

Dissertation volume:

Literature Review

Empirical Research Project

Reflective Commentary

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Psychotherapy

(Child and Adolescent)

Declaration

I, Konstantina Tsoukala, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Candidate Number: GYFV3

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Glossary

List of abbreviations used throughout the thesis presented below in alphabetical order.

AFNCCF: Anna Freud National Centre for Children and Families

Bpf: British Psychotherapy Foundation

CA: Content Analysis

CAMHS: Children and Adolescent Mental Health Service

CBT: Cognitive Behavioural Therapy

CYP: Child and Young Person/Children and Young People

DfES: Department for Education and Skills

EMDR: Eye Movement Desensitization and Reprocessing

EHCP: Education, Health and Care Plan

FCs: Foster Carers

FR: Five Rivers (Independent Fostering Agency)

IFA: Independent Fostering Agency

IFCs: Independent Foster Carers (registered with an Independent Fostering Agency)

IWMs: Internal Working Models

LA: Looked-After

LACYP: Looked-After Children and Young People

NICE: National Institute for Health and Care Excellence

PP: Psychoanalytic or Psychodynamic Psychotherapy

RCT: Randomised Controlled Trial

STS: Secondary Traumatic Stress

SWs: Social Workers

TA: Thematic Analysis

TF-CBT: Trauma Focused Cognitive Behavioural Therapy

UCL: University College London

YP: Young Person/People

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Part 1: Literature Review

Title: Mental Health Needs of Looked-After Children and Young People:
the 'downward' spiral, support systems, gaps, and barriers

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Abstract

Promoting the mental well-being of Looked-After Children and Young People (LACYP) is a priority on a Government Policy Level, as proven by the increasing implementation of relevant statutory demands on National Health Services and Local Authorities. This is a result of numerous findings highlighting a multitude of maladaptive short and long-term outcomes among this population, placing mental health difficulties at the centre of a downward spiral. Weak social and educational attainment, impaired attachment relationships, foster carers' poor mental health outcomes and low retention rates, as well as placement instability are only some of the fallouts that have been associated with the emotional and behavioural difficulties that a high prevalence rate of LACYP is grappling with. Although increasing emphasis is placed on the provision of adequate support for LACYP and foster carers, the limited evidence on the effectiveness of the most commonly recommended interventions and other relevant gaps in the literature, as well as the barriers in service provision and interagency collaboration, can hinder the access to and adequacy of this support. A review of the literature around the nature and characteristics of the mental health difficulties faced by LACYP, the implications that have been positively associated with these struggles, and the system response was undertaken in order to inform practice in this area. Further empirical studies on the assessment tools, effectiveness of implemented interventions, as well as collaborative multi-agency working were proposed.

1.1 Looked-After Children and Young People

1.1.1 Defining 'Looked-After' Status

According to the 1989 and 2004 Children Act of the United Kingdom (UK), the term 'Looked-After' (LA) is used to describe all¹ Children and Young People (CYP) who have been provided accommodation by a Children's Service Department for more than 24 hours or whose care has been granted by the court to a Local Authority (McAuley & Davis, 2009). Another terminology used to describe CYP in the Care System includes 'out of home' and 'alternate' care (Tarren-Sweeney, 2010; Golding, 2010).

The assumption of the parental responsibility by the welfare system can occur for any of the following reasons, which can in turn appear in any combinations. Physical, sexual, emotional, and/or verbal abuse; neglect; domestic violence; poverty; death of caregivers or inability (usually due to parental mental ill health or addiction) to look after the CYP for various periods of time (Rao, Ali, & Vostanis, 2010; Chipungu & Bent-Goodley, 2004; Van der Kolk, 2005). Among the aforementioned causes, abuse and neglect have been identified as the most predominant for registration on Child Protection Registers (Glenndenning, 2012).

¹ under the age of 18 years.

1.1.2 Considering Demographics

Although there are demographic and social policy differences across countries, national and international statistics on compulsory state care placements indicate that the number of LACYP is rising significantly (Elingsen et al., 2011; Vandivere et al., 2012; Delfabbro, et al., 2013; Rees & Stein, 2016; Tucker & Mares, 2013). Overall, an increase of 2%, 13%, 16% and over 22% in the numbers of LACYP has been recorded since 2000 in Scotland, England, Northern Ireland and Wales respectively (Rees & Stein, 2016). An approximate number of 70,000 LACYP was documented in March 2017 in England alone (Department for Education/DfE, 2017).

Furthermore, the types of public care that a CYP might be in can vary not only across the world, but also across the UK due to evolving policies and legislation (Usher, Randolph, & Gogan, 1999; Rees & Stein, 2016). Characteristic examples are the different types of legal status that Local Authority care can include under the umbrella of 'Looked-After' (i.e. foster or residential care; kinship care; special guardianship order; private fostering; home supervision orders in Scotland). Based on the most recent available statistics, 74% of LACYP -with the exception of Scotland- live in foster care, while relatively few are placed in children's homes and other residential settings (DfE, 2017).

1.2 Mental Health Needs

Many areas of disparity have been identified between LACYP and the average population of the same age groups (Wade & Dixon, 2006; Tarren-Sweeney, 2008). Overall, the findings are consistently showing that LACYP present with a high rate of poor physical and mental health, as well as high prevalence of neurodevelopmental impairments, language and learning

difficulties (Halfon et al., 1995; Casanueva et al., 2011; Lange et al., 2013; Pears & Fisher, 2005).

LACYP's mental health difficulties² have been widely recognised as the ones placed at the centre of an *indirect chain mechanism or downward spiral* of maladaptive short and long-term outcomes (Viner & Taylor, 2005; Pilowsky & Wu 2006; Zlotnick et al., 2012; Valentino et al., 2006; Chamberlain et al., 2008; Leathers, 2006). Poor educational attainment, social communication difficulties, high rates of teenage pregnancies, drug and alcohol abuse, unemployment, homelessness, and incarceration consist some of these chain reactions (Chipungu & Bent-Goodley, 2004; Anderson et al., 2004; Zetlin et al., 2005; Rutter, 2000; Ford et al., 2007).

Due to the centrality of mental health difficulties among the “Looked-After” population, this literature review focused on synthesising the evidence base with regards to the different types of emotional and behavioural difficulties in LACYP. More specifically, this work explored areas such as epidemiological data, as well as recommended treatment modalities for the aforementioned needs and their impact on foster placements. Possible gaps and complexities impacting on service provision were also examined.

1.2.1 Methods

A systematic search of a range of scholarly databases in the fields of health, social care, and social sciences was carried out for the purposes of this work. Variations of the following terms were used when carrying out searches:

² This project uses the term mental health difficulties as defined by ICD-10: “to imply a clinically recognisable set of symptoms or behaviour associated in most cases with considerable distress and substantial interference with personal functions” (World Health Organisation, 1992, as cited in Meltzer, Gatward, Goodman, & Ford, 2000, p. 16). The terms mental health difficulties and emotional and behavioural difficulties will be used interchangeably in this study.

'looked-after children and young people', 'foster care', and 'care leavers' This population database was then searched using terms for 'mental health'; 'psychological treatment or intervention'; 'pharmacological treatment'; 'support'; 'service use and access'. Databases searched included, Psych INFO, EMBASE, Medline, Web of Science and the Cumulative Index to Nursing and Allied Health Literature (CINAHL).

Studies retrieved were screened according to the criteria elaborated below.

Study Focus: Studies that were concerned with LACYP and FCs were primarily included. Due to limited evidence on treatment effectiveness among this population, studies focusing on CYP who have experienced neglect, maltreatment, trauma were also included.

Other Criteria: Studies were not excluded based on quality. Only English-language publications were included.

1.2.2 Epidemiology

According to epidemiological reports in Great Britain, LACYP were found to present with significantly higher rates of mental health difficulties in comparison to normative samples (Meltzer et al., 2003; Ford, Vostanis, Meltzer, & Goodman, 2007). More specifically, an incidence rate of 46.4% LACYP was identified to meet the criteria for at least one psychiatric diagnosis compared to 14.6% of children from disadvantaged private households and 8.5% from other private households (Ford et al., 2007; Felitti & Anda, 2010).

Conduct disorder, reactive attachment disorder, anxiety disorder, depression, Attention Deficit/Hyperactivity Disorder (ADHD), and Posttraumatic Stress Disorder (PTSD) comprise the most prevalent mental health diagnoses

that LACYP receive (Kolko & Pardini, 2010; Garland et al., 2001). Increasing attention is being placed on the unique traits of psychopathology associated with chronic childhood maltreatment, including childhood sexual abuse, severe domestic violence, interpersonal violence (Karatzias et al., 2017), as well as abuse taking place within the care system (Knefel et al., 2015). As a result, questions around the need for a distinct psychiatric disorder, such as complex PTSD (Resick et al., 2012) or developmental trauma disorder (Van der Kolk, 2017), have arisen. In ICD-11, the 'Disorders Specifically Associated with Stress' were divided in two categories: PTSD and Complex PTSD (WHO, 2018). The distinction between the two is based on the inclusion of the categorisation 'disturbances in self-organisation' in the case of Complex PTSD, which in turn includes three distinct groups of traits: "(a) severe and pervasive problems in affect regulation; (b) persistent beliefs about oneself as diminished, defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt or failure related to the stressor; and (c) persistent difficulties in sustaining relationships or in feeling close to others" (Keeley et al., 2016, p.113)).

Among the symptoms that are typically implied in the aforementioned diagnoses the following can be included: affect dysregulation; disruptive and violent behaviours; disobedience; interpersonal difficulties (i.e. indiscriminate and uninhibited attempts to receive comfort and affection from any available adult/peer or avoidance/intense reluctance to accept comfort and affection); impaired capacity to engage in daily activities due to lack of motivation; low mood; sense of hopelessness and helplessness; hyper-vigilance; difficulty to concentrate; self-destructive behaviour; impulsivity; inattention; hyperactivity; high-risk behaviours; sleep difficulties; dissociation; enuresis; encopresis; somatization (i.e. racing heart; dizziness; stomach aches) (Broad, 1999;

Copeland et al., 2007; Spratt et al., 2012; Karatzias et al., 2019). Overall, high levels of comorbidity have been identified among the LA population as a reflection of the complexities that the majority has experienced (McCann et al., 1996; Garland et al., 2001).

An association between LACYP's age and the prevalence of emotional and behavioural difficulties among this population has been identified, with higher incidence rates occurring amongst older CYP (Meltzer et al., 2003). According to a number of studies, prevalence rates of 57% up to 96% were found among adolescents in foster and residential care respectively (Meltzer et al., 2003; Tarren-Sweeney & Hazell, 2006; Tarren-Sweeney, 2008b). It is important to note that although age has been associated with poorer mental health its effects have been perplexed by the age at which children enter care, with older children entering the care system with poorer mental health (Tarren-Sweeney, 2008b).

Simultaneously, even though the prevalence of mental health difficulties among YP in care is undoubtedly high, variations in the incidence rates may reflect differences in the prevalence of protective and risk factors. One typical example is placement stability, which has been associated with decreased prevalence rates of LACYP's mental health difficulties. This phenomenon was conceptualised in the context of the significance that lies within a placement's security in meeting the LACYP's emotional needs (Office for National Statistics Studies, 2003, as cited in Meltzer et al., 2003; Hyde & Kammerer, 2009; Sanchez-Cao et al., 2013; Leve et al., 2012; Bernedo et al., 2012). Unsurprisingly, placement instability has been established as a risk factor (Utting, 1997). In this way, a possible explanation behind the reasons why LACYP present with greater problems on a social, behavioural and emotional level in comparison to

traumatised CYP who have not entered the care system could be offered (Bellamy et al., 2010; Sanchez-Cao et al., 2013; Leve et al., 2012).

1.2.3 Aetiology

The high prevalence of mental health difficulties among LACYP has been strongly associated with genetic factors, LACYP's adverse pre-placement psychosocial experiences, and experiences of state care (Bebbington & Miles, 1989; Skuse et al., 1999; Rao et al., 2010; Meltzer et al., 2003; Rutter, 2000; Newton et al., 2000).

The attachment theory (Bowlby, 1973, 1980) framework has been central in conceptualising this phenomenon (Howe & Fearnley, 2003). In order to make this association more comprehensible, it feels important to summarise the main tenets that transpire attachment theory.

According to Bowlby (1973, 1980) and Ainsworth (1967), infants are born with a multitude of behaviors which promote proximity to or contact with the mother. These manners were epitomized with the term 'attachment behavior' and their use was restricted to the infant's active attempts for achieving proximity or retaining contact with the mother/main caregiver. Furthermore, Bowlby (1969/1982) defined the system that organizes these behaviors as 'attachment behavioral control system' and emphasised that the organization and activation of this control system could be affected by conditions which involve danger or cause stress

It was during the last quarter of children's first year of life that Bowlby placed their ability to translate interactions with their mother/main caregiver into the so-called *Internal Working Models* (IWMs). An important attribute of these models is that their complexity increases with age and their role expands in the assessment of past, current and future relationships (Cassidy & Shaver, 2008).

Simultaneously, IWMs involve both representations of the self and the caregiver and are therefore considered complementary to one another in the sense that parents' reactions towards their child are internalized and considered to be part of his/her own self (Cassidy & Shaver, 2008). Finally, although IWM's ability and necessity to be updated was emphasized, Bowlby (1969/1982) enlisted several reasons which ensure their relative stability. Overall, he noted that children's familiarity with particular kinds of interactions with their caregivers often affects the way they perceive new experiences, triggers resistance to change, and turns into an unconscious automation (Bowlby, 1969/1982).

Holding attachment theory (Bowlby, 1973, 1980) in mind, while also considering the frequently unmet or inconsistently met needs of LACYP in regards to the formation of 'intimate bonds' with a consistent caregiver which, it can be hypothesised that LACYP's IWMs are compounded by lack of intimacy and experiences of abrupt disruptions (Minty, 1999; Wilson et al., 2000). According to these models, an internalised sense of mistrust prevails one's internal world, which is often translated as a conviction that he/she is "inherently undeserving of love" (Lieberman, 2003, p.280); at the same time, others, especially adults, are perceived as unreliable and un-protective. The impact of these internalised convictions on long term relationship functioning has been described as inevitable (Tarren-Sweeney, 2013).

Alike attachment theory, psychoanalytic theory on 'Object Relations' posits the infant's first relationship with the 'other', often referred to as object, at the centre of his/her emotional development (Greenberg & Mitchell, 1983). It is through that relationship and more specifically through the infant's joyful interactions and relationship experiences with the main caregiver, who is consistently able to respond to his/her spontaneous manifestations and take in

his/her primitive anxieties in order to contain, process, and eventually return them 'in a better shape', that the infant's 'maturational potential' is allowed to be actualised (Winnicott, 1965; Bion, 1962). For the majority of LACYP, the lack of or disruption in the caregiver's capacity to offer containment has been associated with the development of a 'false self'⁴ (Winnicott, 1965), as well as the inability to regulate feelings (Sloan Donachy, 2017).

The use of various mechanisms, such as projection⁵, as well as the employment of defences have been looked at in detail in psychoanalytic theory in an attempt to conceptualise the emotional and behavioural difficulties that traumatised children grapple with (Khan, 1963). Consequently, an emphasis has been placed on the different ways in which one's behaviour can be driven by the unconscious need to deal with terrifying states experienced in the past. For example, a child's violent or very distant behaviour could be driven by feelings of impotence and fear, which he/she feels the need to defend against by engendering the exact same feelings into the people around him/her.

In addition, further insight has been achieved through neuroscience and developmental research (McCrorry et al., 2010; Music, 2016). More specifically, the knowledge on the effects that trauma and neglect have - even from the time of pregnancy - on the child's developing brain is used as a way of understanding the difficulties occurring for the majority of LACYP (Beers & De Bellis, 2002; De Bellis, Baum, Birmaher, Keshavan, Eccard, Boring, Jenkins, & Ryan, 1999; De Bellis, Keshavan, Clark, Casey, Giedd, Boring, Frustaci, & Ryan, 1999). As it is now known, the human brain development is dependent on experiences and in

⁴ Defined as a 'defence organisation', which protects the self against "instinctual satisfactions and object relationships as they constitute a threat to the individual's personal going-on-being" (Winnicott, 1965, p.47).

⁵ mechanism particularly relevant to deprived children who had little experience of containment and attunement; it involves placing unwanted aspects and emotions to another person in order to get rid of them (Knight, 1940).

cases of trauma and/or neglect deficits in Executive Functioning (EF) can occur (DePrince et al., 2009). More specifically, it has been found that brain areas central to EF, such as the prefrontal cortex, can be badly affected by early life stress and trauma (Andersen et al., 2008; Yuen et al., 2009). This in turn impacts on many EF skills, including working memory, concentration and attention skills, planning complex cognitive behaviour, making decisions, expressing personality and moderating social behaviour, as well as emotional regulation, general intelligence and reasoning (Shimamura, 2000; Yang & Raine, 2009).

Additionally, there is evidence that over-arousal in the autonomic nervous systems and hypersensitivity to the limbic system -both of which interact in the physiological processing of emotion- can result from trauma and/or neglect (Porges, 2011). Consequently, stress hormones, such as cortisol and adrenalin, are recurrently released; this in turn results in states of high stress levels forming the way that the infant learns to naturally be (Schoore, 2003). The hyper-alert state that LACYP are often in has been associated with a heightened sympathetic nervous system that is hard to 'down regulate' (Greenspan & Wieder, 1997; Porges, 2011). Finally, the over-activation of the parasympathetic nervous system, which in the case of traumatised CYP can be caused every time feelings of fear and/or shame are instigated, can lead to the significant decrease of blood pressure and heart rate. It is then that the left side of the brain (the one that specialises in cognitive functioning and conscious memory) goes into shut down mode, letting the survival mechanisms of the right side of the brain take precedence. Overall, these physiological responses are often clinically referred to as 'fight/flight and freezing'.

1.2.4 Treatment

The proneness of LACYP to face mental health difficulties and the urgency for early and effective interventions have been recognised by Government Policy Documents, such as 'Promoting the Health and Well-Being of LACYP' (DfE, 2015) where statutory regulations to services involved with this population's care are set.

The early screening for LACYP's mental health difficulties has been considered pivotal in securing better outcomes, which is why one of the statutory expectations that was set for all local authorities has been the inclusion of the Strengths and Difficulties Questionnaire⁶ (SDQ; Goodman, 1997) in every⁷ LACYP's annual health review (Glascoe, 2000; HM Government, 2015). Although there are three similar versions of the SDQ for parents/carers, teachers (of CYP aged 2-17 years), and YP (aged 11-17), which could be used individually or in combination using a multi-informant algorithm, only a single-report completed by the child's carer is routinely used in LACYP's mental health screening in England and Wales (Wright et al., 2019).

Goodman et al. (2004) reported insufficient information on the screening efficiency of single-informant SDQs in this population and indicated that large numbers of children with mental health difficulties would be missed when only a single SDQ was used. However, additional SDQs are only collected from teachers and YP themselves if a possible difficulty is indicated (HM Government, 2015). Consequently, SDQ's effectiveness as the only screening method for mental health difficulties among this high-risk population has been increasingly

⁶ the SDQ is a brief, 25item emotional and behavioural screening questionnaire for CYP.

⁷ this standard is relevant to all LACYP who have been in care for at least 12 months (HM Government, 2015) and are between the ages of 4 and 16.

doubted (House of Commons Education Committee, 2016; SCIE, 2017; Wright et al., 2019).

On a larger scale, considering the fact that the SDQ is designed to capture symptoms which match with criteria for psychiatric diagnoses, while also taking into account the fact that the distinct psychiatric diagnosis of complex PTSD was only recently included in the ICD-11 (WHO, 2018), the SDQ may not have the ability to identify the LACYP who require treatment by specialist services, such as Children and Adolescent Mental Health Services (CAMHS).

This problem fits with the general lack of adequately verified assessment measures that could capture the clinical picture of psychopathology, but most importantly identify the individual, often complex needs of the LA population (O'Connor et al., 2000; De Jong, 2010; Tarren-Sweeney, 2009; Greeson et al., 2011; Gerrity & Folcarelli, 2008). In response, the use of measures designed to identify internalizing difficulties, which are commonly identified in this population and can go unnoticed (Golding, 2010), such as the Revised Children's Anxiety and Depression Scale (RCADS), and the Assessment Checklist for Children and Adolescents have been proposed as part of a wider assessment (Chorpita et al., 2000; Tarren-Sweeney, 2018).

Although the aforementioned inadequacies can hinder the provision of the targeted and dedicated support that LACYP need, services like CAMHS are still considered to play a key role in LACYP's well-being (DfE, 2015). The therapeutic interventions that are routinely recommended in these services are based on cognitive-behavioural, psychodynamic, attachment and/or systemic bases (National Institute for Health and Care Excellence/NICE, 2010).

Starting from Cognitive Behavioural Therapy (CBT), a distinct psychological intervention, it is important to note that its essence lies in the

collaboration with the patient and is held within a time-limited and task orientated context (Beck, 2011). More specifically, the patient identifies with the therapist his/her “self-perceived difficulties” (Hodges, 2018, p.87), including anxieties, fears and thoughts that impact on aspects of daily life, and is subsequently supported by the therapist to establish connections among them, while gradually develop more adaptive thinking strategies in relation to the targeted symptoms (Karatzias et al., 2019).

CBT has been recommended as one of the front-line treatment modalities for a number of diagnoses commonly obtained by LACYP, such as depression, anxiety, and PTSD (NICE, 2004, 2005a, 2005b, 2006). Although there is a limited number of studies assessing the effectiveness of CBT within the LACYP population (Hodges, 2018), there is more evidence to support the use of this treatment modality when looking at the wider context of chronic childhood maltreatment and complex PTSD (Deblinger, et al., 2001; Jaberghaderi et al., 2004; King et al., 2000; Runyon et al., 2010; Smith et al., 2007).

According to the evidence, CBT is recommended for CYP presenting with trauma-related symptoms (Stallard, 2006; Ramchandani & Jones, 2003). In the context of childhood maltreatment, the efficacy of a more focused version of CBT, namely Trauma-Focused CBT (TF-CBT), which in turn brings together trauma-sensitive interventions with cognitive behavioural, family and humanistic principles and techniques, has been supported by the evidence (Cohen et al., 2005; Cohen et al., 2011; Deblinger et al., 2006; Deblinger et al., 2011). The inclusion of the primary caregiver(s) in TF-CBT offered to children, who are presenting with PTSD symptoms in the context of having endured sexual abuse, has been also shown to be effective for both groups (Deblinger et al., 2006; Stauffer & Deblinger, 1996). However, the lack of a distinct therapeutic process

was identified as problematic; this resulted in the recommendation of clearly divided treatment phases that will be primarily promoting stabilisation, continuing with the resolution of traumatic experience(s), and finally endorsing a sense of personality integration (Cook et al., 2005; Deblinger et al., 2006).

It is worth acknowledging that the abovementioned collection of studies was rather heterogeneous in the sense that the participants were not necessarily among the LA population (Deblinger, et al., 2001; Jaberghaderi et al., 2004; King et al., 2000; Runyon et al., 2010; Smith et al., 2007; Stallard, 2006; Ramchandani & Jones, 2003; Cohen et al., 2005; Cohen et al., 2011; Deblinger et al., 2006; Deblinger et al., 2011; Cook et al. 2005; Stauffer & Deblinger, 1996) and their experiences of maltreatment varied [i.e. physical abuse (Runyon et al., 2010); domestic violence (Cohen et al., 2011); ; sexual abuse (Stauffer & Deblinger, 1996; King et al., 2000; Jaberghaderi et al., 2004; Cohen et al., 2005; Ramchandani & Jones, 2003; Deblinger et al., 2001; Deblinger et al., 2006)]. Additionally, majority of the evidence focused on single trauma incidents (Deblinger, et al., 2001; Jaberghaderi et al., 2004; King et al., 2000; Runyon et al., 2010; Ramchandani & Jones, 2003; Cohen et al., 2005; Cohen et al., 2011; Deblinger et al., 2006; Stauffer & Deblinger, 1996). which is not typically the case for LACYP. Small sample sizes (King et al., 2000; Smith et al., 2007; Runyon et al., 2010; Smith et al., 2007; Stallard, 2006; Stauffer & Deblinger, 1996)), as well as limited ethnical diversity (Jaberghaderi et al., 2004; Ramchandani & Jones, 2003; Cohen et al., 2011) and lack of control groups (Cohen et al., 2011; Jaberghaderi et al., 2004; Stallard, 2006; Stauffer & Deblinger, 1996) consisted additional limitations, further impacting on the ability to generalise those findings and draw firm conclusions. .

Eye Movement Desensitization and Reprocessing (EMDR) has been also recommended for the treatment of PTSD in CYP (NICE, 2018) as there is growing evidence supporting its efficacy (Rodenburg et al., 2009; Gillies et al., 2015; Moreno-Alcázar et al., 2017). Although both CBT and EMDR target the traumatic memories of the patients, EMDR differs in the sense that it uses bilateral sensory stimulation, which is repeated until the dysfunctional cognitions that accompany the trauma can become more functional and tolerable (Shapiro, 2007). The effectiveness of this treatment modality for the LA population has been doubted as the participants in the aforementioned studies had endured variable experiences of trauma, including both single and non-single incidents (Rodenburg et al., 2009; Gillies et al., 2015; Moreno-Alcázar et al., 2017). It is characteristic that in a systematic review and meta-analysis of RCTs on psychological treatments for Complex PTSD, an association between cases where the trauma had originated in childhood and poorer treatment outcome was identified (Karatzias et al., 2019).

