**Evaluating Team-Based Learning for Assessing Parental Capacity for Change**

A Report of Recent Research in Child Protective Services in England

 January 2017

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**Acknowledgements**

The Nuffield Foundation is an endowed charitable trust that aims to improve social well-being in the widest sense. It funds research and innovation in education and social policy and also works to build capacity in education, science and social science research. The Nuffield Foundation has funded this project, but the views expressed are those of the authors and not necessarily those of the Foundation. More information is available at [www.nuffieldfoundation.org](http://www.nuffieldfoundation.org)

**Evaluating Team-Based Learning for Assessing Parental Capacity for Change**

**Executive Summary**

**Purpose of the Research**

Team-based learning approaches offer an alternative to training modes of skill development that have been suggested as better suiting the changing nature of the way social care work is undertaken. Team-based learning approaches build on the work of Michaelsen, Knight & Fink (2004) and follow an approach to learning that emphasises the application of knowledge within team structures. It is a form of employee development where a team of professionals interact to apply knowledge to simple and complex problems with the feedback of the facilitator as the content expert. However, there is little research identifying how best team based learning should be designed nor what factors increase its effectiveness specifically within social care nor outside educational settings. This study was therefore conducted to compare traditional training with a team-based learning intervention to identify whether either of these learning approaches had an impact on social workers’ knowledge and skills in the area of assessing parental capacity to change, and if one approach was more effective than the other.

**Team-Based Learning**

Team-based learning has been suggested to result in enhanced learning outcomes compared to approaches that rely on more traditional didactic methods (Anwar et al 2012). Students master content through repeated iterations of a three-step process that consists of (1) preclass preparation, (2) assurance of readiness to apply learned concepts and (3) application of content through group problem-solving activities. Haidet et al., (2012), comment that, “TBL moves beyond basic acquisition of facts to emphasize meaningful application of session or course content in real-world scenarios” (p293).

There are some key differences that distinguish team-based learning from traditional forms of training delivery. The basis of the learning approach draws upon the notion that cooperative structures such as teams create unique conditions for social learning (Buniss, Gray & Kelly 2011; Hernadez 2002). A further difference is the focus on participant accountability for learning. In traditional training programmes, the trainer identifies content for participant to have learned by the end of the training programme. Participants may have been given some pre-reading but there is no guarantee that they will have looked at it let alone learned any key concepts. During training feedback is often highly variable. As a consequence accountability for learning is fairly low. Team-based learning adopts an alternative approach to how learning is structured and requires higher levels of learner accountability.

Prior to each session participants are required to learn specific assigned content. Individuals and teams then apply this specified content to problem-solving discussions during the session. A key element of team-based learning is that individuals receive frequent and immediate feedback during the session on their learning from the facilitator as a content expert. Feedback on learning and performance is built into the learning delivery through a mechanism referred to as readiness assurance tests. Each time participants attend a session they are given tests/quizzes that they complete first individually then together in their team. These test the learning they were expected to have gained from the pre-reading. However an important aspect is that these tests require participants to *apply* the learning in a problem-solving format. In so doing this should enhance the transferability of learning to real-life practice. There is some empirical evidence that increased accountability to the peer group, a key feature of team-based learning appears to play a significant role in the learning gains observed in a variety of settings (Koles et al., 2010; Warrier et al., 2013).

There has been extensive evidence suggesting the successful application of TBL across disciplines including business (Clarke, 2010; Michaelsen et al 2009), marketing (Chad, 2012), medicine and health (Haidet et al., 2010), organizational psychology (Haberyan 2007), nursing (Cheng, et al., 2014; Mennenga. & Smyer 2010) and midwifery (Moore-Davis et al., (2015) and Social work (Gillespie 2012; Macke, Taylor & Taylor 2013). Multiple advantages of the TBL method have been reported (eg Michaelsen 2004; Watson et al., 1991; Garrett, 1998). These benefits can be categorised as improved learning outcomes (Koles et al 2010) and problem solving abilities (Kelly et al., 2005); and improved teamwork and communication skills (Thompson et al., 2007). Bahramifarid et al (2012) published a review of 75 TBL studies in medical education and concluded that students’ academic performance in TBL courses has generally been rated equal or superior to performance under traditional didactic approaches.

In more recent systematic reviews of the TBL literature in health professionals education, Fatmin et al (2013) and Haidet et al (2014) reported improvements in knowledge outcomes in educational studies that compared TBL methods with other methods such as the traditional lecture. To date, the effectiveness of TBL has not been addressed in depth in the social work literature. It has been suggested however, that this form of pedagogy offers significant advantages to the social work profession (Macke & Tapp 2012). Robinson, Robinson, & McCaskill (2013) for example, suggest “The field of social work…seems to be a natural fit for active and cooperative instruction because the very nature of the professional environment is one where social work professionals are collaborating cooperatively with clients and stakeholders at every level of the profession (p774)”.

*The objectives of the study were as follows:*

1. To compare the impact of training and team-based learning approaches on participants’ knowledge and practice in assessing parental capacity for change
2. To assess the impact of team-based learning on key behavioural indicators (improved quality of assessments).
3. To identify if co-worker support enhances the transfer of learning from training and team-based learning approaches to professional practice.
4. To identify factors associated with the effectiveness of team-based learning in supporting participants’ knowledge and practice gains in assessing parental capacity for change.

**What we did**

The research project took place between September 2014 and August 2016. Prior to conducting this evaluation study 12 staff based in children services from 8 local authorities in England were invited to join a change project to develop a learning pack covering knowledge and skills involved in the assessment of parental capacity to change within children’s services. Work on developing the learning pack lasted 12 months and was coordinated and administered by Research in Practice, a non-statutory organisation whose mission is to champion evidence-informed practice in children’s services and who were a partner in the research project. The pack was designed based upon Dawe & Harnett’s C2C model and consisted of four modules, each of a half. Key features of this assessment model include the use of standardised instruments in assessment in order that an objective measure of change can be determined, the use of goal setting and goal attainment scaling and the use of evidence-based interventions (in relation to the latter the course content drew heavily upon recent systematic reviews i.e. Barlow & Hall 2012; Barlow & Schrader-McMillan 2010).

A mixed methods research design was employed to achieve the objectives of the study combining both quantitative and qualitative approaches. We asked staff from local authority children’s services to participate in either one of two differing ways for developing staff skills in this assessment technique, training or team-based learning. The sample consisted of 5 local authorities who received training (84 participants) and 3 local authorities who agreed to take part in the team-based learning component (64 participants). Staff from two teams in one of the local authorities participating in the team-based learning also agreed to act as a comparison group (19 participants). A comparison group is often used in research studies as participants in this group are separated from those who are attending either training or team-based learning. This means neither of these learning interventions could have affected any changes in this group. This can help us to make a judgement as to whether any changes to those in either the team-based learning or training groups could reasonably be inferred as due to these learning interventions.

We assessed whether the learning interventions resulted in improvements to participants’ knowledge about this model of assessment by designing an on-line questionnaire. This tested participant’s understanding of the assessment model through asking whether number of statements relating to the assessment model were true or false. We refer to this type of knowledge as *declarative* knowledge (knowing what). There was also a section in the questionnaire that asked participants to *apply* their knowledge of the model and answer questions relating to a short case study. We refer to this type of knowledge as *procedural* knowledge (knowing how). Participants completed this questionnaire before they attended either training or team-based learning and then again four months later. We encountered a number of problems with the evaluation specifically in obtaining data relating to any changes in knowledge as a result of attending training or team-based learning. A number of participants found completing questionnaires difficult within the constraints of the workloads. Consequently, although starting with a total sample of 167, complete data sets (baseline and post-course measures) were obtained for only 39 or just over 23% of the total sample for knowledge measures. Details of those completing on-line questionnaires are displayed below.

Table: Numbers of Participants Completing Baseline and Follow up Measures

|  |  |  |  |
| --- | --- | --- | --- |
|  | Registered | Baseline Measures | 4 Months Post |
| Training | 84  | 66  | 29 |
| Team-Based Learning | 64  | 46  | 6 |
| Comparison Group | 19  | 16  | 4 |
| Total | 167  | 128  | 39  |

The evaluation also attempted to determine whether any learning gained through training or team-based learning was subsequently used on the job. To do this we undertook an audit of 50% of the caseloads held by participants. We checked cases to see whether specific aspects of the assessment model were evident in their practice. Specifically, we looked for 5 key behavioural indicators. These were (1) whether an assessment of parental capacity to change had been undertaken; (2) whether SMART goals had been used as part of this assessment; (3) whether Goal Attainment Scaling had been used in the assessment; (4) whether standardised instruments had been used to take baseline measures and reused to assess change and (5) whether evidence-based interventions had been drawn upon as a means to achieve the goals that had been set in the assessment of change. Cases were coded using a coding frame where participants received one point for each time a behavioural indicator was found in a case. Measures were taken within 1-3 weeks prior to any participant attending either training or team-based learning and again between 6-12 months following participation. Of the 167 participants who were registered to attend either training or team-based learning or participate in the comparison group, baseline behaviour (case audit) measures were obtained for 150 participants. We were able to collect audit measures again for 90 (54%) of the original 167 participants following attendance on training or team-based learning. Details of those from the three groups (training, team-based learning and comparison) from which audit measures were collected are displayed below.

**Table : Baseline and Follow-Up Case Audit Measures**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Registered | Baseline Measures | 6 Months Post |
| Training | 84  | 68  | 45  |
| Team-Based Learning | 64  | 63  | 32  |
| Comparison Group | 19  | 19  | 13  |
| Total | 167  | 150  | 90 ) |

**Findings**

We highlight the key findings from the study below as they relate to the research objectives that we set for the project

1. *To compare the impact of training and team-based learning approaches on participants’ knowledge and practice in assessing parental capacity for change*

One of the chief findings from the study was that participation in training resulted in improvements to both declarative (knowing what) and procedural (knowing how) forms of knowledge as indicated by performance on the knowledge test and case vignettes contained in the on-line questionnaire. What was surprising however was that we failed to find any significant improvements in procedural knowledge from those who participated in the team-based learning, whilst improvements in declarative knowledge were only significant at the .10 level of significance. These results would suggest that the training was far more effective than team-based learning for increasing participants’ knowledge of the model for assessing parental capacity to change. However, these results do need to be treated with caution because of the high level of attrition (participants not completing questionnaires for a second time following either training or team-based learning). We only managed to obtain complete data sets for 29 participants who attended training. Whilst the number for team-based learning was far less than this, with only 6 complete data sets obtained. With such low numbers it is difficult to determine statistically whether any real changes have occurred.

1. *To assess the impact of team-based learning on key behavioural indicators (improved quality of assessments).*

We found that neither training nor team-based learning resulted in any significant changes to skill acquisition as indicated by examining any differences between baseline and follow-up scores from the case audit data. The qualitative data we obtained from interviewing a sample of training and team-based learning participants over the telephone would seem to corroborate this, and offers some insights as to why this might have been the case. The first possible explanation lies in the model for assessing parental capacity to change that formed the core content of the learning. A number of participants indicated that they were not comfortable in using standardised instruments for measuring change nor in the goal attainment scaling process which requires a degree of numeracy. This is interesting in that it resonates with comments a number of social workers had made when developing the content of the training/team-based learning contained in the learning pack. The level of self-efficacy in using such tools appears fairly low, exacerbated by limited expectation to undertake capacity to change assessments using these tools by their agencies.

1. *To identify if co-worker support enhances the transfer of learning from training and team-based learning approaches to professional practice.*

We needed to make some changes to the original research design in order to secure local authorities participating in the study. One of those changes related to the anonymity of participants when collecting case audit data. Consequently, we were unable to test this proposition. However, given that we failed to find any changes to professional practice as indicated above it would seem unlikely that co-worker support would have made any significant difference in this case.

1. *To identify factors associated with the effectiveness of team-based learning in supporting participants’ knowledge and practice gains in assessing parental capacity for change.*

Team based learning has three key components: (1) advanced preparation by learners through reading materials, (2) both individual and then team testing of learning and (3) the majority of time during sessions devoted to the application of learning through problem solving exercises such as case studies. On the face of it then, one would expect the emphasis on the application of learning to be more effective at enhancing skill acquisition and transfer. Perhaps contributing to the failure to find any significant impact of on skills were factors undermining the intervention. Previous research has found that shared beliefs and knowledge is important to achieving consistent practice among human service workers and that these workers develop their practice through group norms and team interactions (Sandfort, 1999)

Findings from the qualitative data suggest that the benefits thought to be gained from a team-based learning pedagogy were significantly undermined by the high level of turnover among the teams that participated. High caseloads alongside challenging work conditions have been cited as key factors associated with high rates of turnover among child protection service workers (Alwon & Reitz 2000; Zlontnik et al., 2005). Team cohesion reflects the extent to which team members are committed to one another in the achievement of team goals and has been found to be associated with team performance scores on a psychiatry knowledge test (Thompson et al 2015). The high turnover would have significantly affected team cohesion and potentially therefore undermined any positive impacts of team based learning on skill acquisition.

