Supporting foster carers to meet the needs of looked after children: a feasibility evaluation of the Reflective Fostering Programme

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Abstract

This study presents the feasibility and pilot evaluation of the Reflective Fostering Programme (RFP), a recently developed, group-based program to support foster carers, based on the concept of 'reflective parenting'. This innovative development follows calls by the National Institute for Health and Clinical Excellence (NICE) and other organisations to help improve outcomes for children in care by providing better support to their carers. This study aimed to establish whether it is possible to implement the RFP, and to gather preliminary data on the acceptability and effectiveness of the programme. Twenty-eight foster carers took part in the study. Results indicate that training and delivery of the RFP were feasible; the programme was felt to be and relevant and meaningful to both foster carers and social care professionals delivering it. Preliminary pre-post evaluation showed a statistically significant improvement in foster carers' stress, their achievement of self-defined goals and child's emotion lability and overall strengths and difficulties. There were no statistically significant changes in carers' reflective functioning, although some foster carers reported on changes in reflective capacity during focus groups. Preliminary findings about the feasibility of training and delivery of the RFP, as well as the acceptability and effectiveness of the programme, are encouraging, but further impact evaluation is needed.

Keywords: Fostering, reflective functioning, foster carer, looked after children, mentalization, parenting stress

Introduction

Children in out-of-home placements, known in the UK as Looked after Children (LAC), are a group at heightened risk of emotional and behavioural problems (NICE, 2013). At 31st March 2017, approximately 74% of looked after children in England were placed in foster care (Department for Education, 2017). Many of them have experienced relational trauma prior to placement and may demonstrate troubled and troubling behaviour (Villodas, Litrownik, Newton, & Davis, 2016). More than 45% of looked after children have a diagnosable mental health disorder—five times the prevalence of mental health disorder among children in the general population (Meltzer, Corbin, Gatward, Goodman, & and Ford, 2003). Research indicates that a secure, supportive foster care placement is associated with better outcomes for the child than placements in which the child has a less secure attachment to the carer (Joseph, O'Connor, Briskman, Maughan, & Scott, 2014). However, challenging behaviours of children who have previously experienced relational trauma may impact on the quality of caregiving, even among experienced and sensitive foster carers. This in turn heightens the risk of placement instability and associated poor emotional and behavioural outcomes for looked after children (Biehal, Ellison, & Baker, 2011; Farmer, 2005; Rubin, O'Reilly, Luan, & Localio, 2007).

In light of concerns about the poor outcomes of looked after children and the strain that is placed on foster carers, there have been efforts to develop interventions to support foster carers and help them offer the best possible quality of care to children (Dickson, Sutcliffe, Gough, & Statham, 2009; Fisher, 2014; Luke, Sinclair, Woolgar, & Sebba, 2014). However, despite these efforts, interventions have often been poorly evaluated, and there remains a lack of high-quality evidence related to effective interventions, especially for primary school age children (NICE, 2013). While some existing interventions focus on improving carer–child relationships, the majority concentrate on reducing problem behaviour and have been criticised for their lack of focus on improving the capacity of carers to respond to the child's relational needs (Luke, et al., 2014). Given the prevalence of attachment problems and relational trauma among children in foster care, it seems appropriate to focus on helping carers keep the needs of the child in mind, so that they are best able to support each child's development (Redfern et al., 2018).

Research suggests that a carer's capacity for parental reflective functioning (PRF) may be important in enabling carers to best respond to worrying or disruptive behaviour and support the emotional well-being of the children in their care (Cooper & Redfern, 2016). PRF (or 'parental mentalizing') refers to a caregiver's capacity to think about their own and their child's mental states and how these may underlie behaviour (Slade, 2005). High levels of PRF (also referred to as 'mind-mindedness') have been related to lower levels of perceived stress in relation to parenting (McMahon

& Meins, 2012), possibly because better PRF helps the carer to understand their child's behaviour, rather than seeing it as simply 'naughty' or 'difficult'. PRF has been shown to be associated with many important facets of parenting such as sensitive caregiving, tolerance of infant distress, strengthened parent-child relationships, and secure attachment (Fonagy, Steele, Steele, Moran, & Higgitt, 1991; Huth-Bocks, Muzik, Beeghly, Earls, & Stacks, 2014; Rutherford, Booth, Luyten, Bridgett, & Mayes, 2015; Stacks et al., 2014). When a parent is able *to mentalize about their child*, it can contribute to the child feeling understood as a person, providing a sense of agency and value. Studies have shown that high PRF is positively associated with improved cognitive and socio-emotional outcomes in children, and reduces the risk of child psychopathology (Ensink, Begin, Normandin, & Fonagy, 2017; Laranjo, Bernier, Meins, & Carlson, 2010). The ability of caregivers to offer 'reflective parenting' (Cooper & Redfern, 2016) appears to be especially important for children that have experienced early adversity (Adkins, Luyten, & Fonagy, 2018; Jacobsen, Ha, & Sharp, 2015; Midgley et al., 2017).

The promotion of reflective caregiving has therefore been the focus of a new intervention, the RFP, aimed at supporting foster carers of children aged 4-11. The RFP has been developed by staff at [REMOVED FOR BLIND PEER REVIEW] in response to a call from the National Society for the Prevention of Cruelty to Children (NSPCC) to develop more effective interventions for looked after children and their foster carers. The theoretical rationale, development and structure of the programme have been described in more detail elsewhere (Redfern et al., 2018). In brief, the RFP is a group-based intervention delivered by social care staff to support foster carers. The programme consists of ten, weekly, three-hour sessions, delivered by two trained facilitators, to groups of around 6-10 foster carers (Redfern et al., In press). The RFP builds on the Reflective Parenting model (Cooper & Redfern, 2016), which promotes both self-focused and child-focused reflective functioning within a context of managing emotional states and stress. It uses a set of tools that represent the principles of reflective parenting in a shortened, highly engaging form, for foster carers to use on themselves and on the children in their care. Unlike other mentalization-based interventions for fostered and adopted children, which were designed to be delivered by mental health specialists (e.g. Midgley et al., 2017; Jacobsen, Ha and Sharp, 2015), the RFP was designed to be easily learned by social care professionals, so that it could be implemented and tailored to fit the needs of a wide range of foster carers.

