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The Long-Term Impact of Therapeutic Residential Care Programmes

A Literature Review for Mulberry Bush School

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1 Executive Summary

Mulberry Bush commissioned Pro Bono Economics to complete a literature review to explore, review and contrast the different ways in which therapeutic residential care providers measure the long-term impacts of their practices.

Background

Across the 2,000 residential homes in the UK, 1-in-10 children in care have complex needs and require specialist support

Mulberry Bush is a small school specialised in therapeutic residential care (TRC). They offer three-year placements for girls and boys aged between five and thirteen years who have usually suffered from severe and chronic neglect, severe emotional, physical and sexual abuse and complex family breakdown.

Understanding how to measure the long-term impacts of such care is particularly salient given that, across the 2,000 residential homes in the UK, 1-in-10 children in care have complex needs and require specialist support. This review provides an overview of the important literature in this sphere, enabling Mulberry Bush to review its practices and ensure that it is delivering a real and impactful service.

Scope of this study

This paper has reviewed a wide range of literature in the health and social care sectors to better understand how TRC providers assess the long-term impact of their care. The relevance of literature was assessed based on four key features of the Mulberry Bush school:

- Size of school
- Age of children treated
- Cause of requiring treatment
- Residential treatment

Key findings

This literature review made some important observations on the current landscape of the research on long-term impacts of therapeutic residential care:

1. Whilst it seems that there's a relative paucity of research in this sphere, it is definitely expanding and has done quite significantly over recent years.

2. Much of the research has been carried out outside of the UK, and the Department for Education has noted the gaps in research here in the UK.

3. Much of the literature emphasises the use of longitudinal studies in order to fully capture the effects of therapeutic residential care, with some using randomised control trials to help improve the robustness of the results.

4. There are significant limitations to this research such as selection bias and a lack of a globally standardised framework, making it difficult to ensure that results are robust.

5. There is a significant body of research focussed on measuring the more immediate impacts of TRC, which may be of use in developing a framework for measuring impacts over the longer-term.

Implications

These findings paint a mixed picture of the feasibility of measuring the long-term impacts of TRC. However, it's positive that there is a burgeoning research interest in this area, and that there exists some research to base recommendations off. Given the landscape of the research, this paper recommends that MBS:

1. Clearly defines its overall aim of treatment and within that, the short, medium and long term outcomes that it believes best reflect the realisation of that overall aim.
2. Clearly defines the methodology by which outcomes will be measured, including how and by who, and if by multiple stakeholders, how those views will be synthesised.
3. Builds a framework to systematically measure outcomes at regular intervals after children leave the facility.

2 Introduction

Mulberry Bush is a small school specialising in therapeutic residential care (TRC) in rural Oxfordshire that offers three-year placements for girls and boys aged between five and thirteen years. Children at the Mulberry Bush School (MBS) have usually suffered from severe and chronic neglect, trauma, emotional, physical and sexual abuse and complex family breakdown. The primary task of the school is to provide therapeutic care, treatment and education for these children with the aim of re-integrating them into an appropriate school, family and community life.

Given that the primary aim of the school is the reintegration into wider society, there is little formal research on the long-term effectiveness in the years following the completion of these programmes. Mulberry Bush approached Pro Bono Economics to ask for analytical support to understand whether there are identified best practices with regards to how best to measure the long-term impact of therapeutic residential care on young persons.

This area of research is particularly interesting and extremely important; 1-in-10 children in care have complex needs and, as such, require specialist care and support across any one of the 2,000 residential homes in the UK, recognising that not all of these can be defined as offering therapeutic residential care in the same vein as MBS. Yet, despite the importance of understanding the long-term efficacy of therapeutic residential care, it's still a seemingly nascent area of research, as much of the focus has been on the immediate results upon completion of the programme.

It is clear that MBS is achieving its primary task. Indeed, a report by UCL Institute of Education clearly indicates that children show many improvements in a predefined set of measures[1], including socio-emotional adjustment and educational achievements, during their time at the school. Evidence on the successful reintegration of those children back into wider society, however, is lacking. Of specific importance is evidence on the long-term outcomes of children in therapeutic residential care. Given the added emphasis on using evidence-based practices in policy making, and therefore in academia, the academic space has become more populated with research on outcomes of residential treatment over the past decade (Helgerson et al. 2005). On one keyword search[2], 742 results were returned from between 1970 and 1980; 1,239 between 1980 and 1990; 5,810 between 1990 and 2000, and 20,259 between 2000 and 2010. Though a crude measure, this at least gives some indication as to the direction of travel of the volume of research in this sphere.