According to an RCT conducted in 2010 by Farkas and colleagues, the use of EMDR for CYP who had been exposed to maltreatment and were presenting with conduct problems and difficulties of both an internalising and externalising nature was recommended. The participants in this study had been randomly assigned either to EMDR combined with MASTR (another manualised treatment recommended for young people who have endured trauma and are presenting with conduct difficulties) or routine care, which was in turn offered in different forms, including individual, dyadic, group, family therapy or other not specified types of treatment. The lack of a clearly defined alternative treatment, as well as the increased dose of treatment received by the EMDR and MASTR

group consisted a significant limitation in the comparison between experimental and control group.

Psychoanalytic or Psychodynamic Psychotherapy (PP) is another core treatment modality within specialist mental health services (Midgley, & Kennedy, 2011). PP is based on the provision of a predictable setting “in which attempts can be made to understand the communications of the patient” (Boston et al., 2009, p.122) via the detailed observation and monitoring of the relationship that is developed between therapist and patient. According to psychoanalytic theory, it is in this way that the therapist gains access into the CYP’s current internal world, where old patterns that form the ways in which new relationships are negotiated sit; it is through the understanding of this process that new, more appropriate ways of relating are allowed to develop (Robinson et al., 2017).

It is due to the early attachment trauma that most CYP have experienced that this treatment modality has been considered particularly relevant for this population (Green, 2009; Hunter, 2002; Hunter-Smallbone, 2009). Although a lack of empirical evidence evaluating the effectiveness of PP with LACYP has been identified (Midgley & Kennedy, 2011; Midgley et al., 2017). There is some evidence supporting that CYP who have experienced maltreatment, abuse and/or neglect can benefit from PP, with a preferential impact on PTSD symptoms (Gilboa-Schechtman et al., 2010; Trowell et al., 2002). However, the group of CYP who participated in these studies was too diverse in terms of diagnostic presentations and therefore it is hard to draw clear conclusions.

Clausen et al. (2013) looked specifically at the impact of long-term/open ended psychoanalytic, relational play therapy on twenty LACYP, placed in foster care. Significant reduction in symptoms of mental health impairment, including a

wide range of presentations, such as depression, anxiety, sleep disturbances, dissociative experiences, was identified. At the same time, improvements in relationships and decrease in school problems were reported (Clausen et al., 2013). It is due to the study's small sample size, lack of a control group, but also due to clinical change being measured by therapists that this study's findings were limited.

Aside from psychological therapies, the prescription of psychoactive medication (i.e. Selective Serotonin Reuptake Inhibitors/SSRIs; stimulants; benzodiazepines) is also employed in the context of managing the clinical symptoms that CYP, including LACYP, present with (Bramble, 2003). However, pharmacological treatment is not among the first line options and is typically recommended with caution when CYP's mental health difficulties are causing significant impairment(s) in at least one domain of their lives even after adjustments and modifications in the environment have been implemented and reviewed (NICE, 2004, 2005a, 2006).

Overall, a lack of well-designed studies, including RCTs and/or synthesis of different forms of evidence (i.e. qualitative and quantitative research; observational and experimental studies), which would evaluate the effectiveness of psychological treatments among the LA population, has been identified (Midgley et al., 2017; Shepperd et al., 2009; Karatzias et al., 2019). This 'gap' has been attributed to a number of possible factors, as enumerated below: 1) substantive differences in policies and legislation within the welfare systems across the world; 2) lack of appropriately validated measures specifically designed for this population; 3) complexities around the definition of LACYP's well-being and heterogeneity of difficulties among them; 4) difficulties to access LACYP (i.e. due to frequent placement moves), but also to gain consent for

participation in research; 5) difficulties to engage this population, possibly due to internalised mistrust in others; 6) difficulty to compare LACYP, whose experiences prior to and while being in the care system are very specific to the particular child, with other groups (Midgley et al., 2017; Craven & Lee, 2006; NICE, 2013; Hodges, 2018).

1.3 Implications

1.3.1 Impact on Foster Carers

The systems around LACYP, especially FCs, are amongst the most important support resources for this population. As a better understanding of LACYP's mental health needs is acquired, it is important to acknowledge the impact on FCs' psychological well-being as well (Greeson et al., 2011; Leve et al., 2012).

Numerous studies have investigated the impact that LACYP's emotional and behavioural difficulties can have on FCs and identified various closely linked factors that can precipitate the pressure they are faced with. More specifically, systemic pressures in terms of increased expectations in regards to FCs' role (Nutt, 2006; Sinclair et al., 2004), miscommunication between Services (i.e. school, CAMHS, GPs, Local Authorities), and gaps in clear definition of professionals' roles often accompany the mental health difficulties that LACYP grapple with. All these factors have been identified to engender overwhelming feelings in carers, leading to elevated levels of challenges and stress related to their role (Heller et al., 2002; Murray et al., 2011; Vanderfaeillie et al., 2013; Whenan et al., 2009; Sinclair et al., 2004).

Furthermore, secondary traumatic stress⁸ (Figley, 1995b) and compassion fatigue⁹ (Figley, 2002) have been described as possible consequences of caring for CYP who have experienced chronic trauma, leading to what has been known as 'blocked caregiving' (Baylin & Hughes, 2016). An association between these emotional states and the carers' use of avoidant cognitive styles, which are in turn associated with psychological inflexibility and thought suppression aiming to the avoidance of trauma, has been also established (McLain, 2008; Ottaway & Selwyn, 2016; Hannah & Woolgar, 2018).

As a result, LACYP might feel unable to find a way of connecting with their carers. Henry's (1974) theory on 'double deprivation' was very helpful in distinguishing the deprivation which was initially inflicted on LACYP (usually experienced by their biological parent(s)) from the one later inflicted by their carers. More specifically, Henry (1974) placed the origins of this 'deprivation' at the deep roots of these children's defences, which in turn stop them from taking up the help that is offered to them; FCs/adoptive parents were described as typical examples of sources of support that get rejected by CYP.

Overall, the creation of stress in carers remains a common theme in the nature of LACYP's emotional and behavioural difficulties, which in turn raises concerns over the carers' own "lovability and competence, as well as the child's prognosis for improvement" (Lieberman, 2003, p.280). Feeling ill-equipped to respond to needs, while being at the receiving end of an emotionally distant CYP

⁸ Secondary Traumatic Stress is defined as "the natural consequent behaviours and emotions resulting from knowing about a traumatising event experienced by a significant other- the stress resulting from helping or wanting to help a traumatised or suffering person" (Figley, 1995b, p.7).

⁹ Compassion Fatigue is defined as a "state of tension and preoccupation with the traumatised patients by re-experiencing the traumatic events, avoidance/numbing of reminders' persistent arousal (i.e. anxiety) associated with the patient. It is a function of bearing witness to the suffering of others" (Figley, 2002, p.1435).

with no signs of empathy and/or appreciation, do often lead to another big concern, which is FCs' low retention rates (Whenan et al., 2009).

1.3.2 Impact on Foster Placements

The high levels of strain that can be placed on FCs' by LACYP's emotional and behavioural difficulties, alongside a number of other risk factors, have been associated with another part of the *downward spiral* in the care system, which is placement instability¹⁰ (Wilson et al., 2000; Rostill-Brookes et al., 2011; Farmer et al., 2005; Oosterman et al., 2007). Among these factors, the following have been established as the most important: "older age, longer total time in care, residential care as first placement setting, separation from siblings, experience of multiple social workers, being placed out of area of origin, lack of adequate support, number of previous placements, and poor integration into a foster family" (Rock et al., 2013, p.196).

Therefore, unplanned placement endings have been identified as yet another risk factor compounding LACYP's existing struggles, including formation of attachments, affect regulation, and sense of self-worth (Strijker et al., 2002; Rubin et al., 2007). Simultaneously, placement breakdowns can be experienced as acutely distressing by FCs as well, promoting a sense of failure, role disillusionment and hesitation to offer future placements (Wilson et al., 2000; Nutt, 2006). Consequently, LACYP's mental health difficulties and placement stability are caught up in a bidirectional relationship that has been hard to untangle (Newton et al., 2000; Chamberlain et al., 2008; Leathers, 2006; Farmer et al., 2005; Morgan & Baron, 2011).

¹⁰ as Rostill-Brookes, Larkin, Toms, & Churchman (2011) helpfully pointed out, various terms are being used in the literature to describe an "unexpected placement ending, such as breakdown, unplanned ending, disruption, removal or crisis". In this paper all these terms will be used alternately.

It is worth noting that although a significant body of the literature focuses on the association between placement breakdown and behavioural difficulties displayed by LACYP, the carers' role, as well as the quality of the relationship between the child and the carer are receiving growing attention (McCarthy, 2004; Sargent and O'Brien, 2004; Chamberlain et al., 2006). More specifically, the carers' interest and motivation to look after the CYP under their care have been positively associated with good quality foster placements (Kraus, 1973; Stone & Stone, 1983). Additionally, according to Wilson (2006) it is the interaction and the fit of the relationship between child and carer that have a significant bearing on the placement outcome. Although these findings have been supported by more studies highlighting the association between 'relationship factors' and placement breakdown (Duelling & Johnson, 1990; Brown & Bednar, 2006), Oosterman et al.'s (2007) multivariate analyses showed that their significance diminishes when the number of previous placements and behavioural problems are controlled for.

Overall, there is recognition of the additional collapses and fragmentations that occur in the child's cycle of care when a placement is prematurely ended (Utting, 1997; Rostill-Brookes et al., 2011). Simultaneously, it is established that LACYP who receive high quality care and live in a safe, stable placement are more likely to feel better within themselves, succeed on an educational level, and manage to integrate socially (Sinclair, Wilson, & Gibbs, 2005; Stein, 2005; Cicchetti & Valentino, 2006; Sroufe et al., 2000).

Consequently, ensuring foster placement stability has been prioritised on a government level. This was reflected in a number of policy documents: *Quality Protects* initiative (Department of Health, 1999, as cited in Holland, Faulkner, & Perez-del-Aguila, 2005); Green Paper *Every Child Matters* (Department for Education and Skills, 2003, p.45, as cited in Holland, Faulkner, & Perez-del-

Aguila, 2005); *National Service Framework for Children* (Department of Health, 2004, as cited in Holland et al., 2005); *White Paper Care Matters: Time for Change* (Department for Children, Schools and Families 2007, as cited in Holland et al., 2005). However, the target of 80% placement stability¹¹ that was set by the government was only met by 51% (Department for Education and Skills, 2006). Other studies have provided further evidence, indicating high frequency of placement breakdowns (Minty, 1999; Wilson, Sinclair, & Gibbs, 2000).

All these initiatives signify the importance of the *secure base* model, which was founded on a concept developed in *attachment* theory and described the balance between dependency and autonomy, closeness and exploration that lie behind secure attachment relationships (Bowlby, 1969/1982; Howe et al., 1999; Schofield & Beek, 2005). Similarly, Winnicott's (1965) concept on the *facilitating/holding/good enough* environment is referring to the parental/caregiving capacity of adapting to the infant's growing needs and therefore "facilitating the maturational process" (Winnicott, 1965, p. 239). When applied to LACYP, the *secure base* (Waters & Cummings, 2000) or *facilitating environment* (Winnicott, 1965) concepts are conceptually linked to resilience and suggest that sensitive, available and reliable caregivers can reduce anxiety and promote LACYP's capacity to become more competent in managing new challenges in all areas of life (Cashmore & Paxman, 2006).

¹¹ this target is relevant to all CYP who have been in the care system for at least four consecutive years and have achieved permanence in the same placement for two years or more (Department for Education and Skills, 2006).

1.4 Service Response

1.4.1 Support for Foster Carers

In light of the strong bidirectional relationship identified between the mental health difficulties that LACYP often grapple with, the FCs' psychological well-being, and the quality of care that LACYP receive, increasing emphasis has been placed on the support FCs receive prior to and during placement (Kinsley & Schlösser, 2013).

Foster Care Training programmes generally involve teaching for carers in a group setting and last for a specific number of sessions (Kinsey & Schlösser, 2013). These programmes have received increased attention during the past decade as they have been associated with enhanced caring attitudes and skills, reduced behaviour problems in LACYP, improved relationships between FCs and child welfare agencies, as well as decreased FCs' attrition (Nutt, 2006). As a result, the Children's Workforce Development Council/CWDC launched the Training, Development, & Support (TDS) Standards for Foster Carers in 2007, which consist of 7 *statutory standards* that are a national benchmark for the continuing professional development and training, supervision and support for foster carers (CWDC, 2007, as cited in Everson-Hock et al., 2012). Although all fostering services are expected to implement the standards, it has been reported that within the UK the types of training provided to FCs vary between private fostering agencies and Local Authorities (MacDonald & Turner, 2005).

Although FCs have reported high levels of satisfaction (Minnis & Devine, 2001; Pallett et al., 2002; Allen & Vostanis, 2005), and increased levels of confidence (Pallett et al., 2002) as a result of their attendance to training programmes, the impact on LACYP's well-being and the relationship between child and carer are less clear due to methodological limitations (Berry, 1998;

Dorsey et al., 2008; Lee & Holland, 1991; Rork & McNeil, 2011; Turner, Macdonald, & Dennis, 2007).

Therefore, among various training interventions (i.e. CBT training to help carers manage challenging behaviour; Behavioural management training; Training on communication skills and attachment; Adapted Incredible Years), only one was identified as effective through a large scale RCT, which is *Keeping Foster Parents Trained and Supported (KEEP; Price et al., 2008)*. *KEEP* is a training intervention that aims at exploring with and teaching carers more lenient discipline methods in order to promote positive reinforcement; these techniques are applied in an individual way through group discussion (Kinsey & Schlösser, 2013). Significant decrease in the children's behaviour problems, as well as increased chances of 'positive exits' (reunification with parents) were identified (Chamberlain et al., 2008; Price, et al., 2008). The inclusion of reports from different sources (children, school, carers, social worker), and the use of empirically validated assessment measures have been suggested for future studies (Rork & McNeil, 2011).

A similar methodological problem is faced with FCs' groups, which in turn consist another intervention recommended for FCs (Minnis, Devine, & Pelosi, 1999; Pallett et al., 2002; Hill-Tout et al., 2003; Kinsey & Schlösser, 2013). FCs' groups mainly aim at providing support to a number of carers, while offering them the opportunity to learn and support each other through psycho-education, as well as opportunities that promote the conceptualisation of LACYP's difficulties and the development of management strategies (Kinsey & Schlösser, 2013). A popular FCs' group is the 'Parent Training and Psycho-educational group', which is based on the Incredible Years parent-training programme and offers carers the opportunity to explore different ways of understanding CYP's behaviour and to

develop strategies of managing these behaviours by therapist and carers working together as partners (Webster-Stratton & Hancock, 1998; Pallett et al., 2002; Golding & Picken, 2004). Although growth in FCs' confidence levels, sense of self-efficacy, as well as capacity to communicate with CYP were reportedly achieved through these groups (Pallett et al., 2002; Minnis & Devine, 2001), the impact on LACYP's well-being remains unclear due to methodological limitations (Kinsey & Schlösser, 2013).

Finally, another complication lays with the fact that statutory measures used to assess LACYP's mental health, such as the SDQ, do not capture the difficulties that FCs might be facing. It is for that reason that the use of alternative measures, such as the 'Parent Reflective Functioning Questionnaire' (Luyten, Mayes, Nijssens, & Fonagy, 2017) and the 'Thinking About Your Child Questionnaire' (Wassall, Golding, & Barnbrook, 2011), which could in turn assess aspects of CYP's interpersonal relationships, has been recommended (Wright et al., 2019).

1.4.2 Network Role

Although increasing emphasis is placed on the provision of adequate support to LACYP and their Carers, a worrying gap in services' provision has been identified (Simkiss & Jainer, 2018). More specifically, the services' response to the high prevalence of mental health difficulties among LACYP is considered inadequate and the levels of service use by LACYP are consistently low (Bonfield et al., 2009; York & Jones, 2017). Simultaneously, the FCs' needs remain largely unmet and they continue to sustain the "high burden of care" (Murray et al., 2011, p.150; Tarren-Sweeney, 2010; Vanschoonlandt et al., 2012).

Another complication reported by FCs is the existence of barriers once entering the mental health system, where the long wait for specialist assessments

and treatments was associated with the generation of feelings of impotence and despair (York & Jones, 2017). Overall, the long waiting times and accessibility to provision, which can depend on the area of residence and also be further perplexed in cases of placement moves and subsequent transitions from one Local Authority to another, have been recognised on a national level as obstacles to the timely provision of required support (Department for Education, Department of Health, 2015).

Considering the abovementioned evidence, as well as the long-term impact of LACYP's unmet mental health needs (Simkiss, 2012), there is a policy consensus that no single agency can meet LACYP's needs (DfES, 2006). Therefore, inter-agency commissioning and planning have been supported, leading to the agreement of a transformation plan (NICE, 2013). The following priorities compose the basis of this plan: 1) to promote accessibility to and collaboration between multiple agencies in order to offer the high level of support that is often required; 2) to protect consistency in accessing support; 3) to decrease wait times; 4) to offer specialist consultation and training to schools and carers; 5) to arrange and attend regular inter-agency meetings (Taylor et al., 2007; Department for Education, Department of Health, 2015).

However, various barriers in the inter-agency collaboration have been identified, highlighting the issues of "power imbalances, information exchange, and resourcing being central to any collaborative work" (McLean, 2012; p. 484; Horwarth & Morrison, 2007). More specifically, further complications in the process of sharing information, such as manipulation of referral information as a way of making referrals go through, are considered problematic (McMillen et al., 2005). More obstacles often compound these phenomena, which can include

services' narrow referral criteria, staff configuration, and short-term contracts (Callaghan et al., 2003).

Additional complexities tied to ideologies of service provision, such as the fact that Local Authorities often value the provision of direct treatment to LACYP over the offer of support to the carers or the network, have been associated with the need for further research and evidence-based service typologies evaluation (Robinson et al., 2017). On the other hand, the lack of clear care pathways within specialist mental health services, such as CAMHS, can further complicate the expectations that services have from one another (Vostanis et al., 2008; Williams & Salmon, 2002; McLean, 2012; Lindsey, 2018).

McLean's (2012) study highlighted another problem that can hinder the collaboration between services, named triangulation. Triangulation refers to the "consequences related to the involvement of external or third parties in the family and relational life of children in out-of-home care" (McLean, 2012, p.483). Essentially, McLean (2012) indicated that the involvement of many services in the care of LACYP can potentially hinder the element of normality and also eliminate the carers' or others' (i.e. teachers; care workers) authority in using appropriate discipline, which could potentially promote conflict resolution.

As a result, the advanced support that LACYP and their carers often require, as well as the trusting relationship that services aim to develop with them are often placed at risk due to the aforementioned complications (Williams & Salmon, 2002; McLean, 2012; Lindsey, 2018). Inevitably, LACYP's life stories are held in a compartmentalised way by a long array of professionals, contributing to a further fragmentation of their internal worlds (Williams & Salmon, 2002; Van Eyk & Baum, 2002).

Emanuel (2002) used an alternative way of conceptualising the gaps and complexities in service provision, which she termed 'triple deprivation'. This concept refers to the deprivation that can occur within organisational settings, where professionals "replicate these children's original experience of neglect by allowing them to fall through a hole in the 'net'-work" (p. 164). According to Emanuel (2002), this re-enactment results from the powerful and uncontained projections of disturbing primitive mechanisms and defences against impotence and fear that professionals receive from traumatised CYP and parents/carers. Inevitably, the inadequate service response to LACYP's needs feeds into the cycle of deprivation that had been already inflicted on them.

1.5 Literature Review Conclusions

The aim of this review was to look further into the nature of LACYP's mental health needs, including epidemiological data and aetiology, while also to explore the treatment modalities recommended in response. Additionally, this account intended to gain further insight into the implications that have been associated with the emotional and behavioural difficulties that LACYP grapple with, placing a special focus on FCs and foster placements. Support systems recommended and set within the context of statutory demands were also investigated, while the barriers hindering the access to and quality of the required support were identified. Finally, by reviewing the evidence and establishing the gaps in the literature and the services' response, this study has both research and clinical implications.

More specifically, this account started by accumulating the data on the high prevalence rates of mental health difficulties among LACYP. The evidence on the central role that these difficulties hold within a downward cycle of

maladaptive short and long-term outcomes was subsequently reviewed. As this study progressed, the clinical diagnoses of PTSD, Conduct Disorder, ADHD, reactive attachment disorder, depression, and anxiety were established as the most frequently acquired ones for LACYP. However, the evidence questioning DSM's relevance to the unique traits and complex trauma endured by LACYP, as well as its' capacity to capture specific emotional difficulties, especially those of a more internalising nature, were examined. Similarly, this study outlined the doubts raised on a research, but also government level, in regards to the adequacy of the assessment measures, such as the SDQ, which are routinely used by local authorities and specialist mental health services.

In an attempt to review the evidence exploring the aetiology behind the high prevalence of mental health difficulties among LACYP, the central role of Bowlby's attachment theory in the conceptualisation of this phenomenon was discussed. Additionally, the psychoanalytic theory, alongside the growing knowledge resulting from neurodevelopmental research, were elaborated on in order to facilitate the understanding of the difficulties occurring for the majority of LACYP, such as poor affect regulation, hyperactive and/or dissociative states of mind, impaired social and learning skills (Greenberg & Mitchell, 1983; Music, 2016).

Following this, the recommended treatment modalities that can be offered within specialist mental health services, such as CAMHS, were reviewed. As a result, CBT, TF-CBT, and EMDR were recommended for trauma-related symptoms. Additionally, there is some evidence supporting the effectiveness of PP for CYP who have experienced maltreatment, abuse and/or neglect. However, various methodological limitations, which impacted on the validity of the studies exploring the effectiveness of these treatment modalities, were

identified. Consequently, the need for more empirically validated and targeted to the LA population studies has been supported with the aim of maximising the adequacy of the required support, promoting good treatment outcomes, as well as informing policy and clinical practice accordingly.

As the incidence rate of mental health difficulties among LACYP remains high, the literature looking into the impact that the emotional and behavioural difficulties have on FCs was also reviewed. The poor mental health outcomes that FCs present with and the association with FCs' low retention rates and placement instability, which in turn feed into the cycle of deprivation that LACYP often endure, were subsequently discussed. As FCs' Training programmes and Groups are recommended in response, the evidence in regards to their effectiveness was reviewed. Due to identified methodological limitations, further research was recommended (Berry, 1998; Dorsey et al., 2008; Lee & Holland, 1991; Rork & McNeil, 2011; Turner et al., 2007).

Finally, this account examined the increasing evidence that supports a worrying gap in service provision and justifies the rationale behind the consensus that no single agency can meet the needs of the complex web evolved around LACYP's mental health needs. Due to a series of reported barriers that hinder inter-agency collaboration, the following recommendations were proposed: greater clarity in the delineation of professionals', as well as services' roles and expectations; distinct care pathways; regular inter-agency meetings; transparent communication among carers, professionals, and CYP (Golding, 2010; McLean, 2012).

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Part 2: Empirical Research Project

Title: Placement Support for Foster Carers and Young People under their care:
Exploring the Experience and Perceptions of Carers registered with an
Independent Fostering Agency.

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Abstract

The steadily rising numbers of Looked-After Children and Young People (LACYYP), the high prevalence of mental health difficulties among them, as well as the subsequent strain placed on Foster Carers (FCs') and their low retention rates, result in a pertinent need to capture the FCs' views on multiple subjects around the experience of fostering. The current study aimed at exploring the Independent FCs', all registered with an Independent Fostering Agency, perceived views on the support that they and Young People (YP) under their care received within and outside the agency. Due to evidence indicating higher prevalence rates of mental health difficulties among older ages the focus is placed on FCs looking after Young People of secondary school age. A mixed methods approach was employed for the purposes of this study, utilising a survey concerning both closed and open-ended questions, as well as semi-structured interviews with FCs. In summary, the study's findings were broadly in line with current empirical literature, though some findings shed further light on foster carers' needs, concerns and wishes. Overall, the majority of IFCs reported having benefitted from the support they and the YP received. The carers attributed a number of –overall positive- qualities to themselves, while acknowledging the centrality of their role in the progress of the YP's wellbeing. Simultaneously, they reflected on the complex nature of the YP's presentation, the areas that they felt unskilled in and identified the gaps in the perceived support. Finally, the importance of collaborative communication among them and agencies involved in managing these complexities was valued.

Impact Statement

This is a small scale study that employed a mixed methods approach in order to examine the Independent Foster Carers' (IFCs') experience(s) and perception(s) of the support that they and the Young People (YP) under their care received within and outside their Fostering Agency, namely Five Rivers (FR). Despite the study's limitations, it is important that its' impact on policy, clinical, and research levels are considered.

Reflecting initially on the study's implications within FR, it could be through the more comprehensive understanding of the IFCs' perceptions on what works well and what does not that FR has further evidence to endorse the carers' key role in YPs' well-being. Subsequently, the pressure to provide adequate and accustomed to their needs interventions is intensified. Additionally, the study's findings that have so far received less empirical attention, including the carers' interest to explore what lies behind YP's emotional and behavioural difficulties, whilst reflecting on what these resonate within them, could better inform the interventions provided by FR.

On a larger scale, this study's findings are in line with current policy (DfES, 2006; NICE, 2010) that emphasises the FCs' role as being at the front line of YPs' complex care, therefore requiring adequate support for themselves. Simultaneously, the marked significance that lays within network collaboration, as well as the barriers that hinder this partnership, promote the need for other statutory standards, such as regular inter-agency meetings and transparent communication among carers, professionals and LACYP, as indicated in previous studies (Golding, 2010; McLean, 2012). On a clinical practice level, the aforementioned knowledge obtained through this study can inform the

interventions offered to both FCs and LACYP, including the consultative role that clinicians are expected to hold within the network. Finally, additional research that would use larger participant samples, and also investigate further the relevance of qualitative approaches and routine outcome measures in the exploration of FCs' and LACYP's experience(s) of the implemented support, could be inspired by this study; in this way, service policy and clinical practice will be better informed and shaped accordingly.