Aims

The primary aims of the study were:

(1) to assess the capacity to recruit foster carers to the RFP, and review participant characteristics and levels of engagement with the programme;

(2) to gather preliminary data on the effectiveness of the programme in the following areas: reducing foster carers' levels of stress; strengthening their sense of parental efficacy and reflective functioning; help carers make progress towards personalized goals identified by themselves; reducing the child's emotional and behavioural difficulties; and increasing the child's capacity for emotion regulation;

(3) to assess the perceived acceptability of the programme for foster carers (both in terms of practical issues and the content and delivery of the RFP), identify areas in which the programme could be adapted or improved to better meet the needs of foster carers, and identify potential barriers to, or facilitators of, implementation.

Methods

Research design

Medical Research Council (MRC) guidance on the development of complex interventions (Craig et al., 2013) warns against moving too swiftly towards clinical trials before sufficient development and feasibility assessment work has been carried out. Therefore, this study had a primary focus on piloting and feasibility and utilized a mixed methods design.

Setting

The RFP was delivered by NSPCC staff (all social workers with experience of working in children's social care settings), to foster carers from Local Authorities (LAs) in two areas of the UK, Sheffield and Gillingham. Two RFP groups were delivered in each site, and each group was delivered by two NSPCC facilitators (eight in total) trained by and given weekly consultation from clinical specialists at the [removed for purposes of blind peer-review]. Six to ten foster carers of children aged four to eleven were recruited into each of the four groups. Evaluation, which was funded by [removed for peer review] and carried out by researchers from [removed for purposes of blind eer review], focussed on piloting and feasibility and took place at each of the sites, alongside programme delivery.

Eligibility

Due to the exploratory nature of the pilot project, inclusion and exclusion criteria for foster carers were kept broad. Eligible participants were identified by supervising and/or child social workers in the LAs in each site according to the inclusion and exclusion criteria shown in Table 1.

[Table 1]

Recruitment

Supervising and/or child social workers in each LA were given information about the RFP. They were then asked to identify foster carers who they thought would benefit from attending the programme and invite them to contact the NSPCC directly for further information. These foster carers were then invited to a meeting with the NSPCC and the research team to find out more about the programme, discuss participation and decide whether they wished to participate.

Data collection

In addition to descriptive information about recruitment, retention and demographic data regarding participants, the following outcome measures were administered to foster carers via a secure online database called the Patient Outcome Data (POD) at four time points: baseline (before the programme began), midpoint (after session 5), endpoint (at the end of the final session), and follow-up (six weeks after the end of the programme and thus approximately sixteen weeks after the beginning of the programme).

Parenting stress. The Parenting Stress Index, Short Form (PSI-SF) is a brief, self-report measure comprising 36-items (Abidin, 1995). The PSI has four 12-item subscales: Parental Distress, which is designed to measure the level of distress a caregiver is experiencing in their caregiving role ; Parent-Child Dysfunctional Interaction, which assesses the extent to which the parent perceives interactions with their child to be not satisfying/reinforcing; Difficult Child, which measures how easy or difficult the parent perceives his/her child to be; and Total Stress, which is designed to capture overall parenting stress. The measure has good internal consistency and test-retest reliability and the three-factor structure developed through factor analyses with the full 120-item measure (Abidin, 1995).

Parental reflective functioning. The Parental Reflective Functioning Questionnaire (PRFQ) is a short, 18-item, self-report measure of parental reflective functioning (Luyten, Mayes, Nijssens, & Fonagy, 2017). The measure has three subscales developed through factor analyses with two separate samples: Prementalizing, which is designed to assess inability of the parent to acknowledge their

child's mental states; Certainty About Mental States, which measures how certain caregivers are about the mental states of their child and their ability/inability to recognise the opacity of mental states; and Interest and Curiosity, which assesses caregiver interest and curiosity in their child's mental states. There is preliminary evidence of good internal consistency of the PRFQ and robust theoretical grounding and construct validity (Luyten et al., 2017).

Reflective functioning. Reflective Functioning Questionnaire (RFQ) is an 8-item, self-report measure of reflective functioning (Fonagy et al., 2016). The RFQ has two subscales: Certainty About Mental States, and Uncertainty About Mental States. There is satisfactory evidence for overall validity and reliability of the RFP as a brief measure of reflective functioning (Fonagy et al., 2016).

Parental self-efficacy. The Brief Parental Self-Efficacy Scale (PES) is a 9-item measure of caregiver beliefs and confidence in their caregiving skills (Woolgar, Unpublished). A paper on the reliability and validity of this measure is in progress and has not been published.

Goals in relation to the programme. Goal-Based Outcome Measure (GBO) is a clinical tool that aims to evaluate progress towards a goal in relation to an intervention. GBO compares how far a person feels they have moved towards reaching up to three goals that they have set for themselves at the beginning of an intervention (Law & Jacob, 2015).

Child emotions and behaviour. The Strengths and Difficulties Questionnaire (SDQ) is a 25-item measure of emotional and behavioural difficulties in children aged 3-7 across the following dimensions: conduct problems, emotional symptoms, hyperactivity/inattention, peer relationship problems, prosocial behaviour (Goodman & Goodman, 2009, 2012). The SDQ is a routinely used clinical tool with moderate test-retest reliability, strong internal consistency (Yao et al., 2009), and good concurrent and discriminant validity (Lundh, Wangby-Lundh, & Bjarehed, 2008; Muris, Meesters, & van den Berg, 2003).