**Implications for Policy and Practice**

Research evaluating the effectiveness of training programmes in social services is limited, despite the extensive efforts and resources often allocated to training programmes by social service organisations (Collins, Amodeo, & Clay, 2007). Specifically, in relation to training in the area of child welfare, Collins (2008) bemoaned that “training programs are repeatedly delivered without adequate empirical evidence of their effectiveness” (p.241). Similar to much of the previous research examining the impact of training in social services and child welfare settings more specifically, neither the training programme nor participating in team based learning resulted in any significant changes to practice in the area of assessing parental capacity to change. Comments from participants who took part in interviews, suggest a number of possible explanations as to why the training failed to affect practice. These include the particular characteristics of the assessment model that formed the content of the training, and the lack of reinforcement for use of the assessment model (or training) in the workplace. In order for training to transfer to actual use on the job, the systemic nature of training effectiveness needs to be more fully appreciated by child welfare agencies. This recognises that training is unlikely to transfer to practice unless learners are motivated to use the training in practice and the workplace creates the conditions to support training transfer. A significant problem remains that most organisations persist in the belief that simply participation in training programmes is sufficient in order for training to be effective. As a result, considerable effort is placed in the design of training programmes with a minimal understanding of the broader contextual factors that influence whether training is effective or not.

The use of team-based learning has increased dramatically within continuing healthcare education with the increasing awareness of the importance of teams in delivering quality patient care (Morrison et al 2010; Khune-Eversmann, Eversmann, & Fischer, 2008; Shellenberger et al., 2009). The information contained in child welfare training is often complex and hard to articulate and child protection workers primarily work in teams, so group and team discussion has been suggested as a means to promote a common and shared understanding of new work practices (Frank, Bagdasaryan, & Furman, 2008; Lewandowski, & Glenmaye, 2002). Consequently, a number of authors have suggested that team-based learning should be adopted more widely within social care (Macke & Tapp 2012; Robinson, Robinson, & McCaskill 2013). A number of studies report student positive attitudes towards TBL, including a number of systematic reviews of team-based learning in medical schools (Burgess, McGregor & Mellis, 2014). Although base on limited qualitative data, the study does suggest that the team-based learning approach was received favourably by a number of those who participated. However, implementing the approach in children’s services is not without challenges. The most significant of these concerns the high rate of staff turnover which undermines team cohesion. Although this is likely to have far less effect on knowledge acquisition while participating in a team-based learning intervention, it does have far a more deleterious effect on whether team-based learning can affect changes to actual practice. The approach requires more extensive preparation by learners in reading material that is subsequently tested. This may be difficult in child welfare work environments which are typically stressful working conditions. Team-based learning also requires training and development staff to adopt a different approach to staff development then has traditionally been the case in delivering training programmes. As was found here, not all these staff may be comfortable with the testing element of the intervention which means elements of team-based learning prescribed in the literature are altered in delivery. This variation in delivery may pose problems for reaching conclusions as to the effectiveness of team-based learning more broadly.

Finally, there is considerable evidence that the quality of evaluations undertaken by social care agencies of their training is often poor. Collins (2008) for example, found that follow up evaluations of training to determine the impact on child welfare professionals’ practice was rare in many US states often due to a lack of time and resources (Collins et al., 2007). Even where the evaluation of training is conducted, similar to here, the lack of randomization is often a problem in the research design used. However, a far more serious problem encountered in this study was the high level of attrition by study participants in relation to completing measures. It should be mentioned that of the 8 local authorities taking part in the study, 5 had recent OFSTED inspection reports (2014-2016) judging that their children services required improvement, whilst one was rated as inadequate. The decision by these local authorities to participate in either training or team-based learning to improve assessment skills in this area, may well have been driven by wider political considerations. A survey of child welfare workers in the US voiced concerns that training was being used in order to address agency performance problems and where training was not considered by these workers to be the solution and they were cynical of such attempts (Amodeo, Bratiotis, & Collins, 2009). Whether the high rates of attrition by study participants reflect more local conditions or is more indicative of the poor status accorded to training evaluation within social care more generally is not possible to know. However, high rates of attrition in training evaluation studies in social care has been highlighted in previous studies (Clarke, 2006). There are ethical dimensions to this problem too, as the failure to participate in evaluation studies of this kind is both wasteful and an inefficient use of resources if results are deemed unreliable. Nevertheless, including case audit in the evaluation design did mitigate this attrition to some degree. Future training evaluation studies should consider including as many objective measures of practice to assess behaviour change recognising that high rates of attrition may be likely.

**Conclusions**

Specifically, in relation to training in the area of child welfare, Collins (2008) bemoaned that “training programs are repeatedly delivered without adequate empirical evidence of their effectiveness” (p.241). Similar to much of the previous research examining the impact of training in social services and child welfare settings more specifically, neither the training programme nor participating in team based learning resulted in any significant changes to practice in the area of assessing parental capacity to change. In order for training to transfer to actual use on the job, the systemic nature of training effectiveness needs to be more fully appreciated by child welfare agencies. This recognises that training is unlikely to transfer to practice unless learners are motivated to use the training in practice and the workplace creates the conditions to support training transfer.We found no evidence of any effect from either training or team-based learning on the use of skills on the job as suggested by the case audit data. The significant finding that the training did result in improvements to declarative and procedural knowledge suggesting knowledge of how to use the assessment model in practice does raise concerns. It does suggest there may be factors outside the content and delivery of the training that may have affected the use of the learning on the job.

1. **Introduction**

Significant policy changes in England have refocused the professional practice of social workers on child welfare needs first, rather than immediately towards child protection. This has highlighted a number of concerns on the quality of analysis contained within social work assessments (Barlow, Fisher, & Jones 2012; Turney, 2009; Turney, Platt, Selwyn, & Farmer, 2011). This has taken on added significance within the context of reforms currently taking place within the family justice system. This places an emphasis on improvements in the quality of assessments brought by social workers before the courts. Courts find themselves often having to commission repeat assessments of the capacity of parents to make required changes to their parenting practice required for the safeguarding and well-being of their children (Ward, Brown & Westlake, 2012; Masson, Pearce & Bader 2008; Ward, Brown & Westlake 2012). The consequences of this are significant. A recent report by Brown & Ward (2013) for example, found that this was a major factor causing delays in reaching decisions in care proceedings. These timeframes are important as a child’s chances of achieving permanence with adoptive or foster parents diminish the greater the delay in reaching decisions. Furthermore, poor quality assessments in this area were the reasons for repeated attempts to reunite children with their parents that then lead to failure.

This has given rise to increased scholarly activity examining how the assessment of a parent’s capacity to change can be undertaken more effectively (Barlow & Scott, 2010; Harnett, 2007; Harnett & Dawe, 2008; Platt & Riches, 2016). Although, a number of models have been proposed, they all emphasise the importance of identifying a parent’s motivation to change their parenting behaviour over a period of time rather than just at a fixed time point. Barlow & Scott (2010) summarise the assessment as comprising (1) A cross-sectional assessment of the parents’ current functioning, (2) Specification of operationally defined targets for change, (3) Implementation of an intervention that addresses multiple domains, and (4) Objective measurement of progress over time.

In order for local authorities to deliver pre-proceedings work and court reports of a standard that will expedite court proceedings, it is essential that evidence-based training and training resources are available to achieve social worker improvements in the area of assessing parental capacity for change. However, we are faced with three significant challenges. The first concerns limited information on what should inform the content of training and development activities that might underpin improvements in practice in this *specific* area of assessment. The second is that we have little understanding of what types of training or learning methods are more likely to result in improvements to these particular assessment practices. The lack of an evidence-based approach to the implementation of child protection training and limited findings concerning its effectiveness more generally has been observed by a number of authors (Carter et al 2006; Cheung, Stevenson & Leung 1992; Franke, Bagadasaryan & Furman 2009; Lawrence & Brannen 2000; Leung & Cheung 1998). Third, and most importantly we have no data as to whether any changes to social care workers assessment skills in this area of practice can be sustained over time and have an impact on behavioural outcomes. All three challenges are critical to address the gaps between policy and practice that have been identified in recent research in this area. The latter is of key significance since there is also good reason to believe that social care agencies and those involved in child welfare in particular possess a range of factors that often militate against the learning and development interventions being effective. For example, compared to other types of organisations, work and organisational processes that support knowledge sharing and transfer to practice so critical for ensuring training is effective are not as well developed. This suggests training may have more limited impact in such work environments (Chiaburu, Van Dam & Hutchings, 2010; Curry et al 2005).

There is a need for greater understanding of what modes of training and development for social care workers are more effective, and for new development strategies that enhance the use of trained/learned skills on the job. Team-based learning approaches offer an alternative to training modes of skill development that have been suggested as better suiting the changing nature of the way social care work is undertaken. However, there is little research identifying how best team based learning should be designed nor what factors increase its effectiveness specifically within social care nor outside educational settings. This study was therefore conducted to compare traditional training with a team-based learning intervention to identify whether either of these learning approaches had an impact on social workers’ knowledge and skills in the area of assessing parental capacity to change, and if one approach was more effective than the other.

1. **Team-Based Learning: A New Approach for Developing Social Worker Skills?**

Although the link between training and better service or care outcomes has often been taken for granted (Tryssenaar & Gray 2004), research into the outcomes of training within social care suggests that the effects of training are far from convincing (Carpenter 2005; Clarke, 2001, 2002ab, 2006, 2013). By training we mean traditional, usually class-room based instruction of short durations. Clarke (2001) reported the results of twenty training evaluation studies that had been published between 1974 and 1997 including training in child protection. He cautioned that whilst it was common for training to receive positive responses from trainees and not infrequently produce gains in knowledge, there were real problems in finding that trained skills (e.g. risk assessment, communication, care management) are then used on the job. Since then, similar reviews of in-service training in the care and health sectors have tended to confirm the problematic nature of obtaining evidence for consistent use of training on the job. Walters et al (2005) for example, undertook a systematic review of the impact of workshop training in psychological treatment skills and found limited evidence for the use of training by trainees. A more recent search of social care training evaluation studies published since 1997, located 19 studies that has similarly painted a bleak picture of the extent to which training is found to achieve changes to the actual performance of social care workers (Clarke 2013). Most studies fail to find any evidence of any significant change.

Such evidence points to the need to research and develop improved learning, development and support mechanisms in social care settings. Alternative approaches should better support both on and off the job modes of learning (Billett 2001). These latter approaches differ from training in that they appear better at generating and facilitating the sharing of experiential, tacit and contextual knowledge integral to developing skills in problem-solving (Clarke 2005; Raelin 2000) and professional development (Eraut 2000). Further, problems such as defensiveness, blame and upward delegation of responsibility within child care services have been identified as undermining professional judgement and decision-making (Howe 2010; Searle & Patent 2013; Stanley & Manthorpe 2004). Learning processes that support structured reflection and emphasise *relationships* as the vehicle through which ‘information is collected and transformed into knowledge’ have been suggested as better able to counter these negative trends in practice (Morrison 2010a). Team-based learning is based upon learning through *relationships*. Consequently there has been an increasing interest in team-based learning among educators (Hunt et al 2003; Sharkey & Sharples 2003; Thomas & McPherson 2011).

* 1. **What is Team-Based Learning?**

Team-based learning approaches build on the work of Michaelsen, Knight & Fink (2004) and follow an approach to learning that emphasises the application of knowledge within team structures. It is a form of employee development where a team of professionals interact to apply content to simple and complex problems with the feedback of the facilitator as the content expert. The value of teamwork is consonant with social theories of learning (Bandura 1986), and experiential learning (Kolb 1984), which support the view that individuals achieve optimal learning when they are actively engaged with each other in processing new information. Team-based learning has been suggested to result in enhanced learning outcomes compared to approaches that rely on more traditional didactic methods (Anwar et al 2012). Students master content through repeated iterations of a three-step process that consists of (1) preclass preparation, (2) assurance of readiness to apply learned concepts and (3) application of content through group problem-solving activities. Haidet et al., (2012), comment that, “TBL moves beyond basic acquisition of facts to emphasize meaningful application of session or course content in real-world scenarios” (p293).

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Prior to each session participants are required to learn specific assigned content. Individuals and teams then apply this specified content to problem-solving discussions during the session. A key element of team-based learning is that individuals receive frequent and immediate feedback during the session on their learning from the facilitator as a content expert. Feedback on learning and performance is built into the learning delivery through a mechanism referred to as readiness assurance tests. Each time participants attend a session they are given tests/quizzes that they complete first individually then together in their team. These test the learning they were expected to have gained from the pre-reading. However an important aspect is that these tests require participants to *apply* the learning in a problem-solving format. In so doing this should enhance the transferability of learning to real-life practice. There is some empirical evidence that increased accountability to the peer group, a key feature of team-based learning appears to play a significant role in the learning gains observed in a variety of settings (Koles et al., 2010; Warrier et al., 2013).

