

Abstract:

Restorative Approach (RA) is an ethos and process that has been linked to a reduction of interpersonal conflict and improved relationships in various service settings but whose use is little explored in family services. This paper describes the findings of an evaluation of a training programme; The Restorative Approaches Family Engagement Project that was delivered to voluntary sector family practitioners across Wales with the intent of increasing the use of RA amongst practitioners and agencies, raising practitioner confidence when working with vulnerable families, and improving the extent to which and how practitioners engage with families. The study employed mixed methods. Quantitative measures investigated pre- and post- training practitioner perceptions of confidence, levels of family engagement, and organisational attitudes to RA. Post-training focus groups explored practitioner opinion of RAFEP and perceived changes to service delivery and receipt. Findings suggest RAFEP training promoted practitioner understanding of RA and increased perceptions of confidence when working with families in four specific aspects: developing positive relationships with service users, increasing communication, identifying service user needs/goals, and facilitating change. Qualitative data indicated that practitioners attributed the increased confidence to the service delivery framework engendered by the training and associated tools which facilitated its use and improved family engagement. Whilst host organisations were generally supportive of practitioners attending RAFEP training there was little evidence that knowledge and use of RA had been fully integrated into practitioner host agencies unless the organisation had previously used a restorative ethos.

1. Introduction

Family support is a key part of welfare services that has developed rapidly in many parts of the world in recent years (Canavan et al., 2016). The knowledge base around such programmes indicates that family support services are more effective when built on strong foundations of good communication, accessibility and flexibility (Dahl et al., 2005; Kemp et al., 2014; Manolo, 2007) and sustained use of family-focused, empathetic, strengths-based, respectful ways of working (Daly et al. 2015; Dunst et al. 2007; Forrester et al., 2016; Morris et al, 2008). Establishing these constructs as a framework for family support service provision often demands a shift in organisational culture and associated service delivery. In practice this calls for the abandonment of authoritarian professionally driven services in favour of relationship-based, family-centred working and a rebalancing of power inequalities that persist within social service provision (Dominelli 2002; Featherstone et al. 2014; Morris 2008). In the UK a number of national programme guidelines (Department for Communities and Local Government 2012; Welsh Government 2011) suggest these demands have been heeded, however, evidence indicates that implementation in practice faces challenges (IPS, 2012) with the non-engagement of families with complex needs a persistent concern (Barlow et al. 2005; Bemberg 2006; Morris 2011). Katz et al (2007) divide factors affecting family engagement into practical barriers such as service accessibility, social factors as exemplified by ethnic minorities or persistent poverty and stigma particularly that associated with service use and previous negative experiences. Factors that increase service engagement have also been identified. These include good communication; forming positive relationships with families (Munro 2011; Scott 2013); gaining good understanding of family situations; using strengths-based approaches; providing practical help; and using persistent assertive approaches (Department for Communities and Local Government 2012; Welsh Government 2011).

In pursuit of such practice, growing numbers of UK family programmes are adopting restorative approach (RA) in the belief this is likely to promote relationship-based, family-focused, whole-family approaches. RA is an ethos and practice built on the hypothesis that addressing harms and challenges within communities or between individuals is best achieved by building or restoring relationships (Strang and Braithewaite, 2000; McCluskey et al, 2008; Hopkins, 2009). RA stems from restorative justice, a practice first developed in the criminal justice system as a way to address crime in a more democratic way. Restorative justice operates through a process of facilitated discussion involving the offender and victim and others affected, which seeks to address the effect of offences through collaborative consideration of the harm caused and how it can be resolved in ways

acceptable to all (Van Ness 2005; Zehr 2015). RA differs in that it can be used at two distinct levels: first, the ethos or attitude generated by everyday adherence to restorative values such as collaboration, partnership, inclusiveness, equality, respect and fairness (Burford and Hudson, 2000); second, a process similar to restorative justice (Strang and Braithewaite, 2000; McCluskey, 2008; Hopkins, 2009) but one which focuses on the problem rather than offence. When used in professional practice RA can vary from 'informal' use and application of the underlying ideologies and associated language, to formal restorative circles and conferences (Costello *et al*, 2010). In this, the concept of a social discipline window (Costello, et al 2010) illustrates how RA employs high levels of support and control or challenge to work collaboratively with the individuals involved. To facilitate this a number of 'restorative questions,' can be used. Table 1 sets out the questions and shows how they encourage inclusion and participation and discussion of problematic situations, thereby increasing mutual empathy, motivation to change, and discussion of what should change and how.

