Best Practice Guidelines for the Use and Implementation of Therapeutic Interventions for Children and Young People in Out of Home Care

An Bord Comhairleach um Achtanna na Leanaí
Children Acts Advisory Board

November 2009

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Contents

Foreword

The development of these guidelines marks another significant step forward in the process of ensuring that services delivered to vulnerable children meet the highest possible standard. The process of developing these guidelines emanated from a request to this Board by the Office of the Minister for Children and Youth Affairs following representations from the Social Service Inspectorate.

The concept of therapeutic intervention for children in out of home care settings is highly complex and has to date been subject to a myriad of interpretations and therefore great inconsistency in models of service delivery. This document attempts to unravel this complexity and make it easier for those responsible for planning, delivering and quality assuring such services to work from a common foundation. Our aim is that these guidelines will promote reflective practice and will add greatly to the body of knowledge around the complex area of therapeutic interventions.

Developing these guidelines has not been easy and has involved many hours of research and intense deliberation by a group of very experienced practitioners, policy makers, inspectors and managers.

I want to thank all those who participated as committee members, contributors, researchers and peer reviewers for their time, expertise and commitment.

Particular thanks must go to Gráinne McGill, Advisory Officer, CAAB who skilfully and passionately steered this process resulting, I believe, in a guidance document that will underpin best practice in therapeutic interventions long into the future.

Aidan Browne
Chief Executive
Children Acts Advisory Board

Glossary

Throughout this document, the following relevant terms are referred to and these are explained briefly at the outset for easy reference and to avoid repetition within the text.

Carers: a) trained staff caring for children and young people in a children's residential centre; and b) foster parents.

Care plan: prepared by the placing social worker and is a statutory requirement for the compliance with Article 23 of the *Child Care (Placement of Children in Residential Care) Regulations 1995* and Article 11 of the *Child Care (Placement of Children in Foster Care) and Child Care (Placement of Children with Relatives) Regulations 1995*. The care plan is an agreed written plan, drawn up in consultation with the child, his or her family and all those involved with his or her care, for the current and future care of the child, which is designed to meet his or her needs. It establishes short-, medium- and long-term goals for the child and identifies the services required to attain these goals. The *National Standards for Children's Residential Centres (2001)* and the *National Standards for Children in Foster Care (2003)* require specified actions to be recorded with appropriate timescales and the names of those responsible for fulfilling them.

Child or young person: a person under the age of 18, who is not married.

Children detention schools: for the detention of children sentenced to a detention order by the courts, on foot of a criminal conviction. Children detention schools are also designated as remand centres under the Children Act 2001, for the remand in custody of a child charged with a criminal offence.

Duty of care: the expectation that agencies, staff and managers promote the safety and welfare of children and young people in their care.

Foster Care: the placement with a family of children who cannot live with their own parents. This can include relative or non-relative carers.

Health Service Executive (HSE): is the state agency established under the Health Act, 2004 which provides health and social services nationally. It replaced the 11 Health Boards that provided local services before its establishment.

High support units: open residential units caring for highly vulnerable children requiring intensive intervention as part of the welfare system. They can offer therapeutic input and on site education.

Health Information and Quality Authority Social Services Inspectorate: The Health Act, 2007 places the Social Services Inspectorate within the Health Information and Quality Authority on a statutory basis as the Office of the Chief Inspector of Social Services with specific statutory functions. The work of the Inspectorate has been focused on children in care, primarily on inspection of residential care. The Act makes provision for the inspection and registration of designated centres for older people, children, and people with disabilities, including children.

Irish Youth Justice Service (IYJS): an executive office of the Department of Justice, Equality and Law Reform with responsibility for leading and driving reform in the area of youth justice.

Multidisciplinary assessment: a comprehensive process whereby the full range of needs of an individual child are examined and identified by all the professions and agencies involved in the promotion of the child's health, welfare, safety and development.

National Standards: are agreed sets of principles and criteria for the provision of care in a variety of settings including foster care, residential centres, special care units and children detention schools.

Placement plan: drawn up by the centre in collaboration with the placing social worker, the placement plan sets out the direct care provided to the child and details the implementation of elements of the care plan by the residential centre.

Placement plan agreements: plans for foster care placements. There is a requirement for similar plans for each child placed in a children detention school.

Regulations: set out the regulatory framework for children in the care of the state and enable provisions of the legislation to have full effect and provide for its due administration.

