uncertainty of unplanned treatment.

The review by Lee et al (2010a) has highlighted some gender differences among children in the Boys Town Programme:

- Girls' problem behaviours improved by a full standard deviation on externalising, internalising and total problems, while boys improved their scores by only half a standard deviation. However, in relation to psychiatric diagnoses, no gender differences were found post-discharge;

- While girls had more mental health and behavioural problems than boys when they entered the programme, both girls and boys improved in relation to these problems and no gender differences were found post-placement;

- Premature termination of the placement was more common among boys than girls.

A study of British children who were in care in the 1970s and 1980s (Dregan and Gulliford, 2012) found an association between older age at first admission to the care system and extensive disadvantage in adulthood in most of the outcomes explored (e.g. depression, life satisfaction, self-efficacy, addiction and criminal conviction) – while this point related to children who had been in foster/kinship care, as well as those with experience of residential care, as discussed earlier, the latter are more likely to first enter the care system at an older age.

6.2.2 Children's needs

The extensive review of residential care in the US by Lee et al (2010a) found that while a number of studies looked at the association between the needs of children who were in residential care and outcomes, no clear and consistent conclusions could be drawn on which children were most (or least) likely to benefit from a residential placement. For example, one of the studies reviewed found that children with conduct disorders did not benefit as much from residential care as their peers, while another study found that children with conduct disorders did better than others.

The meta-analyses by Knorth et al (2007) of the impact of residential treatment on children with severe behavioural problems and young offenders in the US, Western Europe and Australia found that those with externalising behavioural problems (e.g. violence, aggression) seemed to make more progress than children with internalising behavioural problems (e.g. depression, eating disorders, substance abuse).

Hair's (2005) review of RTCs in the US found that children diagnosed with conduct disorders had better outcomes if they went back to their family or into foster care rather than a children's home following the residential treatment.

The study of Boys Town by Lee et al (2010b) suggests that behavioural patterns during placement can help to predict outcomes and tailor the support that different children need. For example, children whose behavioural problems increased while in the placement may have been most affected by peer influence or may have been negatively affected by residential care, and for these children, a move to a home-based setting, such as treatment foster care, may be more beneficial. On the other hand, if children improved their behavioural problems while in placement and this improvement was related to the structure the placement provided, it is likely that these children would need structured aftercare services to sustain the improvements made.

Finally, although disabled children represent a large proportion of children in residential care, little is known about their experiences and outcomes. Chmelka et al (2011) found that in the US, where nearly a third of the children in residential care are disabled, this group of children had worse outcomes compared with non-disabled children placed in an RTC – disabled children had more placement changes, poorer peer and adult relationships and higher risk behaviour six months after leaving the centre.

6.3 Conclusion

There is very limited evidence available on 'what works' in residential care, in particular the more robust type of evidence that links the process and structural features of a residential placement with outcomes for children. In England, we have no evidence to answer even the most basic questions of what a residential home leading to positive outcomes for children should look like in terms of: staffing levels, qualifications, pay and working conditions, and inspection ratings (i.e. we do not know if children's outcomes are

better in homes with high ratings than in those with lower ratings). This is in contrast with other children's policy areas where these data have been available for a number of years and have informed policy and practice decisions relating to service improvement. Similarly, while widely validated instruments, based on researcher observations, have been developed in other children's policy areas to assess the processes that determine the quality of a setting (e.g. staff-child interactions), we could not identify any such instruments from the literature on children's residential care.

There is an even bigger gap in relation to evidence on 'for whom' residential care works, both in the international literature and the English evidence base. We could not find a single nationally representative English study carried out in the past ten years directly linking children's characteristics with (quantitative) outcomes from different types of residential care placement.

Bearing in mind these methodological difficulties, the conclusions that can be drawn from the available evidence must be interpreted with caution.

The evidence on 'what works' indicates that to make a difference, residential care must have a purpose and clear goals, and a clear vision and plan for how individual children's lives can be improved. Key process and structural features of good residential care emerging from the evidence are summarised below.

- A residential placement should be part of a continuum of care, with a sophisticated system for identifying which children may benefit from different types of residential placement at some point in their care journey – two evidence-based approaches for assessing needs were identified in Sweden (Multifunctional Treatment in Residential and Community Settings – MultifunC) and the US (Child and Adolescent Needs and Strengths – CANS). The evidence indicates that it is also very important for the residential care to be linked to services and support before and after a residential placement.

- Positive relationships between staff and children and between children themselves are often mentioned in the literature as important to ensure good outcomes from residential care. However, the evidence on the links between relationships and outcomes for children is very limited: this could be largely due to the absence of robust measures to assess the quality of the staff-child interactions in residential care.

- Families' involvement is linked to positive outcomes for children. Here the evidence is more robust as a number of studies have measured the link between, for example, frequency of parental visits and child outcomes. Furthermore, there have been studies that have compared outcomes from residential programmes that place considerable emphasis on working with parents (e.g. by providing family therapy) with those that do not, and found that the former resulted in better child outcomes in the short and longer term.

- A residential placement should aim to provide a 'normal' environment. 'Normal' has been conceptualised and measured in a number of ways in the literature, with positive children's outcomes associated with: small 'family-like' settings; homes providing leisure and academic activities and support; the availability of good food; and last, but not least, safe settings, i.e. free from violence and abuse.

- Hallmarks of good quality in residential care often mentioned in the literature include: a home with vision and purpose; strong leadership; highly skilled, motivated and qualified staff. However, we found very few studies that tried to link these features with children's outcomes.

The evidence on 'for whom' in relation to residential care is not sufficient to draw even tentative conclusions.

7 Children's experiences and views

In this chapter we present evidence from the children. They know how it feels to live in residential care, and may have very different views about what is important from adults. For example, when consulted about the recent package of reforms designed to improve their safety, 49% of children in distant placements considered that the placement had made them safer with only 6% saying that they were less safe as a result (Ofsted, Office of the Children's Rights Director, 2013). As adults, we have a responsibility to make decisions about children's best interests but should never forget to ask what they think.

Information about children's views comes from a range of sources: sometimes (though rarely) research studies will include them as participants and sometimes agencies will consult them in recognition that they have a right to be heard. Whatever the source, surprisingly consistent themes emerge – not necessarily about 'what works' – but about what matters to children. The range of opinions is vast and is inevitably based on personal experiences: a child placed as a teenager in a secure unit is likely to see things very differently from a young child placed in a therapeutic children's home following serious abuse. Even within a single service, some children will describe the home in glowing terms while others hate it, indicating the importance of matching each child's assessed needs to the placement's ability to meet them.

7.1 Relationships with staff

The biggest single variable that determines satisfaction with a placement is the child's relationship with staff. Children are mainly positive about the people who care for them. When the Children's Rights Director consulted children about the best things about living in a children's home, the most positive aspect was the staff:

> ...you have loads of staff that you can talk 2 and they're good listeners;

> ...the staff actually care and keep you safe (Ofsted, Office of the Children's Rights Director, 2013: p. 4).

Similarly, 90% of children interviewed in residential care in Queensland, Australia, felt that their caregivers cared about their best interests and 84% felt understood by them (Southwell and Fraser, 2010) – more so than by their social workers.

Gallagher and Green (2012) undertook a qualitative study with young adults who had been cared for as children in a therapeutic residential service and they all talked about the importance of these relationships. For example:

> Nitesh used to come up with little names – he called me Miss Squiggly Nose. After I left, he made a picture of me using felt. It's still in the loft. It made me feel he actually cared – the same as I cared about him ... He was a genuine person. I was gutted when I did leave because it meant leaving Nitesh (Caitlyn, aged 19: p. 441).

This sense of whether staff are 'genuine' or not occurs repeatedly, just as it did with the Danish children described by Højlund (2011) who were looking for signs that staff really cared about them as individuals and that it wasn't just a job. Or adolescents in residential care in Spain:

They believe that if the social workers demand trust, ask them to share their lives, express their feelings, etc., it is only fair that this is returned by the social workers, by sharing biographical data or information about their daily and personal life. They would like it to be reciprocated, but on the contrary, they understand that it is an imbalanced relationship (Soldevila et al, 2013: p. 287).

This is tricky for staff but can be effective:

[My key worker] treats me like he would treat his own kid, if he had one at 14. He's always interested in my family, asking and that. He's easygoing, flexible and realistic. He grew up in a scheme like me, he knows the score (14 year old boy quoted in Foreman and McAllister, 2006: p. 46).