Table 1: Restorative enquiries (adapted from Hopkins, 2009)

Table 1 also links RA to the recognised evidence-based methods of change of motivational interviewing and solution-focused therapy, but differs in that it embeds these within practice and delivers them within the positive, relationship-based inclusive practice demanded by the underlying values.

Accounts of using RA within family and children's services are beginning to emerge in the UK and wider, with some suggestion that its use leads to better intra-organisational environments (Tariq, 2015, Finnis 2016 ; Kay 2015; Mason et al. 2017) as well as reduced conflict between stakeholders (Fives et al, 2013). Despite this, its use in this arena is still in need of conceptual, theoretical and practical evaluation and consideration (Williams and Segrott 2017). In light of that, this article considers the ability of RA to effect family services by describing the findings of an evaluation of the Restorative Approach Family Engagement Project (RAFEP): a training programme for family practitioners that was recently delivered across Wales.

1.1 Restorative Approaches Family Engagement

RAFEP was developed and implemented by Tros Gynnal Plant, a Welsh third sector organisation with extensive experience of using RA in family contexts. The training concentrated on familiarising third sector practitioners delivering family and allied services with RA principles and concepts; using these to reflect on existing practice and personal values and compare them with those of RA. It also aimed to develop practitioner communication skills in order to help them engage families, build better relationships with them and provide support without generating conflict. An additional intent was to

increase awareness and adoption of RA within practitioner host agencies (www.rafep.wales). RAFEP training was delivered in three phases over eighteen months. Each phase worked with a different cohort of third sector practitioners drawn from the 22 Welsh local authorities. In each phase RAFEP consisted of a main three-day training programme followed up by two 'reflective fora' 3 and 6 months after the initial training.

2. Method

The knowledge that using RA as a framework for family service delivery is still developing in the UK demanded some exploration of its effect on service delivery and receipt. To contribute to this an evaluation of RAFEP was conducted in the second year of the project.

Ethical approval for the research was gained from an ethics committee at Cardiff University.

The evaluation involved practitioners from those working in the nine Welsh Local Authorities who received training during the second year of RAFEP. The study explored the effect of RAFEP on practitioner feelings of confidence when working with families, perceived family engagement and adoption of RA in practitioner host agencies. Specifically, the research questions asked to what extent and how did RA training:

1. Impact on practitioner confidence when working with and engaging families and clients?
2. Change interactions between practitioners and families and clients?
3. Lead to wider RA adoption and use in practitioner organisations and agencies?

To address these questions the study used mixed methods. All training participants were invited to complete a questionnaire at four time points – immediately before training (T1), directly after the 3-day training delivery (T2), three months (T3) and six months later (T4) . The questionnaire primarily yielded quantitative data through closed-response questions although there were some open-ended questions. In addition, focus groups were conducted with a self-selecting subsample of participants 3 months after training.

2.1 The questionnaire

As a suitable RA questionnaire did not already exist, the research team drew on earlier associated measures developed to explore the effect of training social workers in other delivery methods (Holden et al. 2015; Holden et al. 2002; Scourfield et al. 2012) which were informed by Social

Cognitive Theory that argues behaviours are determined by feelings of self-efficacy and confidence (Bandura 1977, 1982). Adaptation to develop measures more pertinent for this study was directed by researcher consultation with RAFEP developers who reinforced the contention (e.g Hopkins et al., 2016) that RA effects change by improving relationships via better communication, mutual empathy, increasing desire for change, identifying what needs to change and how to achieve it. Furthermore, developers indicated that the primary aims of the training were: to increase practitioner confidence when seeking to engage families; have positive effect on practitioner family interactions; promote organisational adoption of RA. This knowledge was used to construct a logic model of how the training was intended to support trainees to adopt RA and facilitate change in practice (figure 1). The model outlines the training resources, the processes that would be undertaken and the hypothesized outcomes.