Residential centre: any place where a child or young person is accommodated, usually as part of a group, and cared for by trained child care professionals, including a multiplicity of placement types, for example hostels, high support units, and children detention schools.

Residential Centre Manager (also known as a Social Care Manager): the person responsible for the day-to-day operations in the residential centre. This person has responsibility for the standard of care, health and safety of the children and staff in the centre and the overall quality of the service provided.

Service level agreement: a formal written document specifying the detail of a service provided to the agency purchasing it. Under Section 38, Health Act 2004, the HSE may purchase a service from voluntary or private providers.

Special Care Order: an order of the High Court to detain a child in a special care unit. The court may make such an order where the behaviour of the child poses a real and substantial risk to his or her life, health, safety, development or welfare, and the child requires special care or protection.

Special care unit: a secure residential centre in which children are detained on foot of a High Court Order due to a real and substantial risk to their life, health, safety, development or welfare. Special care units are part of the welfare system.

Introduction

Context: Children in out of home care are more likely than their peers to have suffered adversity and frequently have had traumatic disruption of relationships and attachments. Their capacity to develop and thrive in their care placement is in part dependent on the quality of the care provided, but is also affected by how they are facilitated to cope with the adverse impact of their earlier experiences.

'Children in public care, whether voluntary or subject to a statutory care order, seem to be among those most at risk from the adverse effects of social inequalities… Such children have poorer physical and mental health and educational attainments during childhood. It is likely that children enter care with poorer health related to social disadvantage and that physical and psychological problems may worsen during care, as a result of problems with access to and continuity of health care… Uncontrolled studies of small groups of children who were in care and tracked into adult life suggest that they experience poor educational attainments and health and social function. Studies of socially excluded young adults suggest that those with a history of public care are overrepresented among homeless young people and the prison population and that young people who leave care at 16 years face unemployment rates of up to 50% to 80%.' [1]

Social Services Inspections: In the course of Social Services Inspectorate (SSI) inspections of children's residential centres and foster care, inspectors have come across some excellent therapeutic work being undertaken with individual children, and care settings that attend sensitively and helpfully to children's problems. However, over the last number of years concerns have been raised relating to the use and implementation of therapeutic interventions in residential centres for children. These include concerns regarding:

- How decisions are made with regard to which therapeutic interventions a child might access;
- The supportive evidence base regarding the appropriateness and efficacy of some therapeutic interventions in relation to the presenting needs/challenges of a child;
- The working relationships between professionals delivering individual therapeutic interventions and other professionals in the care context;
- The appropriate means of safeguarding the child and ensuring accountability regarding therapeutic programmes;
- How therapeutic interventions are evaluated in terms of their effectiveness and contribution to positive outcomes for a child.

Challenging Behaviour and Complex Needs: Professional carers have also told inspectors that at times they can feel overwhelmed by the challenging behaviour and complex needs of some of the children with whom they work. With the growth of special care and high support residential care, a valid expectation has grown that these services would deliver effective therapeutic interventions. Within the children's care sector the demand for care services that can genuinely help very troubled children is persistent.

Concerns Raised: In the report on high support units issued by the SSI, inspectors did not make judgements about specific therapies or therapeutic interventions.[2] They did, however, criticise:

- The application of therapies that appear to lack any independent validation;

[1] See Viner, R.M. & Taylor, B. *PEDIATRICS Vol. 115 No. 4* April 2005
[2] See *The Management of Behaviour: Key Lessons from the Inspection of High Support Units* (2006)

- The blurring of roles and responsibilities between the residential centre managers and the therapists implementing therapeutic models;
- The manner in which the demands of a particular therapeutic model can take precedence over the care planning process and the consequent lack of safeguards with regard to consultation and consent;
- The implementation of models that are poorly understood by staff.

Response to Concerns: The Children Acts Advisory Board (CAAB) in conjunction with a number of key agencies and professions including the HSE (policy, inspectorate, and residential managers), the IYJS, the Health Information and Quality Authority Social Services Inspectorate, and with professional guidance from a number of senior clinicians and academics has produced these best practice guidelines for the use and implementation of therapeutic interventions for children and young people in out of home care settings. A literature review was completed to provide a knowledge base upon which best practice guidelines can be supported. It is available on www.caab.ie