The **Brief Assessment Checklist for Children** (BAC-C) is a 20-item, caregiver-reported measure, designed to assess clinically meaningful mental health difficulties experienced by looked after children (Tarren-Sweeney, 2013). The scale has good internal reliability, concurrent validity and screening accuracy, comparable with the SDQ (Tarren-Sweeney, 2013).

Child emotion regulation. The Emotion Regulation Checklist (ERC) is designed to capture a carer's view of a child's emotional self-regulation and dysregulation (Shields & Cicchetti, 1997). The measure has two subscales: Lability/Negativity, which is designed to capture emotional intensity of

the child, expression of negative emotions, arousal and reactivity, and lability of mood; Emotion Regulation, which measures adaptive regulation, such as socially appropriate displays of emotion, empathy and emotional understanding. The ERC is a reliable assessment instrument with high internal consistency for both subscales, as well as discriminant validity (Kim-Spoon, Cicchetti, & Rogosch, 2013; Shields & Cicchetti, 1997).

At the end of the programme, the research team conducted separate focus group interviews with foster carers (4) and facilitators (2) on their experiences of the programme, using an adapted version of the *Experience of Therapy and Research Interview* (Midgley, Ansaldo, & Target, 2014). Telephone interviews were offered to those foster carers who were unable to attend, including any participants who stopped attending the programme before it ended.

Data Analysis

Quantitative analysis was conducted in two steps: First, we described the sample and reviewed rates of retention and attrition. We then estimated, separately for each outcome measure, the change in mean score at the end of the programme compared to baseline. To this end, we fitted multilevel models, including a random intercept term for participant and a fixed effect for RFP group, to take account of the nested structure of the data. For the analysis of goals-based outcomes, we fitted a three-level model, allowing goal ratings to be nested within goals, which in turn were nested within participants. Effect sizes were measured as Cohen's d, using the pooled sample standard deviation as the denominator. Confidence intervals for Cohen's d were estimated using bias-corrected and accelerated (BCa) bootstrap intervals with 1,000 replications. All outcome scores were used in the analyses, including from individuals who provided information at one time point only. All analyses were conducted using the R software for statistical computing (R Core Team, 2018).

Second, a qualitative process evaluation took place. The focus group interviews with foster carers and facilitators were analysed using framework analysis (Parkinson, Eatough, Holmes, Stapley, & Midgley, 2016; Ritchie & Spencer, 1994). This involved the research team developing an initial framework based on the core research questions, i.e. the overall acceptability of the RFP; aspects of the programme that could be improved; the foster carers' views of the impact of the programme; and the facilitators' experience of being trained and delivering the programme. Each of the transcripts was then thematically analysed by two members of the research team in the context of this framework, to identify core themes. Where differences of understanding were found among the research team, the data was reviewed with the research team lead, to reach a consensual understanding of the data.

Ethical approval

The study was approved by the NSPCC Ethics Committee (reference R-17-88) and the research and development committees in the LAs in both Sheffield and Gillingham. All participants were informed about the content and scope of the study and gave written informed consent before starting the RFP. Confidentiality and anonymity were ensured throughout.

Results

The following section reports on descriptive statistics, quantitative outcome measures across the domains described above, as well as on qualitative findings related to foster carers' experiences of the RFP. A full report of the findings, including data on training, the assessment of programme fidelity, and the acceptability of the research design for foster carers, is available on request from the authors (Midgley, Austerberry, Cirasola, Ranzato, & West, Unpublished).

Recruitment to the study and characteristics of participants

Thirty-four foster carers were screened for the RFP, 32 of whom were eligible, 28 of whom decided to take part in the programme and its evaluation[1] (see Figure 1). Participants were divided into four groups, two in each site (n = 6, n = 5, n = 7, n = 10). Based on the descriptive statistics, there were no obvious differences between the carers in each of the four groups. Five foster carers (all from the first group) did not complete all 10 sessions of the RFP.

[Figure 1]

Participants in the study sample were on average 52 years old, mostly female (86%) and married or in domestic partnership (75%). All but one described their ethnicity as 'White British'. Participants had been working as foster carers for more than 9 years on average, ranging from 1.5 to 35 years. More than 40% of respondents had previously experienced a breakdown of a child's placement. See Table 2 for details.

[Table 2]

[1] Two foster carers who were ineligible for the research attended the programme but were not participants in the evaluation.

With regards to the identified children in their care, respondents reported that the mean age was 8.85 years, and 61.5% were female. Of those who responded, 37.5% reported that the child in their care had previously experienced a placement breakdown and on average the child had been in this placement for over two years. See Table 3 for details.

[Table 3]

Preliminary results regarding effectiveness of the programme

Change in mean score at the end of the programme compared to baseline was estimated separately for each outcome measure (see Table 4 and Table 5). Six-week follow-up data was collected primarily to establish the feasibility of collecting follow-up data. Although not reported here, analysis of change between baseline and six-week follow-up were comparable to the baseline-end of programme findings set out below, and are included in full in the complete report (CITATION WITHHELD for blind peer review).

Carer-focused outcome measures. As illustrated in Table 4, there were statistically significant mean differences in the expected direction, in measures of parenting stress (PSI-SF) with a medium effect size in the 'Total Stress' score and 'Parent-Child Dysfunctional Interaction' subscale, and with a large effect size in 'Difficult Child' subscale. There were non-significant improvements in PSI-SF 'Parental Distress' subscale scores, in scores on the Brief Parental Efficacy Scale (which measures parental self-efficacy), and in all subscales of both reflective functioning measures (the PRFQ, and RFQ), apart from the PRFQ 'Certainty About Mental States' subscale, for which there was a non-significant change towards increased certainty about mental states). There were statistically significant changes, with a large effect size, in ratings of the degree to which personally identified goals (GBOM) set by foster carers had been met.