Figure 1: Logic Model showing the resources input, the expected processes and hypothesized outcomes of RAFEP training

Drawing on the knowledge of the process surrounding RA and the training aims, all four questionnaires contained 30 questions about practitioners' levels of confidence in four aspects of practice: developing positive relationships with families (e.g. 'working with families who are reluctant to engage'); improving family communication (e.g. 'helping families talk about problems in specific terms'); helping families identify goals (e.g. 'help families define their own goals'); and facilitating change (e.g. 'help families learn how to make decisions more effectively'). All questions used five-point scales from 'Not confident' to 'Very confident'. The reliability coefficients (Cronbach alphas) for the four scales were all above 0.9. The third and fourth questionnaires included additional sets of questions about practitioner views of the impact of the training on interactions with families, and attitudes to RA in their organisations. These were analysed individually and used a six-point agree-disagree scale with no neutral point. Additionally, some basic demographic details and information about the practitioners' role was gathered in the first two questionnaires. Questionnaires are available on request from the authors.

The first two questionnaires were administered in paper format; and the third and fourth questionnaires online although a few paper versions were completed. In total, 81 people completed the T1 pre-training questionnaire, 100 (nearly all training attendees) completed the T2 post-training questionnaire, 42 completed the T3 questionnaire three months after training, and 38 completed the T4 questionnaire six months after training. The lower response rate at T1 than T2 occurred because one group in the cohort chose not to complete the questionnaires immediately before training but then most completed T2 questionnaires at the end of the 3-day training. This

discrepancy unfortunately created some complexities for the statistical analysis. In total, 112 practitioners completed at least one of the four questionnaires, but only 17 completed all four. Half of the 112 practitioners completed a questionnaire either at T3 and/or at T4.

Of the 112 respondents 87 (78%) were female, 22 (20%) were male – a comparable split to gender patterning in the social care workforce (Scourfield et al. 2012). Age ranged from under 30 to over 60 years old. All participants worked within the social care sector, most in family work and support roles (40 out of 81 T1 respondents), housing (13), and domestic abuse work (8). Practitioners had varied lengths of practice experience, 17 with less than two years' experience, 15 with twenty years or more. 73% of T1 respondents had received at least one other form of work-based training, most commonly motivational interviewing and solution-focused therapy. 14 people had previously received training in Restorative Justice.

SPSS was used to clean and analyse the data. Statistical testing was carried out for the four multi-item scales of practitioner confidence. Comparisons between groups at the same point in time were conducted using a t-test for two groups and ANOVA for more than two groups. Tests for changes of practitioner confidence between consecutive waves were conducted using a paired-samples t-test. Due to the skewed distributions of scale variables, all tests used robust standard errors. Non-parametric versions of these tests were also conducted and found to broadly support parametric test findings. All differences reported as statistically significant refer to a p-value of less than 0.05 (95% confidence).

2.2 The focus groups

Focus groups explored whether training had made changes in the three levels associated with the research questions, and if so the processes through which practitioners attributed these changes. The focus group schedule explored: practitioner experience of engaging families pre-RAFEP training; why practitioners attended RAFEP training; use of RAFEP attitudes and skills in practice since training; what changes, if any, RAFEP training had on practice, on family engagement and organisations.

Three focus groups were held 3 months after the training. Pragmatically, each was conducted immediately before the first RAFEP reflective fora. Limited study resources accorded that focus groups were held within daily travelling distance from the university, and therefore two were held in South Wales and one in Mid Wales. As the reflective fora and focus groups were held in tandem, the RAFEP project team invited attendees to both in an e-mail, clearly communicating the latter was for research purposes and voluntary. Separate written consent was obtained from practitioners for the

focus groups, and they were advised verbally and through Participant Information Leaflets, that participation was voluntary, and they could withdraw at any time.