Membership of Steering Group

- Ms. Gráinne McGill - Advisory Officer, CAAB (Chair)
- Mr. Andy Denton - Project Manager, National Special Care and High Support Team
- Mr. John Digney - Deputy Director, Ráth na nÓg High Support Unit
- Mr. Mick Fox - Inspection and Monitoring Officer Child Care, HSE West
- Mr. Charlie Hardy - Principal Officer, Child Welfare and Protection Unit, Office of the Minister for Children and Youth Affairs
- Mr. Seamus Mannion - Assistant National Director, Children and Family Services, HSE
- Mr. Mark McGranaghan - Senior Psychologist, HSE South Children's Residential Care Services
- Mr. Kevin McKenna - Lecturer, Dundalk Institute of Technology
- Mr. Michael McNamara - Inspector Manager, Health, Information and Quality Authority, Social Services Inspectorate
- Mr. Tony O'Donovan - Child Welfare Advisor, IYJS
- Mr. David Power - Manager, Step Down Unit, Trinity House Children Detention School
- Mr. John Smyth - National Specialist Children and Family Services, HSE

Terms of Reference

1. To develop a set of best practice guidelines for the use and implementation of therapeutic interventions for children in residential and detention settings and foster care;
2. To define the term 'therapeutic intervention' for the purposes of these guidelines;
3. To ensure that the guidelines comply with existing legislation, regulations, standards and the *United Nations Convention of the Rights of the Child* (1989).

Children to whom these Guidelines Apply: These guidelines apply to all children subject to the provision of the Child Care Act, 1991 and the Children Act, 2001 and their subsequent

amendments. Children 'in care', includes all children placed in statutory and non-statutory services, in foster care, residential centres, high support units, special care units and detention schools, and those who have been placed in hostels, are accessing homeless services and/or are the subject of special arrangements co-ordinated and organised by statutory bodies. These guidelines also should be applied to children with disabilities living away from home. References are made to various assigned professional roles throughout this document. When operating these guidelines the terms used may be interchangeable. For example, a child or young person placed in a children detention school may not have an assigned social worker therefore responsibility for the care and interventions provided will rest with the director of the school.

Promotion of Best Practice: The best interests of the child should be the primary consideration in all child care services and interventions. The purpose of these guidelines is to assist in the duty of care and the promotion of best practice in conjunction with relevant standards, regulations, legislation and other guidance with the child's welfare and protection central to that ethos.

Section 1: What are the General Life Experiences of Children Who Come into Care and Why Might They Need Therapeutic Interventions?

Children coming into care are likely to have had significant experience of some or many of the following:

Separation from parents, siblings, and wider family (including separated children seeking asylum)	**Family support or other early care interventions which have been based on assessed needs, but have not had the desired outcome(s)**
Neglect	**Emotional, physical and/or sexual abuse**
Exposure to domestic violence	**Specific offending behaviour**
Disrupted care/parenting and/or interrupted care	**Parental mental health and/or addiction problems**
Loss of carers through death, abandonment or imprisonment	**Other life circumstances that require a child to live away from home**
Other traumatic experiences	**Inadequate parental care and control**

Many children coming into care have difficulties in development and functioning often correlated to their adverse experiences and for many children leaving their family and being placed in care can also be a very traumatic experience. However, each individual child's history is unique and each child can respond differently to their life experiences and it is the impact of those life experiences on that child that may require a therapeutic intervention. The following behaviours could indicate that a specific therapeutic intervention as well as care might be required:

Impaired social functioning	**Difficulties with self-esteem and identity**
Self-harming behaviour	**Impaired self image**
Difficulties in negotiating and maintaining positive relationships and attachments	**Difficulties with conduct including aggression, rule breaking and antisocial behaviour**
Specific mental health disorders	**Inappropriate sexualised behaviours**

Assessment of Need: While not every child in care requires a clinical therapeutic intervention, a care plan based on a multidisciplinary assessment should identify whether or not a therapeutic intervention might meet a specific need of the child. Assessment, and the strategies that stem from it, must be underpinned by a sustained multidisciplinary approach which, along with the interventions that arise from it, take fully into account the context of the child, the family and community.

Section 2: What is a Therapeutic Intervention?

Definition: National and international literature indicates the lack of a consistent and clear definition of what constitutes a therapeutic intervention. The Compact Oxford English Dictionary defines therapeutic as '**1** *relating to the healing of disease;* **2** *having a good effect on the body or mind.*' Given the lack of an adequate definition to assist in the development of these guidelines, a working group was established to produce a definition in accordance with the terms of reference. This definition is intended to assist in the development and understanding of these guidelines and is not purporting to be a universal definition of a therapeutic intervention.