[Table 4]

Child-focused outcome measures. Findings from the carer-reported measures of child difficulties are reported in Table 5. There was a statistically significant reduction, with a medium effect size, in total scores on the SDQ, which is the most widely-used measure of the well-being of looked after children in the UK. All SDQ subscale scores showed a non-significant mean improvement, with the exception of the 'Emotional Problems' subscale, for which there was a statistically significant mean improvement, with a medium effect size, and the 'Peer Problems' subscale, which had a non-significant mean change in the unanticipated direction. There was a non-significant improvement in scores on the BAC, which measures behaviours identified as common

among looked after children. There was also a statistically significant improvement in foster carer ratings of the child's emotional regulation (ERC), with a medium effect size for the 'Emotion Regulation' subscale of this measure.

[Table 5]

Qualitative findings: Programme acceptability, impact and areas for further development

Acceptability of the RFP. In the focus groups, there was an exploration of whether the structure, as well as the content of the programme, was perceived to be acceptable to the participants. Most foster carers reported that they had "learnt a lot" and "enjoyed" the programme or found it "an extremely positive experience". When thinking back, most foster carers described initial concerns about the "fairly intense" time commitment (three-hour sessions for 10 consecutive weeks). However, by the end of the RFP most foster carers felt "10 weeks a good length" and even if "the idea of committing to three hours sounded really hard... actually it hasn't felt that bad." While a few foster carers suggested shortening the programme, or running it on a fortnightly basis, most felt that the programme ran very quickly and wished it was longer. Several foster carers said that they didn't want the programme to end: "We're all a bit panicking that it is ended. [Laughter] What are we going to do after it? We don't want it to end!".

Relevance of the RFP to foster carers. When asked if they thought that the RFP was relevant to them, the majority of foster carers said "yes". One foster carer explained: "it is relevant to all looked after children... it's helped all of us... not one of us has sat here and said 'Oh you know what? It doesn't apply to me'." Many of the foster carers expressed wishing they had done the training earlier in their careers and said that they would recommend it to new foster carters. Feedback from the one group where there were several dropouts suggested that they did so due to a combination of personal issues (e.g. health issues and other commitments), as well as some frustration that facilitators appeared to be unfamiliar with the programme material. The fact that the technology (power point projector) didn't work properly in the first meeting appears to have created a poor first impression, from which the group did not fully recover.

There was positive feedback from many of the foster carers about the group facilitators, who were described as being "very good", "brilliant", "very supportive, very open, good listeners, non-judgemental". One carer said "they made us feel comfortable didn't they, really engaging, and if we were struggling, they'd take us through". Another explained: "And they did treat us like professionals which you don't always get... and they made a point of saying that we were delivering a course to professionals. That was nice."

When asked if they would recommend the programme to others, the majority of foster carers expressed that they would, saying “absolutely”, “unanimously yeah”, and “yes, definitely”, though one foster carer had a mixed response: “I would tell them about my experience and say that it's worth doing, but you do have to commit yourself for the whole 10 weeks, and I found it's fairly intense.” Most foster carers recommended to roll out the programme more widely: “I think it should certainly be rolled out to other foster carers [Sounds of agreement from the group], it should be a mantra basically for foster... well, parents in general but especially foster carers, parenting troubled children.”

Feedback on content and structure of the RFP. Carers valued that the programme was delivered in a group, hence the opportunity to meet and get to know other foster carers: “More than anything, the group, the people that we’re with, whatever, it’s been quite therapeutic”. They also described the importance of group size for the group dynamics. Several recommended keeping the group size as it is (6-10 foster carers), “intimate groups, so you can actually build relationships with everyone in the room”, but if it was larger, “you wouldn’t have a chance to share”. By contrast, in the one group where several foster carers dropped out, those who remained said that when the group was too small it didn't work as well.

Foster carers agreed that an important element of the RFP was the openness and lack of judgement, “it was nice to be able to talk about how you feel without anyone judging you”. When speaking about the content of the RFP, most foster carers agreed that the content was helpful and interesting. However, some highlighted that the content was not entirely new to them. For instance, one said: “I’ve enjoyed it but, with us fostering for a lot of years, it’s what we’re already doing anyway, isn’t it [Sounds of agreement from the group]... but obviously... we’ve been given a name for it now.”

While the content of the programme was well received, overall, a few foster carers commented that too much content was covered in each session and expressed their wish to have had more time to “share their specific issues”:

> *“I do think that’s a really important thing, that foster carer, especially the more experience you’ve got, the more you’re going to be able to give and share in the training and you can’t have too little of that, there’s always more to take from each other.”*

When speaking about things that could be improved about the programme, some foster carers suggested to simplify the language, as they felt it was “a bit confusing”. One carer said: “Mentalization sounds like a made-up word [Laughs], I mean, I did come to, I do use it now, but at the beginning, all these university terms!”. Furthermore, some foster carers felt that more time should

be spent in the first session to get to know each member of the group, their circumstances and needs. One foster carer reported finding the first session hard and feeling "unzipped". She added:

"*I don't think there was anything wrong in what they were asking* (...) *I think maybe that some of those questions weren't right for me to answer at that point for that particular child... Maybe we needed a bit warm up."*

Impact of the RFP. Those who attended made clear that the programme was largely felt to have been helpful. Most foster carers reported positive changes, including increased understanding of self and others, improved sense of competence, reduced stress, a widened support network, and positive knock-on effects on the children in their care. The majority of foster carers conveyed a sense of general improvement in their lives. One stated "my home life is much better, because of it", while another reported: "I was thinking about it this morning (...) how hard I found it and how desperate I felt at times, but I feel like I've been on a journey and I've come out the other end." Many of the foster carers emphasised that the programme had prompted them to consider themselves more than they would have done previously:

> *"I'd got myself into a situation where I was just looking after the kids. There was no thought for anything else, just what the kids needed, and I felt it would be almost a weakness to say I needed anything. Whereas now, before I do anything, I tend to think 'What have I brought to this? What can I, what am I bringing to this situation? And what do I need?"*

Foster carers valued that the RFP gave them an opportunity to recognise and respect their own needs as well as reflect on their own and their child's feelings. When asked what they liked best about the programme, one carer said, "it's the bit where you take your needs as well, that was the best bit for me", and one replied, "I liked that it was non-judgmental, and you could reflect on your own feelings and where you are and become more conscious very gradually". Another carer reported: "I realised that actually it is important for me to find me... and have my thoughts and feelings considered... so now I've got hold of me again". This emphasis on attending to one's own thoughts and feelings as a foster carer was echoed by other participants:

> *"I think we've noticed as well, we've been on quite a few courses, and on all the other courses it is all mentioned that you must look after yourself, you must keep looking after yourself to be able to carry on, but you don't get any answers on how to do that* (…) *and I think that doing this course is the first one where we actually got, yes, we now know how to look after ourselves."*

Generally foster carers also felt that the programme helped them “calm down a bit” and taught them how to deal with stressful situations in a different way. However, one foster carer said:

> *“I don’t feel that, um, any different about* (...) *dealing with situations when you are under stress, other than, you know, locking myself in my room, which I’ve done on many occasions um, so that I can sort of de-stress before I deal with the situation but that’s not always possible, is it, when you’ve got two kids.”*

Most of the foster carers felt that they had “learnt a lot”, and several reported that they had learnt some new strategies and ways of doing things on the programme. One now felt better able to “get discussions started” with the child in her care; and another explained that the programme had helped them to “refocus on things they needed to do more or better”. Others reported that the course had given them a framework for thinking and understanding; “a name for things”.

Experience of training and delivery of the RFP for social care professionals. Most of the facilitators found taking part into and delivering the RFP a positive experience: “it was new, innovative, pioneering and kind of feeling quite privileged to be on it”. Overall, the three-day training provided as part of the facilitator preparation was well received. The majority of facilitators found the training beneficial and particularly liked the practical and dynamic aspect of it. For instance, one said: “One thing that I really liked about the training is that it was very practical. We did a lot of role playing, a lot of being in the mentalizing stance”. They all agreed that role-playing the sessions gave them “a taste of what you were going to do in the actual group” and appreciated that the trainers modelled the ‘mentalizing stance’ and used role-plays to show how to run the RFP and manage a group. Nevertheless, a few facilitators suggested a follow-up training to advance their skills, with a particular focus on maintaining the mentalizing stance and other 'soft skills'. When asked if there were any aspects of the mentalizing stance that were particularly difficult, some facilitators commented on the challenge of picking up when foster carers were *not* mentalizing; and others said that they initially struggled to use mentalizing language. Most facilitators agreed that they would have liked to receive more training on “how to manage challenging dynamics in a group”, intervening to challenge non-mentalizing and modelling mentalization in the facilitator pair.

Once the programme began, facilitators were offered a one-hour weekly consultation in pairs. The feedback about the consultations was overwhelmingly positive; they were described as “excellent” and facilitators commented that the consultations could "really free you up thinking about the group members" and " really supported the process of delivering the group.” Facilitators described often using the consultations to receive more guidance on how to facilitate mentalization in the group.

Alongside the initial training and the regular consultations, most facilitators recognised the importance of having a co-facilitator to deliver the RFP effectively, especially if it was a colleague with whom they had a pre-existing working relationship, as this could help with "rapport" and feeling able to support each other's mentalizing capacity during groups. One of them said: "I can't imagine trying to run a group on my own. I think that having a co-facilitator is so important… and through the consultations it really helped to think about the dynamics… And how to help mentalize each other".

While all facilitators acknowledged the importance of the RFP manual and appreciated its content, they also unanimously criticised aspects of the format of the manual and provided detailed feedback about how to improve it. All facilitators also commented on the language used in the manual as they felt it was not clear in places: "very academic" and "full of sort of clinical psychology type of speech". One facilitator reported: "Some areas were complicated more than they needed to be in the manual... [mentalizing] is quite a simple concept really, and we lose it with the language".

Most facilitators said that they would recommend the RFP to other NSPCC staff and when asked what has influenced their decision, one of them said "It's transferable knowledge". This was echoed by others, who added: "I've used it with other work." and "You know, it is a tool that can be utilized elsewhere…And it is empowering [Sounds of agreement]." Furthermore, facilitators suggested that the target audience could be extended to foster carers with children of different ages as well as all parents, adopters, teachers and the "system that is around foster carers".

Discussion

Overall, this feasibility and pilot evaluation of the RFP offers indications that foster carers could be recruited to the study, and that data collection methods were feasible. Although based only on observational data, comparison of pre- and post-measures indicated positive changes in carer stress levels, as well as the child's emotional and behavioural well-being and capacity for emotion regulation; and carers reported improvements in relation to their personalized goals for attending the RFP. Qualitative data supported the view that participants generally found the programme relevant to their needs, engaging and valuable; and the perceived relevance and value of the approach was echoed by social care professionals. Analysis of the focus group data also identified some key areas where the programme could be modified in order to make it more meaningful and relevant to those attending.

While the inclusion and exclusion criteria were kept broad in this feasibility stage, almost half of carers and children had histories of placement breakdown and the children in this sample scored highly on baseline measures of psychological difficulties (i.e. the SDQ Total difficulties score and the

BAC), suggesting the presence of emotional and behavioural difficulties that are typical in this population (NICE, 2013). This serves as an indication that it is possible to recruit foster carers who have a history of caring for children with complex needs, a significant proportion of whom have experienced previous placement breakdowns. Study recruitment identified no significant obstacles and there was a high level of retention among those who joined, in three of the four groups. Those who were recruited onto the programme were mostly experienced foster carers, caring for children who had been in care for more than two years. Feedback from foster carers and facilitators indicates that the biggest obstacle to recruitment and retention was the level of commitment required to attend weekly, three-hour sessions, and the greatest facilitator to on-going attendance was the perceived helpfulness of the RFP. For those who stopped coming, both practical issued but also confidence in the value of attending and the perceived competence of the group facilitators, seemed to be key.