Twenty-three participants took part. Eighteen (78%) were female and 5 (22%) male. Practitioners stated they worked in housing associations/support (n=10); family support (n=5); mental health services (n=3); domestic abuse support (n=2); youth work (n=2); and cancer support (n=1).

Deductive thematic analysis was conducted on the three focus group transcripts, each by a different project researcher. Broad a priori themes utilised were: work context of participants; previous service delivery training and experiences; RAFEP training; perceived impact of training on practitioner attitudes, skills and experiences; perceived impact of training on organisations; perceived impact of training on the families/individuals worked with. Each transcript was re-coded by another team member to increase coding validity. Emerging subthemes were coded, collectively discussed and agreed before one researcher verified the coding of all three transcripts.

3. Results

3.1 Quantitative Results. Questionnaires explored differences in practitioner confidence when working with families; family and practitioner interactions, and organisational responses to RAFEP training.

3.1.a. Practitioner confidence.

Changes in the confidence of practitioners when working with families over the time of RA training were measured quantitatively. Questionnaires allowed confidence scores for each aspect of practice to be calculated by summing the scores of questions for each of the aspects of practice: developing positive relationships; increasing communication; identifying needs and goals; facilitating change to be measured, and transformed onto a scale from 0 to 100 for ease of interpretation. Mean scores for all practitioners at T1 are shown in the second column of Table 1. Although the distribution of confidence was skewed towards the higher range of the scale, scores still show that confidence was notably higher for developing positive relations than for the other three aspects of practice. There was no statistically significant difference in confidence according to participants' age, gender, length of work experience or previous training; however, there was a tendency for practitioners at the two ends of the age and experience continua to have higher confidence than those in the middle.

Table 1: Practitioner confidence scores at baseline and changes in confidence over time

Table 1 also shows changes in practitioner confidence scores between consecutive waves of the questionnaire for all available matched pairs of data. There were significant improvements in all four

confidence scores of between six and 11 points out of 100 between T1 and T2. There was only one small significant increase in confidence at later points in time – an increase of around four points out of 100 for confidence in facilitating change between T3 and T4. This broad picture of substantial change in confidence between T1 and T2 and relative stability thereafter was confirmed by an examination of scores for the 17 people who completed all four surveys. The gains in confidence between T1 and T2 tended to be a little larger for this group than for all participants and there was no evidence of change between T2, T3 and T4.

Differences in changes in confidence between T1 and T2 were examined for different subgroups of the sample. There were significant differences with respect to gender and age. Females gained confidence between T1 and T2 (gains in the region of 8.1 to 13.7 for the four aspects of practice) while males did not (small changes of between -2.1 to +2.9). Practitioners aged 30 and above tended to gain more confidence than those below the age of 30. There were no significant differences in changes in confidence according to length of practice experience or people having received previous training. Overall young male practitioners were most likely to lose confidence during training. Finally, there was clear evidence of an association between gains in confidence and attendance at reflective fora. Table 2 shows that, amongst cases for which data was available at T1 and T2, gains in confidence were larger for participants who attended at least one of the reflective fora than for participants who did not. The differences in change scores between the two groups were statistically significant for two aspects of practice – helping identify needs and goals, and facilitating change. Further examination of these patterns suggested that participants who attended a reflective forum tended to have had a lower level of confidence before the training than other participants but to have a similar level of confidence to others after the training.

Table 2: Changes in levels of confidence with different aspects of practice between T1 and T2 for people who attended a reflective forum (either at 3 months, 6 months or both) and those who did not.

3.1.b. Practitioner-family interactions

T3 and T4 asked practitioners to respond to six statements about the impact of RA on interactions with families. Table 3 shows responses at T3. The majority of respondents tended to agree with all six statements. The same patterns were evident at T4 (results not shown due to space considerations).