'A therapeutic intervention is an intentional interaction(s) or event(s) which is expected to contribute to a positive outcome for a child or young person, which is selected on the basis of his/her identified needs, and which is underpinned by an informed understanding of the potential impact and value of the interaction/event involved.'

Therapeutic Intervention Definition Working Group 2008 [3]

Settings for Therapeutic Interventions: A therapeutic intervention in this context refers to a range of situations including:

- The provision of individual therapy for one child, or group therapy for a number of children, by a professional therapist, to address a specific need or range of needs;
- An individualised programme for a child to attain a stated and agreed outcome, which may include rare or emerging models of therapy;
- The day-to-day interactions between carers and children that are specifically organised to achieve identified therapeutic objectives and defined outcomes for children;
- An evidenced-based therapeutic model that informs the philosophy and purpose and function of a residential centre/service or an aspect of the service;
- The use of, for example, positive parenting/care style, such as authoritative parenting, positive regard, appropriate boundaries, active listening, negotiated problem solving as an intended intervention to effect identified outcomes.

[3] See Appendix 1 for membership of the Therapeutic Intervention Definition Working Group

Section 3: What Enhances the Therapeutic Quality of the Care Experience?

Complex Needs: Children in care often have a wide range of educational, social and emotional needs, and a greater risk as an adult of negative life experiences such as homelessness, criminal behaviour or experience of mental health problems.[4] It would be uncommon for a child in care to have one identified issue. Most would have a 'panoply of needs'.[4] Those needs must be met sufficiently if they are to integrate into society as well adjusted individuals.

Our Duty of Care: In all therapeutic interventions the overall duty of care and rights of the child, as underpinned by the United Nations Convention on the Rights of the Child, should inform clinical practice. The principles of a 'duty to care' are outlined in *Our Duty to Care: Principles of Good Practice for the Protection of Children and Young People*.[5] In an amended form, those that apply to therapeutic interventions include:

- Recognising that the welfare of children must always come first, regardless of all other considerations;
- Providing early intervention with children who are vulnerable or at risk with a view to preventing serious harm at a later stage;
- Acknowledging that a child's age, gender and background may affect the way that they experience and/or understand what is happening to them;
- Acknowledging the rights of children to be protected, treated with respect, listened to and have their own views taken into consideration;
- Adopting the safest possible practices to minimise the possibility of harm;
- Adopting and consistently applying clearly defined recruitment methods when engaging therapists and carers;
- Ensuring that there are sound, transparent procedures for children to make complaints;
- Providing training for carers and others involved in therapeutic interventions that clearly explains the procedures to be followed if child abuse is suspected;
- Operating a policy of consultation with parents and children;
- Co-operating with any other agencies and professionals involved in the child's care and protection by sharing information when necessary and working together towards the best possible outcome for the child.[6]

All successful interventions are characterised by relationships that are at their core supporting the whole person in increasing their self-esteem and developing skills that will enable them to make positive choices. This includes a duty of care to ensure that as far as possible children participate on the basis of informed consent.

[4] See the *Carlile Inquiry Report*, UK (2006)
[5] See *Our Duty to Care: Principles of Good Practice for the Protection of Children and Young People* (2002)
[6] Also see Standard: 5.30. *National Standards for Children's Residential Centres* (2001)

Section 4: What is Needed for Therapeutic Interventions to Succeed?

There are 12 features that need to be in place for therapeutic interventions to be effective and these are:

A clear purpose	**Clear management**
A clear theoretical basis	**Carers' training, supervision and support**
Appropriate consultancy	**Partnership**
Clarity of boundaries	**Children's' rights**
Safeguards	**Care planning**
Timescales for interventions	**Added value**

A Clear Purpose: It is important that whatever is being done to address the needs of children is underpinned by an appropriate rationale. This means that:

- The intervention is based on a comprehensive assessment of need that identifies a clear purpose, and on the formulation of a core problem;
- The intervention aims to modify the predisposing, precipitating, maintaining or protective factors, identified in a formulation of the core problem;
- There must be a congruence between the need(s) the intervention is designed to address, its effectiveness, the impact on the child and the desired and actual outcome;
- The intervention is consistent with the child's statutory care plan;
- The purpose is understood by those who engage in therapeutic/care provision and they can explain it and account for its impact and outcomes;
- The intervention contributes to the overall welfare and development of the child.

Where any specific model of therapeutic intervention is used in a residential centre it should be included in the residential centre's statement of purpose and function and be formally examined as part of any inspection or registration of the centre under child care legislation.