The service studied by Gallagher and Green (2012) was unusual in that many of the children were still in touch with staff several years after leaving, with one young woman describing how a staff member was an unofficial 'aunty' to her own child. Or:

When Lesley left, she took me out first to tell me before she told everyone else. I was pretty impressed. We went for a meal. It made me happy (Richard aged 18, quoted in Gallagher and Green, 2012: p. 440).

Good-quality relationships with staff cannot be guaranteed, however, and many children describe the staff group as being mixed:

One is nice, some act like they just come to get the money and go home, act like they care but don't (Petrie et al, 2006: p. 121).

In discussion groups about what made a bad member of staff, children reported:

- staff bringing their personal issues to work with them;
- staff who bully children;
- staff who have favourites or who seem 'down' on particular children;
- staff who use restraint when they shouldn't;
- staff who tell children or young people, sometimes when angry, that their parents do not care about them (Ofsted, Office of the Children's Rights Director, 2013: p. 12).

Other experiences are described in purely negative terms:

The staff, at times, appeared to be more interested in control than supervised parenting. They seemed cold, callous, indifferent to the nuances of the personalities in the house, and more concerned with health and safety or getting signatures on papers than anything else (Prew, 2007).

It is difficult to tease out what supports the development of good relationships. Staff turnover and lack of training are described as barriers by some children, and others may have moved so many times that they have put up defences. Southwell and Fraser (2010) found that the children who were the least positive about their caregivers were younger children (particularly under 12 years) and those who had experienced more than four placement breakdowns. Possible reasons for these differences could be that these children are more traumatised by their experiences and need more specialist support in order to trust adults.

One factor that can have a negative impact on relationships is the lack of confidentiality:

> *Staff write reports three times a day on young people so you can't talk to staff about private things because anything said has to be written in reports. That's no sign of respect, privacy or confidentiality (boy aged 15: quoted in Stevens and Boyce, 2006: p. 12).*

7.2 Institution or home?

Whilst less important than the staff, children comment on how satisfied they are with the home itself. They want to be in a 'safe area' but there is a balance to be struck. A number of homes are in more rural locations than children are used to, and this can lead to feelings of isolation or boredom. In a small community, everyone knows where you come from, and children can feel stigmatised (Gallagher and Green, 2012). The 'feel' of the home is also important and children are critical of the institutional features identified by Berridge et al (2012) such as the 'office':

> *Children's homes are like prisons, or waiting rooms. The entrance is nondescript, empty and foreboding. There are locks on doors, fire extinguishers and cheap Monet wannabe copies on the walls. The carpet is the same throughout the building: a cheap office variety, in muted tones. The whole building evinces a cold feeling the walls are peach, white or blue. Any attempt to make the place homely has been tainted by some drab infusion of oppressiveness. Staff carry big wads of keys. The landing doors where I lived were alarmed on all floors to notify staff if children left their rooms at night (Prew, 2007).*

One phenomenon described by a number of children is the 'locked kitchen' so that they cannot help themselves to food:

> *Nope, we're not allowed in it [the kitchen], 'cause somebody was goin' around stealing knives. There's locks on everything, man, there's even a lock on the fridge. The rule is you don't go in the kitchen (boy, quoted in McManus and Morrison, 2009: p. 20).*

Food is generally seen as important – not just the quality but whether there is any choice:

> *Yeah, I really hate macaroni cheese, and they're making it, I think, in a week three or four times, macaroni cheese (boy, quoted in McManus and Morrison, 2009: p. 15).*

Another aspect of having a 'normal' life is access to activities, and children report mixed experiences. Barriers included a lack of funding (or nobody on duty having access to the safe), not having enough staff on duty to accompany them, or a risk-averse attitude to anything that might be dangerous, such as 'swimming, running, fishing, boxing, paintballing or activities that involved travelling alone' (Ofsted, Office of the Children's Rights Director, 2013: p. 25). In the Queensland study, only half the children felt that they were able to do the same sorts of things that other young people not living in residential care could do all or most of the time (Southwell and Fraser, 2010).

7.3 Rules and control

Although children are usually pragmatic about the need for rules, there are instances where they describe excessive levels of control by staff. Children told the Children's Rights Director that having rules and 'being sanctioned' were the factors that made living in a children's home the most different from living with family. The issue of control is at its most stark for children in secure care. In a consultation undertaken by Who Cares? Scotland (Foreman and McAllister, 2006), children talked about the restricted environment and the 'rules':

> Since I was in my room at the start, I thought this was what it was going to be like the whole time, locked up always … All my meals were brought to my room and staff checked on me every hour. My door was always locked (13 year old girl, p. 17).

> You never ever get told about the rules, they just like say 'you aren't allowed to do that' when you do it (15 year old boy, p. 18).

They also talked about the use of sanctions, physical restraint and single separation. Whilst accepting that all might be necessary at times, they said that staff could abuse them. For example, children could be restrained unfairly just for minor incidents such as swearing, or the methods used could be too rough and not those approved:

> I think the staff take it a bit far. I saw a restraint last night that went too far. It's 'cos they used to work in the jail – some still work there. There was a thumb bent back and knees on the young person's back, four or five staff lying on top of you, all lying over you, holding your arms, your head and your legs … It's not done properly… People get hurt in them (17 year old boy, p .26).

It is not only in secure units where these things happen:

> If you are watching TV and don't want to leave, but the staff want you to, they'll restrain you so you go.

> I have not been restrained in 4 years. I used to do things because I wanted to be hugged (Ofsted, Office of the Children's Rights Director, 2013: p .21).

7.4 Relationships with family

Family continues to be very important to children, regardless of the reasons for their placement in residential care. Even where children acknowledge that it was the right decision to remove them, feelings about parents and siblings are constant themes. When asked what was the worst thing about living in a children's home, the single most common answer was 'missing family'. This was often described in terms of not having the love that comes from family:

> I can't see my family but there is no family love here (Ofsted, Office of the Children's Rights Director, 2013: p. 14).

Sometimes this was accentuated by mixing with other children at school and some children talked about making up stories about their family so as not to feel different:

> It was difficult when the other children came in on a Monday and said that they had a good weekend at home with their parents. I just sat down, keeping quiet. I kept my head down and got on with work. (Yasmin, 17, quoted in Gallagher and Green, 2012: p. 444).

The sense of losing touch with family was acute for some children: one child reported them as 'drifting away'. This was across all countries. In Queensland, contact with family was one of the areas where children were the least satisfied, with one in three Aboriginal and Torres Strait Islander young people feeling that they were no longer still in contact with their communities and more than half of all respondents saying that they did not see their families enough (Southwell and Fraser, 2010).

Children are sensitive about staff attitudes to their family:

> Staff moan about having to make tea for my family. They say [they are] not paid to make cups of tea. I go mental. They are meant to promote family contact and they moan about making tea … I make my mum the tea anyway (15 year old boy quoted in Foreman and McAllister, 2006: p. 32).

Some children do report, however, that relationships with family have improved since living in residential care – particularly if their homes had been characterised by high levels of conflict:

> U can relax more in the children's home but if u had my family u couldn't – it was 1 argument and fight after another (Ofsted, Office of the Children's Rights Director, 2013: p. 14).

Siblings also remain important. A Swedish study showed that more children were dissatisfied with the level of sibling contact than they were with parental contact, and this was more so for children in residential than foster care (Lundström and Sallnäs, 2012).

7.5 The voice of parents

Parents very rarely get asked for their perspective, but a study of couples with children in residential care in Israel revealed a complex mixture of emotions (Buchbinder and Bareqet-Moshe, 2011). In some cases, parents had lost authority over their children and were worried that they would become more and more out of control:

> We are a warm family and we tried to understand and help him, but we saw that there was no choice and they called us into school … there was no choice. Yes, there was no choice; it was either residential care or watch as your child gets lost (p. 127).

This prompted both guilt and loss, and parents sometimes framed it as having made a sacrifice for the good of the child. The behaviour of a number of the children had improved in residential care, and was attributed to the staff setting limits but also caring about their child:

> It's not the same child that we sent two years ago. I am very pleased … they set him proper limits there, he needs to know that no means no. This residential care has been a great help to him … The principal talked to us and you could see that she really cares (p. 130).

While parents were glad about the improvement, there was some anxiety – and further guilt – about what should happen next: would the gains be lost if the child came home?