Table 3: Responses to questions about practitioner-family interactions (T3)

3.1.c. Attitudes to and adoption of RA by agencies

T3 and T4 questions asked about the use and impact of RA on agencies. Patterns at T4 are shown in Table 4. Again, a majority responded in the positive half of the scale (at least slightly agreeing) for all statements. However, there was a greater level of disagreement here for some statements, especially those about RA changing service delivery to families, changing service culture and philosophy, and being embedded in the agency/team. In addition, a minority felt that RA had not yet been fully integrated into the general workings of their service.

Table 4: Responses to questions about attitudes to, and adoption of, RA by agencies

3.2. Qualitative findings

As all but one of the 23 focus group participants had used RA in practice since training, practitioner confidence, their interactions with families and organisational reaction to RAFEP training could be explored qualitatively in the focus groups conducted three months after training. The groups also investigated understanding of RA after training and early use.

3.2.a. Knowledge and understanding of RA

Collectively, practitioners understood RA as a set of principles, values and skills that underpin practice. For some practitioners the training had been an introduction to RA, others had received previous training; some in RA, others in restorative justice. Many of those new to RA described it as an ethos that promoted “*person centred approaches*” (P7, Focus Group(FG) 2), drew on “*family and individual strengths*” (P3, FG2), and “*respects individuals and the situations they are in*” (P4, FG2). Within participants a consensus that RA encourages collaborative work, doing things with rather than to service users emerged, supporting opinion and description of RA elsewhere (Hopkins, 2004, 2009, 2016; Costello et al, 2010). In addition, participants with previous RJ training distinguished between the more formal restorative practices such as circles and conferencing used in RJ, and the informal use of RA encouraged by RAFEP training.

3.2.b. Practice confidence

Practitioners felt the initial training had increased their confidence in using RA whilst its use in practice had raised confidence in their personal ability to work with families. On enquiry, practitioners attributed this to RAFEP training having given them a conceptual and practice framework to employ when working with families as well as knowledge of tools that supported this and facilitated family engagement. Before training, some workers described how although they felt they had always worked in positive, proactive strengths-based ways they had been ‘scrambling’ for a structure or process in which to locate practice skills which RAFEP had provided:

“I think it’s brought everything into perspective. You’re doing it and you’ve probably done it for years, but it lets you bring it all together with far more confidence than I had before” (P5, FG2).

Others felt RA had increased practice confidence by allowing them to reflect on their own practice, and work out what to do next. The Social Discipline Window was instrumental in this. Although it is essentially a conceptual representation of the values of support and control that underlie RA (Costello et al. 2010), practitioners saw and described it as a tool that aided reflection on previous practice and encouraged changing practice to ‘doing with’; a more participatory, strengths- based approach promoted by RA generically. In addition, practitioners felt that learning about RA values and other tools such as active listening and the restorative questions had been beneficial in that they had helped them communicate with families better, which resulted in them gaining an increased understanding of what lay beneath difficulties, promoting better problem-solving skills and higher levels of autonomy. For some, family autonomy had increased to the extent practitioners felt redundant:

“Yesterday I had a bit of a ‘Oh!’. I spoke to a mum about something and she said that she had gone by herself, and I thought ‘Oh! Oh dear, umm. Oh good, yes, well done. I thought I was going with you but you’ve gone by yourself.’ That was a bit of a moment there” (P1, FG3).

Another described how using RA had increased family capacity to resolve conflict in that they had used these tools independently at home. Both incidents illustrate how practitioners felt RAFEP training changed practice by giving a framework and process more likely to help people help themselves, and which in turn gave practitioners confidence that they could and should work this way:

“you know in your head, you’re thinking ‘Why am I doing something for them rather than enabling them to do it for themselves?’ Just gave me a bit of confidence to do it” (P1, FG2).

Using the tools to reflect on service provision and effect also aided decisions of when cases should be closed, as working their way through the questions reassured practitioners that they had done all possible to help service users:

“There comes a time when you’ve got to close the case and it’s made me sort of not feel as guilty about it. [Before]there was a tendency to keep the cases open longer than necessary” (P6,FG2).