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1. **The Research Study**

The objectives of the study were as follows:

1. To compare the impact of training and team-based learning approaches on participants’ knowledge and practice in assessing parental capacity for change
2. To assess the impact of team-based learning on key behavioural indicators (improved quality of assessments and the progress of cases following assessment).
3. To identify if co-worker support enhances the transfer of learning from training and team-based learning approaches to professional practice.
4. To identify factors associated with the effectiveness of team-based learning in supporting participants’ knowledge and practice gains in assessing parental capacity for change

*Specific Hypotheses*

Team based learning is argued to have a number of advantages over traditional learning methods due to its emphasis on three key components: (1) Advanced preparation by learners through reading materials, (2) both individual and then team testing of learning and (3) the majority of time during sessions devoted to the application of learning through problem solving exercises such as case studies (Burgess, McGregor, & Mellis, 2014). Rather than learning merely being construed as the acquisition of facts it is instead a highly learner-centred learning process which places problem-solving at its core. In this way it integrates more constructivist and experiential perspectives of learning where individuals actively engage with one another and the material to solve real life problems (Hrynchak & Batty, 2012). Empirically, two studies conducted within medical schools have reported superior performance on measures of learning for those using the TBL method (Thomas & Bowen, 2011; Zingone et al., 2010). In a more recent study using a randomized research design, TBL was again found to be more effective than traditional teaching approaches with students on a psychology programme (Travis, Hudson, Henricks-Lepp, Street, & Weidenbenner, 2016). This gives rise to the following hypothesis:

*Hypothesis 1: Participants attending team-based learning will demonstrate better performance on measures of both declarative and procedural knowledge in the area of assessing parental capacity for change compared with those who attend training and a comparison group.*

The extent to which team-based learning might also be an effective learning method for skill acquisition and performance on the job remains a relatively unexplored area beyond studies showing improvements in self-reported skills (Seale et al., 2012; Shellenberger et al., 2009; Touchet & Coon, 2005). In a recent study examining the impact of team-based learning on the acquisition of substance use screening, assessment and intervention skills by junior doctors encouraging findings were reported. Thirty-two postgraduate medical students participated in team-based learning in the US and these demonstrated enhanced intervention skills compared to a control group (Walmsley et al., 2013). Given that the acquisition of procedural knowledge has been found to be closely associated with actual use of skills on the job (Kraiger, Ford, & Salas, 1993), we should expect team-based learning to be a more effective learning method to promote skill acquisition and use on the job then traditional training approaches. Team based learning should give rise to greater use of the key skills associated with the assessment of parental capacity to change. This gives rise to the following hypothesis:

*Hypothesis 2: Cases from participants attending team-based learning will demonstrate (a) greater use of setting SMART goals for families, (b) greater use of goal attainment scaling, (c) greater use of standardised instruments to assess change, and (d) greater use of evidence based interventions as part of the change process compared to those attending training or a comparison group.*

Previous research has shown that both learning goal and performance goal orientation are related to both learning and transfer following training (Dierdoff et al., 2010). Individuals are believed to have particular dispositions towards developing or demonstrating abilities in achievement contexts, referred to as goal orientations (Dweck 1986). Two major types of goal orientations have been identified. Learning goal orientation refers to the disposition to seek to develop new skills and master competence in the face of novel situations. Individuals with a higher learning goal orientation have been shown to invest more effort in order to master tasks (Vandervalle 2001). Performance goal orientation by contrast, refers to the disposition to seek positive judgements and avoid negative attributions to validate one’s competence. The avoidance of failure and the need to be seen as competent by others are far greater motivational factors (Elliot & Sheldon 1997; Fortunato & Goldblatt, 2006). These alternative goal dispositions are therefore essentially about promoting either learning or performance appraisal respectively. Individuals with a learning goal orientation tend to hold stronger beliefs that their abilities can be developed and tend to have more adaptive responses to task difficulty and higher expectancy that their effort will result in positive outcomes (Dweck & Leggett, 1988). Those with a performance goal orientation however, tend to view failure as due to a lack of ability rather than effort (Button, Mathieu, & Zajac, 1996). A number of previous studies have found a learning or mastery goal orientation to be a stronger predictor of training outcomes than a performance goal orientation (Fisher & Ford, 1998; Kozlowski et al., 2001; Phillips & Gully, 1997) as well as associated with pre-training motivation (Chiaburu & Marinova, 2005). This gives rise to the following hypothesis:

*Hypothesis 3: Learning goal orientation will be a stronger predictor of both declarative and procedural knowledge than performance goal orientation.*

*3.1 Designing the Content of the Training and Team-Based Learning*

Prior to conducting the evaluation study 12 staff based in children services from 8 local authorities in England were invited to join a change project to develop a learning pack covering knowledge and skills involved in the assessment of parental capacity to change within children’s services. The project lasted 12 months and was coordinated and administered by Research in Practice, a non-statutory organisation whose mission is to champion evidence-informed practice in children’s services and who were a partner in the research project. The organisation works closely with a partnership network, with members consisting of local authority children’s services from across the country. Those joining the change project were drawn from this partnership network and consisted of both social workers and learning and development professionals. The change project was facilitated by a member of staff from Research in Practice and a member of staff from the NSPCC who also joined the project. The aim of the project was to develop a learning pack and associated materials that could be used for delivering training or team-based learning in this area of assessment. The principal investigator joined the project for its duration to provide additional expertise in the area of team-based learning.

The pack was designed based upon Dawe & Harnett’s 2C2 model as guidance and consisted of four modules, each of a half duration. Key features of this model include the use of standardised instruments in assessment in order that an objective measure of change can be determined, the use of goal setting and goal attainment scaling and the use of evidence-based interventions (in relation to the latter the course content drew heavily upon recent systematic reviews i.e. Barlow & Hall 2012; Barlow & Schrader-McMillan 2010). This model also makes explicit use of goal setting theory which has extensive empirical support applied throughout the social sciences (Locke & Latham 2006). Each module was developed as a ‘stand alone’ session that would be delivered in one team-based learning session (Michaelson, Knight & Fink, 2004).

Much of the early development work within the change project involved discussions on the use of the team-based learning approach. The use of testing within team-based learning combined with the preparatory reading required before attending each module were raised as concerns as to whether this approach to staff development was appropriate in children’s services. The project finally agreed that the pack would be underpinned by a team-based learning methodology but how the team-based learning was delivered would have to be amended. Members of the project then became more familiar with the requirements for assessing parental capacity to change based upon the model supported by the facilitators and extensive reading. The project was also supported by a blog as it progressed and materials added to a sharepoint site as the content of the pack was develop ed. On completion the learning pack comprised the following key elements. Each of the four half-day sessions were structured so that they commenced with team testing and feedback based upon the ‘homework’ they had been given prior to the session and addressed one of the four stages in the Dawe & Harnett assessment model.

A case study was designed to be used throughout the learning delivery where additional information was incrementally provided so that participants could address the knowledge and skills required by each of the four stages of the assessment model. The case study formed an important part of the programme in enabling participants to apply the learning they had gained. The case study thus enabled participants to practise setting realistic and time limited goals for families, undertaking goal attainment scaling, using and scoring a number of standardised assessment instruments, and identifying evidence-based interventions that could be used as part of the assessment of parental change. The completed pack was structured with learning materials including powerpoint slides for each session, resource materials (relating to standardised instruments and evidence-based interventions), homework (required reading before each session) and a knowledge test (with answers) designed for each session. The learning outcomes for each of the four sessions were:

Module 1: (1) Gained insight into your own assessment practice and how you can adopt a more evidence-based approach, (b) Increased your knowledge of the Dawe & Harnett C2C model as the basis for guiding decision-making in the assessment of parental capacity to change, (c) Increased your understanding of the impact that the use of standardised measures can have on assessing parental capacity to change.

Module 2: (a) Gained skills in the interpretation of baseline scores generated from standardised measures, (b) Gained skills in case formulation, (c) Gained skills in setting appropriate goals and securing engagement from families.

Module 3: (a) Demonstrate an understanding of evidence-based decision making in relation to family interventions, (b) Identify a range of evidence-based interventions for use with families, (c) Demonstrate an understanding about how intervention outcomes are linked to the GAS process.

Module 4: (a) Gained skills in scoring standardised measures based on new information gained from evidence-based interventions, (b) Gained skills in the analysis of goal attainment scaling, (c) Gained skills in communicating intervention results in court reports.

*3.2 Methodology for the Evaluation*

A mixed methods research design was employed to achieve the objectives of the study combining both quantitative and qualitative approaches. This is consistent with recent calls within the training literature for studying whether learning transfers to behaviour change on the job (Burke & Hutchins 2007). The quantitative component consisted of a longitudinal repeated measures design with measures of knowledge gain collected over a 8 month period during the course of the 2 year study (Sep 2014-August 2016). Measures of behavioural outcomes were taken prior to participants attending team-based learning or training and then again between 6-12 months later. The use of such a longitudinal, pre/post research design and methodology to determine the impact of training and team-based learning is well supported within the literature as better able to capture learning and transfer effects (Clarke 2002a, 2006, 2010). The qualitative component of the study involved conducting telephone interviews with training and team-based learning participants between 8-12 months following their participation in the learning intervention.

*3.3 Procedure and Participants*

The research project initially had agreement from 5 local authorities to participate in the study where team-based learning was envisaged to be delivered by professional training and senior social work practitioner staff in these authorities. Importantly, these staff were also involved in the change project that had developed the learning pack and therefore fully acquainted with the learning content. Shortly after the research project commenced, four of these authorities had to withdraw. Some of the reasons were due to senior managers leaving the authority or due to the authority undergoing significant organisational restructuring which meant they were unable to commit time to the project. Emerging changes in the remaining local authority also meant that they had to significantly scale back their level of involvement. The alternative form of delivery, training was provided by the two facilitators from the change project to staff in five different local authorities who subsequently agreed to take part in the study. Recruiting alternative local authorities to participate in the team-based component of the study proved a significant challenge throughout the duration of the research project which compromised the research design and sample. We initially planned to evaluate six training programmes (approximately 150 participants) and 35 team-based learning interventions (approximately 300 participants) to social workers and other professionals involved in child protection. The final sample consisted of 5 local authorities who received training (84 participants) and 3 local authorities who agreed to take part in the team-based learning component (64 participants). Staff from two teams in one of the local authorities participating in the team-based learning also agreed to act as a comparison group (19 participants). The total sample size was thus 167. Organisational concerns, pressures for delivering training and the challenges encountered in recruiting study participants to the team-based learning meant it was not possible to achieve a random assignment of participants between the three treatment groups thus bias through differential selection processes is a potential problem. These constraints also resulted in having to change the research design. Although initially planning to collect knowledge data at pre, 1month post, 4 month post and 8-month post, the research design was amended to collect data only up to 4 months post training.

*3.4 Ethics*

Approval to conduct the study was obtained from the University of Southampton ethics approval board. Letters were sent by email to participants explaining the purposes and procedures of the study and requesting them to take part in the evaluation. Confidentiality was highlighted as a significant issue both in relation to participants completing questionnaires and in accessing live social work cases as part of the case audit component of the evaluation. In relation to the latter it was agreed in all but one local authority that the principal investigator would be able to view case files at each of the local authorities supervised by a senior member of staff having either submitted a signed confidentiality agreement or being granted access through the authority’s research governance structures. Confidentiality for participants completing questionnaires as part of the evaluation was also emphasised.

*3.5 Measures*

*1. Declarative and Procedural Knowledge of Assessing Parental Capacity for Change*

We collected measures of both declarative and procedural forms of knowledge. Declarative knowledge is that relating to facts whilst procedural knowledge is the application of facts as part of a problem solving process and is more closely associated with the type of knowledge used in practice (Kraiger, Ford & Salas 1993). Declarative knowledge was assessed through administering a test covering the learning content covered on both the training and team-based learning interventions. This included knowledge of the Dawes & Hart assessment of capacity to change model and knowledge of standardised assessment instruments. We assessed procedural knowledge through the use of case vignettes.

Case vignettes assess acquisition of knowledge and its application to novel problem solving situations and have been applied previously in evaluations of practice within social care (Clarke 2002, 2006; MacIntyre et al 2011; Wilks 2004). Two different case vignettes were designed. The first was used for collecting data at the pre and 1 month post time points, while a second different case vignette was designed for collecting measures 4 months post attending training or team-based learning. This was to ensure that participant’s scores on the procedural knowledge test were not influenced by prior exposure to the same case. Previous experiences in using case vignettes asking participants to write “essay type” responses which are then assessed by external raters have often met with high rates of attrition (Clarke 2002b; MacIntyre et al 2011). To help minimize attrition we therefore used a more straightforward multiple choice response format for both measures of declarative and procedural knowledge. Both forms of knowledge were assessed by the use of an online questionnaire.

In order to match responses over time, participants were requested to enter the two initials of their mother’s maiden name followed by the last two digits of their date of birth. The measures of both declarative and procedural knowledge can be found in appendix 1. Declarative knowledge consisted of 13 questions (1-13) with a true/false/ don’t know response format in section A. Participants received one mark if they answered the question correctly. False or Don’t Know responses were not scored. The total possible score from this section was thus 13. The remaining six questions 14-19 in section B asked questions that respondents had to choose whether one or more stated responses to a question were correct. In this instance respondents received one mark for every correct response but had one mark deleted if they chose a response that was incorrect. A maximum of 16 marks were possible if all correct responses were selected. Therefore, a total of 29 marks were possible for declarative knowledge. The two case vignettes and their associated questions were contained in section C. Each question had the following multiple choice responses, Yes, No or Don’t Know. Participants received one mark for a correct answer but no marks deducted for an incorrect answer. A maximum of 4 marks were therefore possible for procedural knowledge.