[1]The 11 Key Elements of MBS, as reported by UCL IOE:

1. Build healthy and mutually trusting relationships with adults and children;
2. Being able to play;
3. Keep themselves and others safe;
4. Ask for help and make use of it;
5. Reflect on and communicate feelings rather than act them out;
6. Function appropriately in a group;
7. Improve self-awareness and value achievement;
8. Contribute to and be involved in school and community;
9. Involve themselves appropriately in their care and care of the environment;
10. Being a successful learner;
11. Use and apply learnt skill and knowledge.

[2] Keyword search: care, children, residential, outcome, impact. Results returned from multi-disciplinary database, economic database, and education resource information center.

This report surveys the evidence of long-term outcomes from therapeutic residential care as well as the broader body of literature on its periphery, which explores how TRC providers are currently measuring their impact. It finishes with concluding remarks before presenting a set of recommendations for Mulberry Bush to consider.

2.1 Methodology

To support Mulberry Bush School in understanding its long-term impacts, this paper has reviewed a wide range of literature in the health and social care sectors to better understand how TRC providers assess the long-term impact of their care.

The key to making a successful attempt at answering the question is a clear definition of the service that MBS provides to the children it cares for. By clearly defining this, we can ensure that the studies surveyed are of relevance.

The main characteristics of the MBS need to be broken down:

- The MBS is a small school, made up of just 30 children.
- The MBS cares for children between the ages of five and thirteen.
- The MBS cares for children that have suffered from one or more of the following: neglect; abuse; trauma, and family breakdown. In most cases the children have complex needs and significant behavioural issues
- The MBS is a residential/therapeutic/educational care school.

We can derive several features of MBS from these characteristics, which we then took into account whilst assessing the relevance of studies. Those are:

- Size of school
- Age of children treated
- Cause of requiring treatment
- Residential treatment

We designed our keyword search to account for as many of these as possible, though inclusion of all had a reductive effect on the results returned. As such, the keywords ‘care’, ‘children, ‘residential’, ‘outcome’ and ‘impact’, were searched using an EBSCO Information Service. Databases that we chose to extract results from, within EBSCO, were ‘Academic Search Premier’, ‘EconLit with Full Text’ and the ‘Education Resource Information Center’. These were thought to give the widest result breadth and did not ostensibly clutter returns.

3 Our Findings

This section first details our findings on the evidence of measuring long-term outcomes for children in residential care before touching on the relative wealth of literature and information on evidence-based practice. Despite being relatively brief, the later section may be useful in formulating an approach for MBS to adopt, given the general paucity of research on long-term impacts.

3.1 Long-Term Impacts of TRC

This section details our findings on the evidence of long-term outcomes for children in therapeutic residential care. It begins by discussing characteristics of the outcome literature more generally, before going into detail on specific findings.

The outcome literature can be split, as it is in Hart, La Valle and Holmes (2015), into short-term, medium, and long-term outcomes. Respectively, they refer to a children's experiences:

- whilst in therapeutic residential placement;
- at the point of leaving and in the following year,
- and beyond the first year after leaving residential care.

Measurement of the outcomes of residential care is generally associated with difficulties that have been widely noted in the literature.

Availability of a robust counterfactual (what may have occurred in the absence of the support) is limited. The ability to say with some degree of certainty that therapeutic residential care has significantly impacted upon the young people is reliant on isolating the effects of the care. In turn, this is reliant on being able to identify what the outcomes would have been had the residential care not have taken place. In other words, for those children who have received therapeutic residential care - what would have happened to them if they had not?

For this to be as effective as possible, a control group must have characteristics as similar as possible to the supported group. This is difficult for several reasons:

i. First, selection bias is unavoidable. Many children that are in therapeutic residential care have very specific characteristics and are in such care as a last resort. It is difficult to obtain a control group with such characteristics that are not receiving similar care.
ii. Second, 'children in residential care' is a very broad group, with a range of subgroups based on placement history, specific behavioural problems, demographic, which all occur before admission to care and that can influence the outcomes considered.
iii. Third, what is not often mentioned in the literature, and would apply specifically to measurement of long-term outcomes, is the variation in post-care pathways. Without controlling for what a care receiver does after leaving care, and the point in time at which outcomes are measured, it is difficult to say with certainty that the outcome was influenced by the care.