3.2.c. Interaction and family engagement

Focus groups also provided information about the mechanisms through which practitioners believed RA affected practice, changed engagement, and affected practitioner family interactions. Participant practitioners felt the participatory and inclusive nature of RA was the key to improving engagement as it promoted contact with more family members. Even practitioners who believed that they had engaged service users well before RAFEP felt using RA elicited a deeper level of engagement:

“We’ve always been good at engaging with families, but I think what people are talking about is the quality of the engagement, and that’s what’s actually changing” (P1, FG3).

with opinion that this difference stems from the focus engendered by RA on inclusion and active listening at the start of engagement processes, with one individual stating that RA had given them confidence to *“actually be able to ask about people’s needs and feelings more” (P1, FG2)*. Others described how they now began interactions by asking family members what they were finding difficult and would like to change, rather than working through referral forms and sending the correct letters which had been their previous “process driven” approach. When reflecting on this, one practitioner felt that although previous procedures had met organisational protocol, it had been largely unsuccessful in eliciting family change as this approach left the root causes behind the referral unrecognised and unmet. Others agreed, and commented that such methods often led to re-referrals:

“Yeah, because what we were finding is that often you work with one family and then a year later they would be re-referred in again” (P5, FG1).

When considering other ways in which RA had changed interactions with families, a few participants felt that RAFEP placed more of the responsibility for service use with users and saw better practitioner acceptance of user decisions not to engage or make changes:

“Some of the women have actually decided that it’s not the right time for them as well you know for our involvement so it does remove the blame” (P6, FG2).

Overall, practitioners felt that RA promoted interactions which elicited better sharing of experiences, situations and problems and although this took longer, this ‘doing with’ was more effective:

“The change has been that I took a step back and the young people are working more with me now which probably will make some processes longer than it would have been before but with a better outcome” (P3, FG2).

Despite this, some instances of service users not liking the more participatory nature of RA services were recounted. Practitioners attributed this to preferences for the previous practice in which practitioners had resolved problems for families and users which had been popular because it required little family effort.

3.2.d. Organisational response to RA implementation and training

Focus group practitioners commented on mixed organisational responses to RA training.

One practitioner believed that the ethos and techniques learnt during training had revitalised their organisation at a difficult time and had a positive effect on service delivery:

“It has given us a framework that we can share with the team, because we are all part-time workers and sometimes we only have a two-hour crossover with colleagues. Using this approach [means] someone can pick up the file and know exactly where we are” (P3, FG2).

A few more participants reported high levels of service user satisfaction as demonstrated in client responses to an internal survey, decreased re-referrals and co-worker recognition that the approach was a good way to interact with families. One organisation had sent further practitioners to RA training and another wanted more practitioners trained to help embed the approach in services. However other practitioners spoke of co-workers displaying negative attitudes to the new way of working despite positive service user responses. Much of this disquiet stemmed from staff and managers who had not been trained in RA interpreting the increased time spent with cases as an over-reliance of the family on the worker.

“Yeah, so, we’re not allowed to do it, we’re not doing all that, but I do it myself. And I find for myself and for my own working it works for me. And so much so that I now get people waiting for me to come in to sort their problems out before I’m even there. It’s all ‘Oh, when’s (name) next in? We’ll come in and see (name)’. So, I know they’re waiting, and I’ve got queues of people coming in to see me, and there’s other people who are standing around not doing much at all.well apparently I understand and I know what they want” (P7, FG1).

When trying to understand negative reactions, some participants felt their organisations were worried about adopting a completely different way of working that was not ‘hand holding’. This antagonism led to some concern that it may be difficult to sustain RA independently:

“We’ve got four other people that work in a completely different way and they can be quite blinkered in the way they approach their work, and they’re quite entrenched in it really. I think if you’re more open to other practices out there you can enhance the work, I’ve found that it enhances the work that you do” (P5, FG3).

4. Discussion and Conclusion

To our knowledge this article is the first to explore the impact of RA training on family practice and practitioner confidence and skills, and overall findings were very positive.