*2. Behavioural Outcomes*

It was initially planned that the local authorities signed up to the research project would use their existing case audit processes to examine whether those participating in team-based learning changed their practice in response to the learning intervention. The challenges to the research project that then emerged meant that this was no longer possible. Instead, the principal investigator undertook the case audit of all those participating in the study. This included those participating in team-based learning, training or the comparison group. Visits were made to all local authorities taking part in the study where access to case records was permitted.

Study participants’ case records were examined to determine whether particular aspects of the assessment of parental capacity to change model that formed an integral part of the training and team based learning were present. The process involved examining 50% of all family cases held by a research participant at that time. All case documentation that were authored by the participant and were held six months prior to and six months following attendance at the intervention were examined. The process involved examining every other case alphabetically listed on the study participant’s list of case records. The case audit process examined each case to determine whether 5 key aspects relating to the assessment of parental capacity to change had been implemented. The audit commenced by first identifying how many family cases were currently held. Then examining every other case to determine whether (1) an assessment of parental capacity to change had been undertaken; (2) Whether SMART goals had been used as part of this assessment; (3) Whether Goal Attainment Scaling had been used in the assessment; (4) Whether standardised instruments had been used to take baseline measures and reused to assess change and (5) Whether evidence-based interventions had been drawn upon as a means to achieve the goals that had been set in the assessment of change. Cases were coded using a coding frame where participants received one point for each time a behavioural indicator was found in a case. Measures were taken within 1-3 weeks prior to any participant attending either training or team-based learning and again between 6-12 months following participation.

3. *Learner Characteristics*

*(i) Conscientiousness*. This was measured using a 10-item measure from the Big Five personality factors contained in the International Personality Item Pool (Goldberg et al 2006) (α = 0.82).

*(ii)* *Goal Orientation*. Learning and Performance goal orientation were measured using the 6-item and 4-item scales developed by Button, Mathieu, & Zajac, (1996). Reliability scores for these two measures were (0.84) and (0.81) respectively.

*(iii).Demographic Measures:* (i) Demographic details were collected on the on-line questionnaire. These were age, gender, ethnicity, level of education and tenure with organisation. Participants were asked to select from a range of categorically coded variables.

1. **Results**

Analysis of quantitative data was undertaken using statistical analysis software package, SPSSV.21

*4.1 Declarative and Procedural Knowledge Measures*

*4.11 The Sample*

The study met a significant problem in relation to the degree of attrition encountered. The number of those registered to attend training, team-based learning and participate in the comparison group are displayed in Table 1. Despite a total sample of 167, complete data sets were only obtained for 39 or just over 23% of the total sample at 4-months post test. At one month post test, only 15 study participants completed measures and of these, 12 responses were from participants not completing baseline measures. As a result one month post measures were not included in any subsequent analyses. Despite a total sample of 167, complete data sets were only obtained for 39 or just over 23% of the total sample at 4-months post test. In relation to the training group, although 78.6% (66) of those registered (84) completed baseline measures, complete data sets at 4 months post-test were only obtained for 34.5% (239) of those initially registered and who were sent questionnaires to complete. There were more significant declines in participation for those participants who attended team based learning. Here, although almost 80% (46) of those registered completed baseline measures, complete data sets were obtained for only 9% of those initially registered. Similar problems were encountered for the comparison group where participation dropped from 84% (16) to 21% (4) of those originally registered.

**Table 1: Participants Completing Measures**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Registered | Baseline Measures | 4 Months Post |
| Training | 84 (50.3%) | 66 (51.6%) | 29 |
| Team-Based Learning | 64 (38.3%) | 46 (35.9 %) | 6 |
| Comparison Group | 19 ( 11.4%) | 16 (12.5%) | 4 |
| Total | 167 (100%) | 128 (100%) | 39 (100%) |

The characteristics of the sample for which complete data sets were obtained was as follows There were 32 women (82.1%) and 7 (17.9%) men. 1 (2.6%) participants were aged between 18-24, 3 (7.7%) between 25-29, 6 (15.4) between 30-34, 5 (12.8%) between 35-39, 5 (12.8%) between 40-44, 8 (20.5%) between 45-49 and 9 (23.1%) aged 50+. 2 (5.1%) participants did not disclose their age. The majority, 35 (89.7%) defined themselves as white British, with the remaining participants defining their ethnicity as follows, 1 (2.6%) as Mixed Black African & White, 1 (2.6%) as any other white. 2 (5.2%) participants did not disclose.

The highest level of qualification obtained by the majority was BA degree with 24 (61.5%) of the sample. This was followed by 6 (15.4%) participants with a Masters degree, 5 (12.8%) with GCSE, and 2 (5.1%) with A level education. 2 (5.1%) did not respond. Finally, the majority of the sample, 16 (41.0%) had been with their organisation for over ten years. This was followed by 8 (20.5%) between 2-5 years, 7 (17.9%) between 6-10 years, 6 (15.4%) under 2 years. 2 participants did not disclose. (Characteristics of the baseline sample can be found in appendix 2).

A series of one way ANOVAs were performed to determine whether there were any significant differences between those completing only baseline measures and those completing baseline and 4 month post measures. The results were all insignificant: gender (*F*=1.52, df=1), p<ns, Ethnicity (*F*=0.24, df=1)p<ns, age (*F*=.03, df=1)p<ns, education (*F*=0.22, df=1) p<ns, tenure (*F*=0.07, df=1).

4.12 The means, standard deviations and correlations among the demographic and knowledge measures are displayed in Table 2 for the study sample using complete data sets.

Of the demographic variables, age was significantly but negatively correlated with education and to be expected positively with the length of employment (tenure) at the organisation. Tenure was also negatively correlated with the level of education. However, level of education was positively correlated with baseline declarative knowledge scores. Of the learner characteristics conscientiousness was positively correlated with learning goal orientation which is consistent with this aspect of personality being associated with individuals applying greater effort in tasks. Baseline declarative knowledge score was positively correlated with both 4-month post declarative knowledge and 4-month post procedural knowledge scores. Finally, 4-month post declarative knowledge scores were significantly correlated with 4-month post procedural knowledge scores.

**Table 2 Correlation Between Variables in the Study**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Mean (SD) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |
| 1.Gender |  | - |  |  |  |  |  |  |  |  |  |  |
| 2. Age |  | -.10 | - |  |  |  |  |  |  |  |  |  |
| 3. Ethnicity |  | .03 | -.13 | - |  |  |  |  |  |  |  |  |
| 4. Education |  | -.002 | **-.37\*** | .07 | - |  |  |  |  |  |  |  |
| 5. Tenure |  | -.03 | **.37\*** | -.20 | **-.46\*\*** | - |  |  |  |  |  |  |
| 6. Conscientiousness | 4.63 (.49) | -.03 | -.01 | -.01 | -.09 | .02 | - |  |  |  |  |  |
| 7. Learning Goal Orientation | 5.43 (.57) | .09 | -.08 | -.08 | .30 | -.28 | **.35\*** | - |  |  |  |  |
| 8. Performance Goal Orientation | 5.11 (.78) | -.19 | -.09 | -.09 | -.12 | -.04 | .05 | .12 | - |  |  |  |
| 9. Baseline Declarative Knowledge | 14.05 (3.99) | -.23 | .11 | .11 | **.51\*\*** | .01 | -.26 | .26 | -.17 | - |  |  |
| 10. Baseline Procedural Knowledge | .51 (.82) | .03 | .05 | .05 | .16 | .16 | .02 | .04 | -.27 | .28 | - |  |
| 11. 4-Month Post Declarative Knowledge | 15.95 (4.59) | -.20 | .03 | .03 | -.20 | .17 | -.18 | .26 | .22 | **.44\*\*** | .24 | - |
| 12. 4-Month Post Procedural Knowledge | 1.85 (1.60) | -.17 | .27 | .27 | .07 | .07 | .04 | .18 | .12 | **.35\*** | .20 | **.44\*\*** |

* 1. Changes in Declarative and Procedural Knowledge

The Mean Baseline and 4-month post Scores for declarative and procedural knowledge for the three groups (training, team-based learning and comparison group) are presented in Table 3. The results show increases in mean scores for participants attending both training and team-based learning. To determine whether these differences were statistically significant a 2 (time [before,after] x 3 (condition [training, team-based learning, comparison group] with repeated measures analysis of variance (ANOVA) was performed with each of the knowledge measures as the dependent variable. A significant effect was found for time x group (*F*=3.27, df=2), p<0.05, partial eta squared = .15 on declarative knowledge scores. The effect of time (change between baseline and 4-month post scores) on its own was not significant (*F*=1.55, df=1), p<n.s. A significant effect was found for procedural knowledge due to time (*F*=5.24,

df=1), p<.05., partial eta squared = .127. However the effects of time by group were only found to be significant at the .10 level (*F*=2.16, df=2), p<.10 for procedural knowledge.

In order to identify which groups showed statistically significant increases in their procedural and propositional knowledge scores, paired t tests were performed to compare the training, team-based learning and comparison group pre and post test scores. The results show there is a significant difference in scores for the training group on propositional knowledge (*t*(28) =-2.57, *p* <.05) and procedural knowledge (*t*(28) =-5.49, *p* <.001). Whereas the team-based learning group only showed statistically significant changes on their propositional knowledge scores (*t*(5) =-2.14, *p* <.10) and that was only at .10 level of significance. Hypothesis 1 was therefore not supported.

**Table 3 Differences in Mean Knowledge Scores**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Condition | N | Propositional Knowledge pre intervention | Propositional Knowledge 4 months post  | Procedural Knowledge pre intervention | Procedural Knowledge 4 months post |
| Training | 29 | 14.31 (4.30) | 16.35 (4.37) | 0.48 (.78) | 2.10 (1.65) |
| Team-Based Learning | 6 | 13.33 (3.67) | 17.67 (4.23) | 0.67 (1.03) | 1.50 (1.38) |
| Comparison Group | 4 | 13.25 (2.22) | 10.50 (3.42) | 0.50 (1.00) | 0.50 (.57) |

*4.2 Behavioural Outcomes*

Of the 167 participants who were registered to attend either training or team-based learning or participate in the comparison group, baseline behaviour (case audit) measures were obtained for 150 participants. The remaining 17 participants were not carrying caseloads at the time of the baseline audit. Measures were able to be collected taken six months following attendance on training or team-based learning for only 90 (54%) of the original 167 participants registered. This was again due to a number of staff not carrying caseloads, but also due to a significant number of staff having left the organisation, moved to another part of the organisation, been promoted, or were on maternity leave. Details of the case audit sample are shown in table 4.

**Table 4: Case Audit Measures**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Registered | Baseline Measures | 6 Months Post |
| Training | 84 (50.3%) | 68 (45%) | 45 (50%) |
| Team-Based Learning | 64 (38.3%) | 63 (42%) | 32 (35.5%) |
| Comparison Group | 19 ( 11.4%) | 19 (13%) | 13 (14.5%) |
| Total | 167 (100%) | 150 (100%) | 90 (100%) |

Table 5 displays the mean number of occurrences found in cases for each of the four behavioural dimensions associated with the assessment of parental capacity to change model that formed the core learning on both the training and team-based learning. Under each behavioural indice column mean scores are initially displayed at baseline and 6 month post intervention scores shown underneath in bold. In order to examine whether any of the elements of the assessment model were being adopted outside undertaking parental assessments of capacity to change specifically, all those from whom complete datasets were obtained pre and post training or team-based learning were also investigated to determine whether changes could be found in either of the four behavioural indices. A 2 (time [before, after] x 3 (Condition [training, team-based learning, comparison group] with repeated measures analysis of variance (ANOVA) was therefore again performed using each of the four key behavioural indices (setting SMART goals, Use of goal attainment scaling, Using standardised instruments to measure change, and use of evidence based interventions to achieve change) as dependent variables. There was no significant interaction effects for time x condition on any of the four behavioural dimensions *Setting Smart Goals* (*F=*1.03, df=2), p< *ns; Goal Attainment Scaling* (*F=*0.49, df=2), p<*ns; Using Standardised Instruments* (*F*= 1.01, df=2), p<*n.s; Use of Evidenced-Based Interventions* (*F=*0.01, df=2), p<*ns.*

*4.21 Case Audit Results only for those Performing Parental Capacity to Change Assessments*

The second set of analyses was performed only on those participants where the inspection of their case records indicated they had undertaken an assessment of parental capacity to change in the six months following attendance at either training or team-based learning resulting in a far smaller sample (55). The results are presented in Table 6. To determine whether the practice of assessments undertaken before and after training or team-based learning had changed a 2 (time [before, after] x 3 (Condition [training, team-based learning, comparison group] with repeated measures analysis of variance (ANOVA) was performed using each of the four key behavioural indices (setting SMART goals, Use of goal attainment scaling, Using standardised instruments to measure change, and use of evidence based interventions to achieve change) as dependent variables. There was no significant interaction effects for time x condition on any of the four behavioural dimensions *Setting Smart Goals* (*F=*1.94, df=2), p< *ns; Goal Attainment Scaling* (*F=*0.81, df=2), p<*ns; Using Standardised Instruments* (*F*= 0.48, df=2), p<*n.s; Use of Evidenced-Based Interventions* (*F=*0.29, df=2), p<*ns.* Hypothesis 2 was therefore not supported.