2.1 Introduction

According to the 1989 and 2004 Children Act of the United Kingdom (UK), Children and Young People (CYP) “residing in court-ordered care” (Tarren-Sweeney, 2008b, p.345) are referred to as ‘Looked-After’ (LA) (McAuley & Davis, 2009). Although the use of this term can vary among countries, there is accumulating national and international evidence indicating that LACYP’s number is steadily rising (Delfabbro, et al., 2013; Vandivere et al., 2012; Tucker & Mares, 2013; Ellingsen et al., 2011). In the UK (except for Scotland), the majority of LACYP¹ live in foster care, while relatively few are placed in children’s homes and other residential settings (Rees & Stein, 2016). It is local authorities that hold legal responsibility for the safety and wellbeing of all LACYP (Waterhouse, 1997), which they continue to do even in cases where Independent Fostering Agencies² (IFAs) are employed (Warren, 1997). It is important to note here that LACYP are generally referred to IFAs when a placement cannot be identified for them; this has been mostly attributed to the shortage of carers and CYP’s complex presentation (Sellick & Connolly, 2002).

There is accumulating evidence suggesting that mental health difficulties are one of many areas of disparity between LACYP and normative samples (Ford et al., 2007; Tarren-Sweeney, 2008a; McAuley & Davis, 2009). The nature of LACYP’s psychopathology is often described as ‘complex’ and ordinarily characterized by conduct disorders, depression, anxiety, attachment difficulties, and inattention/hyperactivity (Meltzer et al., 2003). These difficulties have been mainly associated with convoluted and “time-sensitive” interactions (Tarren-

¹ In the UK, children who are adopted are considered to have exited the care system (Tarren-Sweeney, 2010).

² IFAs “assess, train, pay and support foster carers; they provide placements with their foster carers for a fee” (Selwyn et al., 2010, p.697).

Sweeney, 2008b, p.346) that can include: genetic predisposition, foetal development, conditions during pregnancy, traumatising experiences of abuse and/or neglect before entering care, abrupt attachment ending(s) of the relationship with primary caregiver(s), impermanent nature of foster/residential placements, and any other potentially harmful in-care events (McCann et al., 1996; McMillen et al., 2005; Nutt, 2006; Tarren-Sweeney, 2008b). Prolonged exposure to any of these abusive and/or depriving living conditions has been identified as the primary reason resulting in the positive association between older age of LACYP and higher prevalence of mental health difficulties (Tarren-Sweeney, 2010; Rushton & Dance, 2006). It is characteristic that older CYP are usually referred to IFAs (Sellick & Connolly, 2002).

The implications of LACYP's complex presentation on their carers³ are multifaceted and reported to place a serious strain on them (Levy & Orlans, 1998). Starting from the relationship with the CYP under their care, carers often struggle to relate and develop a consistent bond with them (Murray et al., 2011). This struggle has been mainly associated with the latter's insecurity in the adults' protective function and the subsequent testing of the carers' boundaries so that the familiar narratives of failures are *compulsively repeated* (Freud & Strachey, 1920; McAuley & Davis, 2009). Simultaneously, carers assume increasing financial responsibilities due to the children's growing needs, while having to endure systemic pressures, such as complicated contact with birth family, hard to engage Social Workers (SWs), allegations, and/or placement disruptions (Nutt, 2006; Wilson et al., 2000). On the whole, the high level of demands placed on carers has been associated with negative effects on their own mental health

³ This study was focused on foster carers.

(Hannah & Woolgar, 2018), such as Secondary Traumatic Stress⁴ (STS) (Figley, 1995b). The subsequent effects of the carers' emotional wellbeing on retention rates and placement stability have been identified and highlighted (Newton et al., 2000; Rock et al., 2013; Murray et al., 2011).

Individual and/or group interventions for Foster Carers (FCs) have been largely implemented in response (Dozier et al., 2002). The key forms of support used include advanced and customised to individual needs training, aside from the mandatory 'Training, Support & Development Standards' launched by the Children's Workforce Development Council for FCs (CWDC, 2007, as cited in Everson-Hock et al., 2012). Individual consultation (usually with the allocated support worker), supervision, and/or group interventions are also among the interventions that are often offered to carers (Kinsey & Schlösser, 2013). Additionally, psycho-educational training modules that focus on a range of constructs, such as effects of trauma on the brain and attachment theory, are being offered to carers with the aim of informing and improving their capacity to make sense of the CYP's thoughts and feelings (Hughes & Baylin, 2012). Furthermore, detailed assessments of the children's needs and interdisciplinary, as well as interagency collaboration are receiving growing attention due to findings supporting their importance in alleviating some of the carers' worry in identifying the children's needs and advocating for further support (McAuley & Davis, 2009; Richards et al, 2006; Leve et al., 2009).

⁴ STS is defined as "the natural consequent behaviours and emotions resulting from knowing about a traumatising event experienced by a significant other- the stress resulting from helping or wanting to help a traumatised or suffering person" (Figley, 1995b, p.7). STS's symptomatology has been likened to the one of Post-Traumatic Stress Disorder (i.e. intrusive thoughts and/or images; hyper-arousal; avoidance of thoughts around the traumatic event(s)) (Hannah & Woolgar, 2018, p.630).

A comprehensive approach offering support to both carers and CYP has been found to be needed in some cases (Rosenfeld et al., 1997; McGuinness et al., 2007; Hughes, 2004). These models of interventions are based on the principles of the 'secure base' (Waters & Cummings, 2000) that was developed in the context of the *attachment* theory (Bowlby, 1969/1982; Schofield & Beek, 2005) and the *facilitating/good-enough* environment (Winnicott, 1965). Examples of such interventions are: the *Attachment Focused Treatment* suggested by Hughes (2004) as a model where the therapist's and caregiver's "primary inter-subjective stance of acceptance and curiosity, empathy and/or playfulness" aim at providing children with "new ways of giving meaning to the terrifying and shameful events of the past" (p.269). The ultimate aim of this intervention would be to promote the CYP's sense of control and capacity to create their individual narratives. *Treatment/Therapeutic Foster Care* (TFC) is another example (Rosenfeld et al., 1997; McGuinness & Schneider, 2007) that can be offered for a limited amount of time by professional foster parents with specialist training and knowledge. In the case of IFAs, greater resources, training and support are reportedly offered to carers and CYP (Sellick & Connolly, 2002).

Overall, the aim of these interventions is to promote the carers' wellbeing, increase awareness of their own and subsequently the CYP's needs, while enhancing their confidence and sense of self-efficacy (Dozier et al., 2002; Pallett et al., 2002). Following from Bion's (1962) conceptualisation on the mother's '*alpha function*' and the capacity to receive un-metabolised feelings from the child, modify them and give them back to him/her in a form that can be thought about, the carers' sense of feeling heard and understood is expected to increase their capacity to provide a similar experience to the CYP under their care (Cairns, 2002).

However, the needs of FCs remain largely unmet (Rosenwald & Bronstein, 2008; Sawyer et al., 2007; Tarren-Sweeney, 2010) and they continue to sustain the “high burden of care” (Murray et al., 2011, p.150; Vanschoonlandt et al., 2012). Simultaneously, the shortage of FCs and placement stability remain a major issue (Harber & Oakley, 2012), while the centrality of their role in LACYP’s future development increases the urgency to identify solutions (Pasztor & McFadden, 2006; Leathers, 2006). It is perhaps unsurprising that a step taken towards that direction is to capture the carers’ views on multiple subjects around the experience of fostering (Brown & Campbell, 2007; Hudson & Levasseur, 2002; MacGregor et al., 2006; Minnis et al., 2001).

As a result, there are a number of studies stressing the importance carers place on preventative practices (Nutt, 2006), as well as the level and quality of support received by supervising agencies, when reflecting on the factors shaping their experience of fostering (Rhodes et al., 2003; Nutt, 2006). The specific characteristics of the support needed by carers could be summarised as follows: tailored to the individual needs of the CYP and the foster family; accessible at times of crisis; consistently provided by SW and other professionals involved with the CYP; including practical guidance; promoting accessibility to other specialist services; providing respite and financial aid (Reilly & Platz, 2004; MacGregor et al., 2006; Brown & Campbell, 2007). Being treated with respect by professionals and agencies and feeling like a valued part of the team around the child is another area often cited by carers as a significant factor defining the quality of their fostering experience (Hudson & Levasseur, 2002; MacGregor et al., 2006; Pasztor & McFadden, 2006).

Overall, this is a growing field of research and important questions around needs, complexity, and resources especially in relation to specific age groups of

LACYP remain to be answered (Bonfield et al., 2009; Rosenwald & Bronstein, 2008; Tarren-Sweeney, 2010). Simultaneously, the rapid increase of IFAs raises questions around the experiences of Independent FCs (IFCs), which have been mostly looked at in relation to the support perceived by the agency irrespective of the fact that collaboration with local authorities and multiple stakeholders is still required (Sellick & Connolly, 2002).

2.1.1 Current Study

The aim of this study was to gain greater understanding of the IFCs' perceived views on and experience of the support that they and/or the YP under their care received. The study also aimed to explore the carers' thoughts on how they would want the support to look like. Therefore, the study's primary objectives were to a) describe the carers' lived experience and b) explore their thoughts on support needed.

It is expected that the insight into the IFCs' reflections on the perceived support that they and/or YP under their care perceived, as well as their thoughts on what they would wish to be receiving, would better inform the clinical application of this construct.

Primary research question

What are the Independent FCs' (IFCs') perceptions and experience of the support offered to them and the YP under their care?

Secondary research question

Which are the qualities they would consider necessary in the support offered?

2.2 Methodology

2.2.1 Design

The present study was part of a larger project, carried out at an IFA, named FR, in conjunction with the AFNCCF. The wider study, named 'Experience of Assessments and Interventions in Looked-After Children Population', drew extensive data on a wide range of experiences in relation to Foster and Residential Care within this IFA.

The current research was concerned with exploring the IFCs' experience of support implemented for them and YP under their care. A mixed methods approach was employed for the purposes of this study, comprising of two Sections, A and B. In Section A, a structured survey, concerning both closed and open-ended questions, was utilised. Semi-structured interviews were conducted for Section B in an attempt to gain a more thorough understanding of the phenomena under investigation.

2.2.2 Participants

Overall, the sampling frame used for this study comprised of IFCs registered with FR and looking after at least one YP between the ages of 11 and 18. The reasoning behind this age demarcation was based on evidence suggesting that emotional and behavioural difficulties in LACYP present with higher prevalence among older ages (Tarren-Sweeney, 2008b). It was therefore decided that for this study's purposes the focus would be placed on FCs who would be possibly faced with the most challenging placements. All participants were identified by FR's research team.

Section A of this study was part of the aforementioned larger project and FR's SWs were expected to establish the total number of carers registered with the agency. 240 IFCs were identified and an overall response rate of 19% (n=46) was recorded. The total number of IFCs looking after at least one YP between the ages of 11 and 18 was 55 (23% of total number of IFCs); it was the data of these FCs that were extracted for the purposes of the current study. An overall response rate of 54.5% (n= 30) was recorded for this sub-group.

In regards to Section B, a criterion sampling technique (Patton, 2002) was adopted in order to identify and recruit a relatively homogenous group of FCs. Consequently, this section's participants had to meet the following predetermined criteria:

- To have taken part in Section A of the study;
- To have had at least one YP between the ages of 11 and 18 in their care;
- To have had a YP for a minimum of one year under their care. This was in order to ensure that the interview process would draw on the views of FCs who had substantial experience of the support systems.

Overall, 18 FCs met the above criteria. 6 FCs responded positively and an overall response rate of 33% was recorded. 2 FCs dropped out by informing the FR's research team that they were no longer able to participate due to overload of commitments, while another FC stated that he/she had given it a second thought and changed their minds. Consequently, 3 FCs were interviewed.

2.2.3 Measures

Two measures, which matched the two Sections of the study, were used to assess IFCs' views on the support that they and YP received. For Section A,

a survey was devised by the research supervisor and AFNCCF doctoral research team, including the study's author, in conjunction with FR's research team. Both closed and open-ended questions were used, aiming to promote an active reflection of FCs' experience and assess their views on a number of relevant areas (see Appendix 1). The closed-ended questions focused on extracting information regarding intervention types received by FCs and YP. IFCs' views on having benefitted from the interventions were also questioned within that format. To explore other facets of the carers' experience, open-ended questions were conceived, addressing their views on the interventions and prompting more elaborative responses. The average number of FCs that responded to the closed and open-ended questions was 28 (response rate 93%) and 16 (response rate 53%) respectively.

Semi-structured interviews were conducted with a subgroup of FCs for Section B. A semi-structured interview schedule that allows for and promotes flexibility during interviewing was developed (see Appendix 2). This schedule was constructed around the following four topics: fostering journey; support provided to FCs and YP; experience of network (allied Services, such as Local Authorities, Education, CAMHS) support; overall sense of support. The structure of the questions in the last topic was informed by the common subjects raised by FCs in the survey. The sequence with which the questions were asked varied as they were determined by the individuals' responses. This approach was adopted in order to follow participants' stream of consciousness, while allowing them to tell their story in their own words.

Overall, the use of two measures aimed at achieving method 'triangulation', which refers to the employment of at least two methods of

gathering data on the same phenomenon (Patton, 1999). In this way, the development of a more comprehensive understanding of the study's subject of investigation was promoted; simultaneously, the validity of the methods used was tested through the merging of information from different sources (Patton, 1999).

2.2.4 Procedure

Starting from Section A, a research information pack containing an invitation to the larger project and a consent form was mailed out to all FCs prior to the survey administration. As the survey was sent out to all FCs, irrespective of the CYP's age, a separate information pack and consent form regarding Section B was mailed out to the FR's team by the researcher; this was subsequently forwarded to FCs meeting the abovementioned criteria. The participation in the study was voluntary and the participants were told that they could pause or withdraw from it at any point, without consequences.

For Section A, the survey was piloted on 3 carers identified by the FR's team in order to ensure that the questions were clearly stated and relevant to their experiences. Minor alterations were made following the pilot. The survey used an online software that provides free, customizable surveys, namely Survey Monkey. Invitations to all FCs were instantly sent via email and an electronic reminder was sent four weeks later to those who had not responded. FCs participating in the study were instructed to respond to the questions while having one YP of the agreed age in mind.

Descriptive data were collected through closed survey questions; totals and percentages were calculated using Microsoft Excel. A descriptive qualitative approach of data analysis, namely Content Analysis (CA) (Downe-Wamboldt, 1992; Elo & Kyngäs, 2008), was employed for the analysis of data

gathered from the open-ended questions. CA allows the systematic coding and categorising of big amounts of data by breaking it into smaller units which are divided in groups of content that share a commonality. The choice of this analytic method was based on the nature of surveys that generally allows limited space to participants to expand on their thoughts, but also on the fact that exploring the frequency with which certain subjects are brought up by the participants is permitted (Grbich, 2007). The process of data analysis in CA followed the phases recommended by Elo & Kyngäs (2008) (see Appendix 4).

It is important to note that the total number of valid responses varied due to being dependent on whether each participant had filled in a response or not. Interpreting the meaning of “not applicable” or absence of response was a problem. This response could have also been regarded as a symptom of disinterest, indifference, alienation from or annoyance with the agency. A decision to not include these kinds of responses was made.

For Section B, the identified IFCs’ contact details were sent by FRs’ research team via a secure email account, Egress, both to the study’s author and to an MSc student whose project formed part of the aforementioned larger study and aimed at collating IFCs’ experiences with regards to the interventions offered to CYP in their care. Due to the study of the MSc student addressing all FCs, irrespective of CYP’s age, and therefore being able to draw from a wider pool of participants, a decision to provide him/her with the details of 1 out of 3 FCs that had responded positively was made. Additionally, an agreement that that the MSc student’s interview would be borrowed by this study’s author in order to allow themes to emerge and to increase the sample size was made. This agreement was based on the premise that both researchers would be trained to deliver the interviews in a uniform way and subsequently follow the same interview schedule.

The contact details of the other 2 FCs were given to the study's author. The participant's details were randomly allocated to the MSc student and the study's author by FR's research team.

The interviewees were contacted by the researcher and MSc student via email in order to arrange the details of the interview process. Conducting interviews face to face was not possible for pragmatic reasons (i.e. geographical distances; author's limited availability due to combination of clinical and research roles in the context of undertaking a Clinical Psychotherapy Doctorate). Therefore, the participants were only given the option of conducting the interview on the phone. The interviews were carried out at a convenient time for the participants, each lasting between 30 and 65 minutes. Furthermore, the interviews were audio-recorded in their entirety and all recordings were transcribed verbatim by the researcher. A decision to include significant non-verbal remarks and pauses in the transcripts was made (Lincoln & Guba, 1985).

This generated a large amount of raw data that was subjected to another descriptive qualitative approach of data analysis, namely Thematic Analysis (TA) (Braun & Clarke, 2017). The reasoning behind this decision lied on the fact that TA employs a semantic way of analysing data, allowing the development of themes that reflect its' explicit content (DeSantis & Ugarizza, 2000). More specifically, patterns of meaning are identified through a rigorous process that involves a series of phases, as recommended by Braun & Clarke (2006) (see Appendix 5).

Before moving on to the description of the analytic process, it is necessary to elaborate on the researcher's epistemological stance in order to amplify the position taken when conducting the study. For purposes of further transparency

and rigor (O'Riley, 2011), the researcher's 'reflexivity' in relation to the data will be also discussed.

2.2.5 Epistemological Stance

The current study investigated the FCs' experiences of the support implemented for them and the YP under their care, assessed through a survey and semi-structured interviews. Consequently, both written and verbal language was used in order to construct meaning and identities (Burr, 2003). Although words generally aim at reflecting thoughts, it is important to acknowledge that this is not always the case and there can be inconsistencies in the meaning (Becker, 1996; Burr, 2003). Therefore, the participants' words were conceptualised as single attempts that aimed at meaning-making. Despite the study's exploratory nature, it was partly driven by theory since the topics of interest originated from the literature.

2.2.6 Reflexivity

In the context of qualitative research, acknowledging the centrality of the researcher's self-awareness -known as reflexivity- can add to the value of the qualitative enquiry (Patton, 2002). Consequently, in this section, being the researcher conducting this study, I reflect on the ways my pre-dispositions affected what I observed and understood during the collection and interpretation of the data.

Training in Child & Adolescent Psychoanalytic Psychotherapy and working with severely traumatised LACYP within CAMHS, while collaborating with the network around these families, influenced my preconceptions regarding this project, as well as the way(s) I perceived the participants' accounts and pieced the information together. However, during the interviews I bracketed off pre-

existing ideas and attended as closely as possible to what the carers had to say. In an attempt to acknowledge the aforementioned influences and minimise introducing biases, I repeatedly read the data, trying to familiarise myself with the content. Going through the participants' accounts recursively facilitated the creation of a critical distance between my background or knowledge and the carers' experiences. Additionally, having kept notes of thoughts and decisions during the processes of coding and establishment of contents and themes, helped me ensure that I was not missing any important information. Of note is the fact that I did not disclose my clinical capacity to the participants as it could potentially affect and/or restrict the information they shared regarding their experiences of Specialist Services.

2.2.7 Ethical considerations

The researcher followed the British Psychological Society Code of Ethics and Conduct alongside the UCL Ethics and Data Protection Guidelines. The study was approved by the UCL Research Ethics Committee (Project ID number: 0389/022) and was encompassed in a larger project. All data were anonymously recorded after informed written consent was obtained from each participant. In order to protect the participants' confidentiality, all identifiable names or places were deducted from the interview transcripts. The recordings were destroyed once all transcripts had been analysed.

Considering any issues that could have arisen as a result of the FCs' participation in the study, the researcher was alert to the possibility of difficult feelings being stirred up. Contact details for the research team (telephone numbers and email addresses) were provided on all study documents and participants were given the opportunity to discuss any potential issues with a member of the team. None of the participants raised any issues.

2.3 Results

2.3.1 Overview of findings: Sections A and B

This study's findings are presented in two Sections, Section A and B, pertaining to the two measures employed: an online survey and telephone interviews.

Section A presents the survey findings by initially reporting the quantitative, descriptive data that resulted from the carers' responses to the closed-ended questions. Subsequently, the content findings from the FCs' responses to the open-ended questions that the survey posed are outlined in the same Section. Section B outlines the thematic findings that emerged from the interviews.

2.3.2 Section A- Survey based Study

Descriptive Statistics

Starting from the collection of demographic data regarding this section's participants, no demographic data regarding the IFCs was given. However, FR's SWs recorded some information in relation to the YP looked after by these IFCs (N=30), providing a backdrop for the study's focus on carers. The vast majority (97%) of the YP were of White British origin. Nearly two thirds (63%) were male and over half of the YP (60%) were aged between 15 and 17 years. For 80% of the YP the current placement was expected to be long term, for 17% short term, and for a further 3% a bridging placement. Two thirds (69%) of the YP had been in at least one placement prior to the current one. The sample also contained a sizeable proportion (54%) of YP that had an Education Health Care Plan. Additionally, according to the SW's records, 67% of the YP had input from

CAMHS. Finally, the most prevalent reasons of entering the child welfare system are summarized in Table 1, as indicated below.

Table 1

Reasons of entering care system

Reasons	N	%
Neglect	10	33%
Sexual abuse	8	25%
Domestic violence	6	21%
And/or parental substance misuse	6	21%.

Note. N, sample size

In regards to the survey's first part, namely the one including closed-ended questions, the descriptive data drawn from FCs' responses was subsequently examined using Microsoft Excel, as presented in the Tables 2, 3, 4, and 5 below.

Table 2 summarizes the intervention types that IFCs had received within the last six months.

Table 2

Types of intervention(s) implemented for IFCs within last six months

Types of intervention(s)	N	Yes%	No%
FR Assessments (to help inform practice)	25	40%	60%
CAMHS Assessments (to help inform practice)	26	19%	81%
Advice & support from member of FR Clinical Service	25	28%	72%
Additional Carer Training	27	96%	4%
Carer Support Group	27	85%	15%
Respite Care	25	52%	48%

Note. N, sample size

Table 3 summarizes the intervention types that YP had received within the last six months.

Table 3

Types of intervention(s) implemented for YP within last six months

Types of intervention(s)	N	Yes%	No %
Individual Counselling/Psychotherapy	24	29%	71%
Expressive Therapies (e.g. play, drama, art)	22	9%	91%
Child-Adult Therapies (e.g. attachment work)	22	14%	86%
Group Interventions	21	5%	95%

Note. N, sample size

Table 2 indicates the higher prevalence rates that were recorded for the interventions provided to FCs, with ‘Additional Carer Training’ followed by ‘Carer Support Group’ reported as most implemented types of interventions. Lower prevalence rates of intervention provision were recorded for YP, as indicated in Table 3. Among the listed interventions, ‘Individual Counselling/Psychotherapy’ was identified to be most offered, although the recorded percentage was still relatively low.

Table 4 outlines IFCs’ appraisal of the degree to which they benefited from the interventions.

Table 4

IFCs’ ratings of benefitting from interventions

IFCs benefitting from intervention	N	%
Strongly agree	8	28%
Agree	9	31%
Neither agree nor disagree	8	28%

Disagree	0	N/A
Strongly disagree	4	14%
Total	29	N/A

Note. N, sample size

FCs' ratings were based on a 5-point scale of agreement. FCs' majority (total of 59%) reported having benefitted from the intervention.

Finally, Table 5 presents FC's appraisal of the degree to which YP benefitted from the interventions.

Table 5

IFCs' rating of the perceived benefit for the YP

YP benefitting from intervention	N	%
Strongly agree	4	14%
Agree	12	43%
Neither agree nor disagree	6	21%
Disagree	0	-
Strongly disagree	6	21%
Total	28	N/A

Note. N, sample size

IFCs' ratings were based on a 5-point scale of agreement. Similarly, IFCs' majority (total of 57%) responded with a positive rating, namely most FCs held the view that YP benefitted from the implemented interventions.

Qualitative findings

In regards to the survey's second part, IFCs' responses to the open-ended questions were systematically examined using CA. Two primary categories

emerged: 'Quality of Provision' and 'Implications of (no) Interventions'. A number of subcategories were also identified for each primary category. Both primary categories and subcategories are presented below; the frequency with which each subcategory was brought up by the survey's participants is also recorded. Some of the carers' own verbatim responses are included in order to better illustrate their views.

Table 6 presents a summary of the categories.

Table 6

Summary of categories and subcategories using Content Analysis on survey

1. Quality of Provision
<ul style="list-style-type: none">• Professionalism• Personalisation to Needs

2. Implications of (no) Interventions
<ul style="list-style-type: none">• Foster Carers' Competence• Improved Provision of Care to Young People• Sense of Stagnation

Primary Category One: Quality of Provision

The first category reflects the characteristics identified by IFCs' majority as the most significant components of a successful intervention. The broad category of intervention 'qualities' was manifested in the two following subcategories:

1. Professionalism: this subcategory encompasses the importance of an adequate professional(s)' manner in how interventions are delivered. These factors refer to the professionals' experience and knowledge, trustworthiness, consistency in communication, receptivity to the FCs' and/or YP's needs and dedication in trying to meet these. 62.5% of the participants referred to the interventions' manner of provision.

"... an intervention is good when he/she (Social Worker) is well informed and knowledgeable and when he/she gets to know us and the children in question". (P06)

2. Personalisation to needs: this subtheme's focus is the interventions' adjustment to both FCs' as well as YP's identified needs. 44% of the participants made reference to the importance of customizing interventions.

"...sometimes training needs to be more specific to your requirements so that you can see the benefits". (P09)

Primary Category Two: Implications of (no) Interventions

The second category describes the main areas which FCs pinpointed as having been impacted by the provision or not of interventions. The 'implications' encompass the following subcategories:

1. IFCs' competence: this subcategory is concerned with FCs' increased sense of confidence in their own abilities and skills as a result of the implemented interventions. 62.5% of the participants referred to feeling more skilful.