Overall, there appears to be good 'face validity' for the RFP approach, with high attendance levels and positive feedback from most carers indicating that the approach was perceived to be largely relevant and beneficial for those who attended. Those who stopped attending the programme highlighted the importance of clarifying the time-commitment required in advance of starting and offered some important indications of how the programme could be improved, related to both programme content and delivery. Among those who took part in the focus groups, there was consensus among foster carers and facilitators that the RFP should be rolled out on a wider scale. Feedback from foster carers suggested that they particularly valued the reflective component of the programme and the focus on recognising their own needs and emotions, as well as the group experience and social support that they gained. Being a group-based programme, the RFP aimed to emphasize the strength of the carers' own resources, ideas and strategies to deal with problems, enabling a mutual learning process (Asen, 2002). The positive feedback on the group aspect of the programme was consistent with this aim.

Qualitative data from focus groups was also useful in highlighting some issues that may need improvement, with both facilitators and foster carers feeding back that there was too much content to cover within the allotted time and use of language on programme material that was at times "wordy" and academic. Feedback from facilitators and foster carers about issues with the RFP was shared with the programme development team, to ensure that in the next phase of development the manual will be more user friendly and the language used in the RFP will be simpler and less 'academic'. Additionally, facilitators may need more support on certain elements of the RFP, such as managing complex group dynamics, intervening to terminate non-mentalizing and modelling mentalization; and sufficient training and familiarity with the programme so that they are able to present the material with confidence.

This study was not primarily focused on assessing programme effectiveness, given the relatively small number of participants and lack of a control group, which means that any changes observed could simply be due to the passage of time. However initial findings are promising with regard to the impact on carer stress and the wellbeing of the foster child in their care. In particular, there were improvements in foster carer's self-reported stress across two domains of the PSI-SF: the 'Difficult Child' subscale, which measures how difficult caregivers perceive the child in their care to be, and the 'Parent-Child Dysfunctional Interaction' subscale, which measure the extent to which a caregiver perceives interactions with their child to be satisfying or reinforcing. There were also improvements in carer reports of their child's strengths and difficulties, measured using the SDQ, and their child's emotion regulation, captured by the 'Emotion Regulation' subscale of the ERC. There was also strong indication that foster carers' self-defined goals were being met, as assessed by the GBOM. This is of particular importance given that foster carers may well have quite specific hopes and needs, which may not be captured by standardized questionnaires which focus on domains pre-determined by the research team.

Qualitative analysis of the focus group data from foster carers and facilitators largely confirmed quantitative findings and suggested that foster carers saw improvements in several aspects of their life: increased understanding of self and others; improved sense of competence; reduced stress; a widened support network; and positive knock-on effects on the children in their care. Together these findings serve as a preliminary indication that the RFP may contribute to reducing parenting stress for foster carers and improving their perceptions of their child's emotions and behaviour, as well as their perceptions of their own support networks and feelings of competence. Helping to widen foster carers support networks and increase their feelings of competence may be important as social support and parental competence both appear to have a positive influence on parenting and the parent-child relationship (Belsky, 1997; Teti, O'Connell, & Reiner, 1996). Reducing foster carer parenting stress may also be key, not only because reduced stress is an indicator of improved carer wellbeing but also as stress in carers appears to have a bidirectional relationship with child behavioural difficulties (Neece, Green, & Baker, 2012). Findings from the present study are consistent with evidence that mentalization-based parenting interventions may lead to improvements in both child behaviour and the parent-child relationship (Ordway et al., 2014; Sadler et al., 2013).

While carers' spoke of their sense of increased reflective capacity, the quantitative measures of reflective functioning (RFQ and PRFQ) did not identify any statistically significant change. This may not be surprising given the small sample size and in light of extant literature suggesting that it is challenging to measure quantitative changes in parental reflective functioning as a result of psychosocial interventions (Fonagy et al., 2016). However, there was some evidence from the focus groups of positive shifts in foster carer reflective capacity, with carers reporting that they particularly

valued the reflective component of the programme and felt that there had been improvements in their ability to take a new perspective on their own thoughts and feelings, as well as those of the children in their care.

Although this study appears to demonstrate that a group-based reflective parenting program can have a positive impact on both foster carer stress and foster child wellbeing, there are several limitations to consider when interpreting the results. First, there was no comparison group and randomisation was not built into the design, limiting the strength of inferences that can be drawn from study findings. Future work should involve piloting of randomisation and further evaluation with a larger sample. Second, foster carers participating in the study self-referred themselves to the programme, introducing the possibility of selection bias, whereby certain types of foster carer may have been more likely to put themselves forward. Third, while the results show significant change in carer reports of their child's strengths and difficulties, this study included only foster carers perspectives on the child's wellbeing, without capturing different perspectives and/or situation-dependence of behaviours. Future study should include multiple reports on the child's behaviour, i.e. including the child's, teachers' and/or social workers perspectives.

Collectively findings from the feasibility evaluation of the RFP demonstrate that, while there are ways in which the programme itself could be improved, foster carers and facilitators generally found it to be a valuable approach, which they felt could play a role in supporting foster carers and the children in their care. Preliminary findings about the effectiveness of the RFP are encouraging, but further impact evaluation, using a larger number of participants, a randomized design and a control group, will be necessary if the programme is to be more widely disseminated.