**Table 5 Assessment of Parental Capacity to Change Behavioural Indices**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Intervention | N\* | Mean Case Load | Smart Goals | GAS | Standardised Instruments | Evidenced-Based Interventions |
| *Training*Baseline6 months  | 45 | 9.40 (6.73)**11.84 (5.07)** | .02 (.15).**40 (1.44)** | 0.00\*\***.02 (.15)** | 0.00**.04 (.21)** | .16 (.47)**.07 (.33)** |
| *TBL*Baseline6 months | 32 | 11.34 (3.33)**10.78 (4.16)** | 0.00**0.00** | 0.00**0.00** | 0.00**0.00** | .66 (.97).**56 (2.65)** |
| *Comparison*Baseline6 months | 13 | 16.46 (3.64)**12.77 (6.03)** | 0.00**0.00** | 0.00**0.00** | 0.00**0.00** | .31 (.63)**.15 (.37)** |

\*N=90 Complete data sets; \*\*0.0= no one demonstrated this behaviour

*4.22 The Role of Learner Characteristics*

 In order to examine whether learner goal orientation was more predictive of knowledge gain then performance goal orientation, these motivational factors were regressed against final knowledge scores as the outcome variable with baseline knowledge scores entered as a control variable. Only participants who participated in either training or team-based learning were included in the sample. First age, education and tenure with the organisation were entered as a first block of variables since these were earlier found to have significant correlations with final knowledge scores. Next, baseline knowledge score was entered in the second block followed by conscientiousness. Finally, learning and performance goal orientation were entered in the final block. The results are shown in table 7. Only performance goal orientation was found to be significantly associated with final knowledge scores and this was at the .10 level of significance. Hypothesis 3 was therefore not supported.

**Table 6 Participants Undertaking Assessment of Parental Capacity to Change**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Intervention | N\* | Mean Case Load (SD) | Assessment(SD) | Smart Goals (SD) | GAS (SD) | Standardised Instruments(SD) | Evidenced-Based Interventions (SD) |
| *Training*Baseline6 months  | 30  | 9.40 (6.30)**12.07 (4.30)** | 1.23 (1.57)**2.70 (3.15)** | 0.00**.60 (1.73)** | 0.00**.03 (.18)** | 0.00**.07 (.25)** | .13 (.43)**.10 (.40)** |
| *TBL*Baseline6 months | 18 | 11.89 (3.53)**3.33 (4.04)** | 1.28 (1.18)**2.17 (1.04)** | 0.00**0.00** | 0.00**0.00** | 0.00**0.00** | .72 (1.13)**.94 (3.52)** |
| *Comparison*Baseline6 months | 7 | 17.57 (3.95)**11.57 (5.94)** | 1.43 (.97)**1.71 (.49)** | 0.00**0.00** | 0.00**0.00** | 0.00**0.00** | 0.29 (0.49)**0.29 (0.49)** |

\*N=55 Complete data sets

**Table 7 Regression of personality and motivation factors on final knowledge scores**

|  |  |  |
| --- | --- | --- |
|  | Propositional Knowledge  | Procedural Knowledge |
|  | Beta | R2 | Delta R2 | F | Beta | R2 | Delta R2 | F |
| Step 1AgeEducationTenure | .38.01.82 | .14 | .14 | 1.59 | .22.15-.01 | .05 | .05 | .48 |
| Step 2Baseline Knowledge Score | **.54\*\*** | **.34** | .20 | **3.56\*\*\*** | .35 | **.**15 | .10 | 1.21 |
| Step 3ConcientiousnessLGOPGO | -.08.05**.27\*** | **.42** | **.08** | **2.56\*\*** | -.01.52.22 | .21 | .06 | .95 |

N= 35; \*p<.10, \*\*p<.05, \*\*\*p<.01.

* 1. *Qualitative Data*

All participants registered to attend either training or team-based learning were contacted by email and asked to take part in a telephone interview. 15 participants agreed to participate (Table 8). Interviews were conducted between 6-12 months following attendance on either training or team-based learning. All interviews were undertaken in accordance with the guidelines and codes of conduct recommended by both the British and American Psychological Societies (APA 2002; BPS 2009), recorded and lasted on average 15 minutes. A semi-structured interview schedule guided data collection (Appendix 2). Data were analysed utilising an iterative approach so that data analysis proceeded alongside data collection. Use was made of the constant comparative method (Strauss & Corbin, 1990) where the principal investigator drew upon previous theory in training and team-based learning to identify factors associated with the effectiveness of the learning interventions. Each transcript was treated as a case and initially analysed to identify four key themes: (1) the impact of the training or team-based learning on actual practice (2) factors associated with the effectiveness of the learning intervention and (3) how practitioners were using the model of assessing parental capacity to change that formed the content of the learning intervention. This was followed by more in depth data analysis where datasets were coded identifying more emergent themes and categories.

**Table 8 Interview Participants**

|  |  |
| --- | --- |
| Training | Team-Based Learning |
| 1. Social Worker, Child Protection team, 5 years tenure | 10. Family Support Worker, 7 years tenure |
| 2. Social Worker, LAC Team, 10 years tenure | 11. Children’s social work assistant, 1 year tenure |
| 3. Social Worker, Child Protection team, 6 years tenure | 12. Social worker, child protection team, 10 years tenure |
| 4. Social Worker, Child Protection team, 8 years tenure | 13. Social worker, child protection team, 4 years tenure |
| 5. 16+ Social worker, under 2 years tenure | 14. Social work assistant, 6 years tenure  |
| 6. Principal Social Worker, Child in Need Team, 11 years tenure | 15. Social worker, child protection team, 6 years tenure |
| 7. Social Worker, Child Protection and Court team, 6 years tenure |  |
| 8. Social Worker, Child Protection and Court team, 5 years tenure |  |
| 9. Social Worker, Child Protection team, 2 years tenure |  |

* 1. *Findings*

**The Assessment Model.**

One of the key themes to emerge from the data was that there were particular aspects of the assessment model that formed the basis of the training and team-based learning that participants were not comfortable with or confident in using. This centred particularly on two aspects of the assessment process associated with using standardised instruments and goal attainment scaling.

I struggled with the scoring, you know the scoring and I think. Trying to get my head round that was quite difficult, I’m not very good with numbers at the best of times. **(15. Social Worker, Child Protection team, 6 years tenure, TBL).**

That was quite tricky yes, I found that tricky because I’m not very good at that sort of logical approach really of adding things up and then, so obviously there are ways of doing it so that the person who you were questioning couldn’t adapt their answers to fit wasn’t there? found that quite complicated scoring, yes definitely I did find that complicated. Some people found it really easy and I was struggling to keep up so it depends on your approach I think. **(15. Social Worker, Child Protection Team,Training Group, 10 years tenure).**

I was quite surprised a lot of it seemed to be scoring and adding up scores and almost quite prescriptive really, I don’t know if that’s the right word, but it didn’t sit very well with me I must admit. Towards the end when we did some practice ones where we looked at case studies and I thought oh yes I can see how this is applied but at the time it didn’t seem to have any real world application. **(13. Social worker, Child Protection Team, 4 years tenure, TBL).**

How to use it. They were really complicated I think. The scoring for the one where you had to go to like four. Yes. Scoring was difficult. **(10. Family support worker, 7 years tenure, TBL).**

I think with a lot of training that I’ve done it’s either been a recap of what I already do or I can’t use it. That has been my, that’s not just with that particular training because I can’t really remember much but that’s been my overall sort of view really so there’s only been certain specific training that I’ve actually been able to use… I thought well it was really interesting don’t get me wrong and I came away thinking yes I’ve learnt quite a lot but I didn’t feel comfortable enough to use any of what they had taught **(12. Social worker child protection team, 10 years, TBL).**

the actual working out the measures that’s the bit I struggled with a bit but I liked the goal setting, it’s GAS isn’t it? Goal attainment scaling, and I thought that could be adapted if it couldn’t be done exactly in that way that would take the time because it’s over quite a long period of time isn’t it that the goals are set and our intervention in my team can be quite brief, we could do the initial assessment and then it’s passed on to a different team so it could be adapted for a short term piece of work. . **(6. Principal social worker, child in need team, 11 years tenure, training group).**

For some of the participants, this lack of confidence in using standardised instruments as part of the assessment model also meant they felt it more appropriate for other specialist agencies or professionals to address key issues connected to poor parenting:

I mean if the social worker has done that type of work and they are able to work with them and contribute into it I think it’s ideal for social workers to do some of the work but if the social workers haven’t done that type of training like alcohol abuse and things then it’s better to signpost them to the agencies that can do it. **(11. Children’s social work assistant, 1 year, TBL).**

This seemed to be, I don’t know I’m guessing but I’m guessing it’s more into psychiatric side of stuff with scoring and so on…I did take some stuff away but it was such a long time ago… but it was looking at, it was around depression and anxiety and their capacity to change. **(5. 16+social worker, Training Group, under 2 years)**

I thought the goal setting was good but I don’t use it in the way they said. I didn’t use standardised instruments to look at change. So if its drug or alcohol problems for example I prefer to use the information given to me from addaction. Theyre the experts aren’t they and its part of the multiagency approach. You can also tell whether things have change through your own observation… I mean you can tell if someone is still using drugs by their demeanour and the state of the surrounding… I tend to rely more on more my own professional judgement **(1. Social Worker, Child Protection Team, 5 years tenure, Training Group)..**

Again supporting the case audit data findings, there was also some indication that setting specific and measurable goals was also something that was not adopted in practice:

Just the core assessment process and using the child and family assessments and generic tools would say rather than anything specific in measuring outcomes. It’s a very much crisis driven job isn’t it unfortunately? **(12. Social Worker, Child Protection Team, Training Group, 10 years tenure, TBL).**

It’s difficult because we’re working with a lot of very resistant families particularly in child protection and court teams so our measures, there is limited time for people to make some changes and some of those changes that are lifetime events that people aren’t able to do and then for the family that can be a very negative outcome but they could be positive outcomes for the children. **(13. Social Worker, Child Protection Team, 4 years tenure, Training Group).**

We give them specific goals to do usually when they’ve been put on the child protection plan don’t we, they have to do certain things but I think it’s better to get the family on board to say what they want to change because they are far more likely to make change if they come up with the ideas themselves and can see what the concerns are. **(15. Social worker child protection team, 6 years tenure, TBL).**

saying to parents like OK this is a concern what are you going to do about it and they come up with their ideas of how they can address or obviously some of them argue and say that’s not right and they are far more likely then to change because they are the ones that are coming up and identifying ways of doing that so rather than doing to parents they are more included coming up with their own ways of keeping their children safe. **(9. Social worker child protection team, 2 years tenure, training group).**

A number of comments made by study participants appeared to correspond with the findings obtained from the quantitative data, in that they were not using the assessment model in their practice:

“we have got some of the tools obviously to use the resources that we were given but I wouldn’t say that I’ve had much opportunity to put it in practice as far as the training would want you to. I’ve used some of the questions and the ways of working rather than the actual resources and the tools” (**3. Social Worker, Child Protection Team, Training Group, 6 years tenure).**

It is relevant in that the tools are there to be used and I could use them if I had the opportunity to maybe adapt them slightly, you can obviously adapt them can’t you to fit a particular change that you are looking for or to see what capacity the parent has to do that so I can see the value of them yes definitely. It’s not something that I would be regularly using though. **(4. Social Worker, Child Protection Team, Training Group, 8 years tenure).**

I suppose the goal setting, I have set goals and we use the signs of safety and its kind of.. you can fit it in with that.. we’ve just not had an opportunity to sit down and use it properly like it’s supposed to be used. . **(6. Principal social worker, child in need team, 11 years, training group)**

A number of participants suggested that there was limited opportunity to actually use any learning potentially gained from the learning interventions in their role:

Because I haven’t been given specific families I’ve just been working with individuals and some of them have only been short term. I feel as though that would need to be done with a family. The training is applicable but some work I do with families is short term so like my last Dad and young boy I worked with I was only seeing them for 4 weeks. (**10. Family support worker, 7 years, TBL).**

I was working with children in care initially, I was a social work assistant on the children in care team but I did spend some time in child protection and fostering. I think if I’d gone into child protection it would be something I would be using on a daily basis. **(5. 16+social worker, Training Group, under 2 years)**

I think it’s because a lot of it didn’t directly apply to me that I’ve not put it in my practice and incorporated it into my practice and so it’s gone into the fog of everything. **(14. Social work assistant, 6 years tenure, TBL).**

Yes, that’s not realistic in the team that we work in really because we do the initial bit and then it gets passed on to either the child protection team, child in care team so. It should be directed towards the right teams, longer term teams, like I said our time and caseloads are too high, limited time.. It was useful to pick out little bits I could use, I didn’t enjoy the scaling, the numbering bit, I didn’t enjoy that because I’m not good with numbers. I like the goal setting, I like the different stages, I like the idea of it but it’s not helpful in this team. **(6. principal SW, CIN, 11years, training group)**