"Because of training I feel better equipped to cope with the demands of fostering". (P16)

2. Improved care provision to YP: as a result of FCs' advanced competencies, this subcategory follows naturally and places the focus on the upgraded quality of care that YP receive. 38.5% of the participants referred to this improvement.

"My child benefits from my on-going training and personal development. He also benefits from me attending support groups and supervision as others may give me suggestions or just a listening ear". (P08)

3. Sense of stagnation: in contrast to the aforementioned subcategory, this one reflects how stuck FCs feel when they and/or YP do not receive the support needed. 31% of the respondents made reference to the sense of powerlessness.

"We have asked for help since the boys arrived nearly two years ago, we have spent many hours filling in forms... We are still waiting ...in the meantime, the YP's behaviour is getting worse and he is now in danger of exclusion from school". (P13)

2.3.3 Section B- Interview Based Study

TA yielded two superordinate themes: 'Centrality of Foster Carers' Qualities' and 'What Matters'. A number of subthemes were also identified for each superordinate theme. Both superordinate themes and subthemes are presented below. Participants⁵ own words are presented in quotes in order to better illustrate their views.

Table 7 presents a summary of the themes and subthemes.

Table 7

Summary of superordinate themes and subthemes using Thematic Analysis on telephone interviews

1. Centrality of Foster Carers' Qualities

⁵ pseudonyms were used in order to preserve confidentiality.

- Commitment
- Mediating role to interventions
- Curiosity
- Competencies
- Realistic Expectations

2. What matters- Qualities of Provision Needed

- Accessibility
- Consistency
- Adaptability to individual needs
- Interagency collaboration

Superordinate theme one: 'Centrality of Foster Carers' Qualities'

The first superordinate theme reflects the qualities of the FCs' role, which they perceive as being integral to the overall placement success. This broad theme was manifested by different participants in different subthemes:

1. Commitment: this subtheme is concerned with FCs' dedication to their role despite the numerous hurdles they faced from the moment of deciding to undertake this role to the management of complexities around the YP's care within and outside FR. This subtheme was present in the majority of the participants' narratives.

"...I felt as if I had lots of hurdles to overcome in order to actually become a foster carer with them (FR), but if anything it made realise that FR took their duty of care very seriously...so it was a long time....and financially it was very, very, very tough for me. (Case 3, Lara)

2. Mediation to interventions: This subtheme outlines the facilitating role that FCs have adopted in regards to the shaping of the interventions implemented for YP and was identified in all participants' stories.

"...it took quite a while for the young person to gain the trust (with the therapist)...So, as time went on he'd (YP) gradually start telling me things, but I knew he wasn't telling the therapist. So I said to the therapist "could I come and join the meeting?", which he was quite pleased to do...and I think that opened the way really for some honest talking and I think overall it did work". (Case 1, Carol)

3. Curiosity: This subtheme outlines IFCs' wish to understand what lies underneath YP's behaviours. IFCs' interest in reflecting on their own responses and ways of managing YP's behaviours is also delineated. This subtheme transpired the majority of the participants' narratives.

"...I wish other people involved in the welfare of the child would actually sit and listen... it's always about listening to the child". (Case 2, Susan)

"...There's recently been a new company that actually does the training and they are very good. It's more that you reflect on your own experiences and your own feelings...and I think that's quite helpful really because a child can have all sorts of different behaviours, but it's sort of how you manage the behaviour..." (Case 1, Carol)

Although in the first quote, Susan is highlighting the importance of being interested and eager to understand what might be going on for the YP, it is Carol who refers to an introspective process being cultivated through additional training.

4. Competencies: All participants emphasised the on-going input that they have been having and acknowledged the ways this has shaped their

capacity to meet YPs' needs. On the other hand, they recognised feeling unskilled in some areas of their caring role.

“If you’ve got an angry child, you don’t rise to their anger, you keep calm, you speak quietly, speak on their level...I mean we’ve had lots of training”. (Case 2, Susan)

By referring to the strengths and knowledge gained from the training, including the capacity to contain the YP's difficulties, Susan is making a point about all that she had gained through the training she received.

“...but then we find ourselves in certain situations where we need to be prompted and sometimes I think that there should be more coaching from the social workers to get us to implement the training we received.” (Case 3, Lara)

On the other hand, Lara is identifying the gaps in the perceived training, leaving carers with a sense of not being adequately equipped to manage certain difficulties that may arise.

5. Realistic expectations: Considering the YP's complex clinical presentation, this subtheme delineates the IFC's understanding that progress is a gradual process that involves the setting of small, achievable aims. All participants shared this viewpoint.

“...every year they do mental health type checks and he’s been getting better each time, so, only a little bit, but it’s going in the right direction...”. (Case 2, Susan)

Superordinate theme two: ‘What Matters’

The second superordinate theme describes the interventions' qualities that the participants value the most. 'What Matters' encompasses the following subthemes:

1. Accessibility: this subtheme is highlighting the issue of resources in the interventions' implementation, which are often dependant on factors over which the carers have no control, such as time and place. All participants shared this concern.

"There was a referral in...there was a girl and we put our names forward, but she would have been collected straight from the hospital as she'd taken an overdose ... and they wanted her to come to us or to a place in C., but it had to be with a CAMHS package and our local CAMHS couldn't do that, so this girl was eventually placed in C..."
(Case 1, Carol)

2. Consistency: this subtheme is trying to capture IFCs' emphasis on the importance of having a steady and reliable source of support. All participants highlighted this factor's significance.

"...whenever anything goes wrong I email her or phone her (supervising support worker), or she reads the diary and phones me up...and once a month we have face to face supervision which usually lasts about an hour and half, but many times during the month we're in contact with each other". (Case 1, Carol)

Having someone to talk to, someone to reassure you that you are doing the right thing or give you advice was the common thread linking up all three interviews.

3. Adaptability of provision to individual needs: the value in the interventions' adjustment to the needs of every YP and the families around them was also acknowledged by all participants.

"He (YP) was a very logical sort of person, he didn't really do feelings very well, and I think she (therapist) adapted her therapy to do things, like, he would explain that his thinking was like a grid, and so she would try and make some analogies to do with the way he thought..."
(Case 1, Carol)

4. Interagency collaboration: Finally, all participants highlighted the importance of collaborative communication between professionals, Services and FCs as a precondition for the foster placements' success.

“I was very enthusiastic with the FR’s goal of integrating all their services so that the children can have step outs and step downs in residential care...but then of course you know that for that to actually get to happen everybody needs to be singing from the same hymn sheet really and I don’t get that sense”. (Case 3, Lara)

2.4 Discussion

2.4.1 Analysis of the results

The present study explored the IFCs' perceived views on and experience of the support that they and the YP under their care received within and outside FR. Two methods were employed for this purpose: an online survey and individual interviews.

In summary, the study's findings were broadly in line with current empirical literature. Among a number of interventions implemented for IFCs, their vast majority received additional training and attended support groups with other carers; lower prevalence rates of intervention provision for YP were recorded. Additionally, carers' majority reported having benefitted from the interventions they and YP received. Reflecting on the experience of perceived support, IFCs attributed a number of qualities to themselves, which were cultivated through adequate interventions, yet partly intuitive, and also key to the fostering placement's progress. Simultaneously, FCs reflected on the areas they felt unskilled in and identified gaps in the support perceived both from FR and allied services. Being able to recognise YP's complex clinical presentation, FCs addressed the need for customised support implemented both for themselves and YP, while setting realistic expectations on the progress that can be made.

Finally, factors such as the manner with which interventions are delivered by professionals, the degree to which support is accessible and consistently offered, as well as the collaborative communication with FR and allied services were identified by the carers as determinant of the interventions' adequacy.

In order to address the study's findings sufficiently, this section is considering these in relation to existing literature, exploring both congruencies and disparities. The project's limitations are subsequently reflected upon. Finally, the overall implications of this work are considered and conclusions are drawn.

Demographic data

According to SWs' records, more than half of the YP who were being looked after by the IFCs participating in study's Section A were male, similar to the majority of all LACYP in England and Wales (Department of Health, 2001a). Additionally, more than half of the YP were between the ages of 15 to 17, while all of them had experienced child maltreatment of at least one type. Finally, two thirds had had at least one previous placement experience. Older age, abusive and/or depriving life experiences and placement impermanence are some of the factors that have been positively associated with higher prevalence of mental health difficulties among LACYP in comparison to normative samples (Pithouse et al., 2004; Nutt, 2006; Tarren-Sweeney, 2010). It is therefore unsurprising that 67% of these YP received CAMHS intervention(s), according to SWs' reports. However, taking into consideration the accumulating evidence on difficulties to access Specialist Services such as CAMHS, mainly due to scarce resources, overwhelming caseloads, and long waiting lists (Cleaver, 1996; Ford et al., 2007), this is an interesting finding. According to Ford et al.'s (2007) study, the majority of LACYP presenting with mental health difficulties had had contact with CAMHS

at some stage, but this had not been followed through. Possible further interpretations will be given below, when comparing SWs' with IFCs' reports.

Section A- Survey based Study

Descriptive Statistics

According to the survey's descriptive results, IFCs' vast majority had received 'Additional Carers' Training'. 'Support Groups' and 'Respite Care' were the two other intervention types reportedly implemented for the majority of carers. The high percentages of these interventions' implementation are in line with the literature supporting that IFAs place an emphasis on FCs' role, which they recognise as fundamental in the looking after of the CYP's physical and mental well-being (Staines et al., 2011). The subsequent emphasis on FCs' provision is attributed to previous literature supporting the correlation between additional training and carers' improved well-being (Whenan et al., 2009); increase of FCs' ability in managing the emotional and behavioural difficulties that CYP under their care present with (Linares et al., 2006; MacDonald & Turner, 2005); improved sense of self-efficacy and cultivation of skills necessary to care for LACYP who are struggling. Overall, advanced, customised training, support groups and respite care have been found to contribute to the significant reduction of foster carers' attrition rate (Randle et al., 2017).

Moreover, a significantly smaller percentage of FCs was reported to have been offered advice or consultation sessions with a clinician from FR's team. This was an unexpected outcome as according to the literature IFCs are provided with 'round the clock' support (Sellick & Connolly, 2002). However, the literature on Local Authorities provision is confirming the evidence that the frequency with which carers meet with professionals is limited and inconsistent (Triseliotis et al., 2000). Bearing in mind the fact that IFAs are collaborating with Local Authorities,

but also taking into consideration the complex nature of the reasons for a CYP's involvement in foster care and the subsequent involvement of multiple stakeholders, it might have been hard for FCs to identify in their minds the types of professionals that sit within the FRs' team when answering this question.

Although a variation of interventions was recorded to have been available for YP, a significantly smaller percentage of implementation was recorded for them in comparison to FCs. These findings are partly in line with the literature supporting that IFAs offer a range of interventions to YP (Sellick & Connolly, 2002), but the difference lays in the fact that they are minimally picked up. These shortfalls could be associated with the above mentioned limited resources, long waiting lists, lack or limited awareness of an intervention being needed and/or what is available to access, service cuts, social stigma around mental health difficulties, FCs' reported struggle to navigate the CAMHS' system and/or repeated disruptions due to placement instability (Callaghan et al., 2003; Golding, 2010). Barriers in the collaboration with Local Authorities, inadequate assessment of needs, delays in decision making and/or lack of long term planning, have been also identified as some of the factors hindering the provision of adequate support (Staines et al., 2011). Another factor that has been associated with shortfalls in LACYP's mental health provision is the complex level of needs they present with, which can in turn complicate the referral processes by hindering the identification of key issues (McDonald et al., 2003) and essentially contributing to what has been known as 'triple deprivation' (Emanuel, 2018). This is a concept referring to the ways that the trauma and disturbance associated with severe deprivation and abuse experienced by CYP in care can intrude the professionals' minds and interfere with their capacities to think about

and offer containment to CYP and their families, compounding in this way to the already existing deprivation.

Furthermore, noticing the discrepancy between SWs' and IFCs' reports on CAMHS' involvement it could be hypothesised that this was due to carers having had a clearer view of what is being actively offered to YP and/or an overall different perception of what consists an intervention in comparison to SWs. For example, it could be possible that being placed on CAMHS' waiting lists was considered CAMHS' involvement by SWs, but not by FCs.

Additionally, IFCs' majority was positive in their reviews of the benefit they and the YP had gained from the perceived support. The FCs' satisfaction could be associated with their promoted well-being, as well as increased sense of competency in their role (Whenan et al., 2009) and in managing the CYP's emotional and behavioural difficulties (Linares et al., 2006; MacDonald & Turner, 2005). All the above have been positively correlated with the support services IFCs receive, including advanced customised training, support groups, and respite care (Randle et al, 2017). The IFCs' high levels of satisfaction in relation to the fee and professional recognition and status that have been identified in the literature might have also been the case for these IFCs (Kirton et al., 2003; Ogilvie et al., 2006; Farmer et al., 2007).

However, it is worth noting that 21% of FCs placed themselves in the neutral or ambivalent position of 'neither agreeing nor disagreeing' with the statement of YP benefiting from the interventions, while an equal 21% rated the benefit very negatively. Taking into consideration the smaller percentage of intervention provision to YP, the mixed scoring might be reflecting FCs' disappointment. According to previous studies, FCs' levels of satisfaction were dependent –among other factors- on the allocation of a SW for the CYP under

their care and the frequency of contact with them (Beecham & Sinclair, 2006; Sinclair et al., 2005), which was reportedly limited for the FCs' of this study.

Sections A and B, Survey and Interview Based Studies

Qualitative findings

In regards to the qualitative results of Sections A and B of the study, it is worth commenting initially on the low response rate recorded for both (53% and 33% accordingly). This could be interpreted as an indication of reticence or unwillingness to collaborate further with FR due to dissatisfaction or ambivalent feelings with regards to the support provided to FCs and/or the YP, as shown in previous studies (Gilligan, 1996; Hudson & Levasseur, 2002; Farmer et al., 2005; Buehler et al., 2003). This lack of motivation to dedicate time into something relevant was multi-layered and may well have been attributed to a lack of belief that FCs' feedback would make any difference; the FCs's overall mistrust in the perceived support has been reported in previous studies (Gilligan, 1996; McDonald et al., 2003). Furthermore, the overwhelming demands placed on FCs (Farmer et al., 2005; McDonald et al., 2003) might have constituted the participation in research studies a task that did not feel essential to prioritise. STS and subsequent avoidance of thoughts around the traumatic event (Figley, 1995b) might have also cultivated the need to abstain from participating in a study that is inviting one to reflect on their thoughts and feelings.

Moving on to the analysis of both Sections' results, an overlapping was identified between the categories and themes generated. This was expected as the use of two measures, survey and interviews, namely hearing the story from different sources, in order to gather information on the same subject provided the study with 'triangulation'.

More specifically, category 1, 'Quality of Provision', and theme 2, 'What Matters', reflected the characteristics that FCs' majority identified as the most significant components of a successful intervention. Subsequently, the subcategory 'Professionalism', which placed the focus on the manner with which interventions are delivered, encompassed references to the professionals' (delivering the interventions) years of experience and capacity to evoke trust. This finding is compatible with previous findings, which essentially highlight the professionals' dedication to their role and the relationship that is developed between FCs and professionals (Nutt, 2006; McDonald et al., 2003; Beecham & Sinclair, 2006). The importance of having a 'consistent' and reliable source of support was identified as another attribute that 'mattered' in the mapping out of significant intervention qualities, as shown in previous studies (Triseliotis, 1989; Sinclair et al., 2004).

Furthermore, FCs reflected both through the subcategory 'Personalisation to Needs' and subtheme 'Adaptability to Individual Needs' on the essence of tailoring the interventions to the needs of the specific YP and the foster family as a whole. As supported in the literature, adapting the interventions, especially training, to the carers' and YPs' needs is an "undeniable imperative" (Pithouse et al., 2004, p.28) that helps FCs feel equipped with qualities that can support them in meeting YP's complex needs (Cooley & Petren, 2011; Lyons & Rogers, 2004). Customised, advanced training provision has been described to be at the core of the support package that IFAs offer to their carers (Sellick, 2011).

As expected, the interviews allowed for more in-depth reflections to be made, therefore further subthemes under the theme 'What Matters' were identified; 'accessibility' and 'interagency collaboration' were two of these. More specifically, 'accessibility' was one of the critical elements that referred to the

support being available depending on time, place and resources (Chamberlain & Smith, 2005; Brown & Campbell, 2007). In accordance with the evidence on the difficulties raised by the carers, accessing specialist services has been extremely variable (Barnes et al., 2006). Overwhelming caseloads and limited funds have been associated with SW's limited time and paucity of contact with specialist professionals in cases of YP presenting with severely challenging behaviour (Cleaver, 1996; Pithouse et al., 2004). The importance of interagency cooperation was consistent with existing evidence (McAuley & Davis, 2009; Leve et al., 2009; Cooley et al., 2017).

An overlap between the second category, 'Implications of (no) Interventions', which focused on the main areas that FCs pinpointed as having been impacted by the provision or not of interventions, and some of the first theme's, 'Centrality of Foster Carers' Qualities', subthemes was identified. The subcategory 'FCs' Competence' and subtheme 'Competencies' reflected the carers' increased sense of confidence in their own abilities and skills as a result of the on-going input. As aforementioned, skill enhancement has been associated with the provision of training (Linares et al. 2006; Redding et al., 2000; Whenan et al., 2009). However, as shown in Cooley & Petren's (2011) study, gaps in the carers' skillset were also reported, indicating the need for more specialised training.

As a result of the carers' increased competencies, the 'improved provision of care to YP', as reflected in the relevant subcategory, highlighted the centrality of the caring role (McDonald et al., 2003). The subtheme 'realistic expectations' took this subcategory a step further in the sense that it demonstrated the subsequent improvement in YP's presentation, but also conveyed the FCs'

awareness in regards to the speed with which progress is expected (Whenan et al., 2009)

On the other hand, FCs' difficulty to collaborate with and the lack of trust in the Fostering Agency and allied Services were summarized under the third sub-category 'Sense of Stagnation', confirming existing evidence (McDonald et al., 2003). Limited contact with FRs' clinical team and possible impasses in receiving what is needed are often reported in the literature as factors having contributed to a sense of powerlessness (MacGregor et al., 2006; Rosenwald & Bronstein, 2008). Interestingly, participants in Section B were able to identify deficiencies in the support, as well as in the resources and team cohesion, but there was an overall sense of robustness, yet acknowledgement that a number of factors are required for a placement to work.

Respectively, additional traits that FCs attributed to themselves across the interviews were described among the following subthemes: 'Commitment' (Cole, 2005), 'Mediating role to interventions', and 'Curiosity', (Wilson et al., 2003; Cooley & Petren, 2011). For the participants of this study, the 'commitment' of offering care to LACYP seemed to be strong before, as well as during the undertaking of their caring role. This finding is compatible with existing evidence, which describes the satisfaction of offering LACYP a family who will love and care for them, as well as the difference that can be made in a child's life as the driving forces for foster carers' persistence even in the face of hurdles (Buehler et al., 2003). Furthermore, the carers' intermediary role in shaping and facilitating the interventions offered to the YP, alongside the centrality of the bond formed between LACYP and FCs have been widely acknowledged in the literature (Pithouse et al., 2004; Samrai et al., 2011).

The subtheme of FCs being 'curious' followed smoothly in the sense that it denoted the carers' interest in making sense of what might be lying behind the CYP's behaviour, but also in exploring the ways that these might be resonating with them. It is interesting that this subtheme has attracted little attention so far, yet there are some studies that have associated the consultation sessions provided to FCs with an increased capacity for reflection (Cooley & Petren, 2011; Rahilly & Hendry, 2014). It could be assumed that having had lots of advanced training, FCs in this study were given the space to reflect on the dynamic element in their relationship with the YP. Although there might be a degree to which this quality is intuitive, it is important that there is further research exploring the carers' capacity for introspection.

2.4.2 Limitations

The findings presented herein should be considered in the context of some limitations. Starting from Section A, an online survey, concerning both closed and open-ended questions, was utilised. Since this method of assessment is based on self-reports, a key concern was identified in regards to the effect of 'social desirability', whereby participants respond to questions in a way that makes them appear as if they are coping well and not wishing to be critical about the fostering agency. This possible source of 'response bias' felt particularly relevant to the participants of this study due to this project being run by the fostering agency for which they work. Several measures were taken in an attempt to minimise the likelihood of FCs introducing this kind of bias in the study. Firstly, the importance of confidentiality and anonymity was highlighted in all documents, making all FCs aware that their responses would be pseudo-anonymised using their study ID and therefore they would not be required to use their name at any point after consenting to participate; no additional identifying information, such as YP's

names, was used at any time. Participants were reassured that the research information and data would be file encrypted and locked away with the research team.

Another limitation associated with the use of self-report measures is the 'recall bias', namely the difficulty remembering information from the past, affecting the quality of the research output. It was for that reason that the participants were asked to focus on types of interventions that had been offered to themselves and YP during a specific amount of time, namely the past six months. In hindsight, it may have been that encouraging participants to focus on the types of interventions that were being offered to them and the YP currently would have addressed the possibility of 'recall bias' more effectively.

Reflecting further on the possible bias in the participants' responses, this could have been *reduced* by avoiding the use of double-barrelled questions (i.e. "I feel that the interventions are well monitored **and** processed"), as well as by reversing the wording (i.e. utilising both positive and negatives statements/questions) in order to minimise leading questions and also to prevent 'response sets' (giving a socially desirable answer).

Section B of the study, conducting the interviews through the phone and not in person might have impacted on the FCs' engagement with the author, potentially minimising their willingness to open-up and express their thoughts. Another limitation was the small number of participants, which prohibits the generalizability of the results to the wider population of FCs, despite the fact that this was not the aim of this qualitative study. Moreover there is also the possibility that the carers willing to be interviewed were those who might have had a greater need to narrate their experiences, further limiting the generalizability of the

findings presented herein. Nevertheless, a good rapport was achieved with the interviewees, which enabled an open discussion of their experiences.

Furthermore, the YP under the participants' care were vastly White British; the limited diversity did not allow the exploration of potential cultural factors in relation to perceived views and experience. As all the participants were carers registered with an IFA, the study's findings reflected only the experience of these carers, who have been generally found to feel more positively about the perceived support in comparison to Local Authority carers (Selwyn et al., 2010). Further research could aim to involve both Local Authority and IFCs.

Overall, both Sections of the study covered a large area of subjects, including FCs' perceptions not only with regards to their experience of support, but also to the one of the YP in their care. As a result, the volume of questions, but also the change of subject (i.e. frequent alternations between 'you' and the 'YP in your care') could have impacted on the FCs' capacity to comprehend the questions clearly and to reflect on these while remaining as close to their experience as possible.

2.4.3 Implications

Despite the limitations, the study has clinical and research implications that can inform the support systems provided to FCs and LACYP. Bearing in mind the centrality of the FCs' role in LACYP's wellbeing (Cairns, 2002), which transpired this study's results, and the significance of support as a "key category" in FCs' retention (Samrai et al., 2011, p.44), longitudinal studies that will explore the carers' experiences in depth through the use of qualitative approaches and routine outcome measures are recommended as valuable sources of information that can shape services' provision.

On a similar note, the importance of the professional relationships developed between FCs, link workers and the CYP's SW is highlighted by the current findings. The results suggest that, in line with current policy, all parties need to work together to enable the placement to succeed (NICE, 2010).

The study's findings also confirm the importance of some well-known factors in interventions' implementation, while highlighting others, such as FCs' interest in self-reflection. Further research employing different methodologies, larger sample sizes from varied ethnical backgrounds is required to further investigate the importance of these parameters and hurdles in the carers' experience of support.

Overall, qualitative methods seem to be a useful approach to further understand FCs' experiences of support. Future research could use Interpretative Phenomenological Analysis (IPA) to explore how carers speak about their experience, since this qualitative approach has been described to have a strong tradition in the exploration of perceived experiences and has been used in various studies and with different populations (Palmer et al., 2016).

2.4.4 Validity

Certain standards for the validity of qualitative analysis were followed. Sensitivity both to Section A's and B's context was ensured by carefully collecting the data and showcasing the interviews' raw material. The use of a plethora of verbatim extracts also supported the interpretations being made and validated the emergent themes based on participants' voice. However, interpretations reflected only the researcher's understanding of what the participants described. Existing literature was used by the researcher as the context within which her understanding was processed.

The analysis followed the CA (Elo & Kyngäs, 2008) and TA (Braun & Clarke, 2006) stages and was carried out by the researcher. Extensive discussions with the researcher supervising the study, SH, contributed to the testing of the credibility and external trustworthiness of the interpretations. Ensuring that the analysis was done systematically and the interpretations made sense was the aim. This was further verified by the fact that the study's findings were broadly in line with existing literature. Finally, using two sub-studies contributed to the process of triangulation and resulted in a richer description of the participants' perceptions.

2.4.5 Conclusion

The main aim of the current study was to investigate the IFCs' experiences of the support they and the YP under their care perceived from FR and allied Services, explored through the use of an online survey and individual interviews. The results obtained were compatible with previous studies, indicating an emphasis on the support offered to FCs, mainly in the form of additional training, carer support groups and respite care, as key mediators to YPs' wellbeing and placement success. FCs' majority reported having benefitted from the support they and the YP received. However, the total percentage of FCs reporting feeling uncertain about and strongly unhappy with the benefit for the YP provoked thinking around any possible dissatisfaction with the provision and the quality of support offered for YP. Furthermore, as FCs reflected on their experiences, they attributed a number of qualities to themselves, which were cultivated through the implemented interventions and described as being key to the quality of care provided to the YP and their presentation. Areas requiring more specialised provision for FCs and YP were identified by the carers, who held realistic expectations in relation to the YP's progress when taking into account the

complexity of their backgrounds and subsequent presentation. Finally, FCs evaluated the support's adequacy depending on a number of factors, placing special focus on the collaborative, trustworthy relationship developed with the professionals individually and Services as a whole.

