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**Empowering residential carers of looked after young people:
the impact of the 'Emotional Warmth' model of professional
child care**

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Empowering Residential Carers of Looked After Young People: The Impact of a Psychological Model of Professional Child Care

Summary: Children and young people in public care have long been recognised as a particularly vulnerable group in our society. Many have complex personal, interpersonal and educational needs as a result of pre-care maltreatment. Despite a number of initiatives to change the often-negative outcomes for these children, results have remained stubbornly disappointing.

The model of professional childcare, rooted in psychological research and theory, was designed to enable and empower foster and adoptive parents and residential carers to acquire a deeper understanding of their children's needs and to provide these young people with the informed support required to help them to lead more fulfilling lives.

In this study, we examined the impact of the model in a three-year project involving fifty-three children and young people and their carers in local authority children's homes on two UK sites (northern and southern England). Significant improvements in both behavioural and affective measures were observed following implementation of the model with these young people ($Z_{(N=53)} = 3.978$, $p < .001$). These results demonstrate that this model of professional childcare can achieve positive outcomes for previously maltreated young people in children's homes. Methodological constraints on implementation of the model are discussed.

Keywords: children in public care; group consultation; impact outcomes; psychology-based interventions; residential care practice.

Introduction

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. (Hart and La Valle, 2015, p. 11).

There is no shortage of advice for parents on bringing up their children, as evidenced by the seemingly endless supply of books ranging from the general, e.g. *Teenagers Translated* (Downshire and Grew, 2014) to the specific, e.g. *French Children Don't Throw Food* (Drukerman, 2013). Of particular interest to applied psychologists are the attempts to link practical parenting with results from the expanding neurosciences, e.g. *The Gardener and the Carpenter* (Gopnik, 2016). While such publications may enlighten and embolden committed parents, there is a minority of parents who are not only unable to provide the upbringing that their children need but may even create a toxic living environment for them through rejection, neglect, physical or sexual abuse, and psychological mistreatment.

Such children and young people may end up in public care, where the trauma of these earlier negative experiences becomes only too visible in their personal, social, academic and behavioural development. Sadly, these rejected children can be found in every part of the world (Hillis et al., 2016). Maltreated children are left with feelings of anger, resentment, shame, guilt and bitterness and often these emotions manifest themselves through isolation and withdrawal, disturbing, destructive, self-defeating and violent behaviour and psychiatric illnesses (WHO, 2016).

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3 *Trauma happens when any experience stuns us like a bolt out of the blue; it*
4 *overwhelms us, leaving us altered and disconnected from our bodies. Any coping*
5 *mechanisms we have are undermined and we feel helpless and hopeless. It is as if*
6 *our legs are knocked out from under us.* Levine and Klein (2009), p. 4.
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14 One of the important tasks of the Adverse Childhood Experiences (ACE) studies in
15 the USA (Dube et al., 2001) has been to match retrospectively an individual's current
16 state of health and well-being against adverse events in childhood (the ACE Score).
17 More recently, this connection has been linked to a variety of changes in brain
18 structure and function, especially in stress-responsive neurobiological systems. (See
19 Anda et al., 2006; Perry and Hambrick, 2008; Lanius, Vermattern and Pain, 2010, or
20 Teicher and Samson, 2016).
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32 While each of the 72,670 children and young people being looked after by local
33 authorities in England in 2018 (Cromarty, Bellis and Harker, 2018) would have their
34 own painful stories to tell, they do share some common experiences, chief of these
35 being abuse and neglect (62%); family dysfunction (15%); family distress (8%) and
36 absent parenting (7%). Contrary to widespread belief, only about 2% were taken into
37 care because of their disruptive or disturbing behaviour (DfE, *op.cit.*) In short, most
38 of these young people have been placed into public care as a result of factors
39 beyond their control, rather than dispositional traits.
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51 The National Institute for Health and Clinical Excellence report (2010) estimated that
52 as a result of maltreatment, 60% of all looked-after children and 72% of children in
53 residential care, had some level of emotional and mental health issues. Equally
54 disturbing was the information gleaned in a survey by Pemberton (2011) which
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3 revealed that over two thousand children in the care of local authorities had gone
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5 missing in the year 2010 and although most had returned within a week, seventy-five
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7 had been missing for more than three months and a further forty-five had still not
8
9 been found at the point of writing.
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14 The future of some care leavers could only be described as 'unpromising'.
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16 Recidivism rates are high, with 40% of young people leaving care (aged 19-21) not
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18 in education, employment or training (Department for Education, 2017). The 2015-16
19
20 Survey by HM Inspectorate of Prisons found that 37% of children in young offenders'
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22 institutions and 39% of those in secure training centres had experienced local
23
24 authority care, while 40% of prisoners under 21 had contact with the care system
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26 (House of Commons Education Committee, 2016).
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33 Of course, some young people in the care system can be described as flourishing, or
34
35 at least coping, but too many are wilting or even floundering and these must qualify
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37 as some of the most vulnerable children in our society today. However, socio-ethical
38
39 considerations aside, maltreatment and specialist care represent an enormous
40
41 financial burden. Zayed and Harker (2015) in their House of Commons Briefing
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43 Paper, calculated that in the financial year 2013-14 the gross expenditure on public
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45 care for young people was an estimated £2.5 billion, of which almost one billion was
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47 spent on residential care.
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51 52 **Interventions for change**

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54 For over a decade in the UK, considerable sums of public money have been directed
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56 toward improving educational outcomes for children in public care. While there has
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58 been an improvement in the levels of attainment for children in care, 23% of whom
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3 achieved five A* to C grades in GCSE examinations in 2016, performance is less
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5 than half of that for the general population (59.3%). Therefore, it would seem that the
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7 conclusion of the Office for Standards of Education (2012) still holds:
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12 *“Most outcomes were improving in the local authorities visited, although performance*
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14 *was variable from year to year. There was little evidence, however, that the gap in*
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16 *attainment between looked-after children and other children was narrowing (p. 39,*
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18 *para. 2).”*
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23 Individual child therapy, provided by the Child and Adolescent Mental Health Service
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25 (CAMHS) has been the traditional help and support service for looked-after children
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27 with mental health issues, and it is estimated that once a young person is taken on
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29 by the CAMHS team, the cost of a referral is between £11,0320 - £59,130 according
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31 to the Chief Medical Officer for England (Department of Health, 2013). While such
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33 treatment may have achieved positive outcomes for some, access has been
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35 restricted by both the admission criteria set by some CAMHS centres and also by the
36
37 reluctance of many young people to accept or continue therapy appointments. These
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39 constraints, among others, have been discussed in a series of Central Government
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41 reviews of CAMHS (e.g. National CAMHS Review Committee, 2008, and the House
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43 of Commons Health Committee, 2015). A significant drawback of the CAMHS
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45 approach was summed up by Perry and Hambrick (2008):
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54 *“It is the hope, for example, that some therapy provided for forty-five minutes, once a*
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56 *week, will reverse years of abuse, neglect, degradation, chaos, threat or fear.*
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58 *This is an unrealistic hope.” (p.39, para. 3).*
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3 There has been no shortage of alternative recommendations for helping these
4 children and young people. For example, one promising example appeared in the
5 report prepared by the House of Commons Children, Schools and Families
6 Committee (2009) which noted the success of the 'Social Pedagogue approach' in
7 Denmark and Germany, and was later endorsed in the joint NICE- SCIE (2010)
8 report. However, reliably positive outcomes from this approach in English children's
9 homes have proven elusive, as exemplified by the report from the Thomas Coram
10 Research Unit on the Social Pedagogue pilot programme concluding there was '*...a*
11 *mismatch between the academically-qualified pedagogues and the existing practice*
12 *in the carer workforce*' (see Cameron et al., 2011).
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30 **A different approach?**