I’ve used a couple of them with a case that I’m working on now I’ve used a couple of them trying to make the father understand, putting it in to layman’s terms for him. Well giving him an understanding of why social services get involved, what we need to do to progress to a good outcome and implementing things that they need to do like boundaries for children, not making them excessive, to be able to compromise and things like that. I’ve used it as a one off because I’m the assistant and I work alongside the social worker and then whatever was put in place the social worker will then assess it and see what the changes are (**11. Children’s social work assistant, 1 year, TBL).**

I think it was about measuring capacity and how we can do that and the different ways of doing that …I can see how it could be used in different scenarios but not within my job”**. (2. Social Worker, Training Group, 10 years tenure, LAC Team).**

A number of those interviewed indicated that the lack of time and resources associated with child welfare work meant that implementing new skills was difficult, and they tended to revert to approaches and practices that they were more familiar with

No I haven’t. It is time and I think you tend to use what you are familiar with as well. **(1. Social Worker, Child Protection Team, 5 years tenure, Training group).**

I think a lot of it is time. I think that is one of the things that we just don’t have enough of so you tend to use again what you are very familiar with because you know the processes and how to apply them. I think also on some of the methods the calculations because the calculations are all quite complex. **(8. Social Worker, Child Protection and Court Team, 5 years tenure, Training Group).**

I would imagine so from discussion with colleagues about whether they have the time resource to be able to give the time to designing those tools to fit particular cases is questionable. **(Social Worker, Child Protection Team, 4 years tenure, TBL).**

It was really interesting but I did think at the time I’m never going to have the time and resources to actually do this with families but the idea is fab. **(8. Social Worker, child protection and court team, 5 years tenure, training group).**

It’s time, caseloads are too high so having the time to sit down with individual cases and go through them in the way that this training wants you to isn’t doable, it’s not realistic, there are lots of stages isn’t there to the training, you could do bits of them I guess the goal setting the reviewing it’s over quite a long time span isn’t it **(9. Social Worker, Child Protection team, 2 years tenure, training group).**

sometimes don’t have the time to go through all of that. I understood it but I think if you don’t use it regularly then working it all out is really time consuming. **(7. Social Worker, Child Protection and Court Team, 6 years tenure, Training Group).**

I think you tend to use things that you know that have worked well and being refreshed, I think sometimes you do some training and you think oh yes that’s really good and use it initially and the put it on the backburner because you don’t use it all the time so I always think refresher courses are really helpful things to do because it kind of then jolts your memory to go back and try that again. **(7. Social Worker, Child Protection and Court Team, Training group, 6 years tenure).**

Beyond the content of the training and team-based learning associated with the assessment model, factors associated with the workplace environment considered to undermine the transfer of learning were found to be characteristics of the child welfare agencies participating in the study. In particular, there was a lack of reinforcement of learning within the workplace:

Well the two that I went with actually on the training are off on sick leave so they’ve not been around to discuss it with them and like I say it was quite a while ago and my view is probably that they felt in a similar way that it’s something that you need to be reminded to use and you can get into a habit of not using something because you are not familiar with it. **(3. Social Worker, Child Protection Team, 6 years tenure, Training Group).**

A number of the local authorities participating in the study also had policies and procedures in place that emphasised alternative forms of assessment, that seemed to take precedence:

Well we tend to use that in signs of safety anyway so in that model we’re doing that all the time so I suppose in a different way not directly in the way that it was delivered. Well in the fact that we use the signs of safety model so about whether actions have been completed and whether those actions have been effective so we’re continually assessing families through that process and to see whether there is engagement or whether there is an element of disguise compliance or whatever the case maybe… and that’s what we use throughout all of our approaches within meetings and in our engagement with family. It’s known, other agencies are very familiar with it as well. **(7. Social Worker, Child Protection and Court Team, 6 years tenure, Training Group).**

Not that I’m aware of but I might have been because I’ve been doing a lot of that since I’ve been doing all this training I’ve been using a lot like the signs of safety model and stuff. We’re doing that anyway the evidence based stuff because that’s what we have to do within my work any road. **(8. Social worker child protection team, 5 years tenure, training group).**

it’s not so involved and not so complex but we used a similar assessing framework, we use the framework for assessment you know the triangle but it’s just not quite so specific that’s laid out in the training I guess. It’s not a huge difference in how we assess but it’s very specific in it with the different stages and scaling and it would be nice to have the time to be able to do it all really. It’s just not real, it’s not realistic in our services it’s so high paced, .**(6. principal SW, CIN, 10 years tenure, training group)**

No definitely not, not without ongoing or specific training or manager led training so that everyone needs to be using them don’t they, it’s interesting to use it yourself as an individual to do a particular piece of work and I can see the value in that in anybody’s job but for it to be across the board it would have to be overseen by and then taken up by senior management I would imagine if it was done across the board and I don’t remember there being any management on the training that I did. I know they specified that they would have expected that but that didn’t happen. . **(3. Social Worker, Child Protection Team, Training Group, 6 years tenure).**

This lack of reinforcement of the learning was also suggested in the lack of supervisory support following attendance on training or team-based learning to use any learning that may have been gained in practice:

No there was no follow up or anything and I didn’t discuss it with my supervisor or anything. There isn’t really any expectation that you have to use the training. I use signs of safety and that’s important but I haven’t used standardised instruments to do what was suggested on the training. …There isn’t the time anyway. **(1. Social Worker, Child Protection Team, 5 years tenure, Training Group).**

We may have just touched on it in a supervision but that was probably immediately afterwards, no definitely not something that has been picked up as a tool to be used. I did take it in to my team meeting to look at and everyone was interested in it but not to the extent that it was going to be developed any further. **(9. Social Worker, Child Protection Team, Training Group, 2 years tenure).**

I think because when you sign up for training on a personal basis you have to say why you think that training is relevant to your role and I think that’s really important and I’m sure some people do think oh I’ll go and do some training it gets me out of the office but I think you are less able to do that. You have to justify why you think you need that training. then it’s discussed during supervision what training have you identified you know continual personal development. **(5. 16+social worker, Training Group, under 2 years)**

I think then if it was part of the format that we used regularly then yes I think we would I mean we’re always offered the opportunity to look at different processes and different ways of doing things but I think it’s something that it can get a bit lost. **(7. Social Worker, Child Protection and Court Team, 6 years tenure, Training Group).**

Not that I remember but we do two sets of supervision, we do case discussion and we also do what we call PDS, professional development whatever the S stands for, and we talk about what training it is I need and what training I’ve done and how that has impacted on my work so I suspect that we did discuss it. **(9. Social worker child protection team, 2 years tenure, training group).**

Nothing. There was no follow up, there was discussions in supervision about how we found it but that’s it really. you have to do the feedback form like you do with any training course, I remember doing one of them but it was ages ago and I can’t even remember when was it, it was last year wasn’t it?it’s just really used in our PDS’s, in our personal development career type reviews so it’s not, you’ve just got to do it as and when you can fit it in but nothing, the signs of safety there’s an expectation to use that but not that I’m aware of any other .**(6. principal SW, CIN, 11 years tenure, training group)**

For a number of the participants interviewed, their assessment practice still relied far more on their own professional judgement and observations, rather than using this particular approach to assessing parental capacity to change:

Well I look at why we were there in the first place say for instance a child protection plan why have we put a child on child protection plan and whether there has been any change at the next review so we’ll look at what the parents have done and is it actual change or are they just saying that to get us off their back if you know what I mean? In the way I work how would I assess whether it’s disguise compliance? Well I would start reducing what I was doing and the impact and see whether they were able to maintain that level of change that we want, children are really good aren’t they they are like books you can see whether things have changed at home in terms of children’s behaviour. **(4. Social worker child protection team, 8 years tenure, training group)..**

you can’t just go by what’s being ticked on a box and you are looking at everything else when you are completing that assessment, the demeanour and communication or lack of communication and which boxes to tick. So there is a wide variety of reasons why people tick certain boxes and not others. You do absolutely have to use professional judgement. **(7. Social Worker, Child Protection and Court Team, 6 years tenure, Training Group).**

Now sometimes when it’s quite heavy ended child protection stuff we have to usually do to the parents to keep the children safe and then you can try and get them on board to say look do you recognise because I think that’s the biggest thing whatever model you are using if the parents don’t recognise that there is a problem then they’re not going to make any change because they don’t see it. I think the skill really is to get parents to actually recognise what’s going on for their children usually because of their behaviours. **(12. Social worker child protection team, 10 years, TBL).**

The ones that I use I’m quite comfortable with and again it depends very much on the relationship that you have with the individual. Being the family or the parent or young person, I think that can make a big difference to the outcome of some of the answers that you might have or scoring that you have…. So for example I did an adolescent wellbeing with a young person the other day who is really, really closed and doesn’t want to communicate at all but also is really quite switched on and has an understanding about how to answer the questions to try and alleviate concerns but then you have to, that’s a tick box for her to fill in and if you don’t have the communication with that person then it’s very difficult then to have a proper evaluation at the end of. **(7. Social Worker, Child Protection and Court Team, 6 years tenure, Training Group).**

Nevertheless, there was some suggestion that aspects of the training or team-based learning had been adapted and used by some of the participants in their work with children and families:

I definitely liked the idea of measuring the small targets and then trying to give people achievable smaller targets and you can adapt that with children as well if you are trying to measure their, if a placement is nearing breakdown you can measure their progress. **(2. Social Worker, Training Group, 10 years tenure, LAC Team).**

I think it was about actually recognising what sort of interventions are helpful so particularly using a variety of assessment styles to inform our judgement about what we are going to use next and how to evaluate those particular I think some of the, I’ve forgotten what it’s called, Aadas I think one of them was or there was the adolescent wellbeing and attachment scales and those sort of things and to really help inform what we’re going to plan to use next whether there was difficulty with attachment or with behavioural and I think it just makes you really think about that in terms of rather than having the scattergun effect and using all sorts of different interventions and then seeing which ones work. **(8. Social Worker, Child Protection and Court Team, 5 years tenure, Training Group).**

Finally, there were some interesting insights gained into a number of participants views about team-based learning. Despite being new to these child welfare workers, the testing aspect appears not to have been a problem, although for some, having managers deliver the team-based learning sessions did present some issues:

I enjoyed the team based learning, yes. I didn’t mind [the testing] because it’s all people I work with and we’d done it together anyway we came up with the answers together so it wasn’t an individual doing it we worked on it and then came up with the answers. It was fine. **(14. Social work assistant, 6 years tenure, TBL).**

I did manage that because I think you need to do that. That time what you’ve got which was a couple of hours a week that isn’t the time to learn everything what’s in that pack you need to go home and read it as well to reinforce it. **(15. Social Worker, Child Protection Team, 6 years tenure, TBL).**

Just sometimes with the managers that were delivering it I think there was a bit of pressure on you to get involved more. we weren’t forced to attend we could of if some of us didn’t but I mean because they are managers you felt like you had to come up with the right ideas. Do you see what I mean? Because they are managers and you feel you are being tested a little bit by them as well. I didn’t want to look at it, I didn’t know what I was doing. some of us couldn’t make it on the Thursday morning **(10. Family support worker, 7 years tenure, TBL).**

It did, yes definitely changed the dynamic of the group. We were all from different teams and the managers were from different teams as well even though they did help us a lot they knew what the outcomes were.. so we weren’t like all in together they had an idea of it beforehand. I think if we had all been learning together you would have contributed more. **(15. Social Worker, Child Protection Team, 6 years tenure, TBL).**

I think we were sat around the table in groups and we were like is this right, have I got that right. The people that were taking the course were very good and they took time to explain it to us but it was quite alien to what I’d done before really. **(12. Social Worker, Child Protection Team, 10 years tenure, TBL)**

1. **Discussion**

*5.1 The Impact of Training and Team-Based Learning on Knowledge Gain*

One of the chief findings from the study was that participation in training resulted in improvements to both declarative (knowing what) and procedural (knowing how) forms of knowledge as indicated by performance on the knowledge test and case vignettes. What was surprising is the failure to find any significant improvements in procedural knowledge from those attending team-based learning, whilst improvements in declarative knowledge were only significant at the .10 level of significance. Whereas an attempt was made to increase the rigour of the study through the use of a comparison group, these efforts to improve research rigour in training evaluation were significantly diminished due to the inordinate level of attrition. This was due to many training and team-based learning participants simply electing not to complete pre and post course questionnaires designed to measure knowledge gains (training 29, team-based learning 6). This resulted in a much smaller sample than anticipated, offering low statistical power and therefore less likely to detect a true effect. But a further problem is that small samples with low power that show a statistically significant effect may also give a false positive result. This being the case, the improvements in both propositional and procedural knowledge suggested to have occurred for those who attended training, and improvements in propositional knowledge for the small number attending team-based learning need to be interpreted with caution. Although, it should be mentioned that in relation to the training sample, a number of authors have shown that significant findings in relation to knowledge gain can be found with sample sizes similar to obtained here (Carlson & Schmidt 1999).