2.5 References

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Part 3: Reflective Commentary

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‘Hats off’: a trainee child psychotherapist’s reflections on conducting a doctoral research study while being clinically trained

Introduction

Following the two previous parts, the literature review and empirical research project, which comprise the biggest volume of my thesis, it is through this account that I aim to delineate my reflections on the research component of my doctoral training in Child and Adolescent Psychoanalytic Psychotherapy. More specifically, I intend to shed some light on the thoughts and feelings I experienced, as well as the challenges I met, while going through “the liminal space between research and clinical work” (Edginton, 2013, p.269).

Before outlining the structure of this paper, it feels important that I briefly comment on the associations I had made in my mind long before I started writing it. What I recall from that time is a fantasy that this section would actually be the easiest one to accomplish, as well as an accompanying sense of relief, both of which possibly resulted from the familiarity that lays within the concept of ‘reflection’ in relation to the core of this training, namely the clinical work. It is in that work that the minute examination of thoughts and feelings under the ‘microscope’ of transference and countertransference¹ (Freud, 1912; Heimann, 1950) is encouraged. Although the aforementioned associations persisted as I was writing this paper, it was only gradually that I became aware of the

¹ seminal psychoanalytic concepts, which generally refer to the redirection of the feelings that a patient has for a significant -in their lives- person, often parental figures, to the therapist, and vice versa, namely to the redirection of a therapist’s feelings towards a patient. The significance of both concepts has been considered invaluable within the therapeutic context as they provide the therapist with insight into the patients’ unconscious experiences (motivations, fears, desires) and unresolved conflicts, while giving him/her a real sense of what the patients are attempting to elicit in them (Parsons, 2007).

ambivalent thoughts and feelings I experienced when taking off the 'hat' of the researcher, to whom I would only refer in the third person in the previous sections, and putting on the more personal one, which in turn felt closer to my clinical role. This alternation of 'hats' resulted in my realisation that this section would serve the role of a bridge, binding the often cited as 'split' worlds of research and clinical practice (Henton & Midgley, 2012, p.205) by unfolding my reflections on the journey of engaging with my research project. As illustrated in the title, it is indeed the "marriage (merging) of research and practice" (Henton & Midgley, 2012, p.211), rather than the interchange of the research and clinical 'hats' that I aim to focus on through this section.

Overall, in this commentary I attempt to create a narrative around my experience of conducting a doctoral study by following a chronological order of events. Simultaneously, I draw on empirical evidence associated with the subjects under investigation, as well as on the psychoanalytic literature that I consider relevant to these. I start by briefly setting the scene of where research fits within this doctoral training's structure. Following Winnicott's (1965) theory on the 'maturational process', I continue by describing the different stages that my thinking went through alongside the course of the project I worked on. Last, but not least, I use the parallels that I believe were drawn between myself and the subjects whom I investigated empirically as a type of thread that evolves throughout this account.

Background: starting to make choices

From its onset, the Clinical Doctorate in Child and Adolescent Psychotherapy incorporates research-related courses and projects. The research component includes attending a 'Research Methods' module, conducting a service-based research project (audit), producing (in small groups) a fictitious research proposal as an oral presentation, and finally attending a Journal Club. This process culminates in taking a written exam, covering parts of the curriculum during the first year of training.

I believe I gained a number of benefits from these modules, starting with the strengthening of my skills in statistics, as well as the opportunity to acquaint myself with my training CAMHS placement² and my new (at the time) colleagues by identifying together an audit subject. Simultaneously, I came closer to my fellow trainees by working together on a research proposal and gained more experience in the process of substantiating the possible impact of our fictitious study. However, I admit that these benefits are more clearly felt in hindsight as I recall feeling increasingly overwhelmed by the amount of clinical work I was undertaking at the time, as well as by the overall amount of information I would receive on one day³.

On the whole, these research components remained a helpful introduction to the world of research and the debate between evidence-based versus clinical-based practice. This controversy entails two opposing views, where on the one hand Randomised Controlled Trials (RCTs) are considered the 'gold standard' in

² throughout the whole duration of training I was based in a generic Child and Adolescent Mental Health Service (CAMHS), on the south coast of England

³ every Tuesday all trainees are expected to attend the Anna Freud National Centre for Children and Families (AFNCCF) in the morning for any research related modules and the British Psychotherapy Foundation (*bpf*) in the evening for clinical seminars and workshops.

regards to research methodology and therefore “play a leading role in defining which treatments can be considered ‘evidence based’” (Henton & Midgley, 2012, p. 204). As a result, these treatments are promoted by organisations such as the UK’s National Institute of Health and Clinical Excellence (NICE). On the other hand, many clinicians “attack the privileging of RCTs within psychotherapy research on the grounds of inappropriate epistemology and values, arguing that RCT evidence, whilst internally valid, cannot be generalised to the messy reality of clinical practice” (Henton & Midgley, 2012, p. 204).

Although I did not really know where I was standing amongst this controversy, I was getting increasingly familiar with the concept of evidence-based practices in other contexts as well, with Multi-Disciplinary Team (MDT) meetings being at the centre of these. However, it all felt alarmingly real when the time to make my first important choice in relation to my upcoming research project actually came. In fact it was at the end of the first year of training that we were all, namely all my fellow trainees and I, invited to choose one out of two broad research subjects. As we were informed, this process would be followed by the trainees’ subsequent selection of one among five or six separate topics that would sit under each broad subject. That selected topic would then form the basis of our thesis. Adolescent depression on the one hand, which would draw on material gathered through the IMPACT (Improving Mood through Psychoanalytic and Cognitive Behavioural Therapy) trial, and Looked-After Children and Young People (LACY) on the other, which would in turn look at the Looked-After population of Children and Young People (CYP) who were registered with a social enterprise in the independent sector named Five Rivers (FR), consisted the two wider subjects.

I recall trying to measure my options by exploring the literature on adolescent depression and pre-existing evidence from the IMPACT trial (Ford, Goodman, & Meltzer, 2003; Midgley, Ansaldo, & Target, 2014), while also looking at the evidence on LACYP's complex clinical presentation (Meltzer et al., 2003; Murray et al., 2011). Making a choice and substantiating it proved harder than I had expected as both subjects felt very relevant to my clinical work.

While being stuck in a process of indecisiveness, the inspiration derived from my clinical work. In fact, for the last few months, I had started working intensively (three times weekly) with an adolescent boy, whom I will call Stephen here for the purposes of confidentiality. Stephen had been removed from the care of his biological parents at the age of three years due to physical abuse and neglect. He was subsequently taken into foster care, where he stayed for another three years until he was adopted by a White British, middle class couple. At the age of thirteen and a half, when Stephen started psychoanalytic psychotherapy with me, he was presenting with behavioural difficulties that mainly included angry outbursts, fire setting, and minor offences, such as petty thefts and damage of school property. In his therapy sessions, Stephen would make no direct comments regarding his earlier life and neither would I, which felt important in the context of developing a trusting relationship. It was not until a few months into the therapeutic work that he voiced his frustration with his adoptive parents and informed me of his future plan to go back to the "foster people", as he called them. It was at that time that I realised the significance of the foster carers' loss in this young person's life. The neglect and abuse inflicted by Stephen's biological parents, the loss of them and of his siblings, and the adjustment to life with his adoptive family, were the main factors that I had been trying to contemplate in order to get closer to his internalised experiences. In retrospect, I believe that the

realisation of the 'blind spot' (Freud, 1912a) in my therapeutic thinking opened new, unfamiliar territories that I felt the need to explore. As a result, the choice of the second research subject that I was hoping would bring me closer to the experiences endured by LACYP felt more relevant to my work at the time, and thus my choice of project followed naturally from that.

Upon reflection, I believe that another factor that affected my selection was that the researcher who would supervise the group of studies incorporated within the subject of Foster Care would be the same researcher that had supervised my MSc dissertation almost two years prior to the onset of my doctoral training. To be more precise, I consider the reassurance of working with someone whose research, clinical and supervisory skills I trusted an invaluable source of containment for me. This was especially significant at the time as I was often perplexed by the distinctive yet compounding roles of the different people involved in my training⁴, perhaps similar to the experience of confusion that the Foster Carers' majority is reportedly facing due to the involvement of multiple stakeholders in the care system (Triseliotis, 1989; Sinclair et al., 2004). Simultaneously, being a foreigner, while also having to travel approximately four to five hours from analysis to work and back to my flat, I assume I had a rather complicated sense of where home was, perhaps alike the majority of LACYP, which in turn intensified the need for the 'secure base' (Bowlby, 1988) my supervisor would provide.

⁴ every trainee is allocated to a service supervisor, intensive case supervisor(s), and progress advisor, while having their own psychoanalyst in the context of their personal, at least four times weekly analysis.

Further steps, more choices

The transition into the second year of training required making further choices in relation to the empirical study I was planning to undertake. At this time, detailed information regarding the individual projects that fit under the two aforementioned research subjects was provided. Consequently, the trainees were asked to choose one of these projects as their subject of investigation. The obvious implication of this 'choice' was that a ready-made project would be handed over to us, which felt to me like the beginning of my own parallel journey to the one that foster carers (FCs) have to undertake: although we were both taking an active part in the process, there was an element of a preconception being handed over. In other words, the excitement of giving 'birth' to someone/something was not there from the onset. On the other hand, there was a sense of security in the knowledge that experienced researchers of the AFNCCF team had already identified interesting projects, for which they had made a case by submitting and subsequently being granted permission from the University College London (UCL) Ethics Committee.

Going back to the subject I decided to investigate, it was the project focusing on FCs and their experience of the implemented support that I believed 'matched' best with my interests. Although the specific methods I would utilise for that purpose had not been identified yet, the inclusion of both quantitative and qualitative scales in order to provide a richer description of the investigated subject, was part of the initial discussions. Overall, the reasons behind my choice were fourfold, as elaborated below.

Firstly, I believed that by focusing on the FCs' experiences more light would be thrown on their needs, which reportedly remain largely unmet

(Rosenwald & Bronstein, 2008; Sawyer et al., 2007; Tarren-Sweeney, 2010). It feels worth noting here that this lack of provision was not just another piece of information I was reading about; it was an important part of my own professional experience, which confirmed the positive association between LACYP's emotional and behavioural difficulties, foster carers' low retention rates, placement instability, and further impact on LACYP's mental health (Rostill-Brookes, Larkin, Toms, & Churchman, 2011; Harber & Oakley, 2012).

Secondly, when considering the empirical evidence highlighting the significance of the support offered to the parents/carers of children and young people who receive psychoanalytic psychotherapy (Kennedy, 2003; Kazdin et al., 2006; Trowell et al., 2007), it felt rather clinically relevant to me to engage in a study focusing on FCs. At the same time, reviewing the seminal psychoanalytic concepts that underpin this treatment modality, such as Bion's (1962) conceptualisation on the mother's '*alpha function*'⁵ and Winnicott's (1965) theory on the '*facilitating*' caregiving environment, I was interested in exploring the ways that these theories were applicable to the care system.

Furthermore, I believed that the inclusion of both quantitative and qualitative scales in the investigation of this subject would provide an interesting combination of data that would look at the same subject from different perspectives. As I had not used a qualitative approach before I was on the one hand aiming at promoting my research skills, while on the other hoping that by analysing the participants' experiences in greater depth I would come closer to what I believed I was better at, namely the exploration of someone's internalised experiences. Last, but not least, I was curious in learning more about the Care

⁵ the capacity to receive un-metabolised feelings from the child, modify them and give them back to him/her in a form that can be thought about.

System, especially in relation to the similarities and differences between the ways that Local Authorities and Independent Fostering Agencies operate.

Balancing Act

During the second year of training, the focus was placed on the literature review. Regular group supervision sessions had been scheduled during that stage, giving me a more holistic view of all the projects that fitted under the umbrella of Foster Care and LACYP, while allowing me to refine my scope of interest with the support of my supervisor and fellow trainees. Throughout this process, and as the demands of my clinical work were growing, whilst at the same time preparing for the weekly seminars at the *bpf*, writing up detailed notes for supervision, and meeting deadlines for the submission of clinical papers, I often found myself feeling deflated and worried about the amount of time I could realistically devote to my research.

Another uncomfortable, yet very useful, part of that process was my familiarisation through my clinical work with some of the evidence I was reading about, especially in relation to the strain inflicted on FCs. I often found myself getting a first-hand experience of the trauma that was “entering the consulting room” through my patients’ intrusive projections (Rustin, 2001, p.273) and as a result I struggled to keep my distance from the FCs’ role as receptors of the traumatic reactivation of LACYP’s untrustworthy internal working models (Bowlby, 1969/1982). Similarly, the accumulating evidence on Services’ scarce resources, overwhelming caseloads, and long waiting lists (Cleaver, 1996; Ford et al., 2007; Rosenwald & Bronstein, 2008; Sawyer et al., 2007; Tarren-Sweeney, 2010) consisted another part of the reality that I was experiencing in my clinical work. Although I was protected within my role as a trainee, I had daily contact

with families that had experienced in the past, or were still being affected, by Services' limitations. Simultaneously, I was collaborating with Social Care for most of my cases and was faced with frequent alternations of allocated Social Workers, but also instances of miscommunication that I mostly attributed to lack of actual time and mental space.

Being mindful of the feelings of frustration and sense of impotence that these experiences often generated, feelings that were reportedly shared by foster carers as well (Rosenwald & Bronstein, 2008), I wonder whether by choosing this project I was unconsciously wishing to attain a version of Bion's (1967) 'negative capability'. In other words, I wonder whether on a parallel with a patient's growing capacity to tolerate the confusion as a result of the psychoanalytic process, I was perhaps hoping that my capacity to accept the limitations of external would grow through my engagement with this project.

Action time

In the third year of training and as the main research question was refined to the exploration of the FCs' experience and perceptions of the placement support that they and the young people under their care received within and outside FR, a new round of decisions had to be made. This time I would select the types of methods I would utilise to collect my data. I recall feelings of excitement and trepidation being generated in me while being in that selection process. Upon reflection, I attributed the feelings of excitement to the fact that my project was finally starting to take shape. I also recall being eager to find out what types of support were being offered to the FCs and the LACYP, but also to investigate how they were experienced by them. On the other hand, taking into consideration the fact that I hadn't conducted qualitative research before, I was

apprehensive about the amount of work that would be involved, especially since striking a balance between clinical work and research was becoming rather hard.

In discussions with my research supervisor, we agreed to proceed with the use of a survey, entailing both closed and open-ended questions; the survey would be available to all FCs⁶. More in-depth exploration of the FCs' experiences and perceptions would be attempted through semi-structured interviews. For both measures we decided that the scope of LACY's age would be refined to secondary school years, resulting in the inclusion criterion that all FCs participating in the study would be looking after at least one YP over the age of eleven. This choice was a result of various reasons. Firstly, as the majority of my clinical work was with latency aged children at the time, it felt important that I venture more into the world of adolescence. Additionally, being aware of my own struggle to engage with adolescent patients, whose sessions tended to be filled with silence rather than facilitated by the medium of play as it often happened with children of younger ages, I was hoping that by gaining more insight into the FCs' experience of looking after older YP I would get closer to their internal worlds. Furthermore, being mindful of the evidence supporting that FCs looking after older YP are faced with the highest level of emotional and behavioural difficulties (Tarren-Sweeney, 2010; Rushton & Dance, 2006), I assumed that the carers participating in the study would be more likely to have a broader scope of experience in regards to the support systems available.

Following these decisions, I remained in a position of waiting while the participants were being identified by the FRs' research team. I recall a sense of frustration in regards to my collaboration with FR, as well as strong feelings of

⁶ All FCs were referred by the FRs' research team.

alienation from the project being generated in me, which brought me back to the aforementioned passive aspect of my role in relation to 'a ready-made project'. On that note, it was also disappointing to find that no demographic data would be given regarding the FCs, while the ones regarding the YP under their care would also be limited. The reasons behind that decision were not clear, but the experience of limited and messy data, or even in some cases the reality of no data at all regarding the LACYP had been a familiar one in my clinical work, but also in the literature (Jacklin, Robinson, & Torrance, 2006).

As the process moved on, the survey used an online software, and FCs were able to access it and fill it in within a designated timeframe. I was expecting that the impersonal and 'clean-cut' survey process would be counterbalanced by the use of interviews, which would in turn be conducted on the phone due to the interviewees living across England and also because of my rather limited availability. Although there was an element of familiarity in the fact that the interviews would be semi-structured, and to an extent led by the interviewees, similar to the way I organised initial or review meetings with parents/carers in my clinical practice, there was also something fundamentally different. This involved the absolute lack of any knowledge around the background history of the FCs' and the YP under their care, which I felt uncomfortable with.

Before moving on to the stage of conducting the interviews, it also feels important to acknowledge that the limitations in the communication with FR's team perpetuated the abovementioned uncomfortable sense in me. This time this was due to the fact that the process followed for the selection of interviewees was only communicated to me at a later stage. Interestingly, it was during that time that I felt closer to the position of the YP and associated with their struggle to trust

adults due to lack of participation in decision-making processes. However, the reality of time pressures and the demands of my clinical work taking over contributed to the suppression of my frustrations and the precedence of 'action'.

I subsequently conducted two interviews, both of which lasted around an hour and felt like meaningful communications. Preparation played a key role in my capacity to hold the research schedule strongly in mind, making use of the prompts I had prepared, while being able to bring in the communication skills I had developed from my daily contact with parents/carers and children and young people. Following this creative process, I was prepared that a rather laborious one, that of transcribing the interviews, would follow. What I was not prepared for was the striking resemblance of this process with the one of writing up sessions for supervision and clinical presentations.

Decisions regarding the methods of analysis I would employ were made after careful research and thinking. Content Analysis (Elo & Kyngäs, 2008) and Thematic Analysis (Clarke & Braun, 2017) were the chosen descriptive qualitative approaches of data analysis that the survey and interview data were subjected to respectively. Supervision proved invaluable, especially during that stage, guiding my thinking, and bringing me back to the participants' material. On a parallel with the FCs' reflections on the qualities of interventions that they valued the most, for me it was my supervisor's role as a steady, reliable, and knowledgeable source of support that facilitated my sense of competency in this new territory.

During the fourth and final year of training, the data analysis was completed after a meticulous and long process. This process not only supported my competences in relation to qualitative research, but also provided me with the clinically useful skill of structuring my thinking according to emerging themes

when recording my therapeutic session notes. Most importantly, I believe that in this way I came closer to the FCs' internalised experience of the support that they and the YP were receiving, and their perceived views on the qualities of their role, as well as the interventions integral to a placement's success. Some of these qualities, such as 'commitment' and 'curiosity', resonated with my view of the characteristics that trainee psychotherapists need to develop. Simultaneously, other qualities, such as 'consistency of provision' and 'adaptability to individual needs' brought to mind the significance of the "basic psychoanalytic frame" (Sinason, 2017, p.7) and the emphasis that psychoanalytic work places on the consistency of time, place, therapist, and frequency of sessions. It is within that frame that the patients' "most profound problems" are expected "to be explored and contained by" (Rustin, 1999, p. 132).

Persevering

The last months before the completion and eventually submission of my thesis had a rather draining, yet fruitful flavour. This time coincided with the completion of my clinical work due to my training placement coming to an end, as well as the completion and subsequently presentation of my qualifying paper⁷. Simultaneously, I was applying for Child Psychotherapist posts and undergoing interviews. Around that time, I was also asked to present my empirical study at the Summer Workshop of the AFNCCF⁸ and although I was more than overloaded by work, I undertook the task. Going back to the parallel I had drawn between myself and the foster carers in regards to the passive aspect of our role

⁷ at the end of their fourth year, all trainees are required to submit a final, clinical paper, focusing on one of their intensive cases. Following the marking process of this paper and under the condition that it is classified as a 'pass', all trainees are required to present it at a 'Reading-In'.

⁸ Each year, either during the winter or the summer term, all trainees are expected to take three days of study leave in order to attend a research workshop at AFCNCCF.

and the subsequent limited sense of 'ownership', what I was consciously aiming to do through that presentation was to stay as close to the subject I investigated as possible. My ultimate goal and indeed gain was that the more I engaged in conversations around my study and its' impact the more I felt motivated to carry on.

Concluding thoughts

Overall, my experience of undertaking a research project while being clinically trained followed a gradual trajectory of choices that both consciously and unconsciously matched the clinical experiences I was having. Although this trajectory was not always smooth, I believe that it was through making careful choices that the 'merging' of the two worlds was facilitated. Finally, it was within that new, 'third area' (Winnicott, 1971), created as a result of this process, that I allowed myself to creatively engage in my research study.

Going back to my own experience in relation to this project being the 'child' that was handed over to me, similarly to how foster carers may feel, I found the following extract to be an apt description of the way my attachment pattern with empirical research evolved:

"The parent – child relationship is shaped by the extent to which the adopted child fits or does not fit the adoptive parents' preconceptions, and by the parent's flexibility in changing these preconceptions in response to the actual child."

(Lieberman, 2003, p.280)

My own scepticism and preconceptions regarding the ways that research would contribute or not to my clinical training, which was the essence of what I wanted to do, did not match with what the project eventually held for me. Essentially, it was the clinical experience itself, together with the careful choices that I was

supported in making through supervision, which promoted my flexibility in changing my preconceptions and in meaningfully engaging with the project.

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APPENDICES

Appendix 1: Survey



Evaluation and Experience of Child Care

By answering the questions below, we hope that Five Rivers Child Care Limited will be able to make further improvements to its services and provide the optimal care for the children. This survey is an additional part of the ongoing evaluation which you have been so generously supporting. The remaining questions are much more focused on interventions and assessments, both what your child has had done, and also what your experiences are of these processes. Thank you in advance.

Part One

1. Which of the following intervention(s) have been implemented for the child in your care? Please include anything from within the last six months (please tick all that apply).

- *Child (or Developmental) Psychotherapy*
- *Play/narrative therapy (e.g. Theraplay)*
- *Creative arts (e.g. music, art, drama)*
- *Attachment –based work*
- *Trauma-based work*
- *Psychiatry*
- *Systemic/filial therapy*
- *Other therapies (e.g. EMDR)*

FOR NEXT QUESTIONS, IF YOU HAVE TICKED MORE THAN ONE OF THE ABOVE, PLEASE JUST FOCUS ON WHAT YOU BELIEVE WAS THE MAIN INTERVENTION USED (if none ticked, please skip to the next question)

A. Approximately, how long has your child been having this intervention (listed above)?

- Less than once a month
- One to three months
- Four to six months
- Six to twelve months
- More than a year
- One off

B. How frequent is the intervention?

- More than weekly
- Weekly
- Monthly
- Less than monthly

C. When do you believe it is finishing?

- Finished
- Not known
- In next week or so
- In next few weeks
- Ongoing

2. Which of the following assessments, trainings and care plans have been used within the last six months? (please tick all that apply)

- *Integrated care*
- *Clinical assessments*
- *CAMHS assessments*
- *Clinical consultations*
- *Parent training*
- *Respite care*

FOR NEXT QUESTIONS, IF YOU HAVE TICKED MORE THAN ONE OF THE ABOVE, PLEASE JUST FOCUS ON WHAT YOU BELIEVE WAS THE MAIN ASSESSMENT/TRAINING/CARE TYPE IMPLEMENTED (if none ticked, please skip to the next question)

A. Approximately, how long has your child been having this intervention (listed above)?

- Less than once a month
- One to three months
- Four to six months
- Six to twelve months
- More than a year
- One off

B. How frequent is the intervention?

- More than weekly
- Weekly
- Monthly
- Less than monthly

C. When do you believe it is finishing?

- Completed
- Not known
- In next week or so
- In next few weeks
- Ongoing

4. How involved do you feel in the implementation of these interventions?

- A lot
- Quite a lot
- Somewhat
- Not much
- Not at all

Please can you say how much you agree with the following statements?

5. I feel that Five Rivers' has presented a clear picture of what interventions they can offer and how they can be accessed.

- Strongly agree
- Agree
- Somewhat agree
- Disagree
- Strongly disagree

6. I feel that the interventions are well monitored and processed

- Strongly agree
- Agree
- Somewhat agree
- Disagree
- Strongly disagree

7. I feel that the interventions are clearly fed back to the carer.

- Strongly agree
- Agree
- Somewhat agree
- Disagree
- Strongly disagree

8. I feel that as a carer I have benefited from the intervention(s)

- Strongly agree
- Agree
- Somewhat agree
- Disagree
- Strongly disagree

9. I feel that my child has benefited from the intervention(s)

- Strongly agree
- Agree
- Somewhat agree
- Disagree
- Strongly disagree

Part Two

1. What did you feel about the process of filling in assessments and forms?

- Very positive
- Positive
- Neither positive nor negative
- Negative
- Very negative

2. What did you feel about the process of receiving feedback about the assessments and forms?

- Very positive
- Positive
- Neither positive nor negative
- Negative
- Very negative

3. What would you do differently with the whole process of filling in forms and/or receiving feedback on these assessments?

4. Thinking about what works well, can you think of what a good intervention looks like?

5. Thinking about what doesn't work well, can you think of what a bad intervention looks like?

6. Can you think of any significant changes that you noticed in your child since the intervention? (prompt: these can be good or not good)

7. Can you think of any significant changes in yourself since the intervention?

8. What have you learned from the intervention?

9. If you could design your own intervention, what do you think would be important / most helpful / most appropriate?

Appendix 2: Interview Schedule

Interview Schedule

Topic

1) Fostering Journey/background to fostering

Questions

“Could you talk me through your history as a foster carer?”

Prompts: story as a carer; links with any other agency/local authorities before FR; history behind decision to work with FR; experience of 1st contact with FR; duration of work with FR

“Could you please describe your family structure?”

Prompts: demographics (age and gender of CYP in care/ identifying the YP that will be mostly in mind during the interview and repeating the link with the age group that this study is focusing on)

Topic

2) Interventions for YP- experience

Questions

“Could you please identify the types/ kinds of interventions, if any, that were offered to the YP?”