Additionally, what becomes clear after an in-depth review of the literature is that there is no standardised framework of assessment of outcomes. Whilst it is possible for residential care institutions to evaluate their own success based on their own pre-defined measures (e.g. MBS' own 11 Key Elements), it is less easy to compare success across similar therapeutic residential care institutions. This acts as a hindrance to a meaningful comparison of the different types of care and an eventual evaluation of each. Nevertheless, it is useful to see the variety of methods of defining outcomes, with a view to experimenting with different methods in the future.

The final difficulty, and perhaps simplest, is the lack of detailed evidence base, which is partly due to the fact that very few therapeutic residential care institutions actually measure long-term outcomes. Brown et al. (2011) analysed data from a survey of residential treatment facilities to examine the extent to which they monitor outcomes after discharge. A very small proportion (less than a third) collected data more than one year after discharge i.e. on long term outcomes. Hart, La Valle and Holmes (2015) also note that this issue is more acute with respect to the UK evidence base. This has been corroborated by our own experience as well as MBS itself - the majority of research is from the US or elsewhere.

The most comprehensive review of late 20th century literature is Hair (2005), which offers a review of research from 1993 to 2003. 11 studies are critically analysed, of which we picked out five of relevance to the brief although it should be noted that the children studied are aged 11-15. The results provide no clear consensus on the impact of residential care. The variety of methodologies, however, allows us to assess the effectiveness of each, and identifies what should be taken into account when/if MBS begins to attempt to assess long term outcomes of children that has been in its care. The results are summarised below in a table:

Table 1 Relevant results from Hair (2005)

Author	Methodology	Outcome
Asarnow et al. (1996)	Phone interviews with primary caregivers over a period from two months to three years post-discharge.	At three years, 59% (n = 51; mean age = 12 years) of the youth were re-placed primarily due to behavioural problems.
Erker et al. (1993)	Data collected at intake was compared with data collected through follow-up structured interviews using the measures social adjustment and personal adjustment.	Ten years post-discharge 66% participants (n = 40) were rated as having improved according to social and personal adjustment.
Greenbaum et al. (2002)	Multiple data collected from various sources: youth caregivers, teachers and educational and clinical record.	75% (n = 812; mean age = 14 years) of youth were eventually re-admitted to residential treatment following successful discharge.
Hooper et al. (2000)	Over 24 months follow-up data gathered cross-sectionally from phone interviews with community case workers who were in contact with the youth.	During 24 months, 79% (n = 111; mean age = 15 years) were deemed satisfactory in school; 80% had no legal involvement; 86% did not require more restrictive setting; and data suggests that ongoing contact with supports is related to post-discharge success.
Larzelere et al. (2001)	Measures were completed by the youth at intake, discharge and/or as part of telephone follow-up survey > 6 months post-discharge.	76% (n = 43; mean age = 13 years) reported better quality of life prior to residential treatment and 86% received ongoing individual and/or medication checks.

The most comprehensive review of literature post-2003 is Hart, La Valle and Holmes (2015), which provides a thorough overview of residential care in general, and hones in on the outcome literature. They discuss the difficulties associated with outcome measurement and note that there is “far less evidence on long term outcomes” specifically.

The most useful studies mentioned are Dregan and Gulliford (2012), Vinnerljung et al. (2008), Lee et al (2010a) and Ringle et al. (2010). Lee et al (2010a) is of use given that it uses children who were accepted for a care programme but never enrolled as a control group. This could be viewed as a good example of a control group in this area of analysis, unless we posit that unobservable differences account for the children not enrolling after having been accepted onto a programme. Taking that into account, it finds that children that attended the programme had more positive educational outcomes compared with the control group. Generally, though, the usefulness of the study mostly relates, as before, not from proving a positive or negative impact of residential care, but from making clear the variety of approaches to measuring outcomes and, again, their associated difficulties.

Data issues are a consistent theme in almost all of the studies. Specifically, an inability to control for selection bias, and a lack of information on the quality and features of placements. This makes it more difficult to isolate the effects of the care. Perhaps the most relevant issue, visible only from analysing all studies, is the lack of a consistent and standardised outcome framework.

As with the 20th century literature, this renders it incredibly difficult to compare care institutions and to truly assess the value of their specific characteristics. As Hart, La Valle and Holmes (2015) themselves note, studies on children's residential care tend to focus on a narrow range of negative outcomes and are often defined by service providers as opposed to from the children and/or their parents. They argue that this is in contrast with research in other children's policy areas, where much of the data is collected directly from care-receivers.