 Much remains to be learned about the use and effects of TBL across the diversity of settings, learners and content areas across a wide domain of professional areas (Haidet et al 2012). It is therefore worth speculating as to why the team-based learning may have been ineffective in this instance. One issue is that team-based learning is often implemented with key aspects of the approach absent (Moore-Davis et al., 2015). Effective learning in TBL is based upon key instructional principles that stress the importance of accountability and interactive discussions. Each session of TBL is learning goal directed and requires active team participation. Students progress in their learning from basic content knowledge to the application of that knowledge. For each major unit of course material, students study independently and come to class prepared to take a short individual quiz on the assigned content. The individual quiz is followed by the team taking the same quiz, with team members needing to come to consensus on their answers. Immediate feedback is then provided for team quiz performance. Members of the change project responsible for developing the learning pack raised a number of concerns about the use of individual testing in team-based learning. Consequently, the project decided to adopt primarily a team-based methodology but with some alterations. The most significant of these was that individual testing would not be required, but that the testing would only involve group discussion and testing. The failure to implement the team-based model as generally specified could therefore possibly have had some effect. Although it should be borne in mind that the training that was delivered adopted some similar elements to the team-based learning approach through using some of the group testing exercises. The extent to which the training and team-based learning actually differed in practice is questionable in that the team-testing approach was used in both instances although somewhat modified in relation to the training. Participants in both cases also received supporting reading materials prior to starting either intervention and in some cases occurred before baseline measures were collected. This is likely to have resulted in the high baseline scores received both for training and team-based learning. Another clear difference was the failure to control the consistency in the delivery of team-based learning. Although the same instructors were used in the training intervention, team-based learning relied upon individuals (either managers or training personnel) based in each of the agencies participating in team-based learning to deliver the learning intervention. Elsewhere research has found that instructors need considerable support to develop skills in using team based learning (Anderson, et al., 2011; Thompson et al., 2007). It may well be that the lack of familiarity and experience in delivering team-based learning may have had an effect on the acquisition of knowledge. Finally, learner participation in team based learning require far more preparation time. This has been identified as a chief characteristic that accounts for better performance than other forms of pedagogy in a number of random controlled trials (eg Thomas & Bowen 2011). The qualitative data suggest that it may not have always been possible for learners to read and learn the material required for each team-based learning session.

 Finally, the importance of learner characteristics should be discussed in relation to the knowledge scores obtained. It is significant that the level of education among those attending team-based learning was not as high as those participating training. Indeed, almost a third of the team-based learning cohort were qualified to GSCE or A level whilst the majority of those attending training were education to degree or masters level. This may well have affected the learning outcomes obtained. There were also some interesting findings regarding motivational dispositions. Trainee motivation is recognised as a key dimension of the overall training transfer system (Franke & Felfe 2012; Gengenfurtner, 2013). The motivation of trainees has also been found to be positively associated with training effectiveness in child welfare agencies including training motivation (Curry, McCarragher & Dellman-Jenkins, 2005) as well as related motivational constructs such as learner readiness (Antle et al., 2009) and learning goal orientation (Dierdoff et al., 2010). The failure to find a positive effect for learning goal orientation (reflecting a greater disposition for learning and mastery) but a significant effect for performance goal orientation (albeit at .10 level of significance) was surprising. Performance goal orientation captures an individual’s disposition to avoid failure and the need to be seen as competent by others (Elliot & Sheldon 1997). This may well be reflective of the particular work environment in children’s services which is often described as having a blame culture (Munro, 2010). The failure to find a significant effect for learner conscientiousness was also unexpected. A number of studies and reviews have generally found conscientiousness to be associated with training effectiveness (Blume et al, 2010; Colquitt, LePine & Noe, 2000; Tziner, Fisher, Senior, & Weisberg, 2007). This may suggest that in terms of the effectiveness of learning interventions such as these in children’s services, other factors are far more significant in predicting training effects as far as knowledge acquisition is concerned.

*5.2 The Failure to Impact on Skills*

Despite much of the literature demonstrating superior gains from team-based learning compared to traditional didactic learning methods, it remains the case that all studies published to date on the efficacy of team-based learning were conducted in educational settings primarily focusing on examination grades as the chief performance indicator. In relation to skill acquisition and use on the job, a few studies have primarily reported increases in self-reported skills (Seale et al., 2012; Shellenberger et al., 2009; Touchet & Coon, 2005). To date, only one study has reported changes to skills by implementing team-based learning and that was among a cohort of junior doctors (Walmsley et al., 2013). A limitation with that study however, was the absence of any follow up to determine whether skills were used on the job. In relation to this current study, we found that neither training nor team-based learning resulted in any significant changes to skill acquisition or transfer (use of training on the job) as indicated by the case audit data. The qualitative data would seem to corroborate this, and offers some insights as to why this might have been the case. The first possible explanation, lies in the model for assessing parental capacity to change that formed the core content of the learning. A number of participants indicated that they were not comfortable in using standardised instruments for measuring change, nor in the goal attainment scaling process, both of which require a degree of numeracy. The level of self-efficacy in using such tools appears fairly low, exacerbated by limited expectation to undertake capacity to change assessments using these tools by their agencies. This is consistent with previous research that evaluated the impact of a risk assessment training programme, where the assessment model was deemed far too mathematical (Clarke, 2002a).

 A comment by one social worker interviewed, that the need to potentially explain the use of any standardised instruments in court was insightful. They indicated that they did not feel sufficiently skilled to do so. A number of other interviewees emphasised the reliance they still placed on their own professional judgement, based upon their experience and observation of the family, in reaching and justifying their decisions. There was also some indication from interviewees, which concords with the investigator’s observation of case files. This was that in areas of mental health and alcohol or drug use, these social workers are more likely to expect specialist agencies and other professionals to focus on these aspects affecting parenting with the families they work with. The case audit data also showed no improvement in the use of setting SMART goals, either as part of assessing parental capacity to change or more generally in working with families. Instead goals tended to be in the form of a requirement for a parent to attend a particular intervention programme. For the most part, participation in or completion of that programme was generally the outcome by which success was judged. Observation of the case files thus suggested that most goals were activity driven rather than outcome based.

 The problem with training failing to transfer in the workplace has been widely recognised in the literature (Blume, Ford, Baldwin & Huang, 2010; Cheng, & Hampson, 2007) although estimates vary. Both Baldwin & Ford (1988) and Noe (1986) stated that the majority of training participants do not transfer learned skills to the job. Wexley & Lathan (2002) found that barely 15% of learned skills are used on the job after a year, while London & Flannery (204) place the figure at between 10-20%. Similar to the findings here, evaluations of training programmes in social services and childrens’ services in particular, can show significant effects for changes in knowledge. But also more often than not, show a failure to effect any change in practice (Clarke, 2001, 2002b, 2006, 2013; Liu & Smith, 2012). More recently McMahon-Howard & Reimers (2013), found that participation in a training programme on the commercial sexual exploitation of children resulted in changes to knowledge and beliefs, but no changes in the referral practices of child protection workers. Again, this led them to conclude that the training did not result in the transfer of learning. A number of comments by those interviewed unfortunately echo much of what is already known in the literature as to why training (and seemingly team-based learning) fails to transfer to use on the job both in social care agencies (Clarke, 2002b; Curry, McCarragher, & Dellman-Jenkins, 2005) and more widely (Cheng & Ho, 2001). These include significant problems with the workplace environment in adequately supporting the transfer of learning from programmes such as this. A considerable body of literature has accumulated indicating that both an organisation’s learning culture and training transfer climate are key to support the transfer of training (Rouillier & Goldstein 1993; Tracey et al 1995; Tziner, Fisher, Senior & Wiessbein 20070). Saks & Belcourt 2006). Key aspects of these dimensions include social support from supervisors and peers and organisational policies that are aligned with the use of training (Chiaburu & Harrison 2008; Cromwell & Kolb 2004). Supervisors for example, can assist with training transfer by giving feedback on performance, ensuring trainees are held accountable for implementing training and assistance with managing workload (Chiaburu, Van Dam & Hutchins 2010). Antle et al. (2009) previously found that supervisory support was positively associated with training transfer in child welfare, whereas Clarke (2002b) highlighted the lack of supervisory support in social care agencies is a key factor impeding the transfer of training. In this study too, a number of those interviewed indicated minimal reinforcement of any learning gained through either training or team-based learning through supervisory support. The lack of learning reinforcement of any learning gained can also be seen in that a number of agencies promoted signs of safety as the chief assessment model. Consequently, there was no expectation that in relation to the assessment of parenting capacity to change, social workers should adopt the approach that formed the basis of the training and team-based learning. Finally, the climates of child welfare organisations are typically characterised by task and role complexity and emotional exhaustion (Glisson & Green, 2006). A number of those interviewed indicated that lack of time was a significant factor that affected whether they would adopt the parental capacity to change assessment model.

 Team based learning has three key components: (1) advanced preparation by learners through reading materials, (2) both individual followed by team testing of any learning, and (3) the majority of time during class-based sessions devoted to the application of learning through problem solving exercises particularly using case studies. On the face of it then, one would expect the emphasis on the application of learning in team-based learning to be more effective at enhancing skill acquisition and transfer than traditional training. Potentially contributing to the failure to find any significant impact of on skills were factors undermining the team-based learning intervention. Previous research has found that shared beliefs and knowledge is important to achieve consistent practice among human service workers. Further, that these workers develop their practice through group norms and team interactions (Sandfort, 1999). Findings from the qualitative data suggest that the benefits thought to be gained from a team-based learning pedagogy were significantly undermined by the high level of turnover among the teams that participated. High caseloads, alongside challenging work conditions have been cited as key factors associated with high rates of turnover among child protection service workers (Alwon & Reitz 2000; Zlontnik et al., 2005). The study found a high rate of turnover among the staff who had initially participated in the study. Team cohesion reflects the extent to which team members are committed to one another in the achievement of team goals. This has been found to be associated with team performance scores on a psychiatry knowledge test in a prior team-based learning intervention (Thompson et al 2015). The high turnover among participants in the study would have significantly affected team cohesion, and likely to have undermined any potential impacts of team based learning on skill acquisition.

*5.3 Limitations of the Study*

The small sample size obtained for collecting knowledge measures has already been highlighted as a significant limitation of the study. The collection of only 4-month post measures following the learning intervention is also a limitation of the study. The number of interviews conducted was also much smaller than desirable given the number of participants who were registered to attend either training or team-based learning. The use of case audit for collecting measures to determine changes in practice has been employed before in training evaluations of workers in social care. Some of these studies have similarly found minimal evidence for the use of skills on the job (Cheung, Stevenson, & Leung, 1991; Leung & Cheung 1998; Rodney). There are limitations with the approach adopted here in that cases were rated only by the principal investigator. Greater reliability would have been achieved had there been additional raters undertaking the case audit.

1. **Implications for Policy and Practice**

Research evaluating the effectiveness of training programmes in social services is limited, despite the extensive efforts and resources often allocated to training programmes by social service organisations (Collins, Amodeo, & Clay, 2007). Specifically, in relation to training in the area of child welfare, Collins (2008) bemoaned that “training programs are repeatedly delivered without adequate empirical evidence of their effectiveness” (p.241). Similar to much of the previous research examining the impact of training in social services and child welfare settings more specifically, neither the training programme nor participating in team based learning resulted in any significant changes to practice in the area of assessing parental capacity to change. Comments from participants who took part in interviews, suggest a number of possible explanations as to why the training failed to affect practice. These include the particular characteristics of the assessment model that formed the content of the training, and the lack of reinforcement for use of the assessment model (or training) in the workplace. In order for training to transfer to actual use on the job, the systemic nature of training effectiveness needs to be more fully appreciated by child welfare agencies. This recognises that training is unlikely to transfer to practice unless learners are motivated to use the training in practice and the workplace creates the conditions to support training transfer. A significant problem remains that most organisations persist in the belief that simply participation in training programmes is sufficient in order for training to be effective. As a result, considerable effort is placed in the design of training programmes with a minimal understanding of the broader contextual factors that influence whether training is effective or not.

The use of team-based learning has increased dramatically within continuing healthcare education with the increasing awareness of the importance of teams in delivering quality patient care (Morrison et al 2010; Khune-Eversmann, Eversmann, & Fischer, 2008; Shellenberger et al., 2009). The information contained in child welfare training is often complex and hard to articulate and child protection workers primarily work in teams. Therefore, group and team discussion has been suggested as a means to promote a common and shared understanding of new work practices (Frank, Bagdasaryan, & Furman, 2008; Lewandowski, & Glenmaye, 2002). Consequently, a number of authors have suggested that team-based learning should be adopted more widely within social care (Macke & Tapp 2012; Robinson, Robinson, & McCaskill 2013). Elsewhere, a number of studies have reported positive student attitudes towards TBL, including a number of systematic reviews of team-based learning in medical schools (Burgess, McGregor & Mellis, 2014). Although based on limited qualitative data, this study does suggest that the team-based learning approach was received favourably by a number of those who participated. However, implementing the approach in children’s services is not without challenges. The most significant of these concerns the high rate of staff turnover which undermines team cohesion. Although this is likely to have a far less effect on knowledge acquisition while participating in a team-based learning intervention, it does seem to have a more deleterious effect on whether team-based learning can affect changes to actual practice. The approach requires more extensive preparation by learners in reading material that is subsequently tested. This may be difficult in child welfare work environments which are typically stressful working conditions. Team-based learning also requires training and development staff to adopt a different approach to staff development then has traditionally been the case in delivering training programmes. As was found here, not all these staff may be comfortable with the testing element of the intervention, which means elements of team-based learning prescribed in the literature are altered in delivery. This variation in delivery may pose problems for reaching conclusions as to the effectiveness of team-based learning more broadly.