Prompts: clarify what is implied by ‘interventions’ and give examples (individual counselling, expressive type of therapy like drama or art therapy, attachment work, group work); frequency of work; duration; professional(s) delivering the intervention an

“What do you think was the experience of the intervention for the YP?”

Prompts: helpful or not for both YP and themselves; give examples of where it helped or didn't help

Topic

3) Interventions for carers

Questions

“Could you please identify the types/kinds of interventions offered to you?”

Prompts: clarify what is implied by 'interventions' and give examples (training, consultation with support worker, supervision, support groups, respite); frequency of work; duration; professional(s) delivering the intervention

"Did you find these interventions helpful?"

Prompts: helpful or not for both YP and themselves; give examples of where it helped or didn't help

Topic

4) Network support and collaboration

Questions

"Moving on to the network around the child, could you please describe the level(s) of support received?"

Prompts: clarify what is meant by network and give examples (local authorities; CAMHS; school, etcetera); frequency of work; duration; professional(s) involved

"What was your experience of the work/collaboration with the network?"

Prompts: feelings about it; helpful or not

Topic

5) Overall experience of service received/ Survey led questions

Questions

"Trying to reflect on the main issues reflected in the carers' responses in the survey, being involved in an intervention was often highlighted as an important matter. How did you feel in the process?"

Prompts: examples that perhaps will make points clearer

"Overall, do you feel on top of things?"

Prompts: feeling that you are getting or that you can ask for the support you need

"Is there something in the level of support that you and/or yp receive that you would have to be different?"

Prompts: clear examples on different or not

"Feedback was another area reported as often poor. What has your experience been like?"

Prompts: types of feedback, if received; examples

“Is there anything that we have not covered here so far, or that you have not had a chance to say, with respect to your experience of interventions offered to you and/or YP under your care?”

Appendix 3: Telephone Interviews

Telephone Interview #1 (Case 1)

(Conducted by MSc student)

Interviewer: Researcher (R.)

Interviewee: Carer (C.)

Five Rivers (Fostering Agency): FR

Short conversation saying hello and explaining what the interview will be about

R: How long have you been working with FR?

C: I think it's about 12 years now, so it's quite a long time.

R: And is that with one child or a number of children?

C: We always only have one child at a time, and we've had 8 long-term placements, a couple of respites in between, but the bulk of it has been 8 long-time children.

R: Ok lovely, so I'm guessing you've had a variety of experiences with FR and the services they offer. Could you maybe tell me a little bit about the types of therapies that you or your children have experiences?

C: Well, the children that we've had have been older, so the youngest we've had has been 11. So play-therapy we've never had...hm...I suppose the standout therapy that we've done...well it wasn't a FRs' therapy, but social services possibly funded it with FR finding the therapist...and that was with a child who was sexually abused, so he had therapy for that. And that was quite an ongoing therapy, I think he had it for about a year, with a...sexual therapist.

R: So was that with a psychoanalyst or just with a therapist who you know was a specialist in sexual abuse?

C: Yes, that's right, definitely a specialist, yeah.

R: And what was your experience of that therapy? Did you find it useful, was there anything you would change about it possibly in the future?

C: No, I think I found it very useful. With something like that, as I'm sure you can imagine, it took quite a while for the young person to gain the trust. He was a very closed boy...um...so he found it very difficult to talk about it, understandably, and

I think quite often he'd be saying things that he thought she (therapist) wanted to hear. So, as time went on he'd gradually start telling me things, but I knew he wasn't telling the therapist that. So I said to the therapist: "could I come and join the meeting?", which he (child) was quite pleased for me to do...um...so, I sort of told her, in front of him, and I said that I was going to do that with the sort of things he'd been telling me...and I think that opened the way really for some honest talking. And I think overall it did work, yes. He (child) was a very logical sort of person, he didn't really do feelings very well, and I think she (therapist) adapted her therapy to do things...like he would explain that his thinking was like a grid and so she would try and make some analogies to do with the way he thought. And yes, I think it was useful.

R: Mhmm, and so from what you've said it sounds like you became more involved in the intervention. Do you think that's something you've continued to do with the other children in your care, being involved in their therapies in one way or another?

C: I don't think many others have had therapy. Funnily enough the child we're looking after at the moment has a CAMHS appointment next week. She has apparently been in CAMHS her whole life. She's only been with us for 2 months but um, and she is very anti CAMHS, but at the moment she is extremely depressed, and just recently she took some ibuprofen and she'd been self-harming, so I really do think she needs some anti-depressants, as does the GP, but the GP said it's only CAMHS that can prescribe that. Um, this girl, like I say, is very anti CAMHS, but hopefully it won't be prolonged sessions, but more timing of prescriptions, such as antidepressants, but I don't know.

R: So, will you be working with someone you know from CAMHS from before or someone that she knows from CAMHS?

C: No no, this is a new person to CAMHS, so no, this will be someone new to her and for me.

R: So what do you think about CAMHS, and maybe as opposed to FR, and how they deliver their services?

C: Ah, well, I really can't compare really, because I haven't really had any FR therapy, I don't think. Ah, well, we have, my partner and I, we looked after a girl who was extremely challenging. She'd have tantrums that would last about 5 hours and we were just at our wit's end a bit, so a lady, and I can't remember what her title was, but she was a therapist, who works with the carers really rather

than with the young children, and just gave us coping strategies really and that was very helpful.

R: Ok, and has that carried on with any of the children, or do you kind of only use it when you need it?

C: Well, um, we've had training. But, you know the way the mind works, and when a child is in a complete rage, of course they're not going to come down from that rage and be reasonable and listen to what you're saying, so little things like that of course stick, yeah.

R: And have you found the trainings offered by FR have they been helpful?

C: Oh yes, extremely helpful, yes, so as far as FR therapy is concerned. As I say, play-therapy hasn't really been relevant, because the children have been older, and I think they would've just poopooed that, I think they would not have attended that at all.

R: So by older do you mean kind of older teenagers?

C: Yes, yeah, so most of them have been older, 11 has been the youngest, but you know lots of them, like the girl we've got now who's 15, she'd laugh at play therapy. So most of the therapies that the children have had have been outside FR.

R: So when you say outside FR, who have they been offered by?

C: Well, like either CAMHS, or this sexual [...] behaviour therapist.

R: And, sorry, that was organised through FR?

C: Mmm, yes, I think it was organised through FR, yes, I think that, well I think actually to be honest it was the court as well. This boy, he had a sexual offender's prevention order and part of that was that he did get some therapy, so I think he had no choice in the matter. But yes, I think FR actually sourced the person.

R: And if you could, um, give advice, so to speak, to FR, what would you like for them to offer for you or your children?

C: Um, I don't think they could offer any more really. No, I think they do all they can really, um, I'm sure, well I know it's like that all over the country, but it's like that down here, CAMHS are very overstretched, aren't they? There was a referral in a couple of years ago, there was a girl, and we put our names forward, but she would've been collected straight from the hospital as she'd taken an overdose or something, and they wanted her to come to us, or to a place in C., but it had to be with a CAMHS package, and our local CAMHS couldn't do that, so this girl was eventually placed in C., because for some reason C. CAMHS could offer the

package, so that felt like it was a failure in our local system really, but that wasn't a FR's fault.

R: Mm ok, so when you are in contact with FR, how often is that actually happening?

C: So our supervising support worker whenever anything goes wrong, I email her or phone her, or she reads the diary and she phones me up, um, so once a month we have actual supervision, so that's face to face supervision which usually lasts about an hour and half, but you know, many many times during the month we're in contact with each other.

R: And so, this supervising support worker, that's a FR employee, or?

C: Yes, yes, FR employee. Just this week, I write a diary, and that goes onto a charms system, yoy know, so it's, so she can read what's going on.

R: I see.

C: And the girl that we look after, she'd been to a concert, a little festival at the weekend, and she'd come back with a split lip because a man had punched her, so I wrote that in the diary, so the saw phones me up to say: "oh I think we ought to be letting her social worker know that", so there's always social liaison.

R: Mm, ok yeah, and so are there any parts of the process that you found less satisfactory or that you found particularly helpful?

C: Mm well just the fact that there's always somebody, someone there really. So yeah, we do feel... Unfortunately our last placement ended in an allegation, which is always very horrible, and, um FR were extremely supportive of us and yeah, that's what we've found all the way along... definitely.

R: Mhmm, so do you find that you have more contact with FR than the children in your care.

C: Mm yeah, the children in our care don't have... well, um, they don't really have contact with FR. FR are there for us and the children have their Social Services' Social Worker. You know, if the child is here when we have our supervision, then that's very nice and everything, and possibly once or twice a year there is an unannounced visit, and Five Rivers' likes to see the child and [that] everything's alright then, but no in general Five Rivers' are here for us, and you know the children, if they had a problem or something then they would go to their own social worker.

R: I see, that's great. And, I don't know if you've thought about this before, but if you could design your own intervention or therapy, is there something you'd find

particularly helpful in the future, or something that you feel like you've not been given. I know you say you've been finding FR very helpful, I was just wondering if there was something maybe, something that you've had in mind as well that you'd like to see happening?

C: Um, not that I can think of really. I don't think so, no. I suppose, but this is not really a FR thing...I suppose if children in care could go higher up the priority list as far as CAMHS is concerned, that's about all I can think of really.

R: Mm yeah, ok great. So is there anything else you'd like to add, or any feelings that you've had around kind of your own trainings or maybe past experiences of children who've gone through different interventions, because it sounds like you've had quite a lot of experience with a variety of children, presenting different issues and difficulties?

C: Yeah that's right, um, no just that I do think that Five Rivers' do do a good job and their training courses, they're good. There's recently been a new company that actually do the training, and they are very good. It's more that you reflect on your own experiences and your own feelings, so it's not just textbook stuff, you know it's sort of how that relates to you and, I think that's quite helpful really because a child can have all sorts of different behaviours but it's sort of how you manage the behaviour that can be the problem really. And so these courses that we have right now are quite self-reflective and that's quite useful actually.

R: And do you by any chance remember the name of that organisation?

C: Headspace.

R: Ah I see, yes, so that's in conjunction with FR, is that correct?

C: That's right yes. And I think we have to do four courses each year. There are a couple of courses that are mandatory that you do every two or three years, like Safeguarding and Paediatric First Aid, and Attachment Theory, and then there's all sorts of other ones, you know, self-harming, resilience, caring therapeutically. Yeah, yeah it's all interesting stuff.

R: Ok, great, right well I think we'll leave it with that. Thank you very much for answering my questions, and for talking with me. And, if there's anything you feel like you haven't said or want to add then you have my email address and you can contact me through that.

C: Alright, nice chatting to you.

R: All the best, thank you very much, bye bye.

C: Bye.

Telephone Interview #2 (Case 2)

(Conducted by current study's author)

Total duration of the interview: 55m, 44s.

Interviewer: Researcher (R.)

Interviewee: Carer (C.)

Five Rivers (Fostering Agency): FR

4m, 18s- general introductory conversation- R. introduced herself, brief summary of the project was given. Carer explained that a therapeutic worker from FR got in touch with her and informed her about the research project. Carer was not certain whether she had filled in the survey or not, explaining that she fills in forms and questionnaires for FR all the time.

R.: Before moving on to FR, could you tell me if you were/had been attached to any similar Fostering Agencies, including Local Authority, before? What has your history as a foster carer been?

C.: Yes, we were with another agency, yeah.

R.: Ok. Do you remember which one?

C.: It was the Some-beans...

R.: Is this another independent fostering agency?

C.: Yes, it is.

R.: Ok...and could you tell me how long had you been with them?

C.: About a year and a half.

R.: Ok... 'cause I'm trying to get a bit of a sense of your history as a foster carer...

C.: Yes.

R.: Is that how you started being a foster carer?

C.: With them, yeah. Yeah, we started with them.

R.: Ok. And when you say 'we', you mean you and your husband/partner together?

C.: Yes, my husband, yeah.

R.: And could you tell me how many children had been under your care from that agency?

C.: No, not many, that's why we moved. They didn't have much of a reputation up-north and...and you know it was mainly down south, you know London-wise sort of thing...so, that's why we moved, you know, to another agency. It was like...how can I say it? We just got like respite children really, you know what I mean?

R.: Ok, I see. So you wanted to be a full time foster carer?

C.: Correct, yes, long term.

R.: Is that why you stopped your contact with them and you moved on to FR?

C.: Yeah, yes.

R.: Moving on to FR then, could you give me some information about yourself and your relationship with them? How long have you been working with them for?

C.: Yes, we've been...erm...so... how can I say, yeah 3 years...about, yeah, just nearly three years in there. So, yes. And they have been much better, you know...the support that you get was way, way better than where we were before.

R.: Ok. We will elaborate on that later on, just in the beginning in order to get a bit of a better sense of how your family looks like could you please tell me how many children had or have been under your care?

C.: With FR? Does that count sort of respite as well?

R.: Yes, it's important to get an overall understanding, get a sense of your family and then we will try to focus on the older children.

C.: Children like... All together like...1...3...4...5...I think there was 5...

R.: And some of them were respite you said...

C.: Yes, yeah.

R.: So how many were under your care full time?

C.: Erm 2...no, sorry I forgot...my apologies... there were 6 and there's been 3 full time...

R.: And are these children still under your care?

C.: Erm...2 of them.

R.: Ok...and trying to get some demographics...are they girls? Boys?

C.: Erm...One of each.

R.: And their age?

C.: 16 and 9.

R.: Great. I'm sorry it might feel like I'm asking a lot, but could you tell me the gender of each child?

C.: 16year old boy and 9year old girl.

R.: Ok. So, for the purposes of this study will it be ok if we try to focus on the 16 year old?

C.: Yes, that's fine, but I'm not gonna give you his name though and if I don't...if I feel it isn't right to give you information I'll just say.

R.: Of course, if you feel uncomfortable at any point please let me know.

C.: Fine, yeah.

R.: So in order to help with things getting started, could you tell me a bit about how your first contact with FR had been like and talk me through the contact with the service ever since?

C.: Erm...we first, well I heard about...what was I about to say? I heard about FR through a friend who was in the village who worked there so you know we decided to go with them, you know and we haven't gone back, so...

R.: Sorry...and you haven't?

C.: Sorry, say that again...

R.: So you heard about FR through a friend...

C.: Yes, we heard about FR through another...you know a friend in our village...and then we also saw a stand...you know M*? I don't know if you've heard of M* near S*...erm...it's a shopping centre, they had a stand there so we sort of stopped to go to them from there.

R.: Oh ok...and then you made contact with someone from there?

C.: Ah, yes...I'm trying to remember...erm...we...what did we do now? I can't remember how...I think we must have gotten the phone number from the internet...erm...

R.: Ok.

C.: And then someone came to talk to us from there...you know what I mean? It didn't take too long to go through the application process...plus we were already carers...so a lot of the information was already there, you know what I mean?

R.: Yeah, ok...so it sounds that this was a relatively ok, not very repetitive process for you, you didn't have to go through the same things again...

C.: Yes, well...not as much...some you know, there was some differences but because we had already done, you know, quite a bit of the process...you know

we had already been through the process once...because it's like one massive big form that you have to fill in you know when you start and we had already done that with the other place, so it did make it a bit easier.

R.: Ok...and then after that? You made your first contact, you were approved I suppose...I mean is that how the process works?

C.: Yes, it could...it's a 6 to 9 months process, you know, 'cause they are looking to all your background and the reasons why you want to do it, they look at your childhood...they look at EVERYTHING (emphasises that)...they look at your own birth children and whether they are stable children and then all sorts...you name it...they do DBS (Disclosure and Barring Service) checks obviously on yourself and then family and it takes a long time and then you eventually go to a panel and you know they ask you all questions...and that's usually the last bit...it's like a big meeting where there is about 10 or 12 people in there and you have to answer questions.

R.: Ok. How did you find the process?

C.: Erm...fine...it has to be...you know you deal with children, aren't you? You know...and the vulnerable children so it's got to be thorough...you know what I mean? You know? It has to be that way...so I didn't have a problem at all.

R.: Ok. And because you mentioned birth children...do you also have birth children in your family?

C.: Yeah, we've got two birth children living with us as well (laughs nervously).

R.: Ok, so you are a big family.

C.: Yeah (both R. and C. laugh)

R.: Good, ok. So after that...so you went through the panel and the process was completed. How does it work until you get a child referred?

C.: Well, basically, once you've been approved then your name goes to like...it's like a placement team where they try and match you up you see with the children that are needing care and that's how it works...so they have to do a proper matching process to make sure that you know you are right for that child and vice versa.

R.: Ok...so with you, how did it work? Did they locate the child and then you met?

C.: Yes, yeah.

R.: And is that one of the children that are under your care?

C.: Yes, that's the 16 year old...and the...well both, but the 16 year old has been with us since...we'd been approved for 11 days and then we got the child...you know...the 16 year old...he was 13 obviously at the time...

R.: Ok...so he has been with you for 3 years now?

C.: Nearly 3 years, yeah.

R.: And then? How long after did you get another child?

C.: Erm...just...no...well, we did respite in between and then we got the girl just over a year ago...

R.: I see...Did you have any other children that had been matched up with you and then assessed?

C.: Oh my apologies, there was one other boy, before the girl came we had a boy, but he only was here for a couple of weeks...erm...and then that was a very negative experience though so he moved out.

R.: Ok, is this something that you want to talk more about?

C.: Not really, no.

R.: That's totally fine.

R.: Ok...so trying to go back to the older, the 16year old boy...and I'm aware that it might feel a bit like we are neglecting the 9year old, but as I explained the focus is on the older age group mainly due to the high prevalence of behavioural and emotional difficulties in that age group.

C.: Oh they tend to because they have their hormones swimming all over the place and you know I mean they've got exams at school, which is extra pressure... you know...and they've got outside influences, you know...all sorts of issues...you know that aren't their fault....so, it's understandable why these children tend to struggle more than your younger ones..

R.: Exactly, which is one of the reasons why we are focusing on that age group. So as I said, trying to focus on him...could you tell me a bit about the kinds of interventions that your child has had since being at FR. I can give you some examples of interventions if you don't have some specific ones in mind.

C.: When you say interventions do you mean like CAMHS and things?

R.: That could be one. It could be something outside FR, like CAMHS or it could be within them... like individual counselling, expressive type of therapy (drama, art, play), attachment work, group work, any extra training that you might have had...respite.

C.: Yes, that's true. Well, once a year me and my husband have a week off for our wedding anniversary...just me and him...so they go to respite then...so there was talk of this young man having CAMHS when he first came to us and there was...it took a long while getting some sort of appointment sorted...you know the LAC nurse came...I don't know if you know who a LAC nurse is...

R.: You mean a nurse from the Looked-After children's team?

C.: Yes, yes...she came out...after about 18 months this was, he'd been with us for a year and a half then and the lady came out and she started to talk about... she was reading a report about all this young man's past things...anyway what happened was that she came with her report and started like talking about all the past issues and concerns and so on and basically it caused more harm than good because he just...the head went down, he didn't want to be reminded of all that and we really did work in that 18 months that CAMHS, that CAMHS passed him by. But we just dealt with it ourselves so...'cause we're like casted as what you call therapeutic carers and we...it sounds a bit beget, but we got him to where he is now if you know what I mean, so...

R.: I see...would you like to explain what you mean by therapeutic carers?

C.: Basically what we do is you know like if you've got an angry child, yeah, you don't rise to their anger, you keep calm, you speak quietly, speak on their level, you know...cause if you rise up, they rise up...and then you just let them work through their anger and you know how...you can see when they are starting to...you know the triggers and that sort of thing...I mean we've had lots of training...but some people are like how we deal with it but some other individuals have other rituals, but that's how we work and it seems to work with him, so..

R.: Later on I will ask you more about the specific training you had and the support, so perhaps you could explain a little bit more about what you had. For now, trying to think about your child...I mean going back to your child, it sounds you were disappointed with the delay, but also with the kind of intervention offered.

C.: We were surprised by how long it took them to come, but actually by the time it came to us it weren't needed anyway and to be honest with you when the nurse gave the report to the young man all they did was worse, so...

R.: And just to clarify was the meeting with the nurse a one off appointment? The nurse saw him, gave report and...?

C.: Correct, correct. We decided to not take it any further and to be honest with you every year they do these checks, you know mental health type check types and things and he's been getting better each time, so, only a little bit, but it's going in the right direction.

R.: Are these assessments happening through FR, CAMHS or through someone else?

C.: Erm...Both FR do them and the Local Authorities.

R.: Ok, I assume he is not open with CAMHS anyway...

C.: No, no, he's totally...no.

R.: Just to clarify, did CAMHS/nurse offer something else and you didn't want it because of your negative experience with them or they didn't anyway?

C.: No no...we just didn't want anything other than that...I mean he's done a little bit something with FR recently...you know...erm...how do they call it? You know younger ones talk about their story ...you know it's when...when the therapist starts the story and then you have to end it....

R.: Story stems?

C.: Yes, that! The younger ones do that and the older ones have something on the computer where they have to watch something on the computer...well he did attempt that, but to be honest he just lost interest with it...he just weren't bothered...he's not a person that would like, you know, he won't fill in forms unless he has to...he does have a problem anyway with dyslexia so you know he had no interest in there, you know what I mean? He doesn't want to be treated any differently anyway from anyone else anyway, he just wants to be a lad and you know just like any other normal kid, you know, which is understandable.

R.: Of course...so apart from these interventions did he have anything else from FR? Counselling?

C.: Nooo, he wouldn't take it anyway...no...

R.: Was it offered to him?

C.: Well, he had a therapeutic worker...he has another one now...what's happened was that when he first started coming, as there was a lot of issues, what I used to do was that I was offered this chap, it was a therapeutic worker within FR, before L., and what used to happen was... 'cause he wouldn't speak to the person...so what I used to do was that I would phone the person when...when something cracked up and I was like, trying to work it out...what I used to do was I would speak to the person about the problem, you know the issue...and actually in my own mind while I was telling him I really worked it out in my own head...I was working it out how to deal with it myself, but just by talking about it I got it clear in my own mind how I was to move forward and so then I was really reiterating what I had planned already so then...I then dealt with it that way...so it was actually me that rather than him, you know what I mean...it was me rather than him.

R.: Yes, it makes total sense...as you were talking to him you were processing it already...

C.: I was processing it in my mind, yeah.

R.: You mentioned L. and you mentioned her in the beginning as the person who talked to you about my project...what is exactly her role?

C.: She is a therapeutic worker for FR...she was the person who emailed me to begin with if I would be...if I was prepared to be involved in what you are doing at the minute.

R.: I see...and is she also working with you and your child?

C.: Yes, she's worked with both. Yeah, she put...well, I'm saying that...she came out to speak to the younger one and also set up the computer thing for the older one...

R.: So the therapeutic worker is someone that is working with you all along?

C.: Only the old one, but I don't hear from him now 'cause we've got L. now.

R.: Ok I see...And that is on-going?

C.: If we ever need it, yeah

R.: And what is the level of availability? Is L., the therapeutic worker, someone you can easily email and call?

C.: Yes, correct, yeah.

R.: Do they come and do home visits as well?

C.: If you want to, yeah, but I don't need that...I've only just spoken with them on the phone.

R.: Ok, ok.

R.: So now could you tell me about the interventions you as a carer have had (i.e. attachment work; systemic work; any extra training/support group)

C.: We do all sorts...we do attachment, we have had classes on you know how the brain is different...you know when children are developing how the brain is different to those children who you know haven't had that bond they should have had, you know we have support groups, all sorts...it's just on-going.

R.: So that has been through FR? Was it there all along?

C.: All the time, all the time.

R.: Do these kinds of trainings and support groups last for a specific length of time?

C.: Usually within the school day so that we can get back to school.

R.: Are they one off or do they last longer?

C.: No, we have to do certain mandatory ones, but then the other types, you know, other ones...you know there are all sorts of different...the mandatory ones you have in the first year, you know the first aid and safeguarding and all that....

R.: What about the ones that aren't mandatory...I am aware that I might be going into a lot of detail and this might feel a bit tiring for you, but it's important to understand what the extra ones are for. Do you ask for the extra trainings depending on your child's needs?

C.: They are offered to you... they have a training programme and you choose you know what you can do and when.

R.: Ok. And could you tell me about what you had?

C.: We had carer support groups.

R.: Ok...so, how does it work? You, the carers, meet there, at FR?

C.: Yes...we all meet every so often and you know, like, just share any worries or you know that sort of thing.

R.: Ok and are these all offered through FR?

C.: Yeah, yeah they are all FR.

R.: Did you ever choose a specific training because of having your older child in your mind and thinking 'ok I want that'?

C.: Yes, yeah.

R.: Did that help?

C.: Erm...a little bit, yeah.

R.: It would be helpful if you had an example in your mind of how it helped or what was it...in a daily activity let's say of something that you were struggling with and you thought 'ok I will attend that course and then you did and then you really got something from it...'.
C.: Sort of you know de-escalation and things like that, yes...but there's something that has personal hints so I don't really want to say that thing.

R.: Ok, ok, I understand. So thinking a bit about outside of FR, about the network...CAMHS, school, social services how have you found the contact with the network and how available they have been for you and your child? You mentioned CAMHS earlier and said that they were very delayed, I am just wondering in terms of the network...how has that worked for you?

C.: To be honest with you (laughs awkwardly) I can't think of any outside influence that has helped him...school are absolutely rubbish (laughs awkwardly)...the what...the so-called professionals within school do not know how to deal with a child who is going through the scenarios that a lot of these children have to deal with...they haven't got a clue...and as I said we never actually physically saw CAMHS anyway...we never got that far...we just dealt with it ourselves so there's

been no...the only therapeutic help we've had is the people in FR that have given me pieces of advice...

R.: I see...it sounds hard and that you had to do it all.

C.: Basically, yes, yeah (laughs nervously).