In foster care, the care and placement plan agreement should clearly spell out the purpose of the therapeutic interventions, including any specific therapeutic tasks to be undertaken by the foster carers.

Clear Management: In residential settings there needs to be clarity about the role of the residential centre manager in delivering the functions of the service within the framework of its defined purpose.[7] The manager or person in charge has responsibility for the safety, welfare and development of the children in their day-to-day lives

[7] See Standard: 2.4. *National Standards for Children Residential Centres* (2001)

in the residential centre. Therapeutic interventions should support this responsibility. The manager must provide leadership to staff, and ensure that all care practices are safe and appropriate for the child's needs and consistent with the purpose and function of the residential centre. The total range of care practices in the centre should be managed so as to fully support any therapeutic intervention.

A Clear Theoretical Basis: The theoretical basis of any intervention, either through the model of care adopted in the residential centre or provided to children in response to identified individual needs, should be clear to all those involved in the task, and as far as possible to each child who is subject to the intervention. It should be based on research and reputable practice that can be validated by those who have responsibility for the care plan of the child.

Carers' Training, Supervision and Support: To be effective, therapeutic interventions in the care setting require carers to be well informed, trained in the necessary skills, co-ordinated in their approach, professionally supervised, and supported both by the therapists and managers of the system in which the therapy is being provided.

Appropriate Consultancy: Since the theoretical understanding of the intervention should be underpinned by an understanding of the desired outcome and the impact on the child, it is essential that its effectiveness is frequently monitored. Consultation must be available to carers throughout the duration of the intervention even if the circumstances of care change, such as returning home or transferring to another service. Carers should be able to question appropriately what they are expected to do, assess appropriately the impact on the child, and give feedback and discuss relevant aspects of the intervention with the therapist and the social worker who has responsibility for the child's care plan.

In keeping with the responsibility of the centre manager in relation to the care and welfare of the child and to the centre's model of care, all consultation and direction between carers and the therapist should be through the centre manager. This will ensure the accountability of the centre manager for all practices within the centre, the effectiveness of carers' supervision and support, and clarity of boundaries.

Partnership: In the National Standards for Children's Residential Centres 2001, standard 5.30 requires *'all professionals involved with the young person (to) coordinate their work and (to) ensure that any interdisciplinary differences are overcome in the best interests of the young person,'* as referred to in Section Three above. This applies to therapeutic interventions, for which there should be systems in place to resolve any conflicts or disagreements in the best interests of the child.

Clarity of Boundaries: Many interventions require carers to engage in programmes of intervention with children as individuals or in groups, and carry out specific tasks with defined outcomes. It is important that carers know the expectations and limitations of their role in these situations. It is also important that the relationships that form between carers and children do not become exclusive and beyond accountability. Regular professional supervision of staff and carers should include consideration of the effectiveness and outcome of the intervention and whether a review is required.[8]

[8] See Standard 2:14. *National Standard for Children's Residential Centres* (2001)

Children's Rights: It is important that therapeutic interventions are provided in the context of the rights of the child to good quality age appropriate information regarding the therapeutic intervention, and their consent to participate. Children's rights also include the right to confidentiality, privacy, respect, dignity, appropriate informed consent, consultation and the right to complain or bring to the notice of carers aspects of the intervention that are causing worry or concern.[9]

Safeguards: Children should be assured of appropriate advocacy, the availability of someone they can trust, and independent monitoring of all aspects of care including therapy. Carers should have the means to bring to the attention of the manager of the residential centre/foster service manager or a social worker, concerns about the delivery of therapy or about the impact of an intervention on a child. This includes actual or potential risks for the carers themselves. Social workers, inspectors and monitoring officers should be satisfied that all aspects of therapy in care are safe and in the child's best interests, in accordance with the requirements of their role under the regulations and legislation. They should pursue any concerns or queries that they have with the residential centre manager and therapist and bring them to the attention of their own line manager.

Care Planning: There should be a robust care planning process that ensures that the therapy continues to meet the needs of the child. Ultimately, the expectation of the regulations and National Standards is that the statutory responsibility for a child's placement rests with the supervising social worker[10] whose role is to ensure that the child is safe and that the care provided promotes his/her welfare and development. The care planning process is the statutory channel through which the care and therapeutic inputs can be evaluated in order to determine how well they meet a child's needs.

There may be a need for holding care plan reviews at a frequency greater than the statutory minimum in order to monitor the progress of the therapeutic intervention. There are implications for care and therapeutic input if placements are disrupted for other reasons, such as: carers moving, therapists moving, and changes in the service provision.