> Look, he is dying to come home. He is very angry, all day long. He follows me around, saying: 'Take me out, take me out,' he misses home so much … parents go through a crisis even if it's not immediately visible, but it's something that penetrates deeper and deeper and deeper … the residential care solves one problem and creates another. The physical separation exists and can lead to emotional separation (p. 131).

Children can accuse parents of 'throwing them out' and this puts a strain on parents' relationships, with them blaming each other. The authors call for recognition of the need for active engagement with parents, not just in their own interests but for the child.

7.6 Relationships with peers

Whilst most of the literature about children in residential care recognises the importance of relationships with staff and with family, other children living in the home are rarely mentioned. Yet it is a major preoccupation for children. They talk about the difficulty of coping with other children's aggressive or bullying behaviour, of having their possessions stolen or destroyed, and having to compete for attention from the staff. When asked by the Children's Rights Director (Ofsted, Office of the Children's Rights Director, 2013) how life in children's homes could be improved, responses included: getting the right group of children living together; 'match the kids up better'; not having too many children in the group; 'don't put more than 3 kids or the child will not get lots of time to themselves' (p. 14).

Similarly, when asked about risks to their safety, other children came up again: 'the risk of not knowing about the other young people'; 'other children living here could hurt you'; 'one of the residents setting a fire'; 'kids with mental problems'. Other responses were more about the indirect risks of what adults would call 'peer contagion': 'some yp [young people] sometimes might try to egg you on to do something you don't really wanna do'; 'getting into bad behaviour with other kids' (p. 16).

> *Saturday night feels dangerous because of other young people coming in drunk. (Boy, 16 quoted in Stevens and Boyce, 2006: p. 7).*

It is not surprising that, given the needs of the population that residential care is meant to serve, rivalry and jealousy between children will arise.

> *In care, you are craving this kind of love but you never really get it … The one thing you need most is to feel genuinely loved. You never quite got that. That's why we used to play up, so that we could get some attention for us. I was a past master at getting attention — I used to throw tantrums. I felt like they [other children] were getting attention and why wasn't I? (Caitlyn, aged 19: quoted in Gallagher and Green, 2012: p. 440).*

In theory, residential homes are meant to consider the impact on the group of possible new admissions, but it is unclear how far this happens in practice, particularly in settings taking emergency or short-term admissions.

7.7 Being involved

Each child should have both an overarching care plan, and a specific placement plan setting out the purpose of their stay in residential care and how long it is for. The extent to which children are clear about their plan is variable. In some instances, children had not even known that the placement was happening, particularly in the Scottish study of secure care:

> *[Social work] never told me I was going to a secure unit, they told me I was going to a residential [school] … we drove in the garage and I was like: 'Is this a secure unit?' It was the first thing I said to [staff member] when I went in: 'Is this a secure unit?' He was like that: 'Aye'. They never even told us I was going to secure (14 year old boy quoted in Foreman and McAllister, 2006: p. 11).*

In other types of placement and where a move was planned, some children describe having prior visits to a home and occasionally having an element of choice. This did not necessarily mean that they had been fully involved in decision making about the reasons for the move. Only 3 out of 39 children consulted by Who Cares? Scotland thought that their placement had been chosen to better meet their individual needs. The reasons they thought they had been moved were:

> *Because (they) had used all the care homes up and no one wanted someone with behaviour like me.*

I was told I had too many foster placements that broke down (Macdonald et al, 2013: p. 9).

When children are consulted, there is some evidence that they are less positive about family placements than adults, and would have preferred residential care.

I used to have trouble living with another family, after everything, so at that time community homes were better. I couldn't cope at the foster placement, they tried to make me one of the family (Jenny cited in Kendrick, 2013: p. 81).

The Children's Rights Director in England found that children under 14 consistently reported being better informed about the plans for them than older children, including those in residential care (Ofsted, Office of the Children's Rights Director, 2014a).

Sometimes children found it easier to talk to their key worker, or other staff in the placement, than their social worker or through formal review meetings:

I don't want to be involved because I hate talking to hundreds of people you don't know (15 year old boy quoted in Foreman and McAllister, 2006: p. 16).

If children do not feel listened to, they may communicate through their behaviour. This can include acting in a way that they think will disrupt an unhappy placement:

I learned that no-one listens to you in foster and children's homes. Even if you run away. Running away was a protest but it never even worked (16 year old girl quoted in Barry, 2001: p. 14).

This was confirmed by children specifically consulted about running away from care, who said it could be a way of getting moved to a new placement: 'it was my way of saying I didn't want to be there, without actually saying' (Ofsted, Office of the Children's Rights Director, 2012: p. 10).

7.8 Programmes and interventions

Children experience a range of interventions within their placements: some units offer external therapy and others rely on residential staff to adopt a particular approach, but there is remarkably little evidence of the interventions that children receive – or what children think of them. Children sometimes refer to 'key worker' sessions, but it is not clear if these are an intervention, or just a chance for children to say what's on their mind.

The children in Gallagher and Green's study (2012) had received a play therapy session once a week. They were very mixed about how helpful this had been, with some children finding it intrusive and uncomfortable whilst others reported that it was helpful:

I did find it a waste of time sometimes ... I was silent for the first two years and I was told 'if you don't say anything, you will not get to the point of being ready to move on'. (Richard, 18)

I found the therapy with Paula helped. When I was nine, I had missed out on a childhood from when I was 20 months old. In therapy I went back to using a bottle and a dummy for about six months. I wanted to be a baby for a bit. (Emily, 24 quoted in Gallagher and Green, 2012: p. 441).

Staff had also undertaken Life Story Work with the children, and this was generally better received:

I found it good because I don't remember a lot of stuff from the past. I had blocked it all out. I liked it that they went and found out all of the information, then told me about it slowly, a little bit at a time. I was so young when everything happened, it helped me remember everything. (Lucy, 21 quoted in Gallagher and Green, 2012: p. 442).

A US study is specifically looking at children's views about the therapy they receive in residential care: the Adolescent Subjective Experience of Treatment (ASET) study (Foltz, 2012). The majority of children (70%) are said to be positive about the value of individual therapy in helping them learn how to manage difficult emotions, and think it could improve their life. Others are negative (17%) or neutral (13%): 'I don't like it – they try to be nosey', 'It sucks, I don't like it at all'. The relationship, or 'feeling connected', with the therapist is an important factor, however.

Children in secure care are likely to receive programmes that will help them stay out of trouble when they leave. Those consulted by Who Cares? Scotland were mixed about the benefit of these, particularly whether they would be able to apply them in the real world.

Actually, it's quite good but they are talking to you about these things in a secure unit. It's going to be totally different when you get out to the community again. They should do the programme work with you then (15 year old boy quoted in Foreman and McAllister, 2006: p. 37).

There is widespread agreement about the importance of education. The attitudes of residential care staff make a real difference in supporting children to attend – and do well – in education. From getting children up in the morning, through to good communication between the home and the school/college, and making sure children did their homework, were all examples given:

If you have homework, your real parents aren't bothered, but here we have to show them and do it and take it in the next day (Ofsted, Office of the Children's Rights Director, 2013: p. 22).

Improved engagement with education as a result of being in residential care was mentioned as one of the main benefits in both the consultations undertaken by Who Cares? Scotland of children in secure and open settings. This is not consistent, however:

It depended what staff were in … it depended what unit you were in … one unit I was in, they never got us up for school … I went to another unit, they had education. They pushed you. The education was better (boy aged 18 quoted in Stevens and Boyce, 2006: p. 12).

Children can also feel stigmatised at school:

When I first went to school some people knew I was in a children's home. Some of them were
nasty about it and it made me feel embarrassed more than anything. (Claire, 17 quoted in
Gallagher and Green, 2012: p. 444).

7.9 Moving on

Some children go home from residential care, others will move to another placement or
into independent accommodation. When asked what helps – or hinders – them in making
that transition, children talk about a mixture of practical and emotional preparation. Most
of the younger children in Gallagher and Green's study (2012) had moved on to
permanent family placements, and had experienced phased introductions. This was still
emotionally challenging however:

I had no family since I was three years old, so I didn't know what a parent should be. I was not
troubled. I put on an act for what I thought Mum [foster carer] wanted in a little girl. I wasn't
normal (Caitlyn, 19 quoted in Gallagher and Green, 2012: p. 446).

Older children are often both excited and scared about the prospect of independence. It
is sometimes only with the benefit of hindsight that they realise how ill-equipped they had
been:

You've got eight staff about you every day an' every night an' then all of sudden you've got no-one
(21 year old woman quoted in Barry, 2001: p. 15).

For the significant proportion of children who go home after leaving care, whether in a
planned or unplanned way, the need to make sense of and rebuild family relationships is
acute.

This is like my home. Now, this is where I stay. This is where most of me is from. All the staff in
here is like all my parents. Even the kids. When I leave this place I will be sorry to see it go … When
I stay at my mum's for an overnight, it's not like staying at home. It's just like going to see a pal
(15 year old boy quoted in Barry, 2001: p. 20).

7.10 Conclusion

Many of the children's perceptions mirror those of policy makers and practitioners. They
confirm much of the evidence in Chapter 6 about 'what works' in terms of the information
about the purpose of the placement, the quality (and genuineness) of relationships with
staff, the importance of family and the need for a comfortable and homely environment.
There are some important differences, however. They place much greater significance on
the relationships within the group of children than is always recognised by adults,
sometimes feeling threatened by, or in competition with each other. They express very
mixed opinions about the value of the 'specialist' support they have received within the
placement, demonstrating that one size definitely does not fit all. Disappointingly, there is
also ample evidence that they do not always feel that they can talk to staff, or be heard,

and that this can lead to their trying to achieve change through running away or otherwise disrupting their placement. Not only are children able to describe the reality behind the rhetoric, but they do not always agree with the rhetoric itself. Most importantly for the purpose of this review, they do not necessarily agree that residential care is a last resort.

Although the children's views described in this chapter provide us with rich data, they are based on a small number of studies and it is difficult to say how representative they are. Children in residential care may be there for a range of reasons, and will have different plans in place. Some will be going home or moving on to a permanent placement: others will remain in some form of residential care until independence, and we know that a proportion will experience considerable disruption. Research that allowed us to describe the views of children following these different pathways would be particularly valuable, as would some way of linking their views to different types of home. Finally, the voice of parents with children in residential care is completely lacking in the English research literature, which is a major omission.

8 Moving towards evidence-based policy and practice

In this chapter, we consider how the evidence base on residential care in England needs to be improved to better inform policy developments at the national level, local planning and residential care practice.

We first consider the main gaps in the evidence base in this country in relation to the key question of 'what works for whom and how'. We then suggest options for collecting data to improve the evidence base on residential care policy and practice.

8.1 Gaps in the evidence base in England

As discussed in the previous chapters, there are some major gaps in the English evidence base on children's residential care, which leave some key questions unanswered, including:

- What are children's experiences and outcomes from children's homes in England? We do not have this evidence because studies carried out in the past decade in England have tended to be small scale and not based on sampling strategies that can provide accurate national statistical estimates.

- What are the broader experiences and outcomes of children in residential care beyond the more typical narrow focus on pathologies and problems? A broader perspective on the wide range of (positive and negative) influences and experiences is needed to understand how policy and practice can effectively intervene to support children's wellbeing and life chances.

- To what extent can we attribute differences between children in residential care and their peers in family-based care to their setting, rather than to the fact that these two groups are very different, and these differences have a great influence on the outcomes considered when looking at the impact of a placement?

- What are the features of English residential homes that can help to explain positive or negative outcomes from residential care and 'what works' (and does not work)?

- Which children are most (or least) likely to benefit from different types of residential placement?

- What do children and their families think about residential care?

8.2 Measuring outcomes from residential care

In Table 3, we have outlined the range of outcomes that would need to be measured to assess the effectiveness of residential care. In line with research on child development, these outcomes are broad, to enable one to better understand how residential care interacts with other influences and experiences in a child's life, and result in different outcomes for children with different characteristics.

Longitudinal (quantitative) data is required to establish causal effects, and this data would need to be collected at different points in time:

1. just before or at the point of entry – the baseline;
2. while in residential care – short term outcomes;
3. at exit and after leaving residential care – medium- and long-terms outcomes.

As discussed in previous chapters, the more comprehensive the baseline data is the more confident one can be that change (or lack of it) can be attributed to residential care. Exploring short-term outcomes is important, as these relate to more immediate expectations from a placement: if these do not move in the expected direction, it is unlikely that the intervention will have a positive effect in the longer term. Studying medium- and longer-term outcomes is also important, as it is not unusual for interventions to produce short-term benefits that are then not sustained in the medium and long term.

Table 3: Children's outcomes and characteristics

	Before/ at placement entry	In placement	At exit/ post-placement
Gender, age and ethnic origin	V		
Disability and special educational needs	V	V	V
Length of time in care and reasons	V		
Type and number of previous placements	V		
Behaviour, emotional and cognitive development	V	V	V
Relationships with family, peers and staff	V	V	V
Mental health issues	V	V	V
Offending behaviour	V	V	V
Sexual exploitation	V	V	V
Self-risk/risk to others	V	V	V

	Before/ at placement entry	In placement	At exit/ post-placement
Academic achievement/school attendance	V	V	V
Family functioning	V	V	V
Children's involvement in decisions about the placement and their care	V	V	V
Children's views on staff, services and support available, facilities, how the home is run	V	V	V
Engagement in recreational/sport activities	V	V	V
Family views on and involvement with placement	V	V	
How safe children feel in the placement		V	
Successful programme completion			V
Destination and stability of discharge and subsequent placement(s)			V
Services and support provided to child and family	V	V	V
Wellbeing measures	V	V	V
Health	V	V	V
Employment and earnings			V
Relationships and family formation			V

8.3 What makes a difference

Collecting longitudinal data on children's outcomes will help to answer the question of 'what works for whom', but to answer the question of 'how' residential care can lead to positive outcomes, and what type of residential placement is most suitable for children with different needs, comprehensive data are required on what happens in the residential placement.

Based on the evidence reviewed earlier, a tool to assess the quality of residential care would need to collect data on:

- **Planning**: how children's needs are assessed and appropriate residential care identified; (expected) length of placement; provision of specific support (e.g. therapeutic intervention); aftercare support and services; how the home works with other agencies/professionals.

- **Relationships**: to measure the effectiveness of the interaction between staff and children, and between children. This is typically done through researcher observations, but could be complemented with data provided by staff and children (as suggested in Table 3 for the latter).

- **Working with families**: how the home works with families, whether siblings are placed together, involvement of parents and children in assessment and care planning.

- **A normal life**: provision of recreational and academic facilities and support; quantity and variety of food provided; use of spaces; the physical environment; particular 'family-like' features (e.g. use of house parents); children's involvement in the running of the home; working practices.

- **Quality of leadership**: a measure of this could be developed based on tools developed to measure leadership in schools and early years settings.[21]

- **Staff**: qualifications, training and supervision, staff:child ratios, pay and working conditions.

The quality of a setting could also of course be measured by linking children's outcomes data with Ofsted ratings.

8.3 Research design options

We believe that the sample for a study of residential care should be drawn from the wider population of children in care,[22] for two main reasons:

1. to identify a comparison group, i.e. children with no experience of residential care,[23] which is required to establish the impact of residential care;

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[21] See the evaluation of Children's Centres https://www.gov.uk/government/publications/evaluation-of-childrens-centres-in-england-ecce

[22] Another option would be to have a sample of children on the child protection register or children in need, which would have the considerable advantage of providing data that could help to inform early intervention (e.g. children at the edge of care), as it has been argued elsewhere (Holmes and McDermid, 2012).

[23] As was done in many of the studies reviewed, it will be necessary, through data modelling, to ensure that the comparison group is as similar as possible to the 'residential care' group. This could be done, for example, by selecting children 'on the edge' of residential care who are very similar to the residential care group in terms of characteristics that affect outcomes of interest.

2. children in England typically spend a relatively short time in residential care, and experiences before and after a residential placement are very important in assessing outcomes.

As well as comparing outcomes for looked-after children with and without residential care experiences, the data would allow one to explore whether positive (or negative) outcomes are associated with particular kinds of homes, depending, for example, on the quality ratings discussed above, Ofsted ratings, cost of a placement, location, size and sector.

There are three different ways in which data about children's outcomes and characteristics could be collected:

- **Administrative data**: data that are collected for other purposes but can be and often are used for research purposes. Data increasingly used in research include: health data; data from the DfE children looked after data return (SSDA 903), Outcomes statistical returns and pupil database; and DWP and HMRC benefits and income data A number of (non-English) studies reviewed earlier used administrative data. The advantage of administrative data is that it is cheap, as there is no data collection involved. The disadvantage is that it does not normally include all the data one needs and its quality is variable. A further issue is that, as far as we know, data linkage between the central government data sources mentioned above and local authority social services data has never been attempted in a large-scale study. The feasibility of accessing social services data, its suitability for research purposes and the feasibility of linking it to other data sources would need to be assessed.
- **The New Life Study**:[24] this is a longitudinal study involving 80,000 children born between 2014 and 2018 who will be followed up into adulthood. It is the most comprehensive English study on children's development and will collect data on children's experiences and outcomes as they grow up. The advantage of using this study is that the data are very robust, very comprehensive and free, and these data can be linked to the central government data sources mentioned above. The disadvantage is that the study is likely to collect very basic information on children in care, which would seriously limit the scope of the analysis. To deal with this potential data deficiency, the DfE would need to add questions to the study to collect additional information about children in care and/or to link the survey data with social services data – permission to add questions to this study is difficult (but not impossible) to obtain.
- **A longitudinal survey of children in care**: a dedicated survey would have the big advantage of being designed to meet the specific need to fill the evidence gaps in the residential care evidence base. The disadvantage would of course be the cost. Improvements in web-based data collection methods could help to limit

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[24] The Millennium Cohort Study, which is following up children born in 2000-01, would not be suitable because the sample of looked after children is too small (i.e. 145).

the costs, as would linkage with administrative data, but a dedicated study would still require a major investment compared with the other two options.

As discussed above, data on children outcomes would need to be linked to data on the characteristics and quality of a residential home. The kind of comprehensive assessment described above would be expensive to carry out for a large-scale study, although similar assessments have been done on a relatively large scale in early years research.[25] One could also consider using the more extensive measures of quality to study in-depth settings where children seem to be doing particularly well. For all other settings, a more basic quality assessment could consist of, for example, Ofsted ratings and the DfE Census of the Children's Home Workforce, combined perhaps with some basic information about the setting's characteristics.

8.4 Conclusion

There are big gaps in the English evidence base on residential care, in contrast with the more comprehensive evidence base that has been available to inform policy and practice decisions in other children's policy areas in the past decade.

While the fact that children in residential care are very different from looked after children in other types of placement will make any research looking at comparative outcomes challenging, a sophisticated design and an adequately resourced research programme can fill the evidence gaps outlined above. A feasibility study will be required to fully scope out the methodological options and costs, but we believe that in order to produce robust evidence to answer the questions above the research programme will need to include:

- A longitudinal quantitative study to collect evidence on a wide range of children's outcomes and experiences before, during and after a residential placement, and the characteristics of these children.

- The longitudinal study will need to include a comparison group, i.e. children who have not experienced residential care but who are as similar as possible to children who do – this would enable one to assess with a certain degree of confidence the extent to which differences in outcomes are due to the home rather than to children's characteristics, and experiences before and after a residential care placement.

- The collection of comprehensive data on the features of residential placements linked to effective practice, including: processes (e.g. quality of staff-child interactions, leadership, interagency working); structural features (e.g. facilities,

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[25] See the evaluation of Children's Centres https://www.gov.uk/government/publications/evaluation-of-childrens-centres-in-england-ecce and the longitudinal study on the Effective Provision of Pre-School, Education (EPPE) http://www.ioe.ac.uk/research/153.html

staff levels, qualifications, working conditions); and any specialist support that children and their families receive.

- The ability to link data on children's outcomes and characteristics with data about the features of children's homes to answer the question of 'what works for whom and how'.

Options for obtaining data on children's experiences and outcomes include:

- Use of administrative data on children's health, education and income collected from central government departments and local data from children's social services.

- Use of data from the New Life Study, a longitudinal study that will follow up a very large sample of UK children into adulthood.

- A dedicated longitudinal survey of looked-after children, including a sufficiently large group of children with experience of residential care.

Options for collecting data about the quality of residential placements include:

- Linking Ofsted ratings on children's homes with children's outcomes from the administrative and/or survey data sources described above.

- Linking data from the DfE Census of the Children's Home Workforce with children's outcomes from the administrative and/or survey data sources.

- Developing instruments for comprehensive quality assessments of residential settings, which can then be linked to children's outcomes obtained from the administrative and/or survey data sources.

At the moment the English evidence base on residential care does not allow one to answer the key question of 'what works for whom and how'. Not knowing what works in residential care means that a great deal of money could be spent on services that may be ineffective or even harmful. The consequences of getting it wrong in this policy area can be very negative both in terms of children's lives as they grow up, but also in terms of long-term costs to society. It would therefore make sense to explore the feasibility and costs involved in improving the quality and comprehensiveness of the evidence base on residential care, so that policy makers and practitioners can have access to the kind of evidence base that has been available for over a decade to their colleagues in other children's policy areas.

9 Final conclusions

Can't really think of anything [negative] because it was such a positive experience. I loved it there – I didn't want to leave. I learnt to control my anger, respect other people more, and learn better communication skills. It just taught me how to behave ... It was absolutely lovely – I got on with all the staff (Peter, 18 quoted in Gallagher and Green, 2012: p. 441).

It may be argued that residential care should be seen as a high quality, specialist service for those who are unable to benefit from foster care or who are unsuitable for it. Despite the best intentions of managers and staff, it would be difficult to conclude from the current evidence that this is what we currently have (Berridge et al, 2012: p. 92).

In the introduction to this review, we indicated that the findings were likely to be complex and this has turned out to be the case, as the above quotes illustrate. There is no simple answer to the question of 'what works' in residential care, partly because of gaps in the evidence, but also because we first need to answer the more fundamental policy question, 'what is residential care for?' Although there is consensus that residential care is an essential component of the service to looked-after children, the challenge is to develop a shared vision that enables the 'right' children to be placed in the 'right' place, and at the 'right' time.

9.1 Last resort or placement of choice?

The most pressing need is to clarify which children will benefit from a residential rather than a family placement and at what point in their care journey. At the moment it is predominantly but not exclusively used for older or more troubled children within the care system, three-quarters of whom have a history of failed placements behind them. This is because of the explicit message within international policy, and reflected implicitly within English statements equating permanency with a family placement, that residential care is a last resort. There are a number of problems with this approach. Firstly, it does not reflect the evidence described earlier that some residential care can achieve positive results in the right circumstances. Secondly, it does not reflect the views of children. Many say that the idea of living in someone else's family is uncomfortable for them and, although it is impossible to quantify, there is some evidence that children will disrupt placements they do not like in order to be moved. The 'last resort' rhetoric also gives a negative message to society: the implication being that only the worst children live in residential care, with media references to 'homes from hell'. Children are aware of this perception and struggle to retain a positive sense of who they are and what they can achieve. Not all countries see residential care in this way. They have a much stronger tradition of family support and offer a flexible range of services, of which residential care is just one element.

The fact that residential care in England is not, in policy terms, defined as a permanent placement also affects the way it is used. If residential units are only a stopgap until children can be moved on to a family, what are they actually meant to do with them while

they are there? In countries with a tradition of social pedagogy, staff in residential care are actively engaged in bringing the child up, usually in partnership with parents. Yet when asked about their purpose, 81% of homes in England describe themselves as caring for children long-term until they are ready for independence (Thornton et al, 2015). This is a confusing message for all concerned, including children.

9.2 Home or treatment facility?

Because of the lack of clarity about the purpose of residential care, it is difficult to develop suitable provision. The smaller the population of children in residential care, the higher concentration there will be of children with complex needs. Different methods of assessing children's needs are used, but there is agreement about the prevalence of high levels of emotional disorder (although the proportion with externalising behavioural problems as opposed to unhappiness and anxiety may be less than popular perception suggests). Children are also at increased risk of trauma related difficulties as a result of their removal from home. They require either therapeutic support or specific treatment that is unlikely to be available in a mainstream placement. The challenge is to develop *a continuum of services* that can meet each child's assessed needs, whether in a family or residential setting. Although there has been growth in the number of children's homes, it is difficult to assess what they actually offer. There is no agreed definition or separate registration category, and it is left to local commissioners to evaluate the claims. There also seems to be a major gap in provision for those children with disorders that require more than a therapeutic milieu: the term 'treatment' has not been adopted by the sector and it is unclear which agency would be responsible for such provision, particularly given the acute shortage of children's psychiatric beds.

We need a more sophisticated way of assessing and aggregating the needs of children likely to enter residential care so that a continuum of provision can be developed that matches those needs. Many European countries offer a much more flexible range of residential care than we do, with more respite, part-time and shared care arrangements. They also have placements that blur the boundary between foster/residential care or secure/open care. Boundaries are also much more permeable in terms of family involvement, with an expectation that part of the unit's role is to engage families, even if a child will not be returning home. Neither do staff see their responsibilities as stopping at the door of the unit. They work in the family home and may have a continuing role with children who have moved on.[26] If this wider range of provision is to be developed, the elements would also need to be properly defined so that commissioners would know what to expect from a placement claiming, for example, to be 'therapeutic'. In theory, the current system of each home having a Statement of Purpose and each child having a

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[26] It is encouraging that the Children's Innovation Programme is supporting projects such as 'No Wrong Door' in North Yorkshire, which will test out the effectiveness of a more flexible service.

Care and Placement plan should provide this framework, but we know that it does not. A revitalised and more consistent approach is needed so that each placement has a clear purpose, specifying the desired outcomes for the child, how they will be achieved and timescales for review.

One difficulty in ensuring that the right provision is in place is the fact that over 60% of residential placements are in homes run by the private or voluntary sectors. There are high concentrations of homes in certain areas, but not matching the areas where the children come from. The Association of Directors of Children's Services has described the market in residential care as unsystematic and 'provider-led' (Association of Directors of Children's Services, 2013). Whilst there is nothing to suggest that private and voluntary sector homes are of a lower standard than local authority homes, we do know that their staff are less well paid, less qualified and work longer hours. They are also under pressure to operate at full capacity, with the ensuing risk that they may take children whose needs they cannot meet, or who will not fit well with other children already placed. Whatever the reality, practitioners may have a degree of scepticism about whether the description of a home is accurate or clever marketing. A common language about the different types of home would offer greater transparency to support their decisions.

9.3 Raising standards

No type of home, however well-conceived, will work unless day-to-day practice is of a high quality. There will be new Quality Standards, linked to inspection, from April 2015, which should provide a better framework for assessing the aspects of a home that really matter. The 'what works' literature reviewed in Chapter 6 offers some clues but, as always, there are challenges in implementation. Formal programmes and interventions are important, but even more important are the people who are delivering them. Factors such as having a shared vision, good leadership, skilled staff and good interagency working cannot be externally prescribed. Whilst it is important to offer specialist and therapeutic placements, *all* staff should be able to develop therapeutically informed relationships with the children they care for. Whenever children are asked, they will say it is the staff that make the difference. This is not reflected in the status, pay or training that residential care staff in England receive. Unlike the countries where staff receive extensive training in social pedagogy, the qualification framework is either competency and care based, or designed for field social workers. There is no unifying theory that supports staff to work together. This is not to denigrate the work that is done: children are overwhelmingly positive about the staff who look after them but this may be based on personal commitment and qualities rather than a proper framework of support.

If the new Quality Standards and Inspection Framework are effective, they could form the basis of a quality framework that would allow child outcomes to be tracked across placement type. At the moment, the data collected do not allow for this level of analysis. For example, we do not even know whether the children with better outcomes have come from residential or foster care, or whether there is any correlation between good

outcomes and a home's Ofsted rating. Neither do we know whether children with a particular set of needs are in one type of placement or another so that we can compare their outcomes. This will be particularly useful if a broader range of provision is developed. At some point, we will need to know, for example, whether children with a conduct disorder benefit from an expensive therapeutic placement or do just as well in a well-run home 'as usual'. They have developed a system in Israel that links children's needs and outcomes with their placement and findings from inspection. Without such a system, questions about 'what works' cannot be fully answered.

Whilst outcomes are extremely important, so are children's experiences. Some things are very difficult to measure, such as whether a place feels 'homely'. The Children's Rights Director has developed a 'happiness scale' (Ofsted, Office of the Children's Rights Director, 2014b) in an attempt to assess how happy children in registered settings are in comparison with other children. However it is done, the ongoing process of asking children about their experiences is essential if we are genuinely interested in raising standards.

Appendix 1 Search strategy

Below we list the databases and search terms used for the search. The search generated 2535 data items and 296 items were initially selected (based on the abstracts) A second round of screening (based on the full text) and some reference harvesting resulted in a total of 172 data items included in the review.

Databases and websites screened were:

- ERIC
- British Education Index
- Australian Education Index
- PsycINFO
- International Bibliography of the Social Sciences
- Web of Science
- Social Care Online
- Applied Social Sciences Index and Abstracts
- www.gov.uk
- NCH
- Barnardo's
- Howard League
- Research in Practice

Search terms for ERIC/BEI/PsycINFO (Ebsco)[27]

Residential care terms

Children* N1 homes or Young N1 offenders N1 institute* or residential N1 schools or Secure N1 training N1 centres or orphanage* or residential N1 childcare or family N1 group N1 home

or (Residential N2 care or residential N2 accommodation or residential N2 homes or residential N2 placements or secure N2 units or secure N2 accommodation or care N1 homes or institutional N1 care or residential N1 treatment or residential N2 programme* or residential N2 settings or residential N2 facilities or congregate N1 care or group N2 home or group N1 care or institutional N1 care) and (child OR child's or children* OR schoolchild* OR Boy or boys OR Girl or girls OR Prepubescent or young N1 (boy* or child* or girl*) or adolescen* or juvenile* or youth*)

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[27] These terms were adapted as necessary for the other databases, and a simplified search was applied to the web pages and Social Care Online

Research terms

ethnolog* OR content analysis OR ethnograph* OR audio* OR video* OR observational N1 methods OR participant N1 observation OR narrat* OR discourse* OR repertory N1 grid OR behavio#ral N1research OR thematic N1 analys* OR phenomenol* OR grounded N1 (theory OR studies or study OR research) OR purposive N1 sampl* OR field N1 (note* OR study OR studies OR research) OR biographical N1 method* OR theoretical sampling OR theoretical N1 sampl* OR life N1 world OR life-world OR conversationN1 analys* OR theoretical N1 saturation OR thematic N1 analys* OR interview* OR snowball OR case N1 (studies OR study) or transcrib* or transcript* or qualitative

or

outcome* or quantitive or Evaluat* or effect* or random* or longitud* or cohort* or comparison* or comparative or time N1 series or time-series or timeseries or pre#test or pre test or post#test or post test or impact* OR correlat* OR predict* or experiment* or research* or follow up or follow#up or prospective or retrospective or meta N1 analy* or meta#analy* or review* or empiric* or quantitative or what N1 works

or strategy* or policy or policies or model*

Exclude

learning N1 disabilit* or mental N1 disabilit* or Developmental N1 disabilit* or autis*or learning N1 disorder*

(((((ZE "learning disabilities") or (ZE "learning disorders")) or ((ZE "mental disorders") or (ZE "mental retardation"))) or ((ZE "developmental disabilities"))) or ((ZE "autism")) – Psycinfo subject terms

Boarding N1 school*

Limits

Publication Date: 20000101-20141231; Publication Type: Academic Journal, Book, Periodical; Language: English, Italian, Spanish; Publication Type: Books, Collected Works (All), ERIC Digests in Full Text, ERIC Publications, Journal Articles, Numerical/Quantitative Data, Reference Materials – Bibliographies, Reports (All), Speeches/Meeting Papers; Publication Type: All Journals, All Books; Language: English, Italian, Spanish; Population Group: Human; Document Type: Bibliography, Chapter, Journal Article; Methodology: CLINICAL CASE STUDY, EMPIRICAL STUDY, FIELD STUDY, INTERVIEW, LITERATURE REVIEW, MATHEMATICAL MODEL*, TREATMENT OUTCOME/CLINICAL TRIAL; Exclude Dissertations

Appendix 2: Summary of the evidence on outcomes and effectiveness

Citation	Context – country, year and type of programme	How outcomes were assessed	Limitations of the research
Attar-Schwartz, 2008, 2009	A study of children in residential care carried out in 2003 and 2004 in Israel. One of the papers looked at factors associated with school functioning (2007) and the other factors associated with psychological outcomes (2009). In Israel, institutional placement is the most common solution for abused and neglected children, while foster homes are resorted to rarely or as an extreme measure.	The study was based on data reported annually by social workers on all LAC in residential care. 4,420 children (ages 6–18) in 57 settings were included. Additionally, data on the characteristics of the settings were collected through a structured questionnaire completed by the supervisors at the Ministry of Welfare.	• Additional variables would have been required to better control for selection bias. • More data is needed on contextual factors. • The study relied on administrative data, and although it examined a wide range of potential risk factors, a substantial amount of the variance in children's psychosocial condition still remains to be explained (2009).
Berridge et al, 2011	Evaluation of the pilot programme that tested social pedagogy in children's homes in England (fieldwork period not found).	The evaluation included 18 pilot homes that had employed a social pedagogue and 12 comparison homes that did not employ one. The outcomes evaluation involved a longitudinal quantitative study of children (N=114) in 27 homes who were followed up after 5-9 months. The process evaluation involved an in-depth exploration of 12 homes (9 pilot and 3 comparison). Comparison homes were mainly selected from the same local authority (LA) as pilot homes to control for local circumstances and were also matched to the pilot homes in term of size and purpose.	Children in the pilot and comparison homes were different in relation to variables expected to influence the outcomes investigated by the evaluation, but it does not seem that these differences were controlled for when assessing outcomes.

Citation	Context – country, year and type of programme	How outcomes were assessed	Limitations of the research
Berridge et al, 2012	Study of children's homes and short-break units for disabled children in England (fieldwork period not found).	Data collected from 16 homes which catered for 200 children. Baseline and follow-up surveys collected data on outcomes from 59 children; administrative aggregate data were collected for all 200 children.	• No comparison group, so we do not know if outcomes would have been the same or different if children were in another type of placement. • It is not clear what the sampling procedure was used to select homes (e.g. whether selection proportionate to size was used) and how children were selected within the sampled homes. • Homes do not seem representative of all homes in England (e.g. while DfE data show that just over 40% of residential homes are LA run, two-thirds of homes in this study were LA run) and it does not appear that data were weighted to take this into account, thus limiting the generalisability of the estimates.
Biehal et al, 2014	Study of officially reported cases of abuse or neglect in the UK, 2009-2011.	Data were collected via a survey of all local authorities (74% response rate). Follow-up of 111 substantiated cases of abuse or neglect (87 in foster care and 24 in residential care), concerning a total of 146 children.	• The study only focused on official reported cases of abuse and neglect. • The follow-up sample of substantiated cases in residential care was small and a quarter of the cases were from two units characterised by a culture of physical coercion and compliance. The authors say that for these reasons, the results for residential care should be

Citation	Context – country, year and type of programme	How outcomes were assessed	Limitations of the research
			considered exploratory.
Davidson-Arad and Klein, 2011	Study carried out in Israel in residential homes comparing the wellbeing and self-esteem of 12–14 year olds placed together with their siblings with those who were placed without their siblings. In Israel institutional placement is the most common solution for abused and neglected children, while foster homes are resorted to rarely or as an extreme measure.	Sample selected from 6 homes and included 91 children placed with siblings and a comparison group of 103 children matched with the study group in relation to age, gender and time in care. Data collected via self-completion survey.	• Two-fifths of the children contacted did not participate in the study and the low response rate raises questions about the representativeness of the sample and the generalisability of the findings, especially since there was no information on the characteristics of non-participants. • The study was limited to adolescents aged 12–14 and we don't know if the results would apply to children of other ages. • Information for the study was derived solely from self-report, with all of its potential biases.
De Swart et al, 2012	Meta-analyses of studies carried out in North America and Western Europe 1980-2011. The focus was on therapeutic interventions that engage children and young people (CYP) in a constructive process of change (i.e. not boot camps) and are based on previous research on their potential positive effect. Examples of interventions were: social skills training and cognitive behaviour therapy.	Only experimental and quasi-experimental studies included (N=27); meta-analyses were based on a combined sample of over 17,000 CYP.	• Publication bias. i.e. studies of programmes showing an effect are more likely to be published than those not showing an effect. • Use of studies of moderate (rather than exclusively high) quality. • Heterogeneous effect sizes for some analysis.

Citation	Context – country, year and type of programme	How outcomes were assessed	Limitations of the research
DeSena et al, 2005	This study of SAFE Homes, developed by the State of Connecticut, was carried out in 1999-2000. Their key features are: 1) facilitate assessment and treatment planning; 2) community-based; 3) allow siblings to stay together when placed; 4) allow children to continue in their school of origin.*	Outcomes were collected after a year from 342 children who received SAFE Home services and compared with 342 matched foster care control children. The 684 children were selected from a larger pool of 909 children in care using propensity score matching to control for hidden bias in treatment group assignment.	• The administrative data used were not verified against external sources, even though it was known that the social services records used were often incomplete. • Analysis was based on retrospective record review and did not have measures of child wellbeing and service use, both important outcomes to consider in fully evaluating cost-effectiveness
Dregan and Gulliford, 2012	Study of British children in public care in the 1970s and 1980s.	Analysis of the 1970 Birth Cohort Study, with data collected when cohort members were 16 and 30. At age 30 there were 431 people in the sample who had been in care (this constituted 58% of cohort members who were in care).	• Poor data on reasons for admission to care that could be used to control for selection bias. • Limited information on placement patterns. • Outcomes relate to care experiences in the past when the system and population profile were rather different. -No data on quality of care.
Euser et al, 2014	Study comparing prevalence of maltreatment in residential and foster care among Dutch children who were in care in 2010.	Sample of 12-17 year old children (N = 329) in residential and foster care selected from the 2010 Netherlands' Prevalence Study of Maltreatment of Children and Youth.	Cannot be sure how far it was possible to control for selection bias – e.g. no information on experiences before placement or placement history, and it is therefore unclear whether the increased risk

Citation	Context – country, year and type of programme	How outcomes were assessed	Limitations of the research
	The Dutch system seems to have similarities with the English system where foster care is the default option unless there are specific reasons (e.g. behaviour problems) requiring a residential placement.		of physical abuse in residential care was caused by the characteristics of the care arrangements or by previous negative experiences of the adolescents in out-of-home care.
Hair, 2005	A review of studies carried out 1993-2003 to explore the factors associated with the effectiveness of residential treatment – all studies were from the US apart from one Canadian.*	Review of 18 studies that focused on RTCs that: (a) had a treatment programme for children with severe emotional and/or behavioural problems, (b) employed trained staff, (c) provided some on-site schooling for at least some children, and (d) aimed to return them to the family, alternate caregivers or independent living.	• Limited evidence on the quality of the studies reviewed is provided, but the author points out the methodological weaknesses and design limitations of the studies on the effectiveness of residential care and the need to interpret the findings with caution; however, the consistency of some of the results is also noted. • Information on the design of the studies reviewed not provided.
Harder et al, 2012	The study was carried out in 2007-08 in one secure unit in the Netherlands, where children were locked up 24 hours a day and could only go out under supervision. As in England, Dutch secure homes take children from both the welfare and justice systems.	A group of 22 children were followed up on three measurements in time: on admission, 10 weeks after admission and 7 weeks after leaving the unit. Data were also collected from 27 care workers via interviews and questionnaires.	• Small sample size, high attrition and non-response bias • Results are not very conclusive.
Hayden, 2010	The study aimed to assess if residential care is 'criminogenic', based on research carried out in 2007 in 10 children's homes	The original research was part of research focusing on the implementation of a restorative justice approach. Analysis was	• The study was based on one county only, so was not nationally

Citation	Context – country, year and type of programme	How outcomes were assessed	Limitations of the research
	(9 open and 1 secure) in a large county in England. The homes studied were piloting a restorative justice approach which aimed to reduce conflict and offending behaviour.	based on trend data based on offending, incident records and police call-outs over seven years (2001–2007), with some critical assessment of this measure provided. The research also included a 1-year cohort study (2006–2007) of all the 46 young people resident or admitted to the 10 homes in a 1-month period (2/3 boys, 1/3 girls).	representative. • No comparative data from LAC not in residential care and no statistical control appear to have been applied. • Response rates do not seem to be reported.
Justice Studio, 2014	A study of Secure Children's Homes (SCHs) in England and Wales carried out in 2013. SCHs look after children aged 10-18 who have complex needs and who: 1) have been given a secure welfare placement under Section 25 of the Children Act 1989; 2) are placed there by the youth justice system after having been sentenced; or 3) have been remanded on suspicion of a criminal offence.	The study included: • quantitative data on children's demographics, education, health, safety, reoffending (provided by some SCHs but it is not clear how many, as various numbers are provided). The study probably covered around 1,000 young people, but again, the numbers seem to vary. • A review of all Ofsted reports for all SCHs back to 2009. • interviews with managers of 16 SCHs • interviews with the lead mental health professional.	Lack of transparency about the research methodology, and the evidence presented looks rather inconsistent.
Knorth et al, 2007	Meta-analyses of studies assessing outcomes from different types of residential care (and residential v. home care) carried	27 studies included with a total sample of 2,345 children – 540 children included in pre-experimental studies (i.e. without	• Weighted mean effect sizes could only be calculated for a minority of pre-experimental studies; for quasi-

Citation	Context – country, year and type of programme	How outcomes were assessed	Limitations of the research
	out 1990-2005 in residential care from the US, the Netherlands, Australia, Canada and Finland. Studies focus exclusively on young offenders or children aged 12-18 with psychiatric/severe behavioural problems.	control group) and 1,805 CYP in quasi-experimental studies (no experimental studies were included). Non-controlled studies were examined without carrying out moderator analysis due to lack of data.	experimental it was not possible to calculate mean effect sizes. • Only short-term outcomes were considered; other meta-analyses show that longer-term outcomes seem less favourable. • The analysis lacked some important predictors (e.g. the nature and severity of the problems of the children and their families), only age and type of treatment were included and the latter was very roughly described. • The studies did not look at how an intervention worked.
Lee et al, 2010a	A review of US studies about children in the welfare system in the US carried out 1996-2009.*	A review of 99 empirical studies and 4 reviews which compared the outcomes of children in residential care with other forms of care.	• Most studies reviewed provided little context for the programme. • Many studies relied on research carried out by placement providers. • There was no consistency in the studies reviewed on the outcomes measured and when they were measured. • Few studies collected data post-placement; when this was available it suffered from attrition, and inconsistent

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Citation	Context – country, year and type of programme	How outcomes were assessed	Limitations of the research
			time frames and informants. • The review provided little information on the controls used by the studies to deal with selection bias.
Lee at al, 2010b	The study based is on data from Boys Town, a large youth-serving organization in Nebraska, USA. Boys Town serves YP who are formally involved with a public system (child welfare, mental health or juvenile justice) as well as YP privately placed by parents or other caregivers.*	This was a retrospective longitudinal study which analysed administrative data from Boys Town. The sample consisted of YP in placement at least 90 days and who left the agency's main campus between 1 June 2002 and 31 December 2005 (n = 744). While sample consisted of YP from one particular programme, comparison of some key outcome variables seems to suggest YP in this study were broadly comparable with other youths in group care settings in the USA.	• The use of administrative data and attrition at follow-up constrained the type and amount of data available. • Some of the follow-up data are missing and the available follow-up data are based on self-reports, which may be susceptible to social desirability bias or other influences • Narrow outcomes measures used.
Lindquist, 2011	A Swedish study that explores relationship between planning and outcomes among children who entered the care system in 1991. There are two types of residential facilities in Sweden: correctional facilities, which treat children with the most serious problems; and HVB-homes for other LAC; the study focused on this type.**	Administrative data of all 13–16 year olds placed in an HVB-home during 1991 and followed up till they left residential care or until their 18th birthday. In addition, the data set contains information on post-treatment outcomes at the age of 25. The data set consists of 357 placements of 336 different children in 173 facilities. The number of observations from a single facility varied from 1 to 10.	• Whether length of treatment was decided in advance is a rather crude measure and detailed information on preparations undertaken by the social services and the type of treatment undertaken at the residential facilities would be required for more informative analysis of the association between planning and outcomes. • Children were not randomly assigned to different degrees of pre-treatment planning; although the analysis

Citation	Context – country, year and type of programme	How outcomes were assessed	Limitations of the research
			controlled for a wide range of children's characteristics, the possibility of selection bias remains.
Mota et al, 2013	A study of children in residential care in Portugal to explore the relationship between peer relations and outcomes (fieldwork period not found).	A cross-sectional survey of 109 children aged 0-15 who were residential care from and who were selected from 13 residential homes.	• Limited because the sample was small. • Although the homes were randomly selected, data were only collected from those who agreed to participate in the study. • All measures were self-reports, making them susceptible to common-method variance. • Some of the scales presented low levels of reliability. • Although structural equation modelling was used to test causal models, the data were collected at a single point in time, so the results cannot provide proof of actual causal relationships.
OCC, 2012	An inquiry into sexual exploitation in England carried out in 2012.	The Inquiry received 115 written evidence submissions from 70 local areas. In addition OCC spoke to 167 individuals across 78 agencies during 14 site visits, and took oral evidence from 68 individuals.	This is not a research study.
Ofsted, 2011	The study was carried out in 2001 to identify what contributes to success and effective	Ofsted inspected more than 1,400 children's homes six times over three consecutive	Insufficient information about the methodology to judge the quality of the

Citation	Context – country, year and type of programme	How outcomes were assessed	Limitations of the research
	practice in children's homes in England.	years, and of these only 35 succeeded in being judged outstanding at every inspection. Twelve of these were selected for the study. No other information was provided about methods.	evidence.
Rayan et al, 2008	A study of LAC in Los Angeles county to compared delinquency among children in residential and foster care. Study used data from 2001-05.*	Use of administrative records and propensity score matching to match children in residential and foster care. The sample (N=8,226) included children aged 7-16 with at least one placement episode and with no prior arrests before the first placement.	• Ability to control was limited by the data available and despite the sophisticated modelling, it is possible that differences between children in residential and foster care were not entirely controlled for • The analysis was limited to official arrests and it is possible that unknown or unreported juvenile offending in foster placements is more common.
Ringle et al, 2010	A study of US-based Treatment Family Homes (TFHs) carried out in 2007-09. TFH is a family-style and community-based programme that caters for children aged 12-18. The Homes are staffed by a specially trained married couples (Family Teachers) who live in the home and provide structured supervision in daily living and treatment activities.*	The sample selected from 8 sites: cohort 1 was a 5-year follow-up and included 188 children in their 20s who were in care in the late 1990s; cohort 2 was a 16-year follow-up including 224 adults in their 30s who had been in care in the 1980s. Data were collected via survey – telephone, internet or postal. There was approximately a 50% response rate.	• While the analysis does not indicate a non-response bias this cannot be ruled out. • Some predictors used differed between the two cohorts, although the main one (length of stay in the home) was the same.
Shechory and Sommerfeld	A study of residential homes in Israel to examine the relationship between home-leaving age, length of stay in a residential care facility and attachment styles, as well	68 children aged 6–14 took part in the study. They constituted 70% of all the children in a single residential care facility; the remaining 30% were excluded from the	• A small-scale study based in one home with a large group (1/3) excluded because they were considered to be

Citation	Context – country, year and type of programme	How outcomes were assessed	Limitations of the research
2007	as behaviour measures indicative of maladjustment. (Dates for fieldwork period could not be found). In Israel institutional placement is the most common solution for abused and neglected children, while foster homes are resorted to rarely or as an extreme measure.	study, as they were defined as 'mentally retarded' and could not participate. The questionnaire was completed by social workers who had been working in the system for an average of 4 years, had daily contact with the children and had known the child for at least a year. The Attachment Questionnaire was filled out by the child, in their living room, with one of the social workers in attendance.	'mentally retarded'. • Assessment of placement quality was rather weak.
Timmerman and Schreuder, 2014	A review of studies on sexual abuse in residential care carried out 1945–2011 (although most were from the 1990s and 2000s) in a number of different countries.	International review of peer-reviewed research literature on sexual abuse in residential care based on 66 studies.	No comparative data on incidence of sexual abuse in other types of placements (e.g. foster care).
Vinnerljung et al, 2008	Swedish children who entered the care system in 1991, which includes comparative analysis of outcomes from residential and foster care.**	Administrative data for 1,100 LAC and a comparison group who were non-LAC.	• The variable used to control for selection bias was described by the authors as rather crude. • No information about placements was included in analysis, apart from whether it was residential or foster care.

Notes:

* The US system has many commonalities with England in relation to: percentage and profile of looked-after in residential care, and reasons for entry. However, a wider range of residential options and specialised programmes is available in the US compared with England.

** The proportion of children in residential care in Sweden is higher than in England and as young offenders are placed in the welfare system, in Sweden 'troubled and troubling' behaviour is a more common reason for LAC status than abuse and neglect, and entry into care in adolescence is more common.

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