R.: So my next question was how much have you been able to access the network, but I guess it sounds that you couldn't really...

C.: Well, they don't...education do not understand why a child behaves this way. They...they just handle every child with the same brush, you understand what that means?

R.: Yes.

C.: Yeah and so...yeah...you've got your Social Workers and they sort of like you know they are there at the end of the phone, but they are not, they...they aren't trained in that field as such, they've got so many other children to deal with, you know what I mean, they are just there to make sure you are alright, keep the kids alright, you know, they are not therapeutically trained.

R.: I see, so does your child have a social worker allocated to him?

C.: Yes, we have one and he has one.

R.: Ok and they are there you say to check that things are staying ok, right?

C.: Hm, yeah.

R.: So it sounds that you are left thinking and doing the therapeutic/emotional work...and is it you that has to communicate this to school?

C.: It often comes to that, yes...whenever there is an issue it's always myself that has to advocate for him.

R.: Ok, ok.

C.: Always has been from day 1.

R.: Hm. Did you expect it to be like that?

C.: No, not as much as I have to do and I'll be honest sometimes I've felt like I've not been trained to be able to deal with the scenarios that I have had to deal with, but I've dealt with them the best...the way I thought that was best and well he is not the child that he was 3 years ago... so, you know I must have done something right somewhere (laughs nervously).

R.: Yes, of course, it sounds that you are working very hard.

C.: Very...(laughs nervously)

R.: I'm aware that I have a lot of questions in mind and that might feel a lot, so please let me know if you need a break.

C.: No worries.

R.: Again, going back to the interventions both offered to the child and you...I know you've said that your child wouldn't really want them, but thinking of whatever he had, how did you find them, having the therapeutic worker, the training, the groups...I know we have probably touched on this matter, but I wonder if you have an idea of how he found having a therapeutic worker...you said about the nurse that he didn't like that...

C.: No he didn't.

R.: What about the therapeutic worker? You mentioned that he found the story stems boring, but did he share anything else with you?

C.: He doesn't like doing anything you know that separates him from anyone...you know...any normal kid...you know, he just...if there's any, if he's got worries and stuff sometimes it builds up and then it just breaks out...erm , but usually it's myself that he'll go to and if he wants to or sometimes bottles it up.

R.: Ok, so when it came or comes now to talking to L. or someone from FR how does he find that?

C.: He doesn't talk to them.

R.: Ok. So we assume he doesn't like that.

C.: No, no.

R.: So he's fine with you knowing in whatever way, even by bottling things up, but not anyone else.

C.: Exactly.

R.: How about you? How are you finding the interaction with them? You said when talking to them you actually do the processing and come up with a plan, which is often a big part of what happens in therapy, I wonder how important it is for you to have this person at the end of the phone or your house?

C.: It is...yeah, sometimes it is that reassurance that you're doing things, the right thing the right way. And like the other day, you know, the therapeutic person, you know, it was to do with something else, but she just said 'well, whatever it is you are doing, carry on doing it' (laughs). And sometimes it's not so much what you are saying to that child, it's the way you say it, and that's the massive thing....you've got to think hard how you are going to word it, if you don't word it right then you know...you're in trouble...

R.: This is very important, yes. And being in the support groups and the training...how is that?

C.: It is positive....you and other people are all in the same scenario, so you can fire up at each other, you know what I mean?

R.: You can share you mean your difficult experiences?

C.: Yes you can give people advice who perhaps are going through a hard time and things like that 'cause you might have similar experiences.

R.: Does that help you as a person?

C.: Sometimes, sometimes or I'd like to think that I've helped someone else.

R.: Ok, yeah...and the sense that people are going through the same as you.

C.: Sometimes, yeah, sometimes people are...sometimes people, like us, go through the same with school and that and you want to pass things on to them, how to sort things out...so it's good to pass these things across.

R.: And are you attending these by yourself and your husband?

C.: Ah, bit of both...'cause my husband has his own business as well.

R.: Ok. And something last about that, if you could think back and remember something specific that was useful, is there? Let's say an advice a tip, something that you remember was useful?

C.: Am....that I got advice from someone else?

R.: Advice that you gave or were given by someone else that really helped you? Something that has stayed with you?

C.: We gave a family advice that wanted to move their child's school and we've been through that process, you know, and we supported them with that to do...you know what I mean?

R.: Ok, and was that useful for you?

C.: Useful for both, yeah.

R.: It sounds that sharing your experiences and helping people is very important for you.

C.: Yeah, absolutely, 'cause you know how hard it is...(laughs nervously).

R.: Yes. Now from the survey and trying to reflect on that and using what the carers have shared, I will mention a number of issues that came up. Many people didn't feel very involved in the interventions.

C.: I think, I think that we're dealing pretty fine doing things the way we are, but I do wish that other people who are involved in the welfare of the child would actually sit and listen to the person who knows this child best, I mean ourselves, and you know how to work things around...you know a different way...it's always about listening to the child, that's what we did the other day in a different scenario, we sat down and listened to what he had to say and then we came to a compromise between us all and that's what you should do.

R.: What do you have in mind when you say scenario?

C.: Yeah...we sat down, they say their side of things, we say our side of things and then we work together on coming to something in the middle.

R.: They? The children?

C.: The children, yes.

R.: In terms of FR or any other Service do you feel you are on top of things? What I am wondering is whether you feel you can get or ask for the support you want when you want it.

C.: Yes, yeah... I'll ask for it.

R.: And you trust that you would get it?

C.: I would get it... it might take a little while, but yeah.

R.: Is there something in terms of what is being offered to you that you would have liked to be different about this process?

C.: Erm...I'm ok with FR...you know, I'm alright with that, it's the outside influences that cause problems.

R.: Ok, meaning?

C.: Meaning schools and some...you know some, a lot of these children have...how can I say it? I don't want to go into detail, but you know they have family situations that they find hard to deal with so...well, the school doesn't understand that...

R.: I see...so, it has a lot to do with school, with your complaint from the,..(interrupted by the C. here)

C.: It's always me battling with the school and they just want to exclude, which is ridiculous.

R.: I understand. So the school was thinking of excluding him.

C.: It's an on-going thing, there's always something coming up and they just don't seem to get into that kid's head...you know what I mean? They don't understand how it works, so it gets frustrating.

R.: Of course. It's very sad to hear that (pause follows for a few seconds). Going back to the survey, some carers complained that interventions were more for them than for the child or young person. What is your view on that?

C.: But the kids don't want them though, they don't want to talk about this stuff, you know what I mean?

R.: I understand. It has to do with the child more than FR you mean?

C.: Sorry I can't hear you.

R.: I guess I am wondering whether you would want the interventions to be any different.

C.: Am...I mean at the beginning we could have done with CAMHS being quicker, but actually in the end it worked out anyway...I can see I would have probably been like that if I were a kid...I wouldn't want talking about all that...it's always a difficult thing to do....they want to move forward, they don't want to dwell on the past.

R.: I understand. Thinking of the support provided to you, would you like things to be or have been any different?

C.: We are ok, thank you, we have a decent Social Worker so we are ok.

R.: Ok. Going back to the survey, communication with services was another area that was often highlighted as important and I wonder what your experience has been like.

C.: Not too bad, I think sometimes they don't always fully understand, you know when you are trying to deal with a situation, cause you are the one living it, aren't you? But it's not too bad...we've been ok mainly, much better than you know...I know there are certain authorities that are shocking, so ours is ok, much better than that.

R.: So, if you could think in regards to the style of communication...

C.: We are ok, you can just text them or phone...usually the young man Social Worker is harder to get hold of... is harder to find 'cause he's got more caseload to deal with, you know what I mean.

R.: The Local Authority Social Worker you mean? They are harder to reach?

C.: They are, they always are...every Local Authority.

R.: I understand. Moving on to the subject of feedback I wonder what your experience of receiving or not receiving feedback has been like.

C.: Erm...feedback from what?

R.: For example when you take part in a project, like this one, or filling in a questionnaire?

C.: We do get, but we're more involved than most carers are, so that makes it different....but not too bad...

R.: I'm happy to hear that (pause follows for a few seconds). And now if you were to think of the best type of support for your young person, how would that look like?

C.: Just being there for him, just being a listening ear for him. you know if he lashes out, you just let him work it through, just show him you are there 24/7 and when they need you.

R.: It sounds that when you talk about support you don't have interventions in mind you have yourself and your husband in mind as being the ones.

C.: We are the first point of contact...my husband works as well, so you know... it's usually myself.

R.: I see. Finally, do you have any thoughts on how you would want things/support to be for you and others in similar situations?

C.: About what thing, sorry?

R.: From what you say I could assume that you would want the network to be more involved, more supportive. Is that correct?

C.: I would like it, I would prefer it if schools were more accommodating, and they were better trained, you know that would make a difference for the kid and for all, but they never are...so that would be a big it...for myself anyway.

R.: Having been an advocate for your children, would you want more people to be able to do that?

C.: No, lots of people have seen the problem...Even the special schools for children who have been excluded and so on...even they don't always go about things the right way.

R.: Ok. That's great. Thank you very much for your time and all the information you shared with me. Do you have any other thoughts?

C.: No, thank you. Goodbye.

R.: Goodbye.

Telephone Interview #3 (Case 3)
(Conducted by current study's author)

Total duration of the interview: 1h, 3m, 56s

Interviewer: Researcher (R.)

Interviewee: Carer (C.)

Five Rivers (Fostering Agency): FR

4m, 21s- general introductory conversation- R. introduced herself, brief summary of the project was given. Carer explained that a therapeutic worker from FR got in touch with her and informed her about the research project.

R.: Thinking of your history as a carer could you tell me whether you had ever been attached to any other fostering agencies except from FR?

C.: I've only ever worked with FR...erm...I have erm, I have close contact with Local Authority carers through maintaining sibling contact...and I...with one of my previous placements I had a lot to do with...one of the siblings used to come and stay with me a lot from a Local Authority placement...I'm actually in the same position now because I try to maintain sibling contact especially as much as possible... I let the siblings come and have overnight stays and prolonged visits during holidays and things like that so that's...that is my only connection with Local Authority carers.

R.: Ok, I see. So except for the child/children that is/are under your care, you often look after their siblings who come and stay in for a few days.

C.: A few days, yes.

R.: I see. So, is your contact with other Fostering Agencies only through the siblings?

C.: Yes, yes.

R.: Ok, thank you. I wonder if it would help to take me through your journey as a foster carer.

C.: Yes. Well, I've started being a foster carer... I was...I'm trying to think...I was approved in May 2014, my Form F¹ assessment took a long time because I am a single carer and at the time I was in a relationship with someone and he wasn't

¹ Form F is an evaluation process, aiming to assess whether an applicant is suitable to become a foster carer, while also determine the type of fostering they are suitable for and take into consideration any possible terms of approval.

deemed suitable because his ex-wife was an abusive alcoholic and...so I had, so it took a long time for the Form F to come through... for that to go through because they were concerned about somebody else and in the end I had...I had to end that relationship in order to continue through the approval process...erm...so that took a long time. So it was a major decision that I took to become a foster carer.

R.: Hm...it sounds that you had to make a very difficult decision even before starting being a foster carer.

C.: Yes, and I haven't had children of my own either so my approach is....I only think I am quite good with disorganised attachment in the children because I haven't had to un-teach myself standard parenting....so the only parenting I have done is therapeutic parenting that FR has taught me.

R.: I see what you mean, you've always had to assume that there hadn't been a secure attachment in the first place.

C.: Yes, yes.

R.: It sounds that you are very dedicated to what you are doing.

C.: Haha (laughing nervously).

R.: So, going back to your journey in becoming a foster carer, you were approved in May 2014 and since then it has been 3...no 4 years, correct?

C.: 4...4 years, yes.

R.: So, I was thinking whether you could tell me about your first contact with FR. I'm aware of what you said regarding the assessment process lasting long, but perhaps you could tell me a bit more about how you heard about FR and how you ended up choosing them.

C.: I got in touch...Well, I used to have my own business and the stress of that made me very ill and I had to have major surgery and during the recuperation...because I had to let the business go...and during the recuperation it gave me a chance to reflect on everything and I realised I wasn't happy with the way life was going so I got in touch...I'd always hankered after fostering because I love extended family and family life so much and I often find that families just need a break...they just need to be given a chance and you know even the most disrupted families are still families...and how important that whole sense of belonging and everything was and I've always felt quite strongly about that so I decided that I had a natural pause in my life to be able to pursue it. So that's what I decided that I had to do because of the natural pause in my life...and I contacted the Local Authority and to be honest I very quickly realised that as a single person being a foster carer for the Local Authority wasn't viable at all because I wasn't prepared to live my life on state benefits, which is what I would have had to have done in order to pay the bills and I didn't want that stress in my life. So then I contacted a couple of other agencies and in the end I selected FR

because you have to make a choice before starting the process because you can only have one Form F, so I chose FR purely because they were a social enterprise. Because I found the whole idea of profiteering from children's...from children and from broken families distasteful and I didn't want that. I knew I had to live and I knew I needed payment for what I was doing in order to live but it was never, I just didn't, I just found the whole idea of profiting distasteful so I chose FR specifically because of them being a social enterprise.

R.: I see...that's very interesting. It really makes me think that you put a lot of thought in every choice that you made.

C.: Hm, yeah.

R.: So after being approved, how long did it take for a child to be allocated to you for an assessment?

C.: Because it was such a major life change for me, the panel only approved me initially for short term and respite and they only approved me for 6 months as well so it was the whole thing was just one challenge after another...you know I felt as if I had lots of hurdles to overcome in order to actually become a foster carer with them, but if anything it made realise that FR were...erm...they took their duty of care very seriously...I never felt as if I was being discriminated against or anything, I always felt as if this was something that needed to happen in order to safeguard the safety of the children, but when you're in it you are thinking "oh I have another thing that I have to work on now". So I did lots of respite for the first 6 months and then I went back to panel and they approved me...no problem whatsoever. Following the respite placements I've had and I had to wait another 4 or 5 months I think for my first permanent placement... so it was a long time...and financially it was very, very, very tough for me.

R.: I can imagine and I assume that you had to stop working?

C: Yes, I couldn't work...I did cleaning...erm...and I also did odd jobs really, you know casual work, that sort of thing just to...it was amazing, every time a bill came in I seemed to be given some work or found some work, which allowed me to pay that bill, but it was...I was living on a tiny amount through the whole process.

R.: Did things improve when you got your first permanent placement?

C: Yes, yes, a lot.

R: Great. So now could you talk to me about the first child/young person, the first permanent placement that was allocated to you? Is that child still under your care?

C: No, she left me. She was with me for about 16 months.

R: I see...quite a long time.

C: Yes and she was described as being...for a first placement it was a really, really tough assignment because she was described as being the most complex child in C. And she, when she came to me, she had been in care for...let me think...she was....she had been in care for 5 years and I was her 9th placement.

R.: Oh, ok.

C: And she was first seen when she came to me, but she was actually cognitively well behind... and emotionally she was around 3 or 4 and she was a school-refuser as well, so it was a very, very difficult placement.

R.: Ok, I see. And was that child the only one that had been under your care for that time?

C: No, I used to have her sister come and stay a lot...her older sister and I used to also...she had another...she had another older sister...this mother...this woman had 9 children and she had a baby every year and they were all in care...some of them had been adopted, but they were all in care, and so I used to arrange facilitating my home for sibling contact between the 3 older sisters, but one of them was quite violent so I wouldn't have her stay overnight.

R.: I see. I assume that when that ended it must have been very difficult for you.

C.: Oh, yes. I actually took 6 months of when it ended.

R.: I see.

C: Yes, yes. After C. left I didn't want, I didn't want another permanent placement for a while and I did lots and lots of respite, which I really enjoyed. I had one erm girl come to me who was psychotic and she stayed with me for about, for about 3 weeks I think...possibly a month...and she kept drifting in and out of these psychotic states and I seemed to spend half the time in hospital with her...erm...and that was quite tricky, but I knew I couldn't have B., she was just going to be too much for me.

R.: I understand. Could you tell me how your journey in fostering continued after that?

C.: Then I actually went to India for 6 months and just had a complete...complete break from it and decided that I still wanted to be a foster carer so I came back and I hadn't...FR hadn't de-registered me and because I had only been away for 6 months I was able to pick up where I left off, which was so lucky. But I moved regions, so I moved from the C. office to S. to be closer to some friends and it took about...once I came back...it took about 3 months for me to get a placement and that's the same placement that I... she's still with me, she has been with me for nearly 8 months and again she is another extremely complex child...erm...she is a compulsive liar...erm completely disorganised attachment, lots of dissociation...erm we suspect...myself and my service manager...suspect that there is an emerging personality disorder.

R.: I see.

C: So, so sad. Very, very, very sad.

R: Could you please tell me the age of the young person?

C: She is 16 in October...so she is 15.

R.: Ok. And is she the only child that is permanently placed with you?

C: She is because we can't match her. So we are in the process of trying to make her a solo placement because again I'm finding it...because of being on a strand... me being on the strand of flat rate...financially I'm struggling, which is another level of stress that I just don't need.

R.: I understand...and because you mentioned that you put a lot of emphasis on sibling contact, does this girl have siblings that also visit?

C: Yes, she does, she has a younger sister who is with the Local Authority carer in P. 'Cause this child is a P. child, so she is 2 hours away from home. So, every 2 weeks I drive her back to P. on a Saturday and she spends the day with her mother and her sister and so I leave them alone, they don't need to be supervised...so I drop her...I tend to drop J. off at about 09:00 and then I will leave them and pick J. at around 17:00...so they've got almost the entire day that they can spend together and...and I'm...this Saturday I'm picking S., the other sister up and bringing her back 'cause she is gonna spend 3 nights with us here. Unfortunately J. isn't stable enough to spend any time in P.,...no she isn't stable enough to be away from me for...without a FR carer.

R.: I see. And does she go to school?

C.: She does, but she struggles.

R.: Does that mean that you are essentially together all the time?

C: Yes.

R.: And do you have any support? Anyone that can give you some time?

C.: No, not really. I have the time when she is at school...erm...we...FR have given me I think...they have given me 4 nights respite over the last 7 months...erm...At the moment I am feeling very, very tired and drained. There has always been talk of perhaps having babysitters...FR to organise childcare so that I can go out in the evening with friends, but that hasn't materialised, hasn't happened and we've got a, I've been calling for a stability meeting on the placement since February and that's finally going to happen on the 4th June.

R.: Could you please explain what that is?

C: Well, J. made an allegation to the police against me because she is a compulsive liar and she...when she goes out she keeps phoning the police and

making up stories...so she will say "I'm being followed; someone is trying to abduct me; someone is threatening to hurt me; someone is going to kill me" those sorts of things...and in February she was late coming in and I thought to myself "well rather than escalating the thing up to a missing person", which is what the procedure is, I thought I would go out look for her, 'cause I had an idea where she was so I had to go and call her for her tea, her evening meal...and when I got there I found her on a park bench...she was actually making a phone call to the police...she was with a friend in an empty park, but she was making a phone call saying that she was being followed, which just wasn't true at all, so she saw me and she panicked and she run away and I think she backed herself into a corner because she knew...she kind of knew if the police brought her home and I told them what had happened she would be in trouble with the police so she told them that she was scared to come home because she thought I was going to hit her.

R.: I see.

C: Which isn't true, obviously I'm not gonna do anything like that, but because that happened I felt as if I needed a new risk assessment and a procedure to follow for when she is late and things like that and I've been calling that since February and as I said we are now...it's now booked for June...for the 4th June.

R.: Good, I see. And did that allegation mean that you had to be investigated?

C.: No, no, but I became acutely aware of the fact that that may happen.

R.: Yes, I understand. You want to be proactive and make sure that there is the necessary protection.

C.: Yes.

R.: Thinking of what you said about J. and her everyday life I wonder how that feels in the sense of how supported you feel.

C.: Well, I'm not really concerned about school, although I do generally get 2 or 3 phone calls a week from school and... so I can never really go very far because I might have to go and collect her for some reason.

R.: And is J. attending a mainstream school?

C.: She is in mainstream school, yes.

R.: Well, that is a big achievement. Young people with such complex presentation often cannot manage mainstream schools.

C.: Yes, although I specifically chose a school that is very small because...I think there are about 350 pupils in the school...otherwise she wouldn't have coped.

R.: It sounds that something is really working.

C.: But how much she is actually taking in I don't know... I mean CAMHS...I mean she is nearly 16 and CAMHS have said that she needs to have an EHCP (Education, Health and Care Plan), but she hasn't...Since she has been with me we have actually unmasked so, so much to do with poor J. and she...her comprehension is extremely limited, I would say about that of a 5 or 6 year old. So she is able to parrot things, but she doesn't actually comprehend what she is saying or what she is doing.

R.: I understand you are worried about her (pause follows for a few seconds). So, trying to summarize the type of interventions that are being offered to J., you have mentioned CAMHS. Is there any other source of support...any other form of intervention perhaps from FR, the school?

C.: We have CAMHS and obviously myself...erm...she sees a FR support worker for an hour once a week, although to be honest that support worker is only part time and we...it's not very often that we can get a full run of weeks...quite often she might see her once every 3 weeks or once every other week...that sort of thing.

R.: I see.

C.: It's not consistent. And CAMHS doesn't work with the school.

R.: Could you please be more specific about what exactly is being offered from CAMHS?

C.: At the moment she is still on the outreach scheme, which is the crisis management team, while we are waiting for the community side of CAMHS to take her over to start more therapeutic work surrounding her trauma and the outreach team won't let J. go until the other side of CAMHS takes her over 'cause they know that she will just get lost in the system.

R.: And what does the outreach team do for her?

C.: I think they are trying to get her to cope with her emotions, they concentrate very much on her moods and they can't really do anything more than that because they got involved because of her self-harming, but she stopped self-harming now, which is great. Before she came to me she was self-harming every day and I think last self-harming incident was the beginning of the month, and then it was really superficial, but prior to that it had been for about 3 or 4 months.

R.: That's a great change!

C.: Hm, hm.

R.: And in order to understand a bit more about CAMHS' involvement, is there an allocated mental health nurse to J.?

C.: Yes.

R.: I see...and where do the meetings take place?

C.: Erm it's generally, it's...they either go to school, which I don't like...I don't like that that they are going into the school...although they are not often staying in the school and they will take her out of the school and take her for a cup of coffee...erm...that whole thing about CAMHS going into school I just don't like...erm...or I will take J. out of school and take her up to the CAMHS centre.

R.: I understand. Are these meetings with the nurse taking place consistently?

C.: They are. We've got a break at the moment because R. is on holiday and J. is very stable with her self-harming, but they just want to maintain that touch base with her. Erm...we...she is going to see them when she gets back after half term, but I stopped the half term one because J. is very busy and she is seeing her sister for the first half of the week and then for the second half of the week she is going to be in respite because finally I've booked some of my service leave.

R.: Hm, good. So CAMHS and FR are offering support.

C.: Yeah, but the FR one is a very limited resource. We've got only 2 support workers in our particular area and we are, even if you put the hours together they don't make a full time person.

R.: I see (pause follows for a few seconds). I also wonder whether the Local Authority is involved. Does J. have an allocated Social Worker?

C.: She does, but her Social Worker is in P. because she is a P. child.

R.: Oh, I see. Does that mean that you have or not have contact with them?

C.: I have telephone contact with them. She's actually got a new Social Worker who is coming out today to see her...but to be honest...with the best will in the world they can't get to see her every 6 weeks because it means a whole day out for them to...cause it's a 4 hour round trip for them to get to us.

R.: Oh that's a shame (pause follows for a few seconds). So in terms of the support that FR has been offering you, has there been a support worker all along?

C.: No, no there hasn't. Again because of resources we...when J. came we priced...erm...for support and we don't have the resource to fill it, to fill that part of the contract erm so I was...J. used to get 3 or 4 hours a week with her youth worker...erm...and we were meant to be picking that up, but we just haven't been able to...FR just haven't got the resources to do that.

R.: I see. How do you feel about that?

C.: A bit pained really because I don't think we should be making erm ethically we should not be charging something that erm we are not giving...I kind of I think FR can justify in a way because of the support that I give her because I know that I go above and beyond what a Local Authority carer would do, but then again that

is what I believe is expected of me from FR, which is why they put so much training into me...erm...and I don't know how to do, I don't know how to do it any other way other than...you know...when I'm with a child who needs me to be there for that child...I don't think I would be able to function any other way.

R.: I understand...you are very dedicated to these children. And since you mentioned the trainings, could you please tell me a bit more about them? Were/are they tailored to J.'s needs or not?

C: Well the training program I must admit, the training program down in C. seems to be better than in the region I am living at the moment, I also feel that the support I received in C. was greater than the support I am receiving here and when I moved regions it felt as if I was coming to work for a different agency...the erm I don't, don't know whether it's...I can't, can't put my finger on it to be honest, I think it's because they have an office with Y..., it's a central point, whereas in the region I am in at the moment it's so fragmented that there doesn't seem to be...it doesn't feel as if you are part of a team, I think that's what it is...I think. In C. the foster carers were a part of the team as well and you had more support workers and they just seemed to be more hands on with you, whereas in this region we only have my Social Worker and another Social Worker in S. and then we have, then we have the Social Worker who is in the B. office... I think the region is just too big... the area that they have to cover is just too big and it feels very fragmented and it doesn't feel like as if you are part of a team or part of a family, which is a sense that I got when I lived down...when I worked in C.

R.: It sounds that you miss the family network of FR now....

C.: Yes, I do...I was looking for a more balanced feel, but the importance of feeling part of that team is that there are things that you need to let off steam about that you can't do with anybody other than the FR team...so some of the things that you have to laugh at just to relieve the tension really aren't very funny, but they are funny to other foster carers because it's a situation that you are faced with daily erm...but if I was to laugh or make a joke about a certain type of behaviour with my friends they would be horrified (laughs nervously).

R.: I think it's a way of surviving a difficulty with other people who are also facing it...