Timescales for Interventions: Timing and relevance of the interventions are crucial. Once the need has been identified, there should be no delay in accessing the appropriate therapeutic intervention.[11]

Added Value: Any therapeutic intervention should be an added value and provide enhancement to the care of the child. All interventions must be provided within the requirements of the relevant National Standards, benefit the child and enhance the parenting/nurturing aspect of care.

[9] See the *United Nations Convention on Rights of the Child* (1989), the *National Standards for Children's Residential Care* (2001), the *National Standards for Special Care Units* (2001), and the *National Standards for Foster Care* (2003).
[10] See *Report of the Commission to Inquire into Child Abuse, 2009 Implementation Plan*: Action Point 60.
[11] See Standard 5.29. *National Standard for Children's Residential Centres* (2001) and Standard 8.11. *Standards and Criteria for the Children Detention Schools* (2002, as amended 2008).

Section 5: What are the Implications for Practice?

The implications for practice cover 12 areas and these are:

Plans Based on Comprehensive Assessment	**Referral to Therapeutic Resources**
Therapeutic Assessment	**The Child's Experience of Therapeutic Interventions**
Children with Intellectual Disabilities or Communication Difficulties	**Validation of the Proposed Therapeutic Intervention**
The Vetting of Therapists	**Supervision**
Monitoring	**Confidentiality**
Consent	**Accountable Recording and Protection of Information**

Plans Based on Comprehensive Assessment: There is a statutory requirement for all children in care of the HSE to have relevant, up-to-date care plans. The care plans should be based on a comprehensive assessment of need, and should set out both short- and long-term goals. To comply with the *National Standards for Children's Residential Care 2001* and the *National Standards for Foster Care 2003* there is a need for a placement plan/agreement for each child in care that details how the care plan is to be implemented. Good practice would indicate that all children in need should have plans based on comprehensive assessments. In these assessments their individual circumstances may indicate the need for a therapeutic assessment.

Referral to Therapeutic Resources: Once the decision is made that a therapeutic assessment may be appropriate, a referral to a suitable therapeutic resource is made, usually by the social worker or appropriate person. The referral should clearly outline the presenting factors (i.e. behaviours, issues and concerns that are the basis of the determination of need) and indicate what the desired outcome might be. The referral may be made to a variety of therapeutic resources, including Child and Adolescent Mental Health Services, individual therapists, or specialised carers.

Therapeutic Assessment: The appropriateness of the intervention to meet the needs of the child is a consequence of the therapeutic assessment and a decision about who is best placed to provide the therapeutic input. The referrer, parents/guardians, carers and child should have a clear understanding from the therapeutic resource about the scope, impact and **limitations** of the intervention.

The Child's Experience of Therapeutic Interventions: The more stable the care environment the greater the probability that a

therapeutic intervention will succeed. Many children in care and those who go to places of detention experience a multiplicity of placements, carers, social workers, plans and strategies for meeting their needs. Therapeutic interventions should be linked to a care plan focused on continuity of service through care, and prime consideration should be given to the child's experience of care and interventions over time. This should include the impact on the child of living with other children in care.

Particular attention is required to ensure that interventions do not become fragmented when a child is in a short-term placement such as a special care unit or a children detention school. Some interventions could be short-term and completed within the limits of the court order. Every effort should be made to ensure there is continuity of the therapeutic intervention beyond the short-term placement, if this is appropriate for the individual child.

Children with Intellectual Disabilities or Communication Difficulties: Consideration should be given to the following:

- The extra supports necessary to give the child the best chance to understand what is happening and to communicate a response;
- The most effective means of communication for the therapeutic intervention to succeed;
- Assessing the understanding of the content and purpose of the therapy before asking the child to consent;
- Alternative courses of action if the child does not understand a particular intervention and is unable to consent;
- The use of an independent best interest assessor, for example, when a child is unable to consent, in order to determine if the therapeutic intervention is in the child's best interest.

Validation of the Proposed Therapeutic Intervention: There must be a process for the independent validation of the therapeutic interventions. The therapeutic model must be: evidence based, independently audited, peer reviewed, safe, culturally relevant and current. A model is only as good as its proper implementation, and systems need to be in place to ensure that it can be clinically reviewed when necessary.