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Table 1

Inclusion and Exclusion Criteria for the Reflective Fostering Programme Pilot Evaluation

Inclusion criteria
1. Foster Carer currently caring for a child aged between 4-11 years 2. Child had been in placement with them for at least 4 weeks at the point of recruitment 3. Foster carer had identified a need for additional support, in consultation with their supervising social worker and/or the child's social worker 4. Foster carer sufficiently fluent in English to engage in the Programme and the evaluation
Exclusion criteria
1. Foster Carers with emergency placements 2. Foster Carers caring for children currently seeking treatment from a specialist (tier 3) Child and Adolescent Mental Health Service (CAMHS). (Foster carers of children who were currently being seen by CAMHS were not excluded, but where a need for CAMHS had been identified, attendance at the RFP was designed to be alongside a mental health referral, rather than instead of it).

Figure 1

Consort diagram

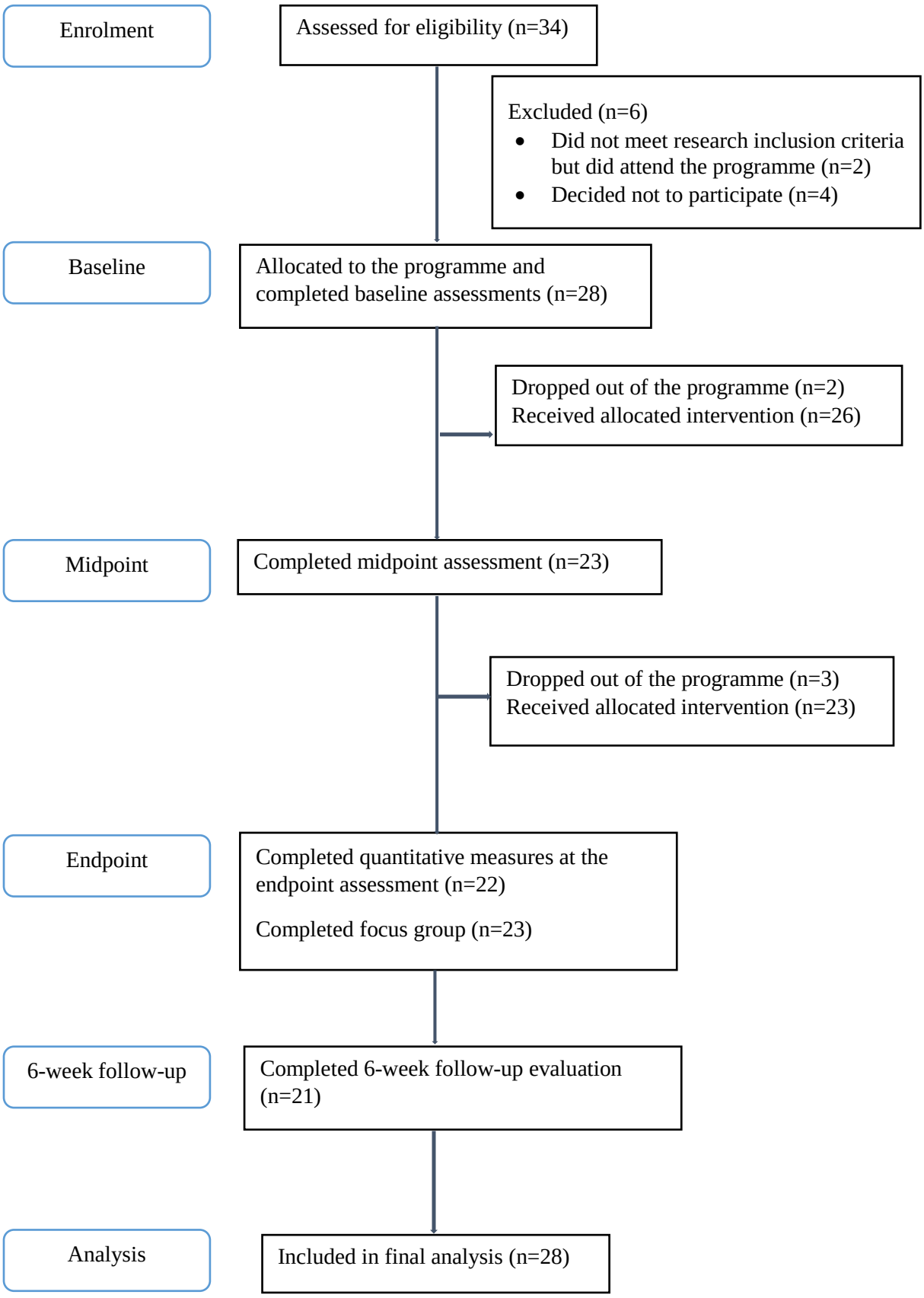

Table 2

Foster Carer Socio-demographics

	f	%
Gender		
Female	24	85.71
Male	4	14.29
Ethnicity		
White	27	96.43
Other	1	3.57
First language		
English	28	100.00
Marital status		
Single	4	14.29
Married/ domestic partnership	21	75.00
Widowed	1	3.57
Divorced	1	3.57
Separated	1	3.57
Education		
Levels/ GCSE	12	42.86
A levels (or equivalent)	4	14.29
Trade/ technical/ vocational training	4	14.29
University Bachelor's degree	5	17.86
Postgraduate degree	3	10.71
Previous placement breakdown		
Yes	11	40.74
No	16	59.26
Missing	1	
	M	SD
Age (in years)	52.32	6.95
Months working as a foster carer	112.25	93.19
Number of children previously fostered	12.96	19.80
Number of LAC currently caring for	1.75	0.80
	Range	
Age range of LAC currently caring for	3-19 years	

Notes. n = 28. *f* = frequency. % = percentage. *M* = mean. *SD* = standard deviation. LAC = Looked after children.