Finally, there is considerable evidence that the quality of evaluations undertaken by social care agencies of their training is often poor. Collins (2008) for example, found that follow up evaluations of training to determine the impact on child welfare professionals’ practice was rare in many US states often due to a lack of time and resources (Collins et al., 2007). Even where the evaluation of training is conducted, similar to here, the lack of randomization is often a problem in the research design used. However, a far more serious problem encountered in this study was the high level of attrition by study participants in relation to completing measures. It should be mentioned that of the 8 local authorities taking part in the study, 5 had recent OFSTED inspection reports (2014-2016) judging that their children services required improvement, whilst one was rated as inadequate. The decision by these local authorities to participate in either training or team-based learning to improve assessment skills in this area, may well have been driven by wider political considerations. A survey of child welfare workers in the US voiced concerns that training was being used in order to address agency performance problems. Moreso, that training was not considered by these workers to be the solution such that they were cynical of such attempts (Amodeo, Bratiotis, & Collins, 2009). Whether the high rates of attrition by study participants here reflect more local conditions, or is more indicative of the poor status accorded to training evaluation within social care more generally, is not possible to know in this case. However, high rates of attrition in training evaluation studies in social care has been highlighted in previous studies (Clarke, 2006). There are ethical dimensions to this problem too, as the failure to participate in evaluation studies of this kind is both wasteful and an inefficient use of resources if results are deemed unreliable. Nevertheless, including case audit in the evaluation design did mitigate this attrition to some degree. Future training evaluation studies should consider including as many objective measures of practice to assess behaviour change as reasonable, recognising that high rates of attrition in these work environments may be likely.

1. **Appendices**

Appendix 1

Declarative Knowledge

Section A

1. Assessing parent capacity to change requires a social worker to assess whether parents are currently able to meet the developmental needs of their children.
2. Assessing parental capacity to change is used in situations when risk factors don’t clearly outweigh protective factors, or vice versa
3. Dawe & Harnett’s protocol for assessing a parent’s capacity to change consists of seven stages
4. Any measure indicating changing parental behaviour is critical to structured

professional judgement in the assessment of capacity to change.

1. The willingness of parents to participate in a particular programme following assessment indicates a capacity to change
2. The Framework for the Assessment of Children in Need and their Families that is contained in the government’s statutory guidance *Working Together to Safeguard Children (2013),* is sufficient for assessing parental capacity to change.
3. Data that showed a parent with alcohol problems initially obtained a score of 5 on the AUDIT test for alcohol misuse and then a score of 3 on the CAGE test for alcohol misuse six months later is a key measure showing a positive capacity to change.
4. Obtaining a number of one-off assessments from specialists from different agencies is the key aspect in enabling social workers to assess parental capacity to change.
5. Cognitive reappraisal is a more effective strategy for parents to use in regulating their emotions than expressive suppression.
6. When examining changes in parental antenatal bonding as part of assessing parents’ capacity to change, parent self-report diaries are more useful in decision-making than ante-natal attachment scales.
7. When assessing parental capacity to change, if you set the same change goal with families then you should follow the same intervention plan.
8. When assessing parental capacity to change, you should only set goals that are achievable by direct work with you as a practitioner.
9. The Depression, Anxiety, and Stress Scale (DASS) is a reliable method for determining when someone has clinical depression.

Section B

1. Which of the following are key components of assessing parents’ capacity to change. Choose as many options as you think correct. One mark deleted for an incorrect answer.
2. The use of standardised tools
3. General goals to improve parenting
4. Professional judgement
5. Must be undertaken over at least 12 months
6. Evaluates parent(s)’ capacity to acquire parenting skills
7. Don’t Know
8. The Integrated Assessment Framework does the following. Choose as many options as you think correct. One mark deleted for an incorrect answer.
9. Provides a means to identify risk factors
10. Specifies how risk factors influence child outcomes
11. Focuses on the parent’s state of mind and emotional regulation
12. Enables you to identify which aspects of parenting ability need to change
13. Don’t Know
14. When examining goal attainment in assessing parental capacity to change, you need to do the following. Choose as many options as you think correct. One mark deleted for an incorrect answer.
15. Have set achievable time-limited goals
16. Rate the extent to which goals have been achieved at 6 and then again at 12 months later after they were set.
17. Rate the extent to which they have been achieved on a scale of 1-5.
18. Only set goals agreed by the parents
19. Don’t Know
20. Which of the following are evidence-based interventions? Choose as many options as you think correct.
21. Parents Under Pressure (PUP)
22. Video Interaction Guidance (VIG)
23. Parent Child Interaction Therapy (PCIT)
24. Court Based Evidence (FDAC)
25. Don’t Know
26. Which of the following information do social workers need in reviewing whether change has occurred in parenting capacity. Choose as many options as you think correct. One mark deleted for an incorrect answer.
27. Direct observation of changes in parent-child interaction
28. The extent of progress towards set goals
29. The use of reliable and valid measures
30. Your previous experience with similar cases
31. Whether sufficient resources are available in your area/agency
32. Don’t Know
33. Which of the following is accurate about the Relationships Questionnaire. Choose as many options as you think correct. One mark deleted for an incorrect answer.
34. Is a non-standardised measure of adult attachment style
35. Measures 3 categories of attachment style
36. Requires individuals to rate themselves against attachment styles
37. Don’t Know

**Procedural Knowledge**

This section contains details about a case study. After you have read the case there are 4

multiple choice questions at the end for you to answer.

**Case Vignette 1**

**The Family** 1. Julie is a single mother of four boys and two girls: Tom, Ricky, Leo, Charley, Kia and

Donna. 2. Sonia is the children’s aunt.

**Background**

The family had been known to a number of services for many years. Julie was periodically

absent from the family home and was involved in criminal behaviour and suspected prostitution to fund her heroin habit. She says this enables her to deal with the stress in her life. Sonia was in effect the primary carer of the four boys and two girls but feels overwhelmed and says she doesn’t always handle her frustration well. The eldest child, Tom, was involved with the youth offending team due to his criminal behaviour. None of the children have been attending school on a regular basis and three of the boys were recently excluded and are supposed to be attending alternative provision. The youngest child was attending nursery only 3 percent of the time, and was behind with immunisations. The family are living on an estate earmarked for demolition, but housing providers have

experienced difficulty rehousing the family due to high levels of anti-social and criminal behaviour, including convictions, robbery, shop-lifting, criminal damage, rowdy behaviour, begging and substance misuse. The local community had had enough of problems caused by the family, and some local people had taken matters into their own hands, trying to push the family out of the area by smashing windows in the property.

**Current Situation**

There are concerns regarding the neglect of the children and serious consideration was given

to removal into care of the younger children. It was agreed with the family that this would be deferred on the condition that they engaged with a key worker and worked intensively on a number of agreed actions to improve the situation. As part of that process, there is a requirement that an assessment of parental capacity to change is undertaken and monitored over 4 months. A number of goals were set for the family including among them:

1. For Julie to receive some assistance with her drug use
2. For Sonia to improve her parenting and relationship skills; and
3. For Tom to complete his youth offending team order.

**Four months later**

Julie was referred to, and has so far stuck with a local drugs support project. She completed the DASS questionnaire 4 months ago and this was repeated recently. Her stress and anxiety scores went from 10 and 7 to 13 and 9 respectively. The family were given a short-term tenancy two months ago and a commitment to the intervention plan was written into the tenancy requirements. Sonia was referred to the family links nurturing programme and says she feels less frustrated and manages her anger better. She recently completed Gross & John’s Emotional Regulation Questionnaire and achieved a score of 20 for emotional suppression. Tom completed his youth offending team order successfully and has left the household to live with his father in another city. This has had a positive impact on his younger brothers who are no longer involved in antisocial behaviour themselves.

**Questions**

1. Focusing only on the 3 goals that were set for this family, do you think these were appropriate?
2. Did Sonia’s referral to the family links nurturing programme demonstrate her capacity to change positively?
3. Do you think Julie’s referral to the local drugs project has had a positive impact?
4. Do you think the safeguarding assessment and analysis framework (SAAF) could be used in order to assess whether there has been evidence of parental capacity to change in the case above?

**Case Vignette 2**

This section contains details about a case study. After you have read the case there are four

 mutiple choice questions at the end for you to answer.

**Family Composition**

Mum, Julie (age 46) Dad, William (age 38) Son, Ryan (age 7).

**Background**

Mum and Dad are in a relationship together and both share parental responsibilities for Ryan. However they live separately and Ryan lives with his mum. Neither of them are currently employed. Ryan is William’s first child, but Julie has older children from a previous relationship, which was both physically and emotionally abusive over a substantial period of time. At the point of referral there were concerns regarding William’s alcohol dependency contributing to episodes of domestic violence which Ryan had witnessed. Ryan has previously been excluded from three mainstream schools by the age of six for disruptive behaviour and there is a regular pattern of exclusions and attendance issues. Julie was struggling to set and implement boundaries with Ryan and stated she found him difficult to manage on a daily basis. There were also inconsistencies in Julie and William’s parenting styles, resulting in disputes between parents and mixed messages for Ryan. Recently, Ryan was assessed by health professionals and volume of health was diagnosed with Attention Deficit Hyperactivity (ADHD). This has resulted in Julie now having to manage a high volume of health appointments. This constant tension exasperated Julie’s mental health. She was anxious, had low self-confidence and depression. She often finds herself “Flying off the handle” when things get too much and results in her being punitive towards Ryan. An assessment of parental capacity to change was undertaken and monitored over 3 months. The following goas were set for the family

1. William to be referred to the local alcohol dependency project with the aim of reducing his alcohol intake significantly, by more than 20 % during the next 3 months.
2. Visits to the family to be undertaken weekly over the next 3 months to observe mother and child interaction and Julie’s parenting style.
3. Julie to see her GP for treatment in relation to her mental health issues and progress to be reported in the next month.
4. Julie to attend a 2-week anger management programme run at the local family climic during the next 2 months.
5. Both Julie and William to attend the local domestic violence programme within the

next two months in order that they can adopt more consistent and nurturing parenting styles with Ryan

**Three Months Later**

The relationship between Julie and William has improved with no further reports of domestic abuse. Both parents indicated that they recognise there were problems with how they were parenting Ryan. William attended the local alcohol dependency project but did not complete the programme. The nurse based there who was William’s key worker has indicated that she didn’t think he was committed. William did however complete the alcohol outcomes record (AOR) when he started the programme and when he last attended. This indicated that he had managed to reduce his weekly alcohol intake by 25% in that six week period. Julie has seen her GP and has been prescribed medication for her anxiety and depression. Julie completed the daily hassles questionnaire and the overall score obtained on the intensity dimension was 40. Observations of mother and baby interaction show that Julie shows increasing warmth and attachment to Ryan, but still reacts angrily at times to his challenging behaviour.

**Questions**

1. Focusing only on the goals that were set for the family, do you think these were SMART goals.
2. Julie attended obtained an intensity score of 40 on the daily hassles questionnaire after she attended the domestic violence programme. Based on this could you judge the programme was effective?
3. In conjunction with William, a goal was set that he should significantly reduce his alcohol intake over the next 3 months. However his commitment was judged poor by the nurse at the alcohol project as he never completed the programme. If you were rating the extent to which William achieved his goal using the Goal Attainment Scaling (GAS) where -2=much less than expected outcome; -1= less than expected outcome, 0=expected outcome, +1=greater than expected outcome and +2=much greater than expected outcome; Would -2 be an accurate rating in your view?
4. Based on the data in the case, which of the following statements would you agree with (select only one)?
5. Neither parent as demonstrated a capacity to change
6. William has demonstrated a capacity to change but not Julie
7. Julie has demonstrated a capacity to change but not William
8. Both parents have demonstrated a capacity to change
9. Don’t Know

**Appendix 2 Semi Structured Interview Schedule**

1. Can you just tell me something about yourself what you do and how long you have been working where you are?
2. Thinking back to the training that was provided on assessing parental capacity to change what were your views of it?
3. What do you think you learned from the training?
4. Do you think you have used any of the training in your practice?
5. The assessing parental capacity to change model was about setting specific goals for change and using standardised instruments to assess whether change has occurred. Have you been able to do this in your work?
6. Assessing parental capacity to change also states you need to use evidence based interventions over a short time period to assess whether change has occurred. Do you think you have been doing this?
7. What do you think have been some of the difficulties you have faced in implementing this model in your practice
8. Did you receive any support from your supervisor or your colleagues to implement the training?
9. Do you think there are
10. What do you think about the team based learning approach?
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