First, the increases in practitioner confidence in using RA support wider evidence that links skills development with increased self-efficacy and confidence (Bandura, 1977; 1982 ; Gist et al, 1989; Scourfield et al, 2012). Moreover, the increases in all aspects measured: relationships with service users, communication, identifying user needs and goals, and facilitating change, gives a rationale for why practitioners felt they could engage families and clients better post training; as well as indicating that RA gave their practice a necessary framework and set of tools that had a positive effect on the whole process of service provision and was more likely to engage service users, stimulate changes and generate feelings of autonomy.

These findings are unlikely to surprise those who describe RA as an approach that builds, sustains and improves relationships (Wachel, 2013, Hopkins, 2004, 2009) or argue that the framework incorporates other strengths based, whole family approaches (Braithwaite, 2016; Williams and Segrott, 2017). It is very encouraging to be able to extend these links to RA use in family support services; a field in which forming positive relationships with families is vital, and has been linked to improved outcomes (Munro, 2011; Crowther and Cowen, 2011). Indeed, in regards to the wider arena of family and children services where demand for greater use of relationship and strengths-based practice is growing (Thomas, 2018; Featherstone et al, 2014; Munro, 2011; Morris et al 2008), evidence that training in RA promotes such practice and does so through a short, relatively inexpensive period of training when compared with other training programmes teaching and promoting such approaches, is heartening.

It was also of interest that practitioners felt that although they had been engaging service users well beforehand, the training resulted in them engaging differently. The inclusive and participatory values and practice of RA were perceived as central to this as they led greater emphasis on listening to families and clients.

In line with RAFEP’s intended aims, increases in confidence in working with families (and in doing so in new ways) appeared to be one of the main mechanisms through which practitioners adopted RA

practice. This increase in confidence was mainly seen between T1 and T2. Set within this overall pattern increases in confidence were less evident for younger practitioners, and for men. The reasons for these differences across age and gender are not immediately clear, and would benefit from further investigation to understand the receipt of, and value for different groups of the RAFEP training.

Our findings also suggest that whilst most practitioners reported having utilised RA in their practice, adoption of, and integration of the approach was less uniform at the level of their broader organisation. As described by participants, RA introduced new approaches to working with families compared with existing practice, and was sometimes met with resistance and an inaccurate perception that it increased both the time spent with families, and their dependence on practitioners. The extent to which organisations as a whole understand and are prepared to embed RA within their ways of working and everyday routines is clearly an important influence on the ability of practitioners to implement the training they receive. Where whole teams or even organisations receive training (rather than a subset of individuals) this may help embed the changes in working which RA calls for. Some efforts to directly target organisational level support for adoption of RA may also have potential value, alongside the training of individual practitioners.

Our study has a number of limitations which should be noted. First, we were not able to explore the views of practitioners who were invited to participate in RA training but could not, or chose not to, participate. Second, focus groups were conducted with practitioners who had committed to attend the RAFEP reflective fora, and the views expressed may have been those who were most satisfied with the training, compared with those who did not attend. Thirdly, although practitioners described positive changes in relationships with families, this research did not investigate the experiences of parents/carers/families and the extent to which they linked RA to positive changes in their interaction with practitioners, or aspects of family communication or problem solving. Ongoing research by the lead author is investigating these issues and the experiences of parents/carers who receive RA-informed services.

Conclusion

This study gives a number of important insights into the ways in which Restorative Approach may help practitioners to strengthen their engagement with families based on the importance of positive relationships and a strengths-based approach. Use of mixed methods helped identify key changes in practitioners' confidence in engaging families (quantitatively), and some of the key mechanisms

which promoted this increased confidence and enabled them to apply the skills they had learnt (through the focus groups). We were also able to examine some of the main barriers to adoption of RA and the connections between individual training and wider organisational acceptance of RA approaches and techniques. Our study has identified that RA has the potential to strengthen the effectiveness and implementation of family support services and gives insight into the operant mechanisms when harnessing RA in this way and the systems and structures needed to embed it at a practitioner and organisational level.

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