31 For children and young people who have not received the positive parenting that all
32 children deserve, and who may also have experienced rejection, violence and
33 abuse, the path to mental health and well-being in adulthood may be a long and
34 difficult one, requiring a sophisticated form of professional care. A thought-provoking
35 study of eighteen focus groups with one hundred and forty children provides the
36 views of looked after children themselves as to what is important to their well-being
37 (Wood and Selwyn, 2017). The collated perspectives of these young people can be
38 summarised as - *relationships* (trusting relationships with carers, peers, teachers,
39 and supporting professionals); *rights* (freedoms from abuse, bullying, stigma and
40 discrimination); *resilience building* (belonging, school enjoyment, access to
41 activities), and *recovery* (a second chance after a mistake and the same
42 opportunities as peers). Clearly, these service users' comments offer key insights for
43 improvements to current professional care and support.
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3 For professional care staff who are looking after unhappy children and young people,
4 the knowledge and skills of parenting cannot be left to the 'natural course' of trial and
5 error. On top of the normal adolescent turbulence, carers of young people in public
6 care are faced by emotional pain-based behaviour which can often manifest through
7 unkind, hurtful, and even vindictive behaviour and the rejection of well-meant
8 kindness and affection. Caring for these children, therefore, requires a high level of
9 conviction, informed carer management and support and thoughtful employment of
10 professional practice.
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21 The approach described in this paper has the aim of enabling and empowering
22 residential carers and foster or adoptive parents to understand and support the
23 children and young people in their care (see Cameron and Maginn, 2008 for earlier
24 developments). The rationale for this approach was to target people who had direct
25 everyday interactions with their children and were therefore ideally placed to carry
26 out 'therapeutic tasks' especially during those "golden opportunity moments" when a
27 young person is seeking reassurance, information, insight or comfort.
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37 The assumptions of the approach are as follows:

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40 • although some looked-after children will benefit from individual therapy, for
41 example from a CAMHS therapist, the people who are most likely to bring
42 about positive change for these young people are those with whom they
43 spend most time - their foster and adoptive parents and residential carers, or
44 other significant adults (like grandparents, or teachers).
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- 51 • these 'direct contact' carers require the knowledge to understand the impact
52 of maltreatment on children and young people in their care. Insights from
53 psychological research and theory can help them to respond to their needs.
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- such a body of knowledge and practice exists in the applied psychology knowledge base. However, this information tends to be scattered in professional journals and clinical/academic-focussed books. Carers require support to make the connection between this knowledge and its relevance to the individual child(ren) in their care.
- combining the carers' specific knowledge of the child with a child psychologist's knowledge generates informed, sensitive and child-focused professional practice to meet the young person's needs.
- such informed practice can enable carers to provide appropriate support. This can improve young people's chances of achieving more fulfilling lives.

The professional childcare model

The model of professional childcare employed consists of a group consultation protocol, which is designed to provide a deeper knowledge of the often complex needs of a young person, leading to professional support, tailored to meet these needs. A previous research paper (Cameron, 2017) reported on the impact of this practice model on fourteen foster and adoptive children, who showed significant improvements in both behaviour and affective outcomes.

A detailed account of the model of professional childcare, together with the psychological theory and research which underpins this model, can be found in Cameron and Maginn (2008, 2009 and 2011) and Maginn and Cameron (2013). The components of the model of professional childcare are designed to empower the significant adults in the lives of children and young people in public care and to

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2
3 enable them to provide professional childcare, which is informed by psychology. In
4
5 brief, the key components are as follows:

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8 • helping a looked-after child to self-manage the maladaptive behaviours and
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10 strategies which s/he developed in response to earlier maltreatment;
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12 • meeting the child's parenting needs and enhancing self-belief and
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14 interpersonal skills. (See *Table 1* for the eight Parent Pillars);
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17 • understanding and supporting a child, who is experiencing developmental
18
19 trauma, to achieve reintegrative adaptive emotional adaptation. (See *Table 2*
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21 for the trauma recovery model by Cairns, 2003);
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24 • identifying and building on the young person's signature strengths (c.f.
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26 Lindley, 2010 and Maginn and Cameron, 2013);
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29 • recording (online), collating, analysing and utilising the data from firstly the
30
31 bespoke 'Progress and Development Checklist' for the young people and
32
33 secondly online surveys of children, carers, children's homes managers, local
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35 authority stakeholders and the psychologist consultant;
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38 • enabling carers to generalise their knowledge from one young person to
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40 others in their care, by taking part in six, half-day workshops, spread over a
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42 year, which introduce the psychological theory and research which underpins
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44 their now familiar practice;
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47 • maintaining fidelity to the model through regular supervision and support for
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49 the psychologist consultants.
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54 This childcare model tasks the psychologist-consultant with integrating the individual
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56 child-specific knowledge and insights possessed by the carers with the theory and
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58 empirical knowledge base in applied psychology (c.f. Kennedy, Cameron and
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3 Monsen, 2009). The resulting co-created and agreed practical support plan is
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5 tailored to the specific needs of an individual child at a particular point in time, is
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7 written up in note form by the consultant and distributed to all consultation group
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9 members. These notes can then become part of the young person's agreed care
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11 plan as they identify *who* will take responsibility for *what* and *why*. Relevant
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13 information can also be shared with school staff and recorded in the young person's
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15 Personal Educational Plan (c.f. Department for Education, 2018; Guidance points 27
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17 and 56).
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24 This professional childcare model uses a reciprocally informative approach. Applied
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26 psychologists can inform and sometimes challenge carers by drawing on information
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28 from psychological theory and research that may support their existing practice, like
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30 avoiding shame strategies, as well as knowledge which runs counter to current child
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32 care practice, (e.g. the 'touch taboo' which can be found in some homes). Carers
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34 can sometimes decide to make changes to existing managing strategies after
35
36 evaluating the outcomes of their efforts. Equally, the carer's detailed knowledge of
37
38 the child, together with additional, focused observations, may modify the
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40 psychologist's perspective, leading to an improved and more appropriate support
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42 plan for the young person.
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Table 1: A summary of the psychological Parenting Pillars which underpin the Personal and Interpersonal Beliefs and Skills component of the model

(a) Acquiring a sense of well-being and self-identity

Pillar 1: *Experiencing primary care & protection.* In addition to all the primary care needs, this might include staff performances like offering reassurance in periods of distress either verbally or with a hug, attending to a child's appearance so that he/ she feels 'good', also, supporting attendance and ensuring continuing success at school.