The Vetting of Therapists: Therapists cannot self-validate. The onus is on the referring organisation to establish the suitability both of the proposed therapeutic intervention and the proposed therapist. The therapist should have a recognised qualification and be registered with a professional body or association, have proven competence, have satisfactory Garda clearance and references, and be engaged in the process of professional supervision.

Supervision: The circumstances in which therapeutic interventions take place may vary considerably. When they are provided in the care environment they should be professionally supervised. Supervision arrangements should be specified in service level agreements with independent therapists. When therapists are independent or are sourced from private practice the social worker should confirm that the therapist avails of clinical supervision. Foster carers, key workers and other staff who are required to carry out therapeutic tasks should have professional supervision that supports them and requires them to give an account of their role in the therapeutic endeavour.

Monitoring: The monitoring officer's role entails ensuring that a residential centre or fostering service is in compliance with regulations and standards, and that the child in whatever care setting is safe and their welfare and development is being promoted. The monitoring officer should include therapeutic interventions in the assessment of care practices, and bring concerns to the attention of the managers of the service or if appropriate, to the supervising social workers or their management.

Confidentiality: There should be a policy and procedure for the guidance of therapists and carers about what information should be shared and what is confidential. The child should know the extent and limitations of confidentiality in a therapeutic relationship with a therapist or carer. When appropriate and possible, the production of reports should be a collaborative process between the child and the therapist, giving the child some control over what is shared.

Consent: The definition of therapeutic interventions in this context includes a requirement for an informed understanding of the potential impact and value of the interaction involved. It should be intelligible to carers, children (depending on age and ability/maturity), parents and others with a bona fide interest. A central consideration is what right the child has to give consent and the necessity or otherwise of consent from parents or guardians. This should not be an assumption and a formal record of consent should be kept. The range of issues regarding consent include the child's right to privacy and seeking consent for recording by any media. It is imperative that in *any* and *all* therapeutic interventions of whatever description and situation that the welfare and best interests of the child is paramount.

Accountable Recording and Protection of Information: The policy on recording and sharing information should be underwritten with clear guidance and rules. The child's right to access information should inform any guidance or rules regarding records. Those who write reports should have a clear understanding that they may be accessed under the legislation for Freedom of Information 1997 and 2003 and Data Protection 1988 and 2003. Therapists should be required to provide reports that are in an accessible language and are signed and dated. The procedures should also cover audio, video and electronic recordings. There should be procedures for the safe storage of confidential information. Rights of access to the information should be clearly defined for the child, family and other parties. The terms under which records are made and maintained should be covered in the service level agreement.

Section 6: How Can Therapeutic Interventions be Evaluated?

Evaluation: Therapeutic interventions are evaluated by several means. They should be based on sound principles, subject to independent research, characterised by reputable reflective practice, and regularly assessed through peer review, clinical supervision and authoritative oversight in the care planning process. The role of the therapist in guiding carers is central to this means of evaluation, as is the primacy of the care planning, which is the responsibility of the social worker. The key question is whether or not the intervention remains suitable to the child's needs and is achieving the goals that were identified in assessment. Depending on age and ability, some of the information required to answer this question should come from the child, who should be asked about their experience of the intervention and invited to express their opinion of its efficacy. This also applies to an assessment of the outcome. Regular review of the therapeutic intervention and any modifications should be an integral feature of care plan reviews. The focus in care plan reviews should be the impact of the intervention on the child and the extent to which the intervention is likely to achieve the intended outcome.

An essential means of evaluation is the day-to-day assessment by carers, social workers, and others with bona fide interest in the child. It is important that those closest to the child are empowered to query, give feedback and raise concerns about any aspect of an intervention.

Service Level Agreements: Where therapy is sourced from independent or private therapists there should be a service level agreement that specifies the terms of reference under which the therapeutic intervention will be provided, including arrangements for the supervision of the therapist and the measures required to evaluate it. The service level agreement should also specify the process through which feedback and reports are provided.

Section 7: How are Outcomes Assessed?

Measuring the success of a therapeutic intervention is specifically connected to the initial assessment that identified the need for it. The outcome is defined at that point and a baseline is established in terms of the issues that need to be addressed. It is essential both at the point of assessment and evaluation that key indicators of impact, progress and value are agreed, and if necessary, timeframes for further intervention determined. Realistic timescales specifying the duration of the therapeutic intervention and the monitoring of its impact should be stated. All outcome measures should include questions as to why a young person did not benefit from a particular intervention, and should that be the case, further assessment should be recommended to ascertain what other potential approaches may be effective.

Future Review of the Guidelines

These guidelines should be reviewed within two years of the date of issue.