Table 3

Target LAC Socio-demographics

	f	%
Gender		
Female	16	61.54%
Male	10	38.46%
Missing	2	
Experienced previous breakdown		
Yes	6	37.50%
No	10	62.50%
Missing	12	
	M	*SD*
Age (in years)[a]	8.85	2.33
Months in current placement[b]	26.32	22.38

Notes. Percentages do not include missing data. *f* = frequency. % = percentage. *M* = mean. *SD* = standard deviation.

[a]n = 26.

[b]n = 22.

Table 4

Carer-focused outcome measures: sample distributions at baseline and endpoint, and estimates of mean change and standardised effect size

	Baseline			Endpoint			Estimated mean change				Std. effect size	
Measure	*M*	*SD*	*n*	*M*	*SD*	*n*	*M* diff.	*SE*	*p*	95% CI	*d*	95 % CI
Parenting Stress Index, Short Form												
Parental Distress	57.70	30.32	27	49.73	30.10	22	-6.36	3.22	0.058	[-12.96, 0.24]	0.26	[-0.31, 0.85]
Difficult Child	88.11	12.73	27	70.64	28.04	22	-15.78	4.73	0.002	[-16.33, -6.10]	0.83	[0.29, 1.39]
Parent-Child Dysfunctional Interaction	87.67	16.08	27	71.64	30.59	22	-15.99	4.95	0.004	[-25.99, -5.76]	0.68	[0.12, 1.24]
Total	85.63	19.84	27	71.73	30.13	22	-11.98	4.09	0.007	[-20.29, -3.63]	0.56	[-0.05, 1.14]
Parental Reflective Functioning Questionnaire												
Prementalizing	2.37	0.88	27	2.09	0.68	22	-0.25	0.17	0.156	[-0.59, 0.11]	0.35	[-0.23, 0.95]
Certainty About Mental States	3.70	0.91	27	4.00	1.02	22	0.29	0.25	0.253	[-0.21, 0.81]	-0.31	[-0.84, 0.23]
Interest and Curiosity	6.22	0.64	27	6.41	0.59	22	0.21	0.16	0.191	[-0.11, 0.54]	0.30	[-0.34, 0.84]
Reflective Functioning Questionnaire												
Certainty	1.13	0.75	28	1.30	0.74	22	0.15	0.13	0.261	[-0.12, 0.42]	0.24	[-0.33, 0.81]
Uncertainty	0.32	0.41	28	0.26	0.31	22	-0.05	0.09	0.536	[-0.23, 0.13]	0.15	[-0.49, 0.66]
Brief Parental Efficacy Scale	29.82	3.56	28	30.91	3.24	22	0.39	0.56	0.490	[-0.76, 1.57]	0.32	[-0.26, 0.82]
Goal Based Outcome Measure[a]	3.90	2.71	25[b], 73[c]	7.13	2.20	21[b], 63[c]	3.18	0.35	0.000	[2.49, 3.87]	1.30	[0.87, 1.71]

Notes. Std. = Standardised. *M* = mean. *SD* = standard deviation. *n* = sample size. *Diff.* = difference. *p* = p-value of test of null hypothesis: no mean change. *CI* = confidence interval. *d* = Cohen's d measure of effect size.

Standard errors, confidence intervals and p-values of mean change were estimated from a multilevel model taking into account the nested data structure.

Confidence intervals of standardised effect sizes were estimated from bootstrapping (BCa confidence intervals). For all measures, standardised effect sizes were calculated so that a positive value indicates improvement.

[a] Respondents set between 1-3 goals on this measure

[b] Number of respondents

[c] Number of goals

Table 5

Child-focused outcome measures: sample distributions at baseline and endpoint, and estimates of mean change and standardised effect size

	Baseline			Endpoint			Estimated mean change				Std. effect size	
Measure	*M*	*SD*	*n*	*M*	*SD*	*n*	*M* diff.	*SE*	*p*	95% CI	*d*	95 % CI
Emotion Regulation Checklist												
Lability/Negativity	38.43	5.70	28	36.68	5.51	22	-1.83	0.87	0.049	[-3.59, 0.00]	0.31	[-0.29, 0.92]
Emotion Regulation	21.29	2.94	28	22.05	3.14	22	0.62	0.52	0.239	[-0.44, 1.69]	0.25	[-0.29, 0.81]
Strengths and Difficulties Questionnaire												
Emotional	4.89	2.58	27	3.95	2.46	22	-0.92	0.36	0.018	[-1.66, -0.18]	0.37	[-0.23, 0.96]
Conduct	4.59	1.80	27	3.86	1.96	22	-0.70	0.47	0.152	[-1.53, 0.28]	0.39	[-0.19, 0.94]
Hyperactivity	6.78	2.62	27	6.32	2.70	22	-0.55	0.30	0.076	[-1.16, 0.06]	0.17	[-0.37, 0.85]
Peer	4.07	2.43	27	4.23	2.37	22	0.17	0.39	0.659	[-0.62, 0.99]	-0.06	[-0.68, 0.48]
Prosocial	5.85	1.92	27	6.32	2.10	22	0.54	0.27	0.058	[-0.02, 1.09]	0.23	[-0.31, 0.81]
Total	20.33	6.82	27	18.36	6.11	22	-2.13	0.97	0.039	[-4.11, -0.11]	0.30	[-0.27, 0.90]
Brief Assessment Checklist for Children												
	19.61	6.77	28	17.68	6.35	22	-1.87	0.95	0.060	[-3.81, 0.09]	0.29	[-0.27, 0.90]

Notes. Std. = Standardised. *M* = mean. *SD* = standard deviation. *n* = sample size. *Diff.* = difference. *p* = p-value of test of null hypothesis: no mean change. *CI* = confidence interval. *d* = Cohen's d measure of effect size.

Standard errors, confidence intervals and p-values of estimated mean change estimated from a multilevel model taking into account the nested data structure.

Confidence intervals of standardised effect sizes were estimated from bootstrapping (BCa confidence intervals). For all measures, standardised effect sizes were calculated so that a positive value indicates improvement.