Pillar 2: *Forming warm relationships.* Children's home regulations require that 'children should feel loved' which can be achieved by 'parenting' which is warm, kind and shows sensitivity and responsiveness, ensuring thoughtful consistency in behaviour management while engaging in activities with the child and encouraging two-way communication.

Pillar 3: *Increasing positive self-perception.* Since much of children's self-worth results from how others treat and respond this pillar can be achieved by positive regard recognition of positive behaviour, protection from abuse or bullying and setting reasonable standards for learning and behaviour.

Pillar 4: *Achieving a sense of belonging.* The devastating effects of rejection, particularly parental rejection, highlight 'belonging' as a major psychological need. Developing this Pillar can involve staff in, including extended family members, valuing cultural affiliations, building a child's personal identity and also creating opportunities for shared fun and humour.

(b) Developing self-belief and self-efficacy

Pillar 5: *Building resilience.* Resilient individuals seem to have the ability to bounce back from adversity. Factors which are likely to enhance resilience in a child or young person include- promoting friendships with school peers who are doing well and providing a key worker who acts as a mentor and offers consistent support/ encouragement.

Pillar 6: *Enhancing self-management skills.* Self-management is the insulation, which prevents inappropriate behaviour when enticing or compelling outside factors try to break through. Examples here include -teaching self-managing behaviour, mentoring basic skills, encouraging on-task behaviour and promoting self-reflection.

(c) Building social interactions skills

Pillar 7: *Improving emotional competence.* Residential carers and foster/ adoptive parents can support and encourage relationships with children and adults outside the family, teach the language of emotion and encourage the development of empathy (i.e. understanding the needs of others, as well as self-needs).

Pillar 8: *Developing personal and social responsibility.* This life-long process involves developing a sense of responsibility for others, accepting differences, treating people in a fair and valuing way and expecting the same treatment from others in return.

Devised by the Pillars of Parenting co-directors and a large number of residential carers and foster/ adoptive parents (revised 2005, 2007, 2013, 2014 and 2018). ©

Table 2: A summary of the three phases of trauma recovery (Cairns, 2003), together with some suggestions for supporting a child through a reintegrative. emotional adaptation process. ©

Stabilisation <i>(Providing a safe and predictable physical and psychological environment).</i>	Integration <i>(Aiding a child or young person in the processing of the trauma, i.e. putting the past in its place).</i>	Adaptation <i>(Enabling the re-establishment of social connectedness, personal efficacy and the rediscovering of the joy of living).</i>
<p>Suggested actions by carers:</p> <ul style="list-style-type: none"> ● Establishing a clear and predictable pattern of daily events for the child. ● Protecting the child from teasing bullying and intimidation. ● Creating a sense of belonging (e.g. personal room decor, choice of clothes, etc.) ● Behaving in an open, valuing and predictable way towards the child or young person. ● Etc. 	<p>Suggested actions by carers:</p> <ul style="list-style-type: none"> ● Stressing the normality of feelings associated with previous traumatic events. ● When naturally occurring opportunities arise, encouraging the child to talk about events in his/ her life and their feelings towards these. ● Becoming a good role model by articulating your own feelings about events in your life or the life of others, as these naturally arise. ● Etc. 	<p>Suggested actions by carers:</p> <ul style="list-style-type: none"> ● Helping the child to accept some of the life changes which have occurred. ● Supporting the child's own efforts to adapt to the changed circumstances. ● Gently challenging dysfunctional or inappropriate attributions for negative events experienced by the child. ● Reminding the child about those areas where he or she can control events in his/her life. ● Etc.

Measuring change in vulnerable children

'Hard data' indicators of change exist and these can include: improvement, or lack of, in school attainment levels, an increase, or decrease, in the number of incidents of unwanted, anti-social and self-defeating behaviour, a reduction, or a rise, in overt self-harming behaviour and absconding, or a reduction or increase in the reported frequency of intrusive thoughts, sleep patterns or night terrors. Records of such broad behaviour changes are important and are routinely recorded in children's homes, However, on their own, these data cannot inform carers *why* these events are occurring and equally important, *what* they are doing, or should be doing, to build

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3 an individual child's personal and interpersonal beliefs and skills and/ or post-
4 trauma, adaptive emotional development.
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10 There are strong arguments for employing meaningful outcome measures that not
11 only provide feedback to the carers (and children) but should also permit external
12 stakeholders to judge the level of success (or lack of success) of any care model.
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19 **Methodology**

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21 The 'Progress and Development checklist' measures both a child's or young
22 person's response to the positive parenting and post-trauma stress support that
23 carers had provided. This online assessment procedure enables carers to assess
24 progress on a five-point, Likert-type scale (items ranging from 'very poor' to 'hugely
25 improved') on (a) each of the eight Parenting Pillars and (b) the three phases of the
26 Cairns model (Reintegrative Emotional Adaptation). To increase the reliability of the
27 ratings, the assessment is usually completed by the young person's key worker and
28 a colleague working together to respond to two questions- *what level has this young
29 person reached on a specific pillar (or a post-trauma recovery phase) and how often
30 does this happen (i.e. most of the time, some of the time or rarely/ occasionally)?*
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48 Data collected can therefore illustrate the young person's progress on (a) well-being
49 and self-identity (Pillars 1-4); (b) self-belief and self-efficacy (Pillars 5 and 6); (c)
50 Adaptation. (See *Table 3* for the criteria for one of the Pillars (Self-management) and
51 *Table 4* for the second phase (Integration) of the Reintegrative Emotional Adaptation
52 sequence.
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Ongoing results can be easily visualised via bar charts, allowing quick visual assessment of improvement (or deterioration) over a longer period of time (see *Figure 1*).