C.: I know (laughs)

R.: I guess that brings me to ask about support groups, meetings with other carers. Is that something that is or was available to you?

C.: Well I do, I do erm once a month...not all the carers turn up and the training as well...you don't get that same, there doesn't seem to be that same buzz...they did calibrate the training better in C. than here, although saying that to be fair I have had to cancel a lot of trainings because of situations that have risen with J. and we don't have the support for me to have gone to the training whereas in C.

if for some reason the child didn't go to school you would have a support worker there to sit with her or to take her out while you went to your training and that just doesn't happen here and has never happened...whereas I think that that is one of the main differences with the two regions...it's that they put more of an emphasis on the foster carer and meeting the needs of the foster carer than I think I get the sense that this region does.

R.: I see...is there anything else that you get, a professional perhaps that you can call on a daily basis should you need to?

C.: Well I've got my Supervising Social Worker.

R.: Ok and is there an on-going contact with that person?

C.: Erm, yes...I think yes. I mean I don't...there are times when I just erm I just have to let off steam and she will just sit at the end of the phone and let me rant (laughs nervously).

R.: Yes, sure.

C.: And I usually feel a bit better after that. One thing that has really helped, really, really helped with the training...erm...is that I have been put on the therapeutic skills level 3 training, which is absolutely superb and it's an on-going course and there is lots of personal reflection on it as well so we are looking at things like projection and transference, but we are doing it, we are looking into ourselves as well so we are able to look at how it would be if it was normal and then transfer it over to the children that we look after and see why things happen, why they do certain things, so I think the next module is on dissociation...you know why our children will suddenly start talking, start to refer to the 3rd person and it's not only fascinating, but it actually chills me out completely because I suddenly realise that there is very little that I can do when something catches within the children, sometimes I just have to let it play its course and pick up the pieces at the end.

R.: I understand. It's a bit like research...you gradually become aware of the limitations.

C.: Yes, yes.

R.: But going back to the training programmes, I was wondering if they are selected by you and then open to your attendance or are they mandatory?

C.: Yes, with all the training we...what happens is at the beginning of the year we get sent the training programme and then we select the ones we want to go on and occasionally...although it hasn't happened here...although when I was in C. my Social Worker...she would say "I want you to go on this one, this is going to help you"...erm but I know I was extremely fortunate in C. because my Social Worker was...had a lot of experience in adult mental health before transferring over to children's services so she was able to draw on a lot of past experiences

with the mental health so I was able to tap in... so supervision with J. was almost like a training session in itself....erm...

R.: I'm sorry, is that the Social Worker you have now?

C.: No, no that was my old Social Worker, in C.. And of course you know M. is very good, very good, but she doesn't have that same depth of experience that, that my previous Social Worker had.

R.: Yes, I understand. Perhaps similarly to the Looked-After children you are experiencing the positives and negatives of moving into a new place...

C.: Yes (laughs nervously).

R.: I am aware I am a bit over the time we agreed...can we have another 15 minutes?

C.: Yes, that's fine.

R.: Thinking of some of the issues that you raised I am reminded of the main topics that came up in the survey, one of which was the sense of involvement in the decisions that are being made for the young people. So, would you say that you have felt involved in the processes?

C.: More in the past than I do now.

R.: And how would you wish your involvement to look like?

C.: Well, I am actually taking proactive steps to get myself involved so I've made...I've put myself forward as the carers' rep for the S. area because we didn't have one before, we recently had a road-show with the senior management team going around all the regions and there were 3 placements available for foster carers and I insisted that I was one of them and I came out from that very, very enthusiastic with the FR goal of integrating all their services so that the children can have step outs and step downs in residential care, we could tap into the educational system that we have and things like that. So I came away feeling really, really positive and hopeful, but then of course you know to actually get that to happen is you know going to be really tricky because you know everybody needs to be singing from the same hymn sheet really and I don't get that sense, but I am making more steps to make sure that I am involved because it's like with everything...if you sit on the side-lines and you wait to be invited erm you are just not going to participate in life at all.

R.: Yes, you are trying very hard (pause follows for a few seconds). Another area that was mentioned in the survey was about the interventions and whether they are geared more towards the carers than the young people. Where do you think you stand in relation to that?

C.: I think the two need to be progressed simultaneously...although we get lots of training we aren't necessarily shown how to practice the training so we are

given all this training and then within the training we are given situations where it could be used...but then we find ourselves in certain situations where we need to be prompted and sometimes I think that there should be more coaching from the Social Workers to get us to implement the training that we received. And this is the gap. I think that there needs to be more strategies given to us for building up resilience and to be...and more de-escalation skills so for us to be able to spot when things are going wrong and to be given different strategies to put things back on course before they escalate into a situation that we then have to let play out. And the same with the children and not just the children in care but the birth children of the families as well... I know it's just me, but I am acutely aware that sometimes birth children are neglected through FR and they need to be given resilience training, they need to be given why situations happen...why there is a strange kid in the house that is being mean to their parents and sometimes simply having a foster child in your home can be utterly detrimental to the well-being of your own children, so I kind of think that FR needs to take more of a holistic approach and instead of saying things like or thinking things like "we need to do this for foster carers"; "we need to do that for them", they need to be thinking of things in whole units.

R.: I understand. Another area that was often mentioned by carers in the survey was feedback. So since J. has been receiving support from CAMHS and the Support Worker from FR have you been updated about her progress?

C.: Yes, with...when D., our support worker, drops J. off she always comes in and gives me a 10 minute debrief, erm always, and I...if there has been an incident leading up to her session I will let D. know what it is and if J. wants to talk about it she's already got the heads up of what it might be.

R.: Ok.

C.: CAMHS now do debrief me...for the first 2 months of their involvement they didn't and then they realised that J. is a very accomplished liar and a lot of what J. was saying in the session was strictly in fact it wasn't true...erm she would just...I mean a lot of it was just what she wanted to hear, so she would say things like "when I am feeling down I am leaving notes for S. in the kitchen and she doesn't..." erm you know "I write my feelings down in a form of a story and I have a story book which S. reads" and she doesn't (laughs nervously). So once they bought into that and a lot of the incidents that she was saying weren't true ...they would then come to me saying "you need to do this because that thing happened", but it hadn't. So now that they have understood how J. is like, they do talk to me, whereas prior to that they didn't talk to me because I have a sense that they might have thought that I was part of the problem.

R.: Hm...it sounds that it's very helpful that they are now involving you. And is school somehow involved? You said CAMHS and school don't work together, but how has your contact with school been like?

C.: Good, yes.

R.: Hm.

C.: They understand...and the other thing I do, which is turning out to be every 2 weeks...I...I have to keep her out of the school for a day just to calm it all down and the school are very, very happy that I do that.

R.: I see.

C.: Because she just can't cope and so I just give her a day and she sleeps the entire day. The other thing that is happening, which is quite good, is because of J.'s constant phoning the police and making up stories they now have the community officer that is going to be involved with her as well, so he is actually going to be attending the meeting on the 4th of June.

R.: Ok, it sounds that it's all coming together in a way.

C.: Yeah.

R.: Finally, the other area that was mentioned in the survey had to do with feedback in relation to questionnaires, assessment tools, psychometric tests, etc. What has your experience been in that area?

C.: I've never really received feedback...erm I often find that...I get the sense that FR wants to do something, but never quite gets to the end of it...so they will gather information and then either the report is never written or it's just not progressed or it gets shelved for some reason, and I think they have, I mean this time it feels different to be honest, there is a different feel to what's happening in FR at the moment in comparison to the previous years, which I feel positive about. I think that previously that there was...that something was being initiated, but was never being followed through to the end.

R.: I see.

C.: I'd like to end by saying that I'm very, very happy with FR and to be honest I wouldn't do this with anybody else, yes.

R.: Ok. Do you have any other thoughts or questions that you would like to share with me?

C.: No.

R.: I would like to thank you again very much for your time, I really appreciate it.

C.: Thank you very much. Goodbye.

R.: Goodbye.

Appendix 4: Content Analysis

An inductive versus deductive approach of Content Analysis was used based on the premise that the aim of the study was to explore the IFCs' experience and therefore allow the categories and sub-categories to derive from the data instead of previous knowledge.

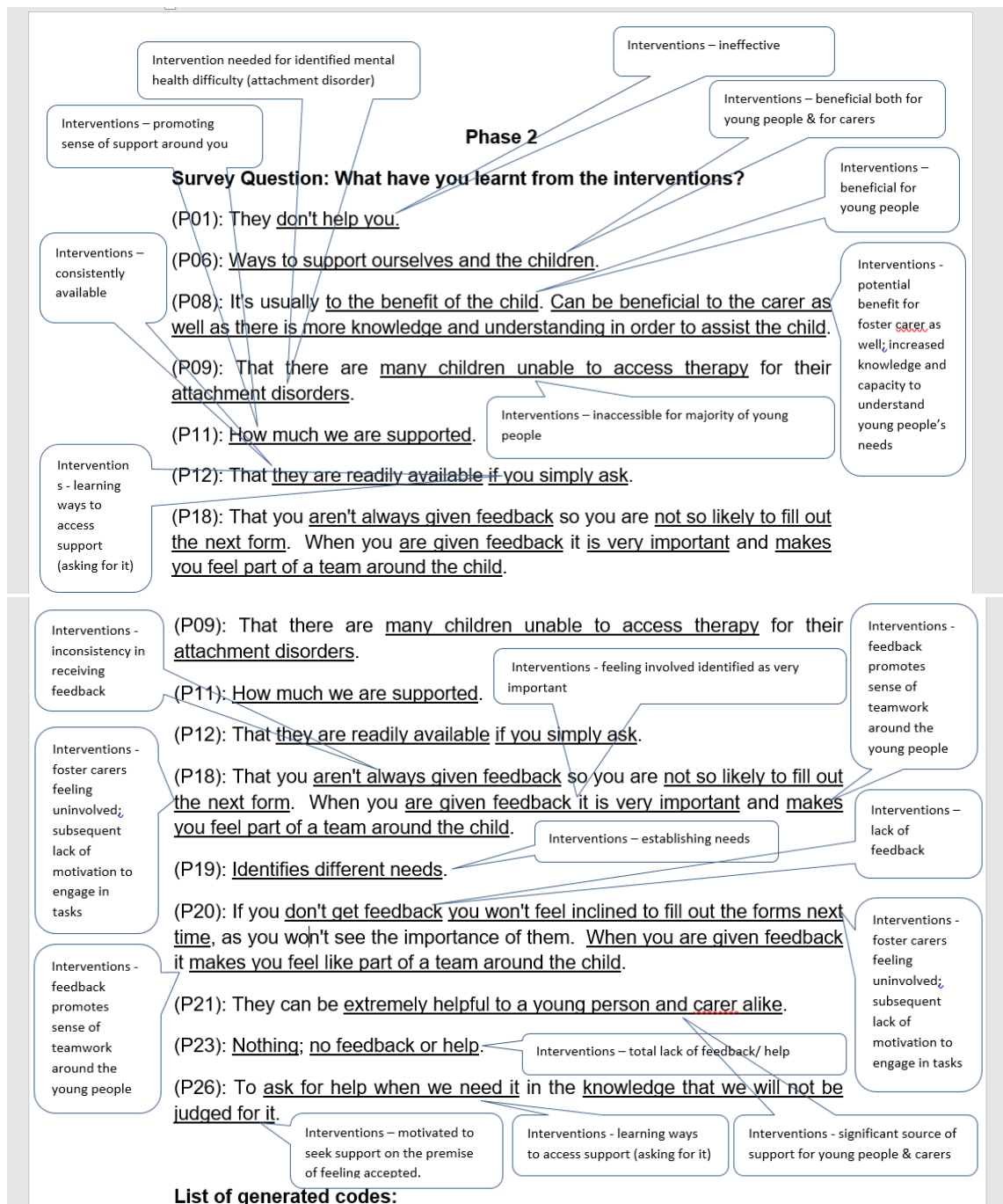
The process of analysing the data, which were gathered from the survey's open-ended questions, using Content Analysis followed three phases, as recommended by Elo & Kyngäs (2008). These phases are described below.

Phase 1: *Preparation.* In this phase, the researcher repeatedly read all the data, namely the IFCs' responses to the survey's open-ended questions, in order to achieve immersion and to grasp contextual details of the IFCs' broader narratives.

Phase 2: *Organising.* This phase entails open coding and creation of categories. For the purposes of this study, the researcher coded areas that discussed support, sense of benefit, and ideas on how support should look like by identifying and highlighting relevant references and labelling them according to their content. The emerged codes were subsequently divided into groups of a similar context under higher order headings. Eventually, a general description of the IFCs' views on the most significant qualities that the support offered to them and the young people should have, as well as on the main areas that they identified to have been impacted by the provision or not of interventions was formed through the generation of categories and subcategories.

Phase 3: *Reporting.* The final stage of data analysis is related to reporting the result of the previous stages. Consequently, the study's author presented the results through conceptual categories and subcategories, which were quantified (as allowed by the nature of this analytic method; Gbrich, 2007), elaborated on, and supported by data extracts.

The screenshots below showcase an example of Phase 2, which was followed during this analytic process. It wasn't possible to illustrate Phase 1 due to its preparatory nature, while Phase 3 was elaborated on in the core context of the empirical study under 2.3 Results Section (pages 76-79).



1. Interventions - ineffective
2. Interventions – beneficial both for young people & carers
3. Interventions – beneficial for young people
4. Interventions - potential benefit for foster carer as well; increased knowledge and capacity to understand young people's needs
5. Interventions - inaccessible for majority of young people
6. Intervention needed for identified mental health difficulty (attachment disorder)
7. Interventions – promoting sense of support around you
8. Interventions - consistently available
9. Interventions - learning ways to access support (asking for it)

10. Interventions - inconsistency in receiving feedback
11. Interventions - foster carers feeling uninvolved; subsequent lack of motivation to engage in tasks
12. Interventions - feeling involved identified as very important
13. Interventions - feedback promotes sense of team work around the young people
14. Interventions – establishing needs
15. Interventions – lack of feedback
16. Interventions - foster carers feeling uninvolved; subsequent lack of motivation to engage in tasks
17. Interventions - feedback promotes sense of team work around the young people
18. Interventions - significant source of support for young people & carers
19. Interventions – total lack of feedback/ help
20. Interventions - learning ways to access support (asking for it)
21. Interventions – motivated to seek support on the premise of feeling accepted

Division of codes into groups of similar context under higher order headlines:

Inadequacy or total Lack of Support: Codes 1, 5, 10, 15, & 19

Impact of inadequacy or lack of support: Codes 11 & 16

Benefit of interventions for young people: Codes 2, 3, & 18

Benefit of interventions for foster carers: Codes 2, 4, 7, 8, 9, 12, 13 14, 17, 18, 20, & 21

Impact of adequate support: Codes 4, 7, 8, 9, 12, 13 14, 17, 20, & 21

Identifying patterns among codes:

Codes 1, 5, 15, 11, 16, & 19: impasse

Codes 4, 9, 13, 14, 17, 20, 21: increased foster carers' competencies/increased care provided to young people

Codes 7, 8, 12, 13, 17, 21: significant attributes of adequate support, including consistent availability of support, and teamwork.

Candidate Categories and Subcategories:

- **Impact of (no) interventions:**
Subcategories: impasse; improved competencies; improved provision of care
- **Important qualities of provision:**
Subcategories: consistent availability; promoting unity

Appendix 5: Thematic Analysis

The process of analysing the data, which were gathered from the interviews, using Thematic Analysis followed a series of phases as recommended by Braun & Clarke (2006). These phases are described below:

Phase 1: *Familiarisation with the data.* The researcher's engagement with the data started by transcribing the interviews. Subsequently, a sense of the whole was obtained through listening to audio-recording and reading the entire transcripts with the aim of grasping the contextual details of the FCs' broader narratives. Initial ideas were noted during this process.

Phase 2: *Generating initial codes.* The author coded areas that discussed support by systematically identifying and highlighting interesting features, which were in turn labelled according to their content. Each extract was coded with as many codes as possible until a list of codes had been generated.

Phase 3: *Searching for themes.* The author identified patterns in the codes across the whole dataset and grouped them into potential themes via mind-map. Different combinations of codes derived through these patterns, which were subsequently arranged and re-arranged until candidate themes and their sub-themes had been devised.

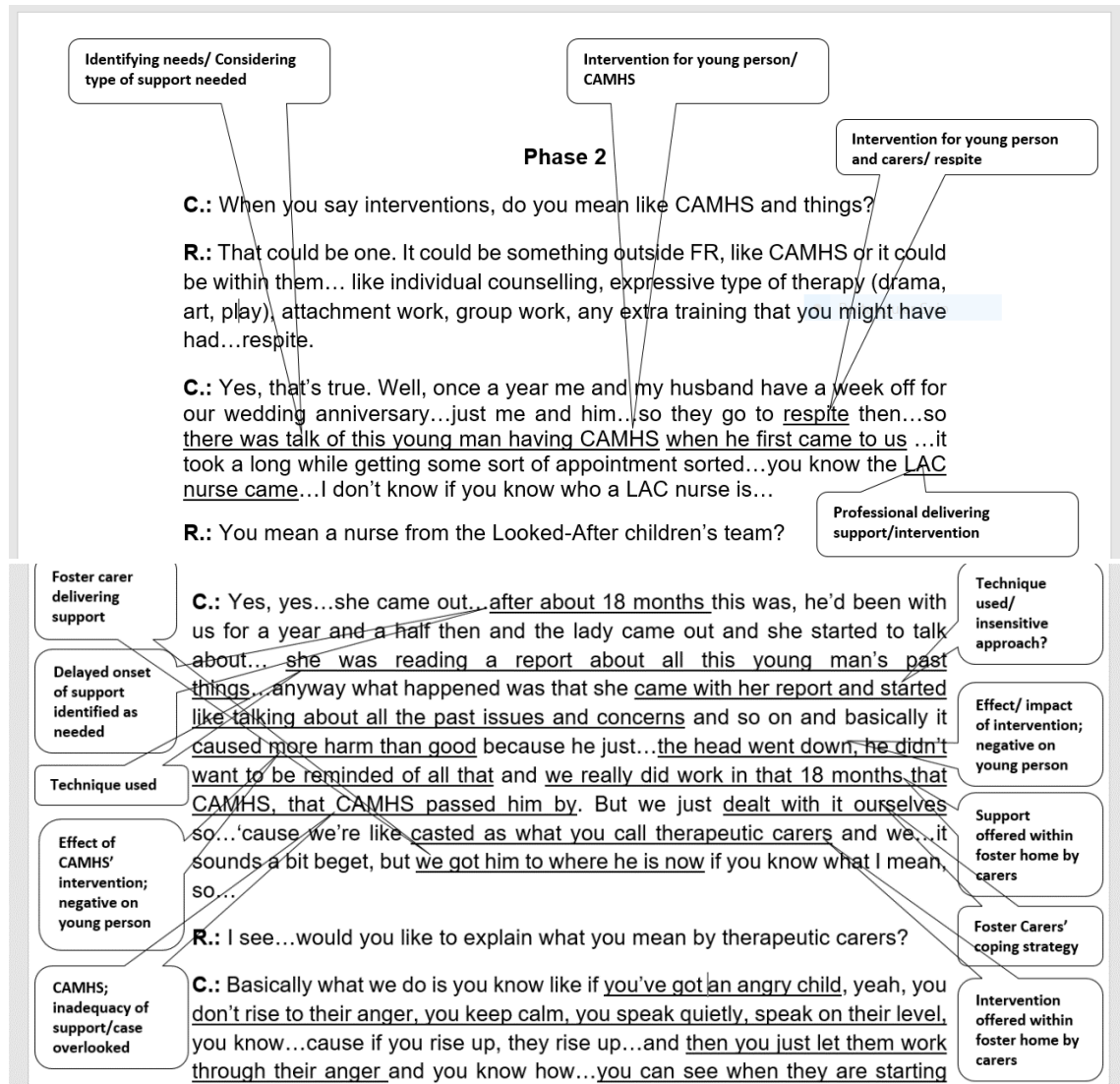
Phase 4: *Reviewing themes.* During this phase, the researcher refined identified themes following a recursive process; the coded data extracts were classified under themes and were then read together under each theme in order to determine whether they adequately and coherently captured data patterns, as well as to ascertain whether themes were sufficiently supported.

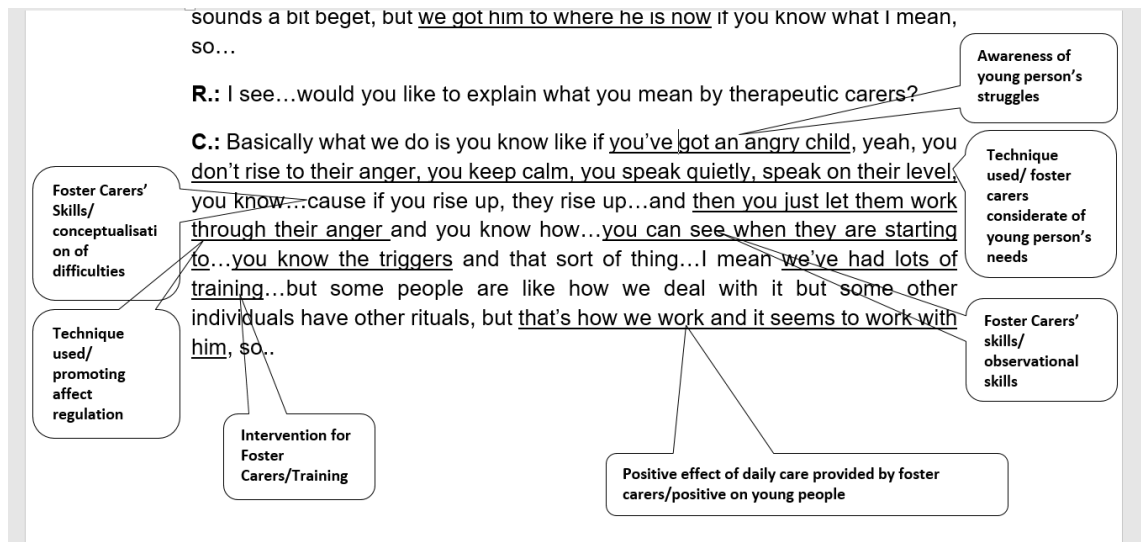
Following that process, the author re-read the interviews to determine whether themes reflected the data and captured an overall picture of meanings IFCs attributed both to the perceived and ideal support. At each stage the author discussed and refined overarching themes and sub-themes with the research supervisor and AFNCCF doctoral research team.

Phase 5: *Defining and naming themes.* This phase involved a detailed analysis that aimed at identifying the over-arching message for each individual theme in relation to the research aims; this was achieved by paying attention to nuances, while still highlighting the overall story that the combined themes could say about the data, providing a concise, coherent, logical, non-repetitive and interesting account of the story that data tell

Phase 6: *Producing the report.* In this phase clear definitions and names for each superordinate theme, as well as the subthemes, were set. A concise definition of each superordinate theme and subtheme, describing their content, was given. Sufficient evidence of the themes within the data was provided (i.e. enough data extracts to demonstrate the prevalence of the theme).

The screenshots below showcase an example of Phases 2, 3, and 4, which were followed during this analytic process. It wasn't possible to illustrate Phase 1 due to its nature of familiarising with the data, while Phases 5 and 6 were elaborated on in the core context of the empirical study under 2.3 Results Section (pages 79-83).





Phase 3

List of generated codes:

1. Intervention for young person and carers/respice
2. Intervention for young person/CAMHS
3. Identifying needs/Considering type of support needed
4. Professional delivering support/intervention
5. Delayed onset of support identified as needed
6. Technique used
7. Technique used/ insensitive approach?
8. Effect of CAMHS' intervention; negative on young person
9. Effect/ impact of intervention; negative on young person
10. Support offered within foster home by carers
11. CAMHS; inadequacy of support/case overlooked
12. Foster Carers' coping strategy
13. Intervention offered within foster home by carers
14. Foster carer delivering support
15. Awareness of young person's struggles
16. Technique used/foster carers considerate of young person's needs
17. Foster Carers' Skills/Conceptualisation of difficulties
18. Technique used/ promoting affect regulation
19. Foster Carers' Skills/Observational skills
20. Intervention for Foster Carers/Training
21. Positive effect of daily care provided by foster carers/positive on young person

Identifying patterns among the codes:

Identifying patterns among the codes:

Codes 5, 6, 7, & 11: unprofessionalism/ inconsistency, absence of reliability, technique not adapted to young person's need

Codes 8, 9, & 11: CAMHS' delivering ineffective intervention

Codes 12, 15, 16, 17, 18, & 19: impact of training on foster carers' skills and subsequently on parenting offered to young person in their care (i.e. observational skills; capacity to conceptualise difficulties)

Code 21: Foster carers delivering effective intervention

Candidate themes and subthemes

- Interventions important elements

Subthemes: consistency, reliability, adaptation to young people's needs

- Foster carers' role

Subthemes: intervention themselves; competent, able to conceptualise struggles

Phase 4

- Interventions important elements

Subthemes: consistency, reliability, adaptation to young people's needs

Review of codes included under this theme and subthemes:

Codes 5, 6, 7, 11, 15, 16, 17, 18, & 19

- Foster carers' central role

Subthemes: intervention themselves; competent, able to conceptualise struggles

Review of codes included under this theme and subthemes:

Codes 10, 12, 13, 14, & 21

Appendix 6: Five Rivers' Photo Project, 'The Masks We Wear'

The images used in this thesis to decorate the beginning of each chapter are photos taken during a short film, named 'The Masks We Wear', made by Five Rivers' Youth Council. You can read more about this project here:

[https://issuu.com/fiveriverschildcare/docs/the_masks_we_wear_for_issuu_2 -
_reformatted_final](https://issuu.com/fiveriverschildcare/docs/the_masks_we_wear_for_issuu_2_-_reformatted_final)