This point bears relevance to one made by Lyons (2015), which deserves direct quotation:

"While the child serving system has been measuring and monitoring outcomes for more than three decades, the promise of actually using outcomes to support change in the functioning of the system has not yet lived up to its full potential…I review what I believe to be a number of ways that we have mistakenly conceptualised outcomes. By working through these myths, we can begin to teach the system to learn from its own experiences to better help child and families."

Lyons makes the argument that residential treatment in the US has been damaging itself by following a set of myths about outcome measurement that could also be applied to the UK. Those of relevance to MBS in their further development of long-term outcome measurement are myths 3 and 5 - respectively "objective is better than subjective" and "measuring multiple perspectives (triangulation) is a foundation of good measurement."

- First, outcomes should not overzealously pursue objective outcomes in a bid to avoid the uncertainty of subjectivity - rather, subjective outcomes that are culturally and environmentally responsive must be used with all parties involved ("consensus") and to only make judgements that matter in terms of what happens next ("transparency").
- Second, parent-reported, child-reported, carer-reported and service-reported outcomes are not guaranteed to converge. Rather, it is entirely possible that the outcomes as perceived by different parties could be divergent. The assumption that all parties have identical perspectives can lead to "very misleading results" and Lyons argues that researchers in this field "have been underestimating the clinical impact of [their] work for years because of this basic problem with conceptualising the nature of measurement of clinical phenomena."

3.2 Evidence-based Practice

In lieu of a rich and large body of literature exploring how to measure the long-term impacts of therapeutic residential care programmes, it seems prudent to explore other ways in which Mulberry Bush may be able to measure its long-term impacts. In particular this is likely to be

borne out of how TRC providers currently evaluate their success and measure outputs in the hope that it might inform a wider approach to long-term evaluation of impacts.

As one might expect, TRC providers are keen to improve their practices and the outcomes for the young people in their care. They are also keen to understand the long-term impact on those they have supported, and to demonstrate this a variety of audiences, notably funders. Consequently, there is a growing base of literature and guidance on how specialised homes can improve their practices and outcomes. This is known as evidence-based practice.

Given the importance of TRC, it's unsurprising that there are various organisations, including the NSPCC, which are committed to improving how organisations measure the outcomes of their practices. In particular, the NSPCC and the California Evidence-Based Clearinghouse for Child Welfare (CEBC)[3] both have extensive guidelines and tools on effective measurement of outcomes. There appears to be little overlap in the tools reviewed, and the NSPCC and the CEBC have both separated tools into 'Parenting' and 'Children's Wellbeing' measurements, as well as tools for 'Screening for Mental Health Needs' and 'Assessing Family Attributes'. Table 2 presents and describes a selection of tools which may be useful in measuring the long-term effectiveness of TRC at Mulberry Bush.

Table 2 Tools for Measuring Outcomes and Evidence Based Practice

Name of Tool	Description
Mood and Feelings Questionnaire	The MFQ is a screener for depression in children and adolescents.
Youth Connections Scale	Identifies the quality and quantity of meaningful connections a youth has with caring adult
Strengths & Difficulties Questionnaire	A mental health and psychological well-being tool for use with 2-17 year olds.
Health of the Nation Outcome Scales for Children & Adolescents	This tool measures a range of physical, personal and social problems associated with the mental health of children and young people.
Trauma Symptom Checklist for Children	This tool is used to measure trauma the extent to which trauma affects young people between the ages of 8-16

Clearly, both the NSPCC[4] and the CEBC[5] websites contain a vast collection of resources and information which help to drive improvements in the measurements of outcomes and subsequent practice of these organisations. Additionally, the CEBC provides a ranking of organisations and programmes depending on whether there is sufficient research which supports the efficacy of that programme.

There is a huge wealth of literature which assesses the efficacy of assessment tools, compares different programmes and practices, and assesses their relative performance. A paper written by Ogbonnaya, Martin and Walsh (2018), assesses the efficacy of using the CEBC for teaching evidence-based practice (EBP). It argues that the "CEBC lends itself well to addressing EBP

[3] The CEBC strives to "advance the effective implementation of evidence-based practices for children and families involved with the child welfare system'.

[4]https://www.nspcc.org.uk/services-and-resources/impact-evidence-evaluation-child-protection/tools-measures-outcomes-children-families/

[5] http://www.cebc4cw.org/

implementation barriers, especially those unique to child welfare and that its resources, searchable database, scientific ratings and guidance have "proved user friendly to diverse audiences".