Appendices

Appendix 1: Membership of the Working Groups

Therapeutic Intervention Definition Working Group

- Mr. John Digney - Deputy Director, Ráth na nÓg High Support Unit
- Ms. Bronagh Gibson - Advisory Officer, Children Acts Advisory Board
- Dr. Fionnuala Lynch - Consultant Child and Adolescent Psychiatrist, Mater Child and Adolescent Mental Health Services
- Ms. Gráinne McGill - Advisory Officer, Children Acts Advisory Board
- Mr. Mark McGranaghan - Senior Psychologist, HSE South Children's Residential Care Services
- Mr. David Power - Manager, Step Down Unit, Trinity House Children Detention School
- Mr. Eric Plunkett - Child Care Manager, HSE West

Approaches to Therapeutic Interventions Working Group

- Mr. John Digney - Deputy Director, Ráth na nÓg High Support Unit
- Mr. Mick Fox - Inspection and Monitoring Officer Child Care, HSE West
- Dr. Thom Garfat PhD - TransformAction Consulting, Rosemere, Quebec, Canada
- Dr. Fionnuala Lynch - Consultant Child and Adolescent Psychiatrist, Mater Child And Adolescent Mental Health Services
- Ms. Gráinne McGill - Advisory Officer, Children Acts Advisory Board
- Mr. Kevin McKenna - Lecturer, Dundalk Institute of Technology
- Mr. Michael McNamara - Inspector Manager, Social Services Inspectorate, Health, Information and Quality Authority
- Mr. Eric Plunkett - Child Care Manager, HSE West
- Mr. David Power - Manager, Step Down Unit, Trinity House Children Detention School
- Mr. John Smyth - National Specialist Alternative Care, HSE

Appendix 2: Acknowledgements

The CAAB and the members of the Steering Committee would like to acknowledge the following people for their invaluable contributions to these guidelines:

- Dr. Helen Buckley - Senior Research Fellow, Children's Resource Centre, Trinity College
- Prof. Alan Carr - Director of Clinical Psychology Training, University College Dublin
- Dr. William Crouch - Clinical Psychologist, Adolescent Department, The Tavistock and Portman NHS Foundation Trust, London, England
- Mr. Brian Dack - Assistant Director Operations, Probation Service Headquarters, Navan
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- Daughters of Charity Child and Family Service, Santry, Dublin 9
- Dr. David Felton - Addictions Clinical Psychologist, Next Step, Drug and Alcohol Services, Western Australia
- Ms. Miriam Galvin - Health and Social Researcher
- Dr. Eduren Garcia - Marie Curie Research Fellow, National Institute for Intellectual Disability, Trinity College Dublin
- Ms. Catherine Ghent - Solicitor
- Ms. Margaret Grogan - Regional Director, National Educational Psychological Service
- Mr. Paul Harrison - National Specialist Children's Services, HSE
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- Mr. Noel Howard - Co-ordinator, Irish Association of Social Care Workers
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- Dr. Fionnuala Lynch MD - Consultant Child and Adolescent Psychiatrist, Mater Child And Adolescent Mental Health Service
- Dr. Cathal P. McAuliffe - Clinical Director/Principal Specialist Clinical Neuropsychologist, The Talbot Group
- Mr. Ian Milligan - Assistant Director (Education) Scottish Institute Residential Child Care, University of Strathclyde, Scotland
- Mr. Paul Murphy - Child Care Manager, HSE West
- Mr. Aidan McGivern - Principal Social Worker, HSE
- Mr. Damien McLellan - Course Leader, MA in Therapeutic Child Care, Carlow College, Ireland
- Smyly Trust Services, Blackrock, Co. Dublin
- Dr. Angela Veale - Lecturer in Applied Psychology, University College Cork

Appendix 3: References

- Child Care (Placement of Children in Residential Care) Regulations, 1995
- Child Care (Special Care) Regulations, 2004
- Data Protection Acts, 1988 and 2003
- Freedom of Information Acts, 1997 and 2003
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- *Our Duty to Care: Principles of Good Practice for the Protection of Children and Young People* (2002) Department of Health and Children
- *Report of the Commission to Inquire into Child Abuse, 2009 Implementation Plan* (2009) Office of the Minister for Children and Youth Affairs
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- *The Compact Oxford Dictionary* http://www.askoxford.com/concise_oed/therapeutic?view=uk
- *United Nations Convention on Rights of the Child* (1989)
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Notes

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