Table 3: The criteria used to evaluate progress and development on Pillar 5 (Resilience) on the Progress and Development Checklist

<p>Pillar 5: Becoming resilient: progress and development</p> <p>Ratings: a=most of the time. b=some of the time. c =rarely/ occasionally.</p> <p>Level 5: This young person can predict or accept negative events and can attempt to manage, learn from and move on from these.</p> <p>Level 4: This young person is able to manage most of the highs and lows of everyday life.</p> <p>Level 3: This young person can manage some problems, but needs support for others.</p> <p>Level 2: This young person is becoming less disheartened and demotivated after minor disappointments or setbacks.</p> <p>Level 1: This young person behaviour is dominated by immediate gratification of current needs.</p>

Table 4: The criteria used to evaluate progress and development on the first phase of the Cairns trauma recovery model.

<p>Stabilisation: progress and development.</p> <p>Ratings: a=most of the time. b=some of the time. c =rarely/ occasionally.</p> <p>Level 5: This young person has periods of contentment, as well as showing signs of developmental trauma.</p> <p>Level 4: This young person is confident to challenge rules and to push boundaries, when he or she feels this is necessary.</p> <p>Level 3: This young person is beginning to form a close relationship with a single member of staff.</p> <p>Level 2: This young person appears to be settling into his or her new home.</p> <p>Level 1: This young person appears to be confused, stunned, numbed, disconnected or living for the present only.</p>

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3 This study conforms to internationally accepted and British Psychological
4 Society recommended ethical guidelines. Individual consent was not obtained from
5 participants as the 'Progress and Development Checklist' ratings are ongoing and
6 recorded by the care staff team to monitor and assess children's progress and to
7 provide information for Ofsted's inspections. For this paper, these data were
8 anonymized prior to authors' access and statistical analysis, ensuring no connection
9 to any individual young person. The assessment of secondary data from this ongoing
10 service meets three major conditions for 'research without consent' and these are- it
11 is clearly of value and benefit, no alternative research design could achieve the
12 same result and there is no risk to the participants.
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28 To maintain confidentiality, managers of the children's homes were given a set
29 of eight-digit code numbers which include a cyclic redundancy check key, for
30 authentication. These unique identifiers are then confidentially allocated to each
31 young person in the home. The code is used by the carer to send the assessment
32 data to an independent collator who maintains an anonymised central database,
33 from which updated data on any code-anonymised individual can then be sent to the
34 children's home manager in the form of a coloured progress chart and report. In this
35 data protection system, only the home will know to which young person the chart and
36 data relate.
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48 Such a tool shows where the successes or difficulties of a young person have
49 occurred and encourages data-based discussion on where the future efforts could be
50 directed. Additionally, the visual display can become a motivational aid to show a
51 young person how far he or she has progressed over a period of time and to discuss
52 and agree future plans for both the individual and the carer(s).
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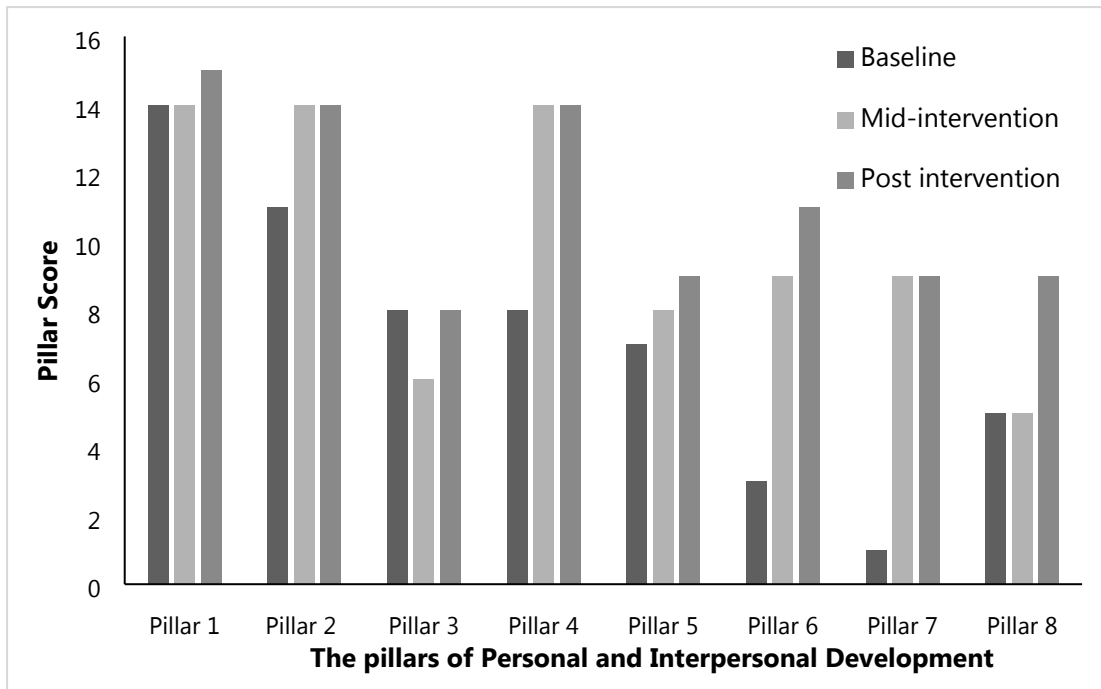


Figure 1: Progress and Development Checklist results of the eight Pillars of Parenting measures for child 1, taken on 04-10-16; 03-02-17 and 11-05-17.

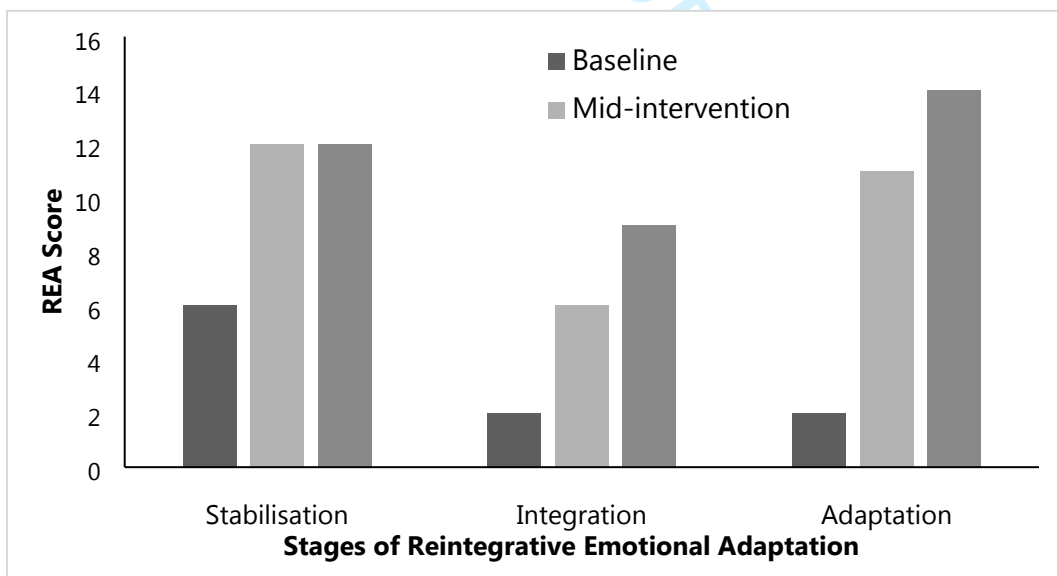


Figure 2: Progress and Development Checklist results of Reintegrative Emotional Adaptation for child 1, taken on 04-10-16; 03-02-17 and 11-05-17.

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3 Alongside a *general factor* (Personal and Interpersonal Beliefs and Skills,
4 representing a sum of the eight Parental Pillars), the Progress and Development
5 Checklist can also be interrogated to provide information on three different
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7 theoretical domains: 1) *Well-being and Self-identity* (Pillars 1-4); *Self-belief and Self-*
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9 *efficacy* (Pillars 5-6), and *Social Interaction and Responsibility* (Pillars 7-8).
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15 Similarly, with the Trauma Recovery model, a *general factor* (Reintegrative
16 Emotional Adaptation) is available from the combination of the three phases
17 (stabilisation, integration and adaptation) as well as separate measures of these
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19 three indices.
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25 **The Current Study**

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28 Data on the impact of the model on fifty-three looked-after children in two local
29 authorities were obtained over a period from March 2015 to November 2017. One
30 group of eight children's homes was in the South of England (twenty-eight children)
31 and the other in three Northern county homes (twenty-five children).
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38 Each home had a dedicated educational psychologist consultant throughout the
39 period and consultation sessions took place fortnightly for the first three months,
40 after which the workshop programme began, and then monthly thereafter.
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45 **Data Preparation**

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48 A *general factor* score for the Personal and Interpersonal Development measure was
49 calculated by summing the scores of each of the eight individual pillars. Three
50 indices, based on the design of the Personal and Interpersonal Development
51 measure were also created (1) Well-being and self-identity, a sum of Pillars 1 to 4;
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53 (2) Self-efficacy and self-management, a sum of Pillars 5 and 6, and (3) Social
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55 interaction and responsibility; a sum of Pillars 7 and 8. These scores, and that of
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3 overall Reintegrative Emotional Adaptation measure, along with its sub-factors
4 (stabilisation, integration and adaptation were calculated at baseline (pre-
5 intervention) and follow-up (post-intervention), both overall and individually for each
6 study site (Southern and Northern).
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13 Single pre-post time points were assessed as they best represented changes
14 following completion of the entire program. Inspection of histograms and
15 Kolmogorov-Smirnov tests revealed that data were not normally distributed, so
16 Wilcoxon Matched Pairs tests were used to assess changes in all measures. For a-
17 priori hypothesised tests (*Personal and Interpersonal Development* and
18 *Reintegrative Emotional Adaptation* measures), alpha was set to 0.05. For
19 exploratory analyses of the three Personal and Interpersonal Development indices
20 and individual Pillars, alpha was adjusted to $<.01$ to mitigate family-wise error rate.
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32 Results

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35 Descriptive statistics for the outcome measures and inferential tests are presented in
36 *Table 5*. Examining both sites combined, the primary finding was a highly significant
37 improvement from pre- to post-intervention in total scores on the Personal and
38 Interpersonal Development (PID) measure ($Z_{(N=53)} = 3.978, p < .001$). Separate
39 examination by site showed significant improvements in both Southern ($Z_{(N=28)} =$
40 $2.947, p=.003$) and Northern ($Z_{(N=28)} = 2.687, p=.007$) sites overall.
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49 For the overall *Reintegrative Emotional Adaptation*, significant improvements from
50 pre-intervention to post-intervention were seen when examining both study sites
51 combined in the *general* score ($Z_{(N=53)} = 4.77, p < .001$) as well stabilisation ($Z_{(N=53)} =$
52 $4.181, p < .001$), integration ($Z_{(N=53)} = 3.306, p = .001$) and adaptation ($Z_{(N=53)} =$
53 $3.654, p < .001$). When examining both study centres separately, the improvements
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in all three stages remained significant (*Table 5*). For all primary outcomes, the level of improvement did not significantly differ across study sites.

Exploratory analyses on the individual Pillars showed significant improvements in Pillars 5 (resilience) and 6 (self-management) in the Southern site and in pillars 2 (close relationships) and 4 (belonging) in the Northern site.

*Table 5: Mean \pm SD scores and statistical tests for the Parental Pillars and reintegrative adaptation stages in both study centres. * = significant at $< .05$, ** = significant at $< .01$.*

	Southern children's group (N= 28)				Northern children's group (N= 25)			
	Baseline	Post- Intervention	Wilcoxon Z	p value	Baseline	Post- Interventio n	Wilcoxon Z	p value
<i>Personal and Interpersonal Development</i>								
Total	55.71\pm22.7	70.36\pm26.7	2.947	.003**	40.08\pm18.0	55.64\pm27.	2.687	.007**
	4	4			8	8		
Pillar 1	8.57 \pm 3.88	10.5 \pm 3.32	2.555	.011	7.24 \pm 3.57	8.92 \pm 4.36	2.235	.025
Pillar 2	9.21 \pm 3.08	10.61 \pm 3.8	2.04	.041	6.8 \pm 3	9 \pm 3	2.827	.005*
Pillar 3	7.04 \pm 3.83	8.14 \pm 3.7	1.536	.125	5.08 \pm 2.71	6.2 \pm 3.34	1.629	.103
Pillar 4	6.5 \pm 4.39	9.18 \pm 5.16	2.588	.01	4.92 \pm 3.61	7.64 \pm 4.59	2.889	.004*
Pillar 5	6.46 \pm 3.85	8.75 \pm 3.7	2.905	.004*	4.28 \pm 2.94	5.96 \pm 4.07	1.438	.15
Pillar 6	5.64 \pm 4.03	8.43 \pm 4.3	2.926	.003*	4.44 \pm 3.03	6.6 \pm 4.29	2.064	.039
Pillar 7	6.32 \pm 4.47	7.57 \pm 4.53	1.911	.056	3.52 \pm 2.47	5.32 \pm 4	2.519	.012
Pillar 8	5.96 \pm 4.57	7.18 \pm 5.01	1.683	.092	3.8 \pm 2.78	6 \pm 3.93	2.554	.011
<i>Reintegrative Emotional Adaptation</i>								
Total	19.68\pm9.06	28.68\pm9.28	3.864	<.001**	13.8\pm8.15	20.4\pm10.6	2.868	.004**
						1		
Stabilisation	7.64 \pm 3.72	11.82 \pm 2.36	3.491	<.001*	6.48 \pm 3.98	9.12 \pm 3.69	2.49	.013*
Integration	6.25 \pm 4.24	8.82 \pm 3.9	2.315	.021*	3.92 \pm 3.33	5.8 \pm 4.21	2.592	.01*
Adaptation	5.79 \pm 4.48	8.04 \pm 4.92	2.602	.009**	3.4 \pm 2.52	5.48 \pm 3.9	2.496	.013*

Tests on changes for the three sub-domains of the Personal and Interpersonal Development measure are provided in *Table 6*. In the Southern site, improvements were primarily evident in the *wellbeing and self-identity* and *self-efficacy* factors. In

the Northern site, improvements were primarily seen in the *wellbeing and self-identity* and *social interaction and responsibility* factors.

Table 6: Descriptive and inferential statistics for the three indices extracted from the PID measure.

	Southern children's group (N= 28)				Northern children's group (N= 25)			
	Baseline	Post-Intervention	Wilcoxon Z	p value	Baseline	Post-Intervention	Wilcoxon Z	p value
<i>Personal and Interpersonal Development</i>								
Well-being and self-identity	31.32 ± 12.25	38.43 ± 13.17	2.452	.014	24.04 ± 9.72	31.76 ± 13.22	2.831	.005
Self-efficacy and self-management	12.11 ± 6.82	17.18 ± 7.54	3.32	.001	8.72 ± 5.5	12.56 ± 7.93	1.982	.047
Social interaction and responsibility	12.29 ± 7.95	14.75 ± 8.54	1.804	.071	7.32 ± 4.85	11.32 ± 7.59	2.666	.008

Discussion

To reduce the impact of the all-too-frequent negative life experiences of many children and young people in public care, high-quality professional childcare and support is crucial. The model, outlined and evaluated in this paper, attempts to identify the essential components for such care and generates practical tasks that residential carers and foster/adoptive parents can integrate into everyday life in their home to improve child well-being. The evidence in this article suggests that these 'direct contact' adults can carry out these supportive tasks with considerable success.

This approach is founded on the principle that, in supporting children with complex needs, moving from a deficit-orientated approach to a knowledge-based, optimistic,

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3 strengths-building approach, can lead to empowerment, increased motivation and
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5 optimism for both carers and their young people.
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8 The present study focused on children and young people in residential care.
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10 Generally, these young people are older and have more complex needs, especially
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12 difficult behaviour, are likely to have experienced several foster care breakdowns
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14 and, as Wharton, Lomax and Thomasoo (2017) claim:
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18 *Research shows that generally, outcomes for children in residential homes are*
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20 *worse than for other looked-after children. This is not surprising, given their high*
21
22 *level of needs and, often poorer pre-care experiences. (p. 6).*
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26 Contrary to this typically poor prognosis, in the current study, the childcare model
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28 produced highly significant improvements in personal and interpersonal development
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30 and adaptive emotional development. This lends initial support to the efficacy of the
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32 approach in looked-after young people and suggests it may be an important tool in
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34 the therapeutic arsenal for improving outcomes for this vulnerable group.
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39 Of course, there are a number of constraints and limitations inherent a field study
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41 evaluation of this kind. In particular, there was no comparison group, the measures
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43 used were broad and unstandardised, and there is the possibility that other
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45 mediating macro-factors may be operating both within the home, for example, the
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47 ethos of the home, the quality of managerial leadership, and staff-shared beliefs
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49 about 'good' childcare, and also outside the home influences, including school and
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51 neighbourhood factors, or the attentiveness of visiting support professionals.
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55 Regarding the former, future research should include standardised measures of child
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57 wellbeing and function to understand and validate the measures used in the current
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3 study. Comparisons with extant, alternative therapeutic approaches will also be
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5 informative. As far as the latter is concerned, the fact that no significant differences
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7 emerged in primary outcome measures between the study sites is promising and
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9 suggests that the approach may be robust against such situational factors.
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13 There are also strengths of this micro-evaluation. Clearly, there was a general
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15 consensus among the residential staff who provided the data that considerable
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17 progress had occurred in almost all of the young people in their care and although
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19 not included in this paper, feedback from other stakeholders was both positive and
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21 complimentary. In particular, managers, local authority officers, CAMHS therapists
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23 and visiting social workers have pointed out cognitive and affective changes in the
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25 care staff including increased empathy, optimism, reflection in their childcare practice
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27 and their frequent use of the knowledge from the follow-up workshops when meeting
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29 new challenges from newly-admitted young people. More objective measures to
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31 quantify these changes will be considered for future evaluation studies.
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40 While random control trials (RCT) will continue to be the gold standard for
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42 demonstrating that an intervention has had the impact that it was designed to
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44 achieve, they also have inherent weaknesses when employed to small innovations
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46 evaluations in applied contexts. There are important advantages which accrue from
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48 shorter term frame, smaller scale and more flexible micro-trials which require less
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50 funding, including the generation of meaningful findings which although they *'may*
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52 *not provide results which are as conclusive as those of larger RCTs, their iterative*
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54 *nature provides a pathway for targeted replication on a faster track than typically*
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3 *achieved through conventional approaches.*' (Center on the Developing Child, 2016,
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5 p. 38).

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8 Given that the intervention described here is, by definition, individualised and
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10 iterative, randomisation, blinding and intensity-matching across groups may prove
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12 challenging. Regardless, the study provides the first evidence for the potential
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14 benefit of this approach for looked-after children.
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19 As far as the model is concerned, replication and evaluation data will continue to be
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21 collected, however, there are a number of broader factors which could be
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23 researched. These include identifying key mechanistic influences on outcomes,
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25 including the enhanced level of carer connected knowledge with practice; increased
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27 staff empowerment; collaborative input between therapists and carers; relevant and
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29 motivational feedback that illustrates the impact of carer efforts, and the supervision
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31 and support component that addresses current issues and pre-empts future
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33 problems and difficulties. Further information which emanates from such studies
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35 could not only indicate improvements to the present model but could also act as
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37 guides for the development of future childcare approaches.
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45 **And Finally...**

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47 In 2016, the UK Central Government published their ambitious plan for looked-after
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49 children and young people. The report, 'Putting children first: delivering our vision for
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51 excellent children's social care' has much to commend it, especially since the vision
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53 statements relating to foster parents and residential care staff include having '*the*
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55 *support and specialist skills they need to love and nurture our most vulnerable*
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57 *children*' (vision 161) and ensuring that supporting professionals form '*a confident*
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3 *profession, resilient when faced with new challenges, mindful of the role our society*
4 *asks them to play in people's lives, and prepared to learn from each other and*
5 *redefine what works when ideas are tested and evidence is shared and understood*
6 *'*
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8 (vision 163).
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15 To attain such laudable aims, alternative models of professional childcare and new
16 approaches to professional training and continuing professional development will be
17 needed. At the beginning of the new millennium, Fraser and Greenhalgh (2001)
18 warned that to work effectively in an ever-changing world, both direct contact and
19 supporting professionals will require new approaches and revised training
20 programmes which promotes not only *competence* as the foundation of professional
21 practice but also *capability* to create future blueprints which enable practitioners to
22 adapt to new situations and unforeseen challenges. The challenge which Fraser and
23 Greenhalgh has set for us is clear:
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35 *'... We must educate not merely for competence but also for capability, the latter*
36 *being the ability to adapt to change, generate new knowledge and continue to*
37 *improve performance'*. (P.799).
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References:

- Anda, R.F., Flitti, F. J., Walker, J. D., Whitfield, C., Perry, B. D., Dube, F. R. and Giles., W. H. (2006) 'The enduring effect of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology', *European Archives of Psychiatry and Clinical Neuroscience*, **256** (3), pp. 174 – 176.
- Cairns, K. (2003). *Attachment, Trauma and Resilience*, London, British Association for Adoption and Fostering.
- Cameron, C., Petrie, P., Wigfall, V., Kleipoedszus, S. and Jasper, A. (2011) *Final Report of the Social Pedagogue Pilot Programme: Development and Implementation*, London, Thomas Coram Research Unit.
- Cameron, R.J. (2017) 'Child Psychology beyond the school gates: Empowering foster and adoptive parents of young people who have been rejected, neglected and abused', *Educational and Child Psychology*, **34** (3), pp.75-96.
- Cameron, R.J. and Maginn, C. (2008) 'Professional childcare: the Authentic Warmth dimension', *British Journal of Social Work*, **38**, pp.1151-1172.
- Cameron, R.J. and Maginn, C. (2009) *Positive Outcomes for Children in Care*, London, Sage.
- Cameron, R.J. and Maginn, C. (2011) 'Living Psychology: The Emotional Warmth dimension of professional childcare', *Educational and Child Psychology*, **28**(3), pp. 44-62.
- Centre on the Developing Child (2016) *From Best Practices to Breakfast Impacts: A Science-based Approach to Building a More Promising Future for Children and Families*, Cambridge, MA, Harvard University.
- Cromarty, H., Bellis, A. and Harker, R. *Children's Social Care in England*, Number CPD-0208. London, House of Commons Library.
- Department for Education (2016) (July), *Putting Children First: Delivering Our Vision for*

1
2
3 *Excellent Children's Social Care*, London, DfE.
4
5
6

7 Department for Education (2017) *Children Looked-after in England (Including Adoption):*
8
9 *Year Ending 31st March 2017*, London, DfE.
10

11 Department for Education (2018) *Promoting the Education of Looked-after Children and*
12
13 *Previous Looked-after Children: Statutory Guidance for Local Authorities*, London,
14
15 DfE.
16

17 Department of Health (2013) 'Our children deserve better: Prevention pays', *Annual Report*
18
19 *of the Chief Medical Officer for England*, London, DoH.
20
21

22 Downshire, S and Drew, N. (2014) *Teenagers Translated: How to Raise Happy Teens*, New
23
24 York, Vermilion.
25
26

27 Druckerman, P. (2013) *French Children Don't Throw Food*, London, Black Swan.
28
29

30 Dube, S. R., Anda, R. F., Felitti, V. J., Chapman, D. P., Williamson, D. F., & Giles, W. H.
31
32 (2001). 'Childhood abuse, household dysfunction, and the risk of attempted suicide
33
34 throughout the life span: findings from the Adverse Childhood Experiences Study',
35
36 *Journal of the American Medical Association*, **286** (24), pp. 3089-3096.
37

38 Fraser, S.W. and Greenhaugh, T. (2001) 'Coping with complexity: Education for capability',
39
40 *British Medical Journal (Clinical Research Edition)*, **323**, pp. 799-803.
41
42

43 Gopnik, A. (2016) *The Gardener and the Carpenter: What the New Science of Child*
44
45 *Development Tell Us About the Relationship Between Parents and Children*, New
46
47 York, Farran, Strauss and Giroux.
48
49

50 Hart, D. and La Valle, I. (2015) *The Place of Residential Care in the Child Welfare System:*
51
52 *Research Report*, London, Department for Education.
53
54

55 Hillis, S., Mercy, J., Amobi, A., and Kress, H. (2016) 'Global prevalence of past-year
56
57 Violence against children: a systematic review and minimum estimates', *Pediatrics*,
58
59 **137** (3), e20154079.
60

DOI: www.aappublications.org/news on November 24, 2018

House of Commons (2009) *Children, Schools and Family Committee, 3rd Report: Looked-after children*, London, DCSF Publications.

House of Commons Health Committee (2015) *Children and Adolescents' Mental Health and CAMHS*, Report HC 481, London, The Stationery Office.

House of Commons Education Committee (2016) *Mental Health and Well Being of Looked after Children*, Report HC 342, London, The Stationery Office.

Kennedy, E.K., Cameron, R.J. & Mosen, J. (2009) 'Effective consultation in educational and child psychology: Training for both for competence and capability', *Educational and Child Psychology*, **30**(6), pp. 626-643.

Lanius, R.A., Vermetten, E. and Pain, C. (eds.) (2010) *The Impact of Early Life Trauma on Health and Disease: The Hidden Epidemic*, Cambridge: Cambridge University Press.

Levine, P. and Klein, M. (2009) *Trauma Through a Child's Eyes: Awakening the Ordinary Miracle of Healing*. Berkeley, CALIF, Ergos Institute Press.

Lindley, A. (2010) *From Average to A+: Realising Strengths in Yourself and Others*, Coventry: Centre for Applied Positive Psychology.

Maginn, C., and Cameron, R.J. (2013). The 'Emotional Warmth' approach to professional childcare: Positive Psychology and highly vulnerable children in our society, Chapter 10 in: C. Proctor and P.A. Linley, (Eds.). *Research, Application and Intervention for Children and Adolescents: A Positive Psychology Perspective*, London, Springer.

National Child and Adolescent Mental Health Review Committee (2008) *A Final Report of the National CAMHS Review*, London, Dept. for Children, Schools and Families.

DOI:

<http://webarchive.nationalarchives.gov.uk/20081230004520/publications.dcsf.gov.uk/eorderingdownload/camhs-review.pdf> on 24 November 2018.

- 1
2
3 National Institute for Health and Clinical Excellence/Social Care Institute for Excellence
4
5 (2010) *Promoting the Quality of Life of Looked-After Children and Young People*,
6
7 Public Health PG28, London, NICE/SCIE.
8
9 Office for Standards of Education (2012) *The Impact of Virtual Schools on the Educational*
10
11 *Progress of Looked After Children*, London, Ofsted.
12
13 Office for Standards in Education and Care (2014) *Inspection of Services for Children in*
14
15 *Need of Help and Protection, Looked After and Care Leavers*, Section 52, London,
16
17 OFSTED.
18
19 Perry, B. D. and Hambrick, E. P. (2008) 'The pp. 38-43.
20
21 Pemberton, C. 'Local Authorities fail to keep records of children missing from care'.
22
23 *Community Care*, (November 14th), pp. 9.
24
25 Teicher, M.H. and Samson, J.A. (2016) 'Annual research review: Enduring neurobiological
26
27 effects of childhood abuse and neglect', *Journal of Child Psychology and Psychiatry*,
28
29 **57** (3), pp. 241-266.
30
31 Wharton. R., Lomax, P. and Thomasoo, R. (2017), *In Your Care: The Role of Philanthropy*
32
33 *for Children in Care and Care Leavers*, London, New Philanthropy Capital.
34
35 Wood, M.and Selwyn, J. (2017) 'Looked-after children and young people's views on what
36
37 matters to their subjective well-being'. *Adoptive and Fostering*, **40** (1), pp. 20-34.
38
39 World Health Organisation Media Centre (2016) *Child Maltreatment*.
40
41 DOI: <http://www.who.int/mediacentre/factsheets/fs150/en/>
42
43 Zayed, Y. and Harker, R. (2015) *Children in Care in England: Statistics*. Briefing Paper
44
45 04470. London, House of Commons Library.
46
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51 Figure legend:

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53 Figure1: The Progress and Development Checklist results of the eight Pillars of Parenting
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55 for child 1, taken on 04-10-16; 03-02- 17 and 11-05-17.

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57 Figure 2: The Progress and Development Checklist results of Reintegrative Emotional
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59 Adaptation for child 1, taken on 04-10-16; 03-02- 17 and 11-05-17.
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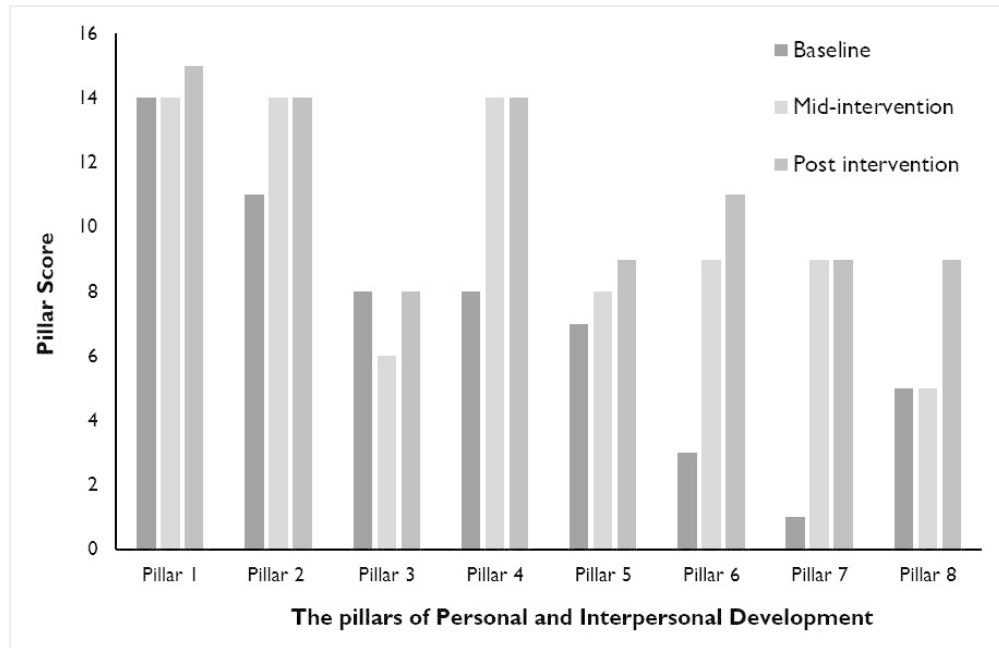


Figure 1

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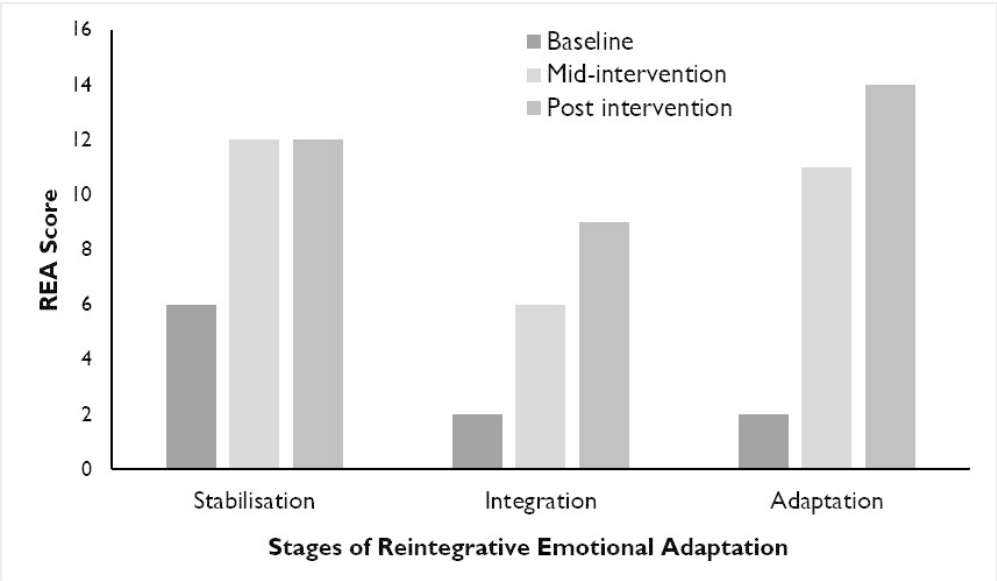


Figure 2