Furthermore, two papers from the National Children's Bureau (2017) and the Social Care Institute for Excellence (2012) offer an excellent review of the different types of assessment methods and practices which children's providers have used.

The Social Care Institute for Excellence focuses more on therapeutic provision for young people and reviews and compares different care methods and practices which are used by those providers. Meanwhile, much like the NSPCC and the CEBC, the report by the National Children's Bureau focusses on evaluation techniques of young people and their individual needs from the care system. These publications taken together offer a good overview of the current state of evidence-based practice and what, if any, practices could be taken forward in the development of a long-term evaluation tool.

Additionally, there's a significant amount of research underpinning evidence-based practices and how they can be incorporated into therapeutic residential care provision. James, Alemi, and Zepeda (2013) argued that incorporating EBP was encouraging and that doing so led to an "improvement in multiple domains of functioning". This dovetails nicely with other research by James (2011) and Whittaker (2017), who reviews the outcomes of 5 papers on incorporating EBPs into TRC provision. Both of these papers find compelling evidence to suggest that incorporating EBPs into TRC methods is effectual at improving outcomes.

Finally, at the time of writing, Weiner, *et al.* (2018) published a paper on the 'Feasibility of Long-Term Outcomes Measurement by Residential Providers'. This paper found that small-scale measurement interventions, specifically "brief, telephone-administered post-care surveys", can be feasible, but those of a larger scale will require a longitudinal approach with tracking at a baseline, during treatment, at discharge and post-discharge. Despite the confirmation that long-term studies are still out of reach for many care providers, it may be reassuring to know that small scale interventions could be a technique that could still provide useful outcome evidence by small scale providers.

Overall, the aforementioned organisations and the relatively rich literature that accompanies the evaluative methods provide a clear, well-defined and evidenced approach to measuring and improving the experiences of young people in care. This is, of course, a means to an end for improving the service and care that therapeutic residential carers provide. Yet, it's important to remember that difficulties in measuring long-term impacts may mean that the focus tends towards introducing practices which will bring immediate or short-term benefits to the young person, rather than long term improvements in their mental or physical health and behaviour if difficulties evidencing long-term impacts persist.

4 Conclusion and Recommendations

Mulberry Bush asked Pro Bono Economics to review the literature around how therapeutic residential care providers have measured the long-term impacts of their provision. This paper has sought to provide an overview of the published literature in the hope that it would allow Mulberry Bush to understand how best to measure its own long-term impact. However, we recognise that the literature review has raised as many questions as answers, and that the difficulties of measuring long-term outcomes are already well-known by the school.

This paper has explored the current research landscape on the long-term measurements of TRC provision. Whilst there is a relative paucity in this research, it is present and also growing. However, significant issues continue to make measuring functional outcomes difficult. These issues have been outlined by this review and are better defined by the American Association of Children's Residential Centers (2014). In light of these challenges, the second part of this paper aimed to offer a different perspective and other solutions on how Pro Bono Economics and Mulberry Bush could develop a different approach to capturing and understanding the impact of the school. However, this is out of scope of the agreed project brief and would need to be discussed further.

From reviewing the literature on measuring long-term outcomes of therapeutic residential care, the authors have offered a set of recommendations which Mulberry Bush may wish to consider in the future to help improve the measurement of long-term outcomes.

4.1 Recommendations

After a careful reading of the literature, it seems clear that there are two key issues:

- First, there is a lack of evidence on long-term outcomes from therapeutic residential care;
- Second, of the evidence on long-term outcomes that does exist, little of it is uniform and standardised, and so is of limited use. Responsibility for building a useful evidence base to be collectively used by the community rests with all those who eventually wish to use it. As such, MBS may play an important role. Therefore, we recommend that:
    1. MBS clearly defines the overall aim of its treatment and within that, the short, medium and long-term outcomes that it believes best reflect the realisation of that overall aim.
    2. MBS clearly defines the methodology by which those outcomes will be measured, including how and by who, and if by multiple stakeholders, how those views will be synthesised. This may require further collaborative work.
    3. MBS builds a framework to systematically measure outcomes at regular intervals after children leave the facility.

These recommendations should impact, and will be impacted by, MBS' 'Theory of Change'. The two are intrinsically linked, as the former provides a mechanism to assess the success